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Contents

Summary

On 30 June 2022, there were around 40,600 people in Australia's prisons. The number of people in Australia's prisons increased by 38% between 2012 and 2022, and the imprisonment rate over the same period rose from 167 people in prison per 100,000 adults in the general population to 201 per 100,000 adults. Most people in prison were either on remand (37%) or serving sentences under 5 years in length (57%), and thousands of people enter and exit the prison system each year (ABS 2023b).

Aboriginal and Torres Strait Islander people (referred to as First Nations people in this report) have a long history of, and continue to be, over-represented in Australia's prisons (ABS 2023a; Johnston 1991). First Nations people represent 32% of the prison population and only 3.2% of the Australian population (ABS 2023b).

People in prison have substantial and complex health needs, which are often chronic. They have higher rates of mental health conditions, chronic disease, communicable disease, acquired brain injury, tobacco smoking, high-risk alcohol consumption, recent illicit drug use, and recent injecting drug use than the general population (AIHW 2019). Improving the health of people in prison, and maintaining those improvements after they leave prison, benefits the entire community (Wallace and Wang 2020).

This report presents the results of the 6th National Prisoner Health Data Collection (NPHDC), conducted in 2022. Data were collected in 2-week periods, in all states and territories except Victoria, which did not participate. There were 371 prison entrants who volunteered to participate in a survey when entering prison during the 2-week data collection period; 431 prison dischargees volunteered to participate in a survey if scheduled for release during the 2-week data collection period or soon after. People in custody during the 2-week data collection period could participate if they visited a prison clinic.

Around 1 in 2 prison entrants reported a chronic physical health condition

Around a half (52%) of prison entrants said they had a history of at least one of the following chronic physical health conditions: arthritis, asthma, back problem, cancer, cardiovascular disease, kidney disease, diabetes, osteoporosis, or pulmonary disease. Asthma (27%) and back pain (27%) were the most common chronic physical health conditions reported. Almost two-thirds (61%) of female entrants had a history of a chronic condition compared with half (50%) of male entrants.

One in 2 prison entrants reported having been told they had a mental health condition, with almost 1 in 5 currently taking mental health related medication

More than a half of prison entrants (51%) reported a previous diagnosis of a mental health condition, including alcohol and other drug use disorders. Female entrants were more likely than male entrants to report:

- a history of a mental health condition (63% compared with 49%)
- currently taking medication for a mental health condition (28% compared with 19%).

Non-Indigenous prison entrants were more likely than First Nations entrants to report:

- a history of a mental health condition (60% compared with 43%)
- currently taking medication for a mental health condition (24% compared with 17%).

Around 1 in 5 prison entrants reported a history of self-harm

Just over 1 in 5 (21%) prison entrants reported a history of self-harm. Females entering prison (42%) were more than 2 times as likely as males (17%) to report a history of self-harm. More than 1 in 4 (29%) younger prison entrants (aged 18–24) reported a history of self-harm – higher than for any other age group.

Two-thirds of prison entrants reported they had previously been in prison

Most people (68%) entering prison reported they had been in prison before, and 2 in 5 (41%) prison entrants had been in prison within the previous 12 months.

Male entrants were more likely to have extensive prison histories than female entrants. About one-third (33%) of male entrants had been in prison 5 or more times compared with 15% of female entrants.

First Nations entrants were more likely than non-Indigenous entrants to have an extensive prison history. About 2 in 5 (39%) First Nations entrants had been in prison at least 5 times before compared with 22% of non-Indigenous entrants.

Around 2 in 5 younger prison entrants reported a family history of incarceration

One in 4 (25%) prison entrants reported that one or more parents or carers had been in prison when they were a child. This was more than twice as likely among First Nations entrants (36%) as among non-Indigenous entrants (15%).

Younger prison entrants (42% of those aged 18–24) were almost 3 times as likely as older entrants (16% of those aged 45 and over) to have had a parent or carer in prison during their childhood.

Around 2 in 5 prison entrants reported having dependent children in the community

Two in 5 (40%) prison entrants reported having one or more dependent children. Of those who had dependent children, 32% had one child and 68% had 2 or more children.

Male entrants (41%) were more likely to have dependent children than female entrants (33%). First Nations entrants (47%) were more likely than non-Indigenous entrants (34%) to have dependent children.

Nearly 1 in 3 prison entrants reported their highest level of schooling as year 9 or under

Prison entrants were asked about the highest level of schooling they had completed – nearly one-third (31%) said year 9 or under. About 1 in 2 (52%) First Nations entrants had completed year 10 and higher. Nearly 9 in 10 (86%) non-Indigenous entrants had completed year 10 and higher.

Nearly 1 in 2 prison dischargees expected they would be homeless on release

Almost a half (43%) of prison entrants said they were homeless in the 4 weeks before prison – 36% were in short-term or emergency accommodation and 10% in unconventional housing or sleeping rough.

Nearly a half (48%) of prison dischargees expected to be homeless on release from prison, with 45% planning to sleep in short-term or emergency accommodation and 2.8% planning to sleep rough.

Almost 1 in 3 prison entrants reported consuming at least 7 standard drinks of alcohol in a typical day of drinking

Almost one-third (31%) of prison entrants reported consuming 7 or more standard drinks of alcohol on a typical day of drinking in the last 12 months. First Nations entrants (39%) were more likely than non-Indigenous entrants (23%) to report consuming at least 7 standard drinks of alcohol on a typical day of drinking in the previous 12 months.

Almost 3 in 4 prison entrants reported being current smokers

Most (71%) prison entrants said they were current smokers. First Nations entrants (79%) were more likely than non-Indigenous entrants (64%) – and females (75%) were more likely than males (70%) – to be current smokers. Almost 1 in 2 (48%) entrants who were current smokers said that they would like to quit.

Almost 3 in 4 prison entrants reported using illicit drugs in the previous year

Almost three-quarters (73%) of prison entrants reported using illicit drugs at least once during the previous 12 months. Entrants aged 25–34 were the most likely to report recent illicit drug use (82%) while those aged 45 and over were the least likely (56%). Cannabis was the most common illicit drug used, followed by methamphetamine.

Almost 2 in 5 (37%) prison dischargees reported using illicit drugs in prison, and 1 in 7 (14%) said they had injected drugs in prison.

See '*The health of people in Australia's prisons 2022: At a glance*' infographic for a visual summary of the key report findings.

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Introduction

People in prison are among the most vulnerable groups in society. They are more likely to have been homeless and unemployed than people in the general community and often come from socioeconomically disadvantaged backgrounds (AIHW 2019).

People in contact with the criminal justice system have higher levels of mental health conditions, at-risk alcohol consumption, tobacco smoking, illicit drug use, chronic disease and communicable disease than the general population (AIHW 2019). This means that people in prison often have complex, long-term health needs. The health of people in prison is so much poorer than that of the general population, such that people in prison are often considered to be elderly at ages 45–55 (compared with at age 65 and over in the general community) (Baidawi 2011; Stojkovic 2007; Williams et al. 2014).

Why is the health of people in prison important?

A large proportion of prison stays are temporary. On 30 June 2022, just over one-third (37%, or 14,900) of the 40,600 people in prison in Australia were on remand while awaiting trial or sentencing. The median time those who were sentenced could expect to serve was 2.2 years (ABS 2023b). This means that people are constantly entering and being released from prison. Once released from prison, most people return to live in the community. With more than 62,000 receptions into and releases out of prison each year, the health of people in prison is a part of public health (ABS 2023a).

National and international standards guide the provision of health care to people in prison. In May 2015, the United Nations Commission on Crime Prevention and Criminal Justice adopted updated standard minimum rules on the treatment of people in prison, known as the 'Mandela Rules' (United Nations 2015). This update of the original 1955 rules detailed the provision of health care to people in prison, and included:

- principles of equivalence (to the community standard)
- independence
- multidisciplinary care (including psychological and psychiatric care)
- dental care
- continuity of care into the community on release (United Nations 2015).

In Australia, the Corrective Services Administrators' Council published revised *Guiding Principles for Corrections in Australia - Revised 2018* (CSAC 2018). These guidelines specifically reference health-care provision in prisons, including:

- equivalence of care for physical and mental health
- access to primary and specialist health professionals
- assessment on entry to identify needs for, and access to, health and disability services
- continuity of care between prison and the community (CSAC 2018).

How many people are in prison in Australia?

The number of people in Australia's prisons grew from almost 29,400 in 2012 to around 40,600 in 2022 – an increase of around 38% (ABS 2023b). The general Australian population increased by 15% over the same period (ABS 2022a). The imprisonment rate of people in

Australia per 100,000 adults in the general population rose from 167 on 30 June 2012 to 201 on 30 June 2022 (Figure 1.1) (ABS 2023b).

Figure 1.1: Number of people in prison and imprisonment rate in Australia, by year, 2012–22

Note: The imprisonment rate is the number of people in prison per 100,000 adults, aged 18 and above, in Australia.

Source: ABS 2023b, Table 2.

Many people enter and leave prison each year. People in prison may be either sentenced or unsentenced (on remand) while awaiting trial and sentencing.

In 2022, the imprisonment rate of males was 379 per 100,000 males in the general Australian adult population. The imprisonment rate of females was 29 per 100,000 females in the general Australian adult population (ABS 2023b).

Aboriginal and Torres Strait Islander (referred to as First Nations in this report) males were imprisoned at a rate of 4,303 per 100,000 males in the First Nations adult population, 16 times the rate of non-Indigenous males in Australia. First Nations females were imprisoned at a rate of 412 per 100,000 females in the First Nations adult population, 23 times the rate of non-Indigenous females in the Australian adult population (ABS 2023b). First Nations people account for 3.2% of the Australian population but for 32% of Australia's incarcerated population (ABS 2022b, 2023b).

It is important to understand how the past shapes the lives of First Nations people today: they have a long history of trauma, cultural dispossession, and forced displacement and assimilation, which affects their physical, mental and social wellbeing.

Disconnection from family and kinship systems, from Country, from spirituality and cultural practices – as well as the loss of parenting practices – are sources of trauma that can be passed from caregiver to child. First Nations Australians' experience of child welfare policies has historically been traumatic, with the policy of forcible removal of children leading to what is now known as the Stolen Generations. These removal policies have long-term consequences, including enduring social, physical and psychological impacts for those directly involved and their families and communities. The over-representation of First Nations people in prisons reflects this history of trauma and the stressors that have affected these people's parents, families and communities.

How are health services in prison delivered?

In Australia, there are several differences in the delivery of health services to people in prison compared with the general community, including funding arrangements and models of service delivery.

In the community, health services are provided by both the Australian Government and the relevant state or territory government department. Health services for people in prison are the sole responsibility of state and territory governments, and the way in which these services are delivered varies among jurisdictions.

In some jurisdictions, the state or territory health department provides prison health services; in others, the provision of health services is the responsibility of the justice or corrections department.

Most jurisdictions use a mix of directly provided services, community health services and contracted health services. Providing mental health services and alcohol and other drug services can be particularly complex, both in terms of the services delivered and the method of delivery.

In prisons, nurses usually provide primary health care (or the first level of contact with the health-care system). In the general community, general practitioners provide most of the primary health care.

Specialist medical care can be provided to people in the prison system, or through services that are not prison based – such as general hospital inpatient and emergency care services – depending on the prison, jurisdiction and service required. For example, some prison clinics deliver dental services and perform x-rays, whereas other smaller prison clinics are staffed by a single nurse only.

The Medicare Benefits Schedule (Medicare) gives residents of Australia access to no-cost or subsidised health care, including no-cost or low-cost treatment and accommodation in public hospitals. Medicare is funded by the Australian Government and does not apply to services provided directly by state and territory governments. This means that prison health services are not provided under the Medicare system (Cumming et al. 2018). The Pharmaceutical Benefits Scheme (PBS), which provides access to medicines at lower cost for Australian residents, is also funded by the Australian Government. Medications dispensed to people in prison are not covered, except for medications that fall under Schedule 100 of the PBS, known as the Highly Specialised Drugs Program.

For people who underuse health services in the general community, prison can provide an opportunity to access treatment to improve their health. Many types of health care are accessed less often in the community than in prison (see ‘Health services’) for various reasons, including cost, work or family commitments, and alcohol or other drug issues (see ‘Health risk behaviours’). The stability of the prison environment may provide opportunities for people to reflect on, and seek treatment for, their health concerns.

The Royal Commission into Aboriginal Deaths In Custody included recommendations for Aboriginal health services to be included in providing mental and physical health care for First Nations people in custody (Johnson 1991). A small number of prisons currently have Aboriginal Community Controlled Health Organisations (ACCHOs) visiting to assist with the delivery of health care. However, ACCHOs can be subject to funding shortages and are often over-stretched to deliver services to people in their communities (Moran et al. 2014; NACCHO n.d; Pettit et al. 2019) which can limit their capacity to reach people in prisons. There is no nationally coordinated approach or body whose role is to assess the specific

health needs of First Nations people in prison (Pettit et al. 2019) – and funding for ACCHOs to visit prisons is the responsibility of state and territory governments.

Objective 3.2 of the *National Aboriginal and Torres Strait Islander Health Plan 2021–31* outlines that health-care providers must have cultural safety values, behaviours and standards embedded in the workplace culture (Department of Health 2021).

Providing and operating health services in a prison environment is not always straightforward. Delivery of services to people in prison can be affected by:

- regimes and processes in the prison environment that make continuity of care between the community and prison difficult
- delays in establishing communication with the community-based doctor of a person in prison, or to confirm existing prescriptions, leading to disruptions to regular medications or to self-medication practices, and leaving prison entrants at increased risk of mental health instability during a particularly difficult time (Bowen et al. 2009)
- uncertainty about exact discharge dates, often affected by bail and parole applications, which makes continuity of care from prison to the community difficult.

The prison population in Australia is increasing, both in overall numbers and in the rate of imprisonment. As a result, prisons in some states and territories exceed 100% prison design capacity. Prison design capacity utilisation is reported in the *Report on Government Services* (Productivity Commission 2023). If prisons are operating above capacity, overcrowding can create issues for maintaining a safe and healthy environment; one strategy used to manage this is to move people between prisons. This can, however, make it difficult for health-care providers in prison to maintain continuity of health care (Grace et al. 2013).

What is the National Prisoner Health Data Collection?

This report presents the results of the *Sixth National Prisoner Health Data Collection* (NPHDC). The NPHDC is the main source of national data about the health of people in Australia's prisons. It presents information on the health experiences of people throughout the whole prison cycle – from entry to time spent in prison, through to discharge – and includes:

- information on the operation of prison health clinics, the conditions and problems they manage, and the medications dispensed
- self-reported information from people as they enter and exit the prison system – (known as prison entrants and prison dischargees in this report)
- summary information, recorded by the prisons.

The NPHDC reports on a set of 94 indicators that provide information on the health and wellbeing of Australia's prison population. See Appendix A for an overview of the *National Prisoner Health Data Indicator Framework* and indicator map.

How is the information collected?

The main data source for this report is the 2022 NPHDC. Data for the NPHDC were collected in 2-week periods in all states and territories except Victoria, which did not participate.

Most data in the NPHDC is self-reported. The NPHDC consists of 5 forms, each collecting different information:

- The Entrants form – completed by a health professional or researcher for people entering prison (or completing quarantine) during the data collection who consented to participate. It included questions on the demographics of prison entrants; mental health; chronic diseases; disability; tobacco, alcohol and other drug use; and health service use.
- The Dischargees form – completed by a health professional or researcher for people in prison scheduled to be released during, or within 4 weeks, of the data collection period who consented to participate. It included questions about demographics; mental health; chronic diseases; tobacco, alcohol and other drug use; use of prison health services; injuries in prison; and preparation for release.
- The Clinic form – completed by a health professional for people in custody who visited the prison clinic during the data collection period and consented to participate. It included questions about demographics, who initiated the visit, the problems managed at the visit, and the type of health professional consulted.
- The Medications form – completed by a health professional on a single day during the data collection period for people in custody who were dispensed prescription medications. It included questions on the demographics of the individual, and medication types dispensed.
- The Establishment form – completed once for each prison clinic. It included questions about whether health services were provided by ACCHOs or Aboriginal Medical Services, and questions about discharge planning, immunisation, full-time-equivalent staffing, pregnant females in prison, and hospital transfers.

These forms were completed either electronically via an online survey or on paper forms.

While the data collected from the forms were comprehensive, additional sources of data were used in this report to provide greater detail, contextualise findings and to ensure denominators were appropriate. These data sources included:

- the Australian Institute of Criminology's Deaths in Custody Monitoring Program reports (McAlister and Bricknell 2022), which provided data on deaths in prison
- the Department of Social Services, which provided data on deaths following release from prison
- the Australian Bureau of Statistics (ABS), which provided the denominator (the number of people in prisons included in the 2022 NPHDC as at 30 June 2022) for the indicators sourced from the Clinic and Medications forms.

More information about data sources and denominators can be found in Appendix B.

How many prisons and people took part?

The NPHDC collected data from 73 prisons in participating states and territories in Australia (excluding Victoria). These included 72 public prisons run by the state or territory governments and 1 private prison run by an independent provider.

Periodic detention centres and court cells administered by corrective services, youth detention centres, immigration detention centres and secure psychiatric facilities were excluded.

Prison entrants, prison dischargees and people in custody visiting the prison clinic were invited to participate in the data collection. They could choose not to participate without consequence. A prison clinic visit was defined as any consultation for which an entry was made in the health service record. The clinic services provided varied between prisons and between states and territories, so not all health services reported on were available at every

site. Data for prison entrants, prison dischargees and people in custody visiting the prison clinic were collected over a 2-week period. Data for medications dispensed to prisoners were collected on one day only.

Prison entrants and dischargees throughout this report

Prison entrants and prison dischargees in this data collection were different groups of people. The surveys of these 2 different groups were administered during the same 2-week data collection period in 2022.

Entrants forms were completed by 371 of the 2,082 (18%) people who entered prison during the data collection period. Over the same period, 431 of the 1,854 (23%) people discharged from prison completed Dischargees forms.

Total entrant and dischargee numbers over the data collection period are sourced from the Establishment form. All participating prisons, except one, completed an Establishment form.

Anecdotal feedback from people in prisons suggests that some of the clinic and medications data were not captured for a number of reasons, including (for example) staffing constraints that affected data collection or obtaining participant consent.

How are people in prison defined in the data collection?

People in prison were defined as adults, aged 18 or over, who were held in custody and whose confinement was the responsibility of a correctional facility. This definition included sentenced people in prison and those held in custody awaiting trial or sentencing (remandees).

Youth offenders, people in psychiatric custody, police cell detainees, people held in immigration detention centres, or Australians held in overseas prisons, were not included.

People aged at least 18, held in full-time custody in correctional facilities in Australia were in scope for the clinic and medication components of the NPHDC.

Who is a prison entrant?

A prison entrant is a person aged at least 18 and entering full-time custody, either on remand or on a sentence. People currently in prison who were transferring from one prison to another were not included as prison entrants.

Who is a prison dischargee?

A prison dischargee is a person aged at least 18, who is expected to be released from custody during, or within 4 weeks, of the data collection period. People being transferred from one facility to another were not included as prison dischargees.

Profile of prison entrants

The majority (84%) of the 371 prison entrants in the 2022 data collection were males. One entrant (0.3%) identified as transgender.

The median age of prison entrants was 35; the youngest person was 18 and the oldest was 68.

- 7 in 10 (70%) entrants were on remand, awaiting trial or sentencing.
- 19% had been in youth detention previously and 69% had been in prison before, including 41% in the last 12 months.
- A large proportion (49%) of prison entrants identified as First Nations Australians (Table 1.1).

Table 1.1: Prison entrants, self-reported characteristics, by state and territory, 2022

Jurisdiction	Prison entrants (number)	Male (%)	First Nations (%)	Median age (years)	Age range (years)
NSW	160	81	39	34.5	18–68
Qld	70	93	30	36	23–63
WA	30	80	73	36	18–68
SA	33	64	49	38	19–62
Tas	6	100	50	31.5	25–42
ACT	10	90	30	41.5	31–60
NT	62	92	90	33	19–60
Total	**371**	**84**	**49**	**35**	**18–68**

Notes

1. Numbers are representative of this data collection only and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.
3. State and territory data should be interpreted with caution due to low response rates for entrants and dischargees in some jurisdictions.

Source: Entrants form, 2022 NPHDC.

Profile of prison dischargees

Most (85%) of the 431 prison dischargees in the data collection were males. Two dischargees (0.5%) identified as transgender.

The median age of dischargees was 35; the youngest was 18 and the oldest was 88 (Table 1.2). Nationally, about 1 in 5 (21%) dischargees reported being in prison for less than 3 months, and about 1 in 8 (13%) for 2 years or more. A large proportion (46%) of prison dischargees identified as First Nations Australians (Table 1.2).

Table 1.2: Prison dischargees, self-reported characteristics, by state and territory, 2022

Jurisdiction	Prison dischargees (number)	Male (%)	First Nations (%)	Median age (years)	Age range (years)
NSW	226	86	36	35	18–83
Qld	19	95	37	32	21–53
WA	50	88	66	37	19–68
SA	50	72	34	36	18–88
Tas	10	80	20	39	25–59
ACT	8	88	0	33	25–45
NT	68	84	88	32	20–59
Total	**431**	**85**	**46**	**35**	**18–88**

Notes

1. Numbers are representative of this data collection only and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.
3. State and territory data should be interpreted with caution due to low response rates for entrants and dischargees in some jurisdictions.

Source: Dischargees form, 2022 NPHDC.

What are the limitations of the data?

The NPHDC was designed as a census, capturing data on the population of interest at a given point in time. However, numbers in this report represent a sample in this data collection, and not the entire prison population. Not all people in prison (particularly prison entrants and dischargees) could be asked to be involved in the data collection. This might be due to prison staffing constraints, physical or mental limitations of people, or uncertain release dates. Of those who could be approached, some did not provide consent to participate. As a result, the NPHDC sample is not necessarily representative of the total prison population. No significance testing was undertaken during data analysis.

The majority of the data collected for the Prison entrants and Prison dischargees forms were self-reported; that is, participants (prison entrants or prison dischargees) answered the survey questions administered by health professionals or researchers. This is a simple and efficient method of collecting data, which provides the direct perspective of the person being interviewed.

Logistical advantages of this method are that interviewers do not need specialised training, and that it is generally quicker than diagnostic interviewing (for health conditions).

The main disadvantage of self-reported data is that there are few ways to validate the responses beyond excluding those where the answers given were impossible, such as where a form might have the participant's age recorded as 1,000. Self-reported data may be compared with other self-reported data (provided where possible throughout this report) but are not directly comparable with data in reports and studies that use other data collection methods.

Comparisons are made between the health of people in prison and those in the general community where data were available. However, the data are not directly comparable due to

different survey sampling techniques (random versus non-random samples) and substantial differences in the demographic profile of people in prison and of those in the general community. Comparisons are included to provide additional context and are made by sex, Indigenous identity, or age group (where possible) to help reduce the likelihood that differences were due to demographic factors rather than being true differences between people in prison and in the general population. No significance testing has been conducted on any comparisons presented.

This report does not make comparisons with data in previous reports on *The health of Australia's prisoners* due to changes to questions and/or response categories over time. Data in the NPHDC are not from a random sample so the coherence of the data across survey cycles is difficult to assess and biases may be present due to sampling error.

A future aim of the NPHDC is to collect much of the data through by-products of jurisdictional administrative systems, rather than as the current entirely separate data collection. This would allow for a much larger and more representative sample, expanding the options for data analysis, and improving the validity and reliability of the collection. But there is substantial complexity involved in adapting the data requirements of the NPHDC to the different administrative data systems in each jurisdiction.

Further information on data collection methods and limitations is available in the Data Quality Statement.

Impact of COVID-19 in the prison setting

From March 2020, a range of measures were introduced in adult prisons to reduce the impact of COVID-19, including vaccinations, social distancing, virtual visits, and the use of personal protective equipment such as face masks.

People in prison are known to have a high vulnerability to infectious diseases due to the living conditions within prison (Ndeffo-Mbah et al. 2018) and, as such, COVID-19 poses a serious risk to the physical health of this population. Measures introduced to reduce the spread of COVID-19 are also likely to have had an impact on the mental, emotional and social wellbeing of a person in prison (Department of Health 2022).

However, there are currently limited data available to understand the extent to which COVID-19 has had an impact on the health and wellbeing of people in Australia's prisons.

For more information on current COVID-19 measures and reported COVID-19 cases within prisons in each state and territory, see:

- Corrective Services New South Wales
- Corrections Victoria
- Queensland Corrective Services
- Western Australia Corrective Services
- South Australia Department for Correctional Services
- Tasmania Prison Service
- Australian Capital Territory Corrective Services
- Northern Territory Correctional Services.

What ethical and privacy processes are followed?

The AIHW Ethics Committee is required to advise on the ethical acceptability of AIHW activities involving information that can potentially identify a person. The committee has been actively involved with the NPHDC since its inception.

The AIHW operates under a strict privacy regime based on section 29 of the *Australian Institute of Health and Welfare Act 1987* and the *Privacy Act 1988*.

The AIHW Ethics Committee oversees the appropriate management of participant consent and risks for potential harm, as well as respectful First Nations research.

The AIHW has a range of policies, protocols and processes in place to manage confidentiality and reliability, including how data should be reported to ensure confidentiality.

The AIHW Ethics Committee gave initial ethics approval for the NPHDC project on 4 March 2008. Amendments and/or new ethics applications are submitted each survey cycle to this committee, as well as to ethics committees in states and territories, as required.

Ethics applications are also submitted to ethics committees who have an interest in ensuring research has a positive impact for First Nations people, as required.

The following committees granted additional ethics approval:

- NSW Justice Health and Forensic Mental Health Network Human Research Ethics Committee (HREC)
- NSW Aboriginal Health and Medical Research Council HREC
- Corrective Services NSW HREC
- NT Health and Menzies School of Health Research HREC
- WA Research Application and Advisory Committee
- Australian Institute of Aboriginal and Torres Strait Islander Studies HREC.

The AIHW manages First Nations data and research in accordance with human research ethics obligations. A Deputy Secretaries Data Group Sub-committee is also overseeing the development of a Framework for the Governance of Indigenous Data. The framework is being developed in partnership with First Nations representatives. Once the framework is available, the AIHW will work to implement processes that align with its intent.

For more information on the AIHW's ethics, privacy and confidential practices, see its Privacy web page.

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Physical health status

Physical health relates to the functioning of the physical body. Some physical health factors are beyond the control of an individual, such as age, sex and genetic make-up; others relate to lifestyle, diet and physical activities (ABS 2001, AIHW 2021).

People's lifestyles, diets and physical activity patterns change once they enter prison, and this can lead to changes that influence health. Engaging in physical activity can improve physical health through reducing the risk of developing heart disease, stroke, chronic health conditions, some cancers and depression (Warburton et al. 2006; WHO 2022). The nutritional value of a diet can also have an impact on physical health and strength as well as on weight (Hannan-Jones and Capra 2016). There are also mental, emotional and social benefits to physical wellbeing (Eime et al. 2013).

This section presents data from the NPHDC on self-assessed physical health, physical activity and weight changes in custody, as well as on incidents of physical and sexual assaults in custody which can harm physical and mental health.

Self-assessed physical health

Prison entrants and prison dischargees were asked to rate their current physical health; as well, prison dischargees were asked how their physical health had changed during their time in prison.

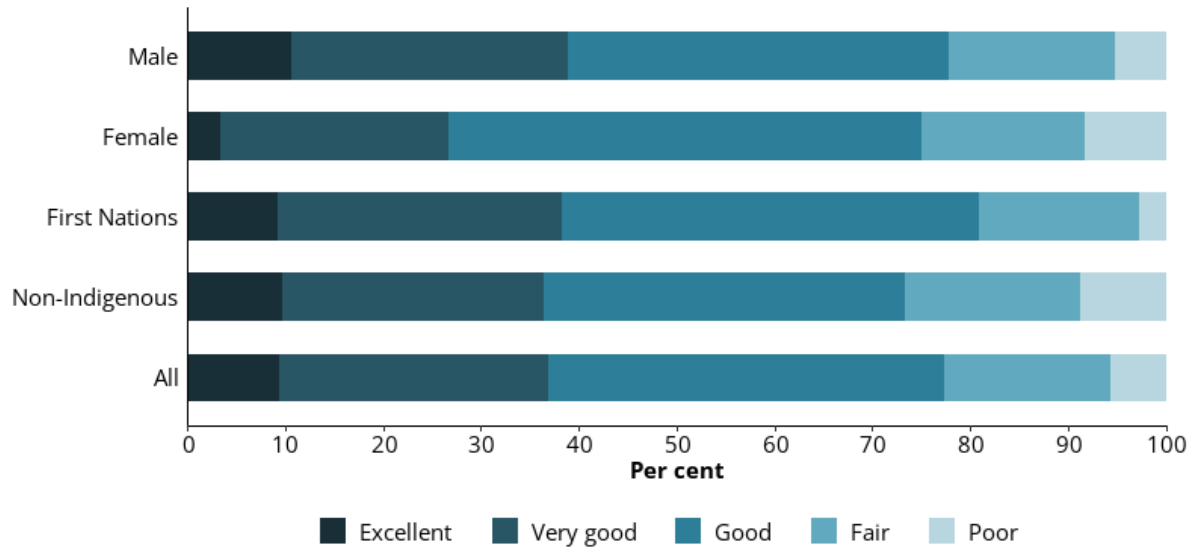
Self-assessed physical health of prison entrants

More than 3 in 4 (77%) prison entrants rated their physical health as good, very good or excellent (Indicator 1.1.1).

Almost one-quarter (23%) of prison entrants rated their physical health as fair or poor (Figure 2.1). Female entrants (25%) were similar to male entrants (22%) in rating their physical health as fair or poor.

First Nations entrants (38%) were similarly as likely as non-Indigenous entrants (36%) to rate their health as very good or excellent.

Figure 2.1: Prison entrants, self-assessed physical health status, by sex and Indigenous identity, 2022



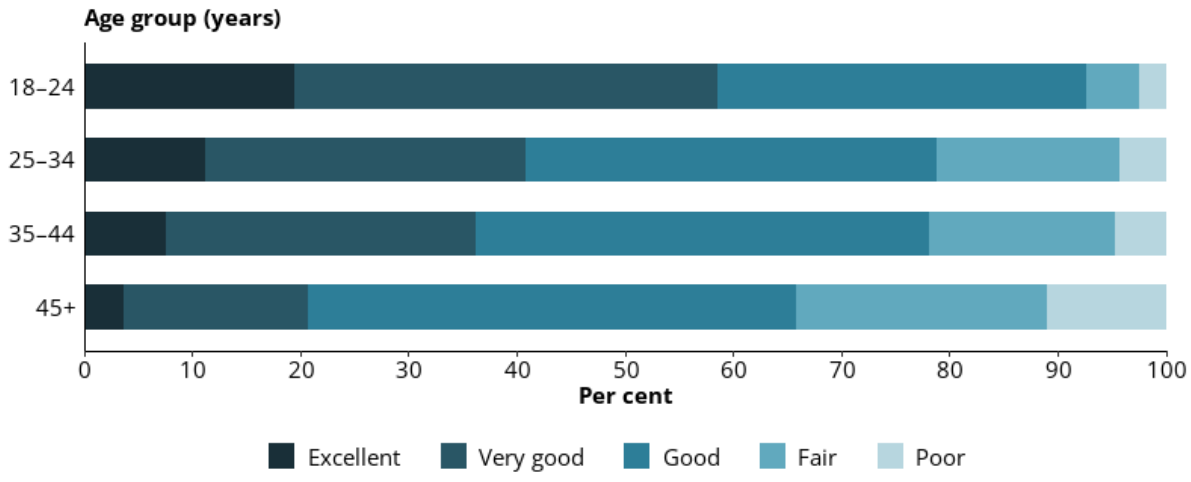
Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Self-assessed physical health rates differed by age (Figure 2.2). More than 1 in 3 (34%) prison entrants aged 45 and over rated their physical health as fair or poor compared with about 1 in 5 (19%) entrants aged under 45.

Figure 2.2: Prison entrants, self-assessed physical health status, by age, 2022



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Source: Entrants form, 2022 NPHDC.

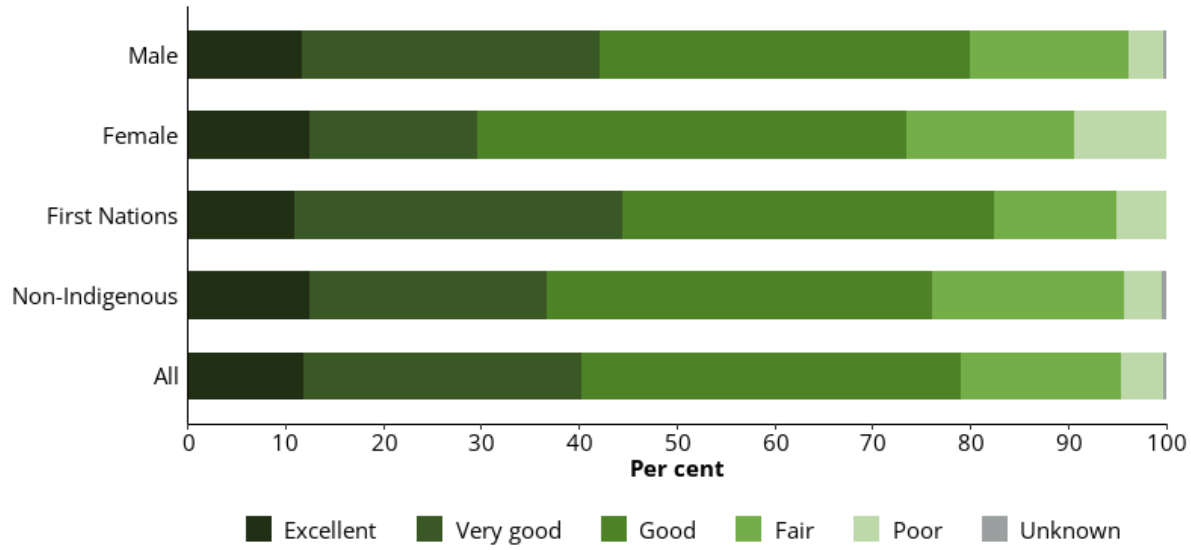
Self-assessed physical health of prison dischargees

Almost 8 in 10 (79%) prison dischargees rated their physical health as good, very good or excellent (Indicator 1.1.2).

About 1 in 5 (21%) prison dischargees rated their physical health as fair or poor. Female dischargees (27%) were more likely than male dischargees (20%) to rate their physical health as fair or poor (Figure 2.3).

First Nations dischargees were more likely to rate their physical health as very good or excellent (45%) than non-Indigenous dischargees (37%) (Figure 2.3).

Figure 2.3: Prison dischargees, self-assessed physical health status, by sex and Indigenous identity, 2022



Notes

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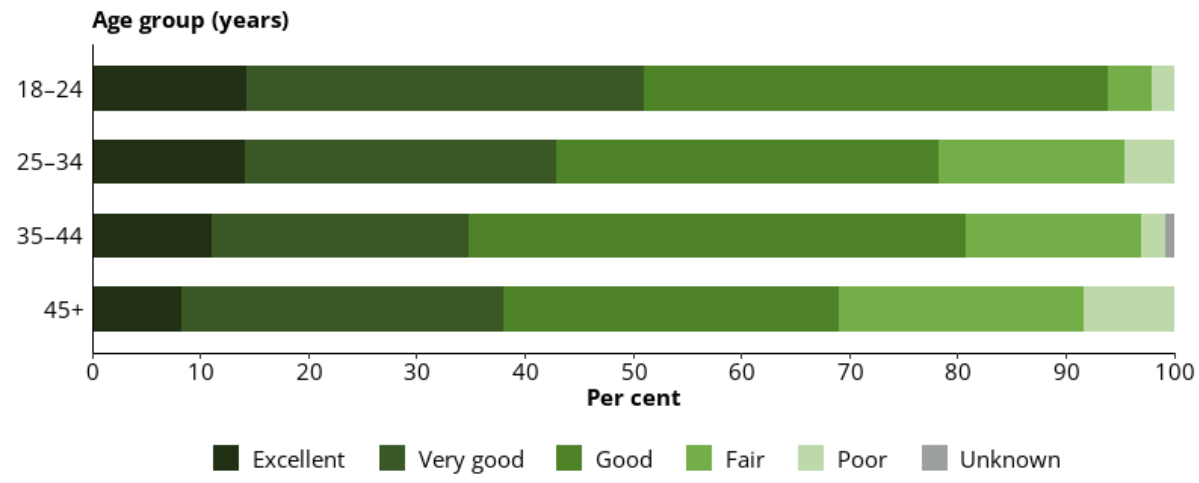
Source: Dischargees form, 2022 NPHDC.

Self-assessed physical health ratings also differed by age. Of prison dischargees aged 45 and over, 31% rated their physical health as fair or poor compared with 6.1% of those aged 18–24.

In every age group, except those aged 25–34 and 45 and over, prison dischargees were more likely than prison entrants to rate their health as good, very good or excellent (figures 2.2 and 2.4).

Figure 2.4: Prison dischargees, self-assessed physical health status, by age, 2022



Notes

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Source: Dischargees form, 2022 NPHDC.

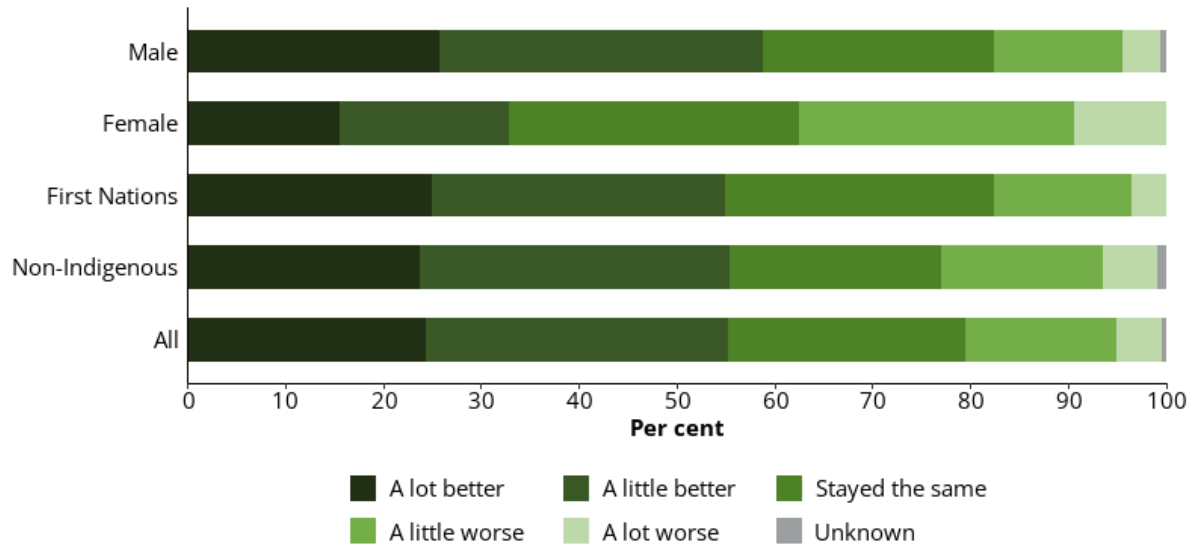
As well as rating their current physical health, prison dischargees were asked if it had changed since entering prison. Almost 4 in 5 (80%) reported that their physical health had improved or stayed the same while in prison.

One in 5 (20%) prison dischargees reported that their physical health had worsened during incarceration (Figure 2.5).

Females (33%) were less likely than males (59%) to report improved physical health and were more likely than males to report that it had worsened during their time in prison – 38% of female prison dischargees and 17% of male prison dischargees said it had worsened.

Just over a half (55%) of First Nations and non-Indigenous dischargees reported that their physical health had improved. First Nations dischargees (18%) were fairly similarly as likely to report that it had worsened during incarceration as non-Indigenous dischargees (22%).

Figure 2.5: Prison dischargees, self-assessed change in physical health status in prison, by sex and Indigenous identity, 2022



Notes

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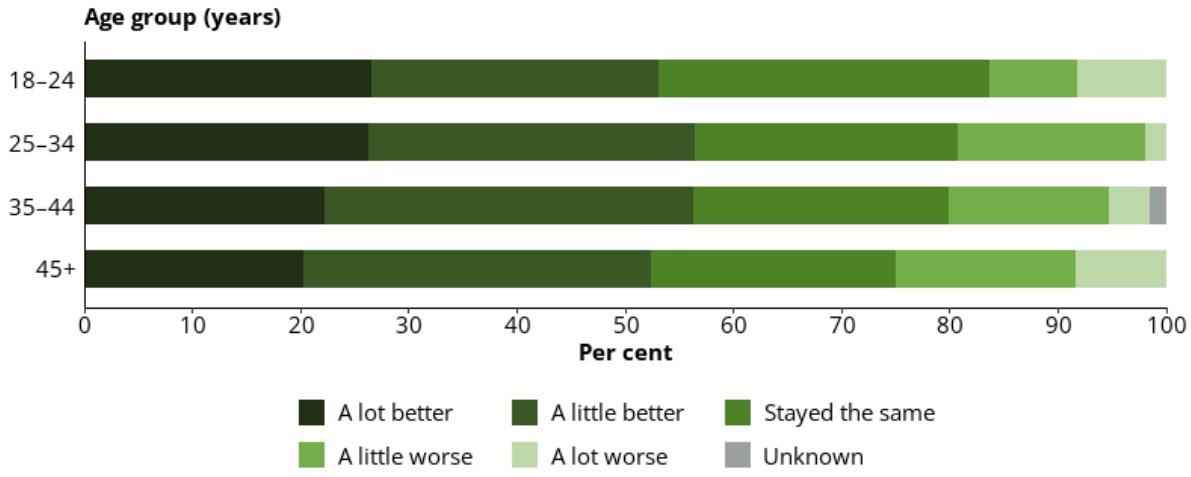
Source: Dischargees form, 2022 NPHDC.

Around one-quarter of prison dischargees aged 18–24 (27%) and 25–34 (26%) reported that their health had improved a lot during incarceration (Figure 2.6). However, the proportions of those reporting that their health worsened during incarceration increased with age, from 16% of those aged 18–24 to 25% of those aged 45 and over.

Figure 2.6: Prison dischargees, self-assessed change in physical health status in prison, by age, 2022



Notes

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Source: Dischargees form, 2022 NPHDC.

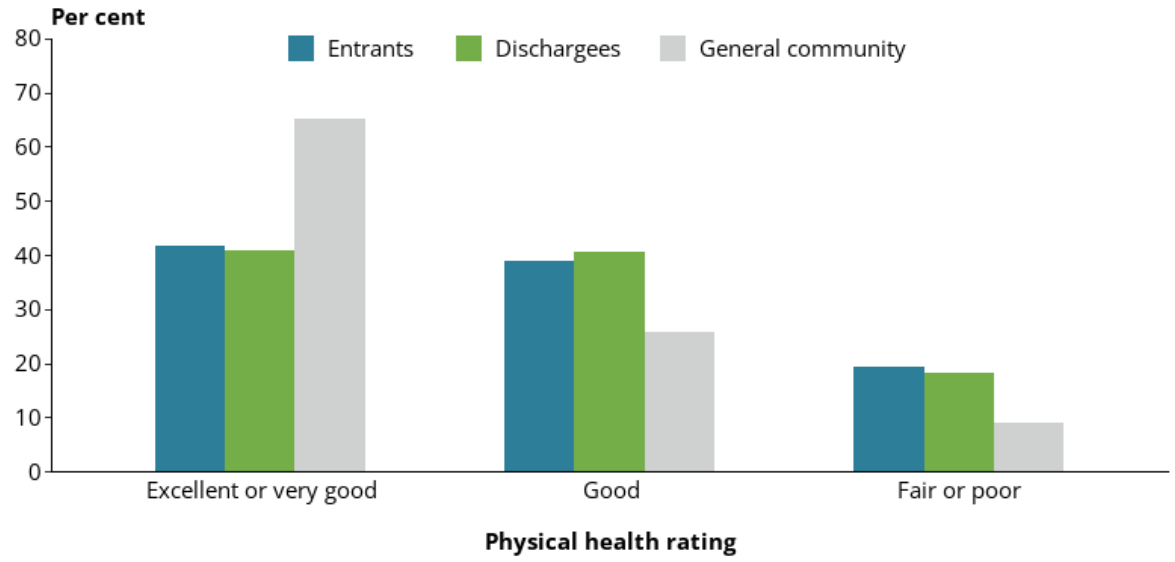
Self-assessed physical health comparisons with the general community

The ABS *National Health Survey* collected self-reported data from the general Australian community in 2020–21 (ABS 2022), including a question to rate their health.

In the NPHDC surveys, participants were asked to rate their physical health so any comparisons must be made with caution. As well, the general Australian community has an older age structure than the prison population, making overall comparisons difficult.

Adults aged 18–44 in the general community (65%) were about 1.5 times more likely than prison entrants (42%) and prison dischargees (41%) of the same age to rate their health as very good or excellent (Figure 2.7). Prison entrants (19%) and prison dischargees (18%) aged 18–44 were about twice as likely to rate their physical health as fair or poor as people of the same age in the general community (9.1%).

Figure 2.7: Prison entrants, prison dischargees and the general community (2020–21) aged 18–44, self-assessed health status, 2022



Notes

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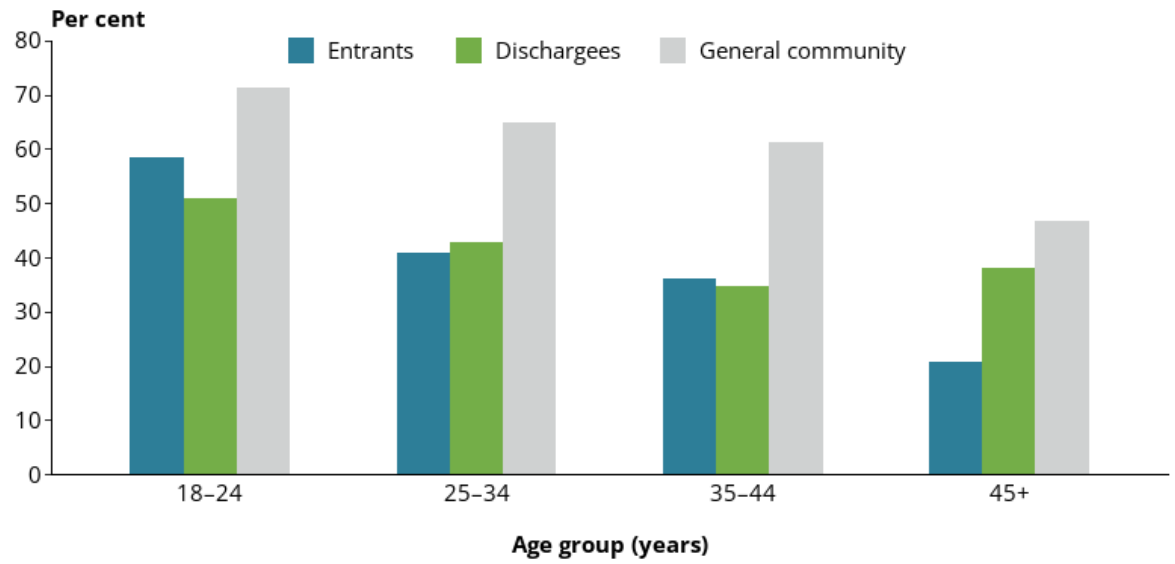
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants and dischargees forms, 2022 NPHDC; AIHW calculations of data in ABS 2022, Table 1.3.

In both the general community and the prison population, the proportion of people who rated their health as very good or excellent declined with age (Figure 2.8). But prison entrants and prison dischargees started to rate their health less positively at younger ages than those in the general community.

This is consistent with literature that shows ‘accelerated ageing’ in prison (Baidawi et al. 2011) as prisoners’ self-reported health was the equivalent of someone in the general population who was up to 40 years older. For example, 36% of prison entrants aged 35–44 rated their health as excellent or very good while 32% of those in the community aged 75 and over rated their health as excellent or very good (ABS 2022). This pattern was particularly noticeable among people entering prison.

Figure 2.8: Prison entrants, prison dischargees and the general community (2020–21), self-assessed physical health status of very good or excellent, by age, 2022



Notes

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Source: Entrants and dischargees forms, 2022 NPHDC; AIHW calculations of data in ABS 2022, Table 1.3.

Activity and weight changes

Physical activity and body weight are 2 major indicators associated with health outcomes (AIHW 2021). The Australian guidelines for weekly physical activity suggest adults aged 18– 64 should engage in either:

- 1.25–2.5 hours of vigorous intensity activity per week
- 2.5–5 hours of moderate intensity activity per week (Department of Health 2021).

Some people are underweight when they enter prison and intend to increase their body weight and/or muscle mass in prison to improve their health. For some people, weight changes occur as a result of regular scheduled meals, which they may not consume in the community. As well, prison can offer people the opportunity to improve their physical fitness if they have access to gym equipment and time to increase their level of physical activity.

Prison dischargees were asked about their level of physical activity during their time in prison. They were also asked whether their weight had changed, and whether they were intentionally trying to gain weight in prison.

Prison dischargees activity and weight changes in custody

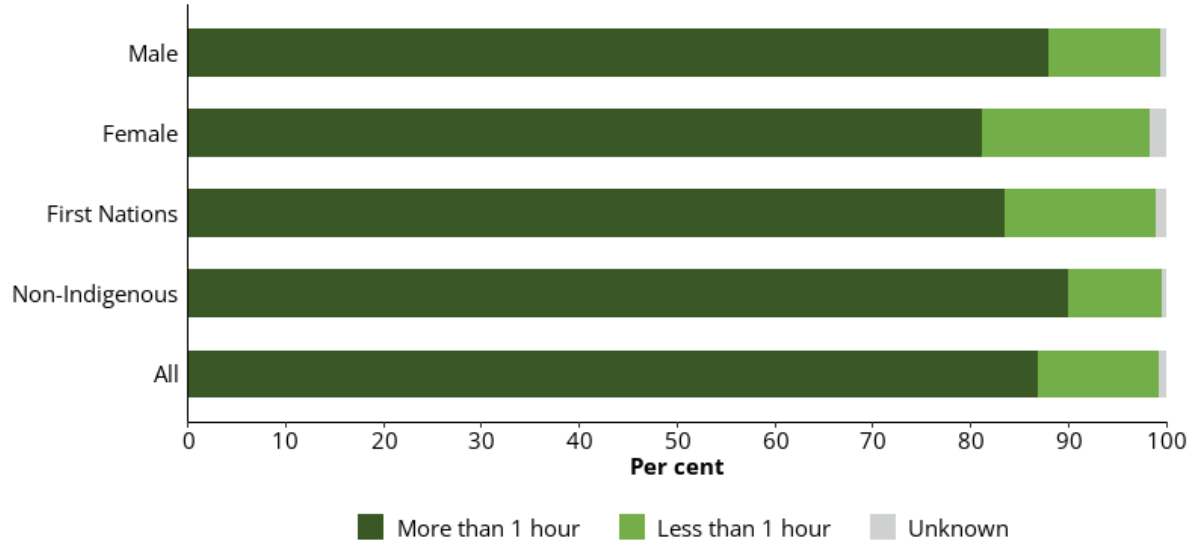
Almost 9 in 10 (87%) prison dischargees reported that they did more than 1 hour of physical activity per week in the previous month (Indicator 1.1.3).

Prison dischargees aged 18–24 and 45 and over (90%) were the most likely to report that they did more than 1 hour of physical activity per week in the previous month, while prison dischargees aged 25–34 (85%) were the least likely to.

Non-Indigenous dischargees (90%) were more likely to report that they did more than 1 hour of physical activity per week in the previous month than First Nations dischargees (84%) (Figure 2.9).

Male dischargees (88%) were more likely than female prison dischargees (81%) to report that they did more than 1 hour of physical activity (Figure 2.9).

Figure 2.9: Prison dischargees, completed more than 1 hour of physical activity per week in the previous month, by sex and Indigenous identity, 2022



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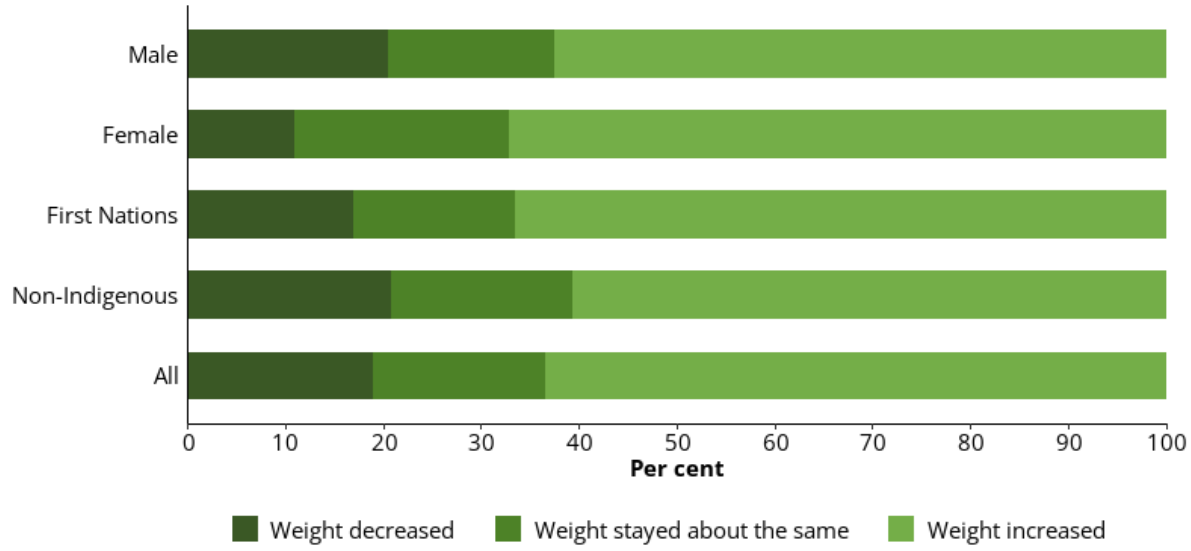
Source: Dischargees form, 2022 NPHDC.

When asked whether their weight had changed during their time in prison, most dischargees reported their weight had increased (63%). About 1 in 5 (19%) dischargees reported that their weight decreased in prison, while nearly 1 in 5 (18%) dischargees reported their weight had stayed the same (Figure 2.10).

Non-Indigenous dischargees (61%) were less likely to report a weight gain during incarceration than First Nations dischargees (67%). Female dischargees (67%) were more likely than male dischargees (63%) to report a weight gain during their time in prison.

Figure 2.10: Prison dischargees, change in weight while in prison, by sex and Indigenous identity, 2022



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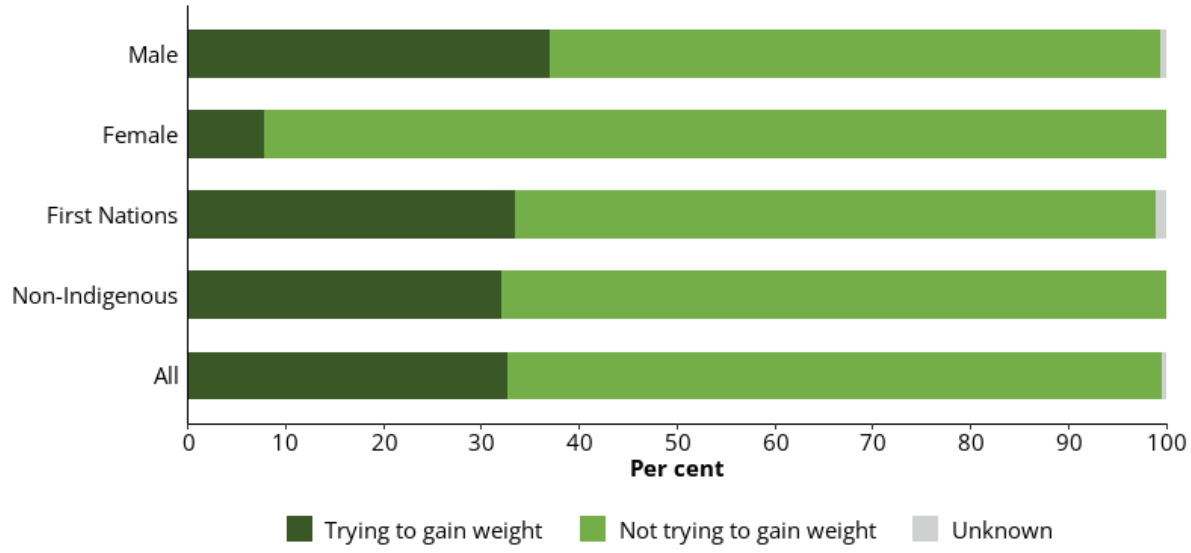
Source: Dischargees form, 2022 NPHDC.

Prison dischargees aged 25–34 (69%) were more likely than dischargees in the other age groups to report a weight gain.

Intention to gain weight

About 1 in 3 (33%) prison dischargees reported they had intended to gain weight while in prison, while more than 2 in 3 (67%) reported they did not. More than 1 in 3 (37%) male dischargees and fewer than 1 in 12 (7.8%) female dischargees reported that they intended to increase their body weight while in prison (Figure 2.11). Female dischargees (92%) overwhelmingly reported they did not try to gain weight in prison compared with more than 3 in 5 (63%) male dischargees.

Figure 2.11: Prison dischargees, intention to gain weight in prison, by sex and Indigenous identity, 2022



Notes

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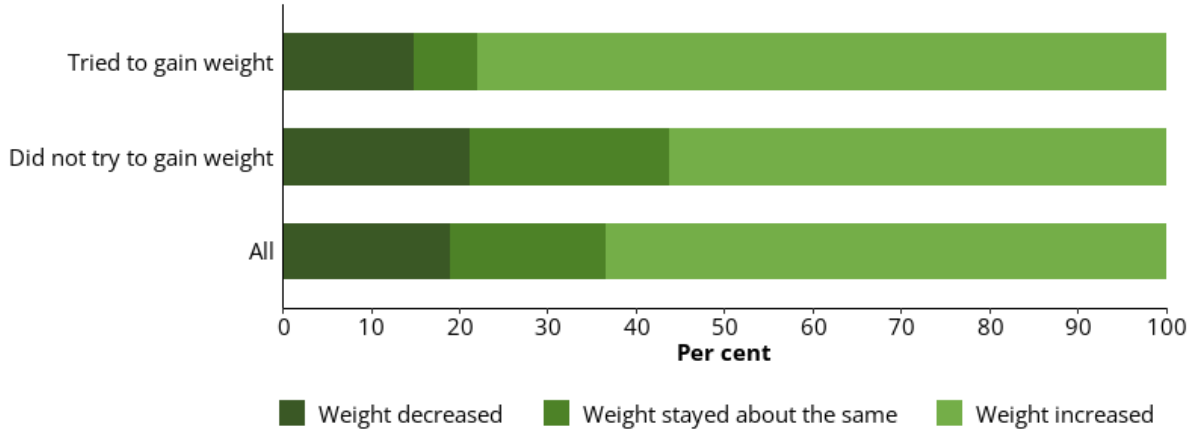
Source: Dischargees form, 2022 NPHDC.

Of the 141 prison dischargees who were trying to gain weight in prison, 78% reported their weight had increased, 7.1% reported their weight had stayed the same and 15% reported their weight had decreased (Figure 2.12). Of the 288 prison dischargees who were not trying to gain weight, 56% reported their weight had increased, 23% reported their weight had stayed the same and 21% reported their weight had decreased while in prison.

Figure 2.12: Prison dischargees, change in weight, by intention to gain weight while in prison, 2022



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Source: Dischargees form, 2022 NPHDC.

Physical and sexual assaults

Assaults by prisoners on other people in custody are often under-reported, making the collection of these data difficult. Violence is an ongoing challenge in prisons, with the risk of injury to both people in prison and staff. Violence in prison can affect service delivery, staffing, contact between prisoners and rehabilitation (Butler and Kariminia 2006). Sexual violence can have devastating effects on the health and wellbeing of the person assaulted, as well as on the community to which that person returns after release (Simpson et al. 2016).

In a survey of people in Queensland prisons, more than 1 in 3 (34%) males and 1 in 5 (20%) females reported having been physically assaulted in prison, and 2.9% of males and 3.8% of females reported a sexual assault (Butler et al. 2010).

A review of health interventions for people in custody found that sexual violence does occur in prisons even though there is little available literature on the issue (Schwitters 2014).

Physical and sexual assaults among prison dischargees

Prison dischargees were asked whether they had been physically or sexually assaulted while in prison.

> About 1 in 8 (13%) prison dischargees reported they had been physically assaulted in prison by another person in custody (Indicator 1.1.4).

Dischargees aged 18–24 (4.1%) were the least likely to report a physical assault while in prison, and those aged 25–34 were the most likely (16%).

Male dischargees (14%) were more likely than female dischargees (4.7%) to report being physically assaulted in prison. About 1 in 6 (17%) non-Indigenous dischargees and 1 in 11 (8.5%) First Nations dischargees reported being physically assaulted in prison.

These data are self-reported and are likely to be an underestimate as people in custody might be reluctant to disclose this information.

Data on sexual assaults were collected by asking prison dischargees whether they had been forced by, or frightened by, another prisoner into doing something sexually that they did not want to do during their current imprisonment.

> About 1 in 50 (2.1%) dischargees reported they had been sexually assaulted by another person in custody (Indicator 1.1.5).

Over 9 in 10 (96%) reported that they had not been sexually assaulted in prison and 1.6% said they wished not to answer. However, these data are self-reported, and likely to be an underestimate of the true number of sexual assaults in prison, as people in custody might be particularly reluctant to disclose this information (Simpson et al. 2016).

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Health conditions

People may enter prison with existing health conditions, or contract or be diagnosed with health conditions while in prison. The health conditions reported in this section include chronic conditions and communicable diseases.

People in the prison system are some of the most vulnerable in our society, and often experience risk factors for chronic conditions and communicable diseases to a higher degree than people in the general population (AIHW 2019).

Chronic conditions

Chronic conditions are complex, long lasting, and a leading cause of illness, disability and death in Australia (AIHW 2023).

Various factors can influence a person's likelihood of developing a chronic condition. These can include the socioeconomic areas in which the person lives, and their access to medical care (AIHW 2021).

Some risk factors associated with chronic conditions are considered preventable, including poor diet, physical inactivity, obesity, tobacco smoking, at-risk alcohol consumption, illicit drug use and unsafe sexual practices (AIHW 2023).

The major chronic physical condition groups investigated as part of the NPHDC were asthma, arthritis, back problem, cardiovascular disease, diabetes, pulmonary disease, chronic kidney disease, osteoporosis and cancer. Mental health conditions, also a group of chronic conditions, are reported in 'Mental health and self-harm'.

This section includes self-reported findings from prison entrants about chronic physical conditions. Information about people in prison taking prescribed medication for chronic conditions can be found in 'Medication'.

Past diagnosis of a chronic condition for prison entrants

Prison entrants were asked if a doctor or nurse had ever told them they had any of the chronic physical health conditions investigated as part of the NPHDC and, if so, whether the condition was current.

Self-reported data rely on the respondents' accurate recall and are likely to be an underestimate of true prevalence. Further, some prison entrants might have existing health conditions that are yet to be diagnosed because they have not accessed health services. This might be especially true for First Nations entrants, and those living in remote areas, where access to health services can be limited.

> Just over a half (52%) of prison entrants reported they had ever been told they had a chronic physical condition (Indicator 1.2.1).

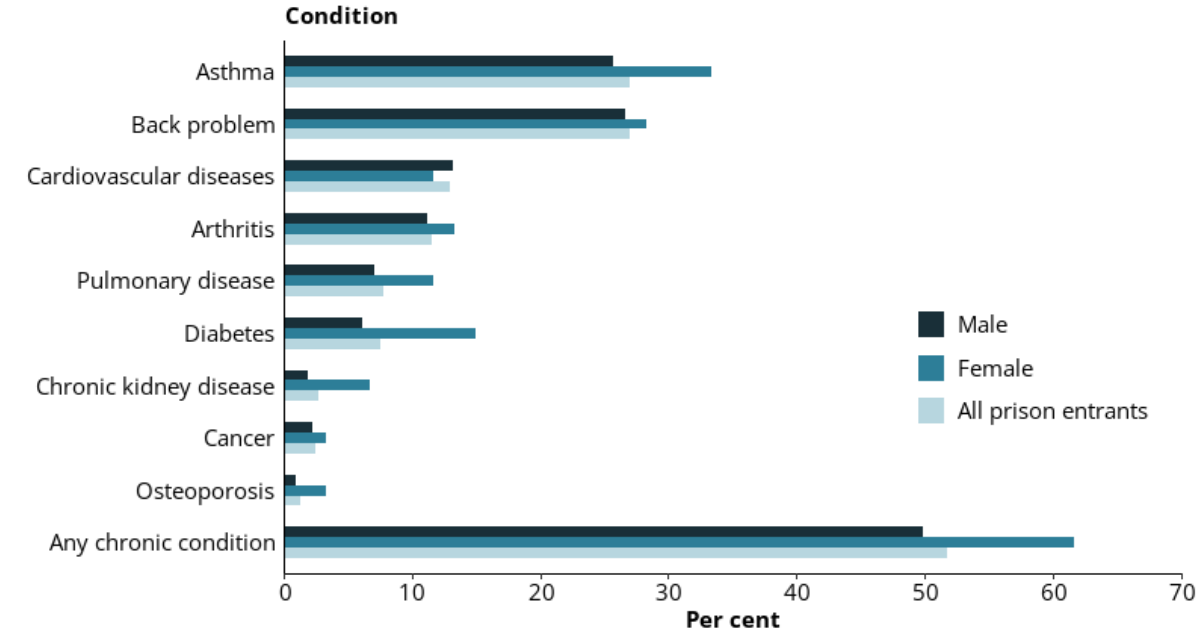
The most common chronic physical conditions reported were asthma (27%) and back pain (27%) (Figure 3.1). Of the prison entrants who reported a chronic physical condition, more than 2 in 5 (42%) stated that it was current when they entered prison.

Almost two-thirds (61%) of female prison entrants reported a past diagnosis of a chronic physical condition, compared with a half (50%) of male prison entrants. Almost 1 in 2 (45%)

female entrants, and about 2 in 5 (41%) male entrants, reported that the chronic physical condition was current when they entered prison.

Non-Indigenous entrants (54%) were more likely than First Nations entrants (49%) to report a past diagnosis of a chronic physical condition. The difference was slightly larger for those reporting a current chronic physical condition – almost 2 in 5 (38%) First Nations prison entrants, and almost a half (45%) of non-Indigenous entrants.

Figure 3.1: Prison entrants, past diagnosis of a chronic physical condition, by selected chronic physical conditions and sex, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.
3. 'Any chronic condition' does not represent a sum of the conditions, as 1 prison entrant might have multiple conditions.

Source: Entrants form, 2022 NPHDC.

Asthma

Asthma is a common chronic inflammatory condition of the airways that can be managed, but not cured.

In 2020–21, 1 in 9 (11%) Australian adults had asthma (Figure 3.2) – females (13%) in Australia had a higher rate than males (9.5%) (ABS 2022).

More than one-quarter (27%) of prison entrants reported being told they had asthma at some stage in their lives. Nearly 1 in 5 (18%) stated that the condition was current when they entered prison (Figure 3.2). Females (33%) were more likely to report a prior diagnosis of asthma than males (26%).

Arthritis

Arthritis is an umbrella term for a wide range of inflammatory conditions affecting the bones, muscles and joints. This often results in pain, stiffness, swelling and redness in affected joints.

In 2020–21, 1 in 6 Australian adults (16%) suffered from arthritis (Figure 3.2), with more females (18%) diagnosed with arthritis than males (13%) (ABS 2022).

In 2022, 1 in 8 (12%) prison entrants reported a past diagnosis of arthritis; 1 in 9 (11%) reported a current diagnosis of arthritis (Figure 3.2). Female prison entrants (13%) had slightly higher rates than male prison entrants (11%) of a reported previous diagnosis of arthritis.

First Nations prison entrants (13%) were more likely to report a previous diagnosis of arthritis than non-Indigenous prison entrants (10%).

For current arthritis, the reported prevalence was lower for prison entrants aged 18–24 (0%) than for prison entrants aged 45 and over (26%).

Back problem

Back problem refers to a range of conditions related to the bones, joints, connective tissue, muscles, and nerves of the back. Back pain and problems were the second leading cause of disease burden in Australia, with 1 in 5 Australian adults (20%) reporting a back problem (ABS 2022) (Figure 3.2).

In 2022, more than one-quarter (27%) of prison entrants reported a past diagnosis of a back problem, with slightly fewer (23%) entrants reporting a current back problem (Figure 3.2). Male (27%) and female (28%) entrants were similarly as likely to report ever having a back problem.

Non-Indigenous entrants (27%) were more likely to report having a current back problem than First Nations entrants (18%). The difference was smaller for ever having a back problem – almost 1 in 3 (30%) non-Indigenous prison entrants compared with almost 1 in 4 (24%) First Nations entrants.

Back problems were more prevalent with age, with 2 in 5 (40%) entrants aged 45 and over reporting a past diagnosis of a back problem.

Cancer

Cancer encompasses a group of diseases where cells in the body grow and spread uncontrollably. In 2018, cancer was the leading cause of burden of disease in Australia (ABS 2022). About 3 in 10 deaths in Australia are attributable to cancer (AIHW 2022a).

In 2020–21, about 1 in 50 (2.1%) adults in Australia had cancer (Figure 3.2). The prevalence increased with age, with those aged 65 and over (5.6%) having the highest rates of cancer (ABS 2022).

In 2022, 1 in 50 (2.4%) prisons entrants reported a past diagnosis of cancer, and 0.3% of entrants reported a current cancer diagnosis (Figure 3.2).

About 1 in 16 (6.1%) entrants aged 45 and over reported a previous cancer diagnosis, and about 1 in 80 (1.2%) reported a current diagnosis of cancer. This compared with about 1 in 80 (1.4%) entrants aged 18–44 reporting a past diagnosis of cancer, and no prison entrants in that age group reporting a current cancer diagnosis.

Cardiovascular disease

Cardiovascular disease is the leading cause of death in Australia and worldwide, and is second only to cancer in its contribution to the burden of disease in Australia (AIHW 2021).

Risk factors include obesity, tobacco smoking, high blood pressure, high blood cholesterol, physical inactivity, poor diet and diabetes (AIHW 2021).

In 2020–21, about 1 in 20 (5.2%) adults in Australia had cardiovascular disease (Figure 3.2). The prevalence was slightly greater among Australian males (6.4%) than females (4.0%) (ABS 2022).

In 2022, 1 in 8 (13%) prison entrants reported a prior diagnosis of cardiovascular disease; 1 in 12 (8.1%) reported a current diagnosis (Figure 3.2). Male entrants (13%) were similarly as likely to report a past diagnosis of cardiovascular disease as female entrants (12%).

Cardiovascular disease in First Nations prison entrants (15%) was fairly similar to that reported in non-Indigenous prison entrants (11%). The difference was slightly less in those reporting a current diagnosis – 1 in 10 (9.8%) First Nations entrants reported a current cardiovascular disease diagnosis compared with 1 in 15 (6.5%) non-Indigenous entrants.

Previous diagnosis and current self-reported cardiovascular disease increased with age, as did rates in the general population (ABS 2022). Almost 1 in 3 (30%) prison entrants aged 45 or over reported being told they had cardiovascular disease at some stage in their lives.

Chronic kidney disease

Chronic kidney disease refers to all conditions of the kidney affecting the filtration and removal of waste from the blood for 3 months or more. It is identified by reduced filtration by the kidney and/or by the leakage of protein or albumin from the blood into the urine.

In 2020–21, 1.3% of Australian adults reported having chronic kidney disease (ABS 2022) (Figure 3.2).

In 2022, 2.7% of prison entrants reported a chronic kidney disease diagnosis at some stage in their lives; 1.9% of entrants reported having a current chronic kidney disease (Figure 3.2).

Female entrants (6.7%) were more likely to report a chronic kidney disease diagnosis at some point in their lives than male entrants (1.9%).

Overall, there was a low rate of current chronic kidney disease with First Nations entrants (2.7%) having a similar rate to that of non-Indigenous entrants (1.1%).

Diabetes

Diabetes mellitus (diabetes) is marked by high levels of glucose in the blood. It is caused by the body’s inability to produce insulin, or the body not being able to use insulin effectively, or by both factors.

There are 3 main types of diabetes:

- Type 1 diabetes is an autoimmune disease with usual onset in childhood or early adulthood.
- Type 2 diabetes is the most prevalent form of diabetes. It generally has a later onset than type 1, and is considered to be largely preventable due to lifestyle risk factors.
- Gestational diabetes involves higher-than-normal blood glucose levels during pregnancy.

In 2020–21, about 1 in 20 (6.8%) Australians had diabetes (ABS 2022) (Figure 3.2). The rate of diabetes increased with age, from 1.4% of people aged 25–34 to 16.9% of those aged 65 and over (ABS 2022).

In 2022, 1 in 13 (7.5%) prison entrants reported a previous diagnosis of diabetes; 1 in 17 (5.9%) reported a current diagnosis (Figure 3.2).

First Nations entrants (9.3%) were fairly similar to non-Indigenous entrants (6.0%) in reporting a past diagnosis of diabetes.

The self-reported prevalence of a prior diabetes diagnosis increased with age, from 3.5% of entrants aged 25–34, to about 1 in 4 (16%) entrants aged 45 and over. For current diabetes, the self-reported prevalence rose from 2.8% of entrants aged 25–34 to 1 in 7 (15%) entrants aged 45 and over.

Osteoporosis

Osteoporosis is a chronic condition characterised by a person's bones becoming fragile and brittle, with an increased risk of fractures.

In 2020–21, 1 in 20 (4.6%) of Australian adults had osteoporosis (Figure 3.2). The prevalence was more common among Australian females (7.5%) than Australian males (1.5%) (ABS 2022).

In 2022, a very small number (1.3%) of prison entrants reported being diagnosed with osteoporosis at some stage in their lives; 1.1% of entrants reported current osteoporosis (Figure 3.2).

Female entrants (3.3%) were similar to male entrants (1.0%) in reporting a past diagnosis of osteoporosis. Female entrants and male entrants were similarly as likely to currently have osteoporosis (1.7% and 1.0%, respectively).

About 1 in 45 (2.2%) non-Indigenous entrants reported being diagnosed with osteoporosis at some stage in their lives, and less than 1.0% of First Nations entrants reported the same diagnosis. The findings were similar for non-Indigenous (1.6%) and First Nations entrants (0.5%) with a current osteoporosis diagnosis.

Pulmonary disease

Pulmonary disease is a chronic condition that includes chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, chronic pneumonia, chronic bronchitis and emphysema.

In 2020–21, 1 in 50 (1.9%) Australian adults had COPD (Figure 3.2). The prevalence was slightly more common among Australian females (2.6%) than Australian males (1.1%) (ABS 2022).

Of prison entrants in 2022, 1 in 13 (7.8%) reported having a past diagnosis of pulmonary disease. Fewer than 1 in 20 (3.5%) entrants reported currently having pulmonary disease (Figure 3.2).

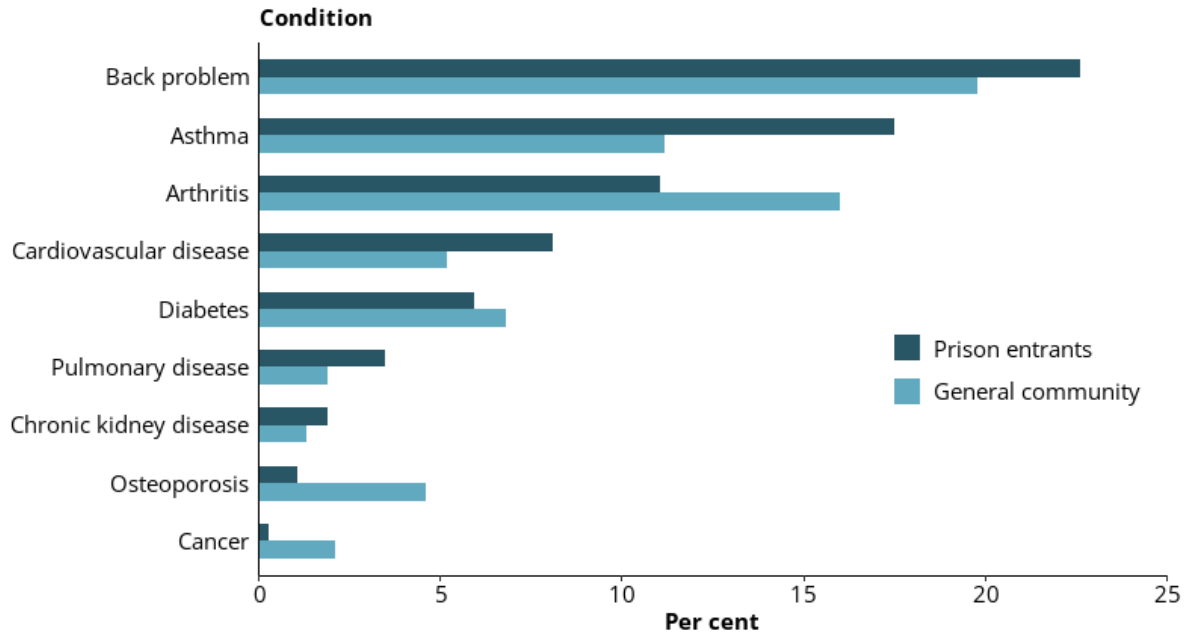
A history of COPD was more common among female entrants (11.7%) than male entrants (7.1%).

Chronic conditions comparisons with general community

Figure 3.2 shows that back problem, asthma, cardiovascular disease and pulmonary disease were more common among prison entrants than the general community. Arthritis, osteoporosis, cancer and diabetes were more common among the general community than prison entrants.

Direct comparisons between the general community and the prison population cannot be made due to non-random survey sampling and differences in the demographic profile of the populations. However, some conditions that are more common among older people (for example, arthritis or osteoporosis) may be more prevalent in the general community due to the prison population's having a younger age profile.

Figure 3.2: Prison entrants (2022) and the general community (2020–21), current chronic physical condition, by selected chronic physical conditions



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: AIHW analysis of ABS 2022, Table 1; Entrants form, 2022 NPHDC.

Communicable diseases

Communicable diseases, or infectious diseases, are spread from one person to another, or from an animal to a person, through viruses or bacteria in the air, food, blood or other bodily fluids. The Australian Government monitors communicable diseases through the National Notifiable Diseases Surveillance System, which coordinates the surveillance of more than 50 communicable diseases (Department of Health 2016).

Due to good sanitation practices, and the use of antibiotics and immunisation programs, communicable diseases are not generally a major issue in Australia (AIHW 2022b). But, some communicable diseases – particularly bloodborne viruses, and sexually transmissible infections (STIs) – are more prevalent in the prison population than in the wider Australian community (Butler and Simpson 2017).

This is due, in part, to the higher level of at-risk behaviours that people engage in before and during incarceration, compared with the general population. These include injecting drug use, needle-sharing, unsafe sexual practices, amateur tattooing and physical violence (Butler and Simpson 2017).

COVID-19

COVID-19 outbreaks have been reported in prisons across Australia. Given the high level of vulnerability of the prison population, COVID-19 poses a serious risk to the physical health of prisoners. Measures introduced to reduce the spread of COVID-19 are also likely to have had an impact on the mental, emotional and social wellbeing of people in prison (Department of Health 2020).

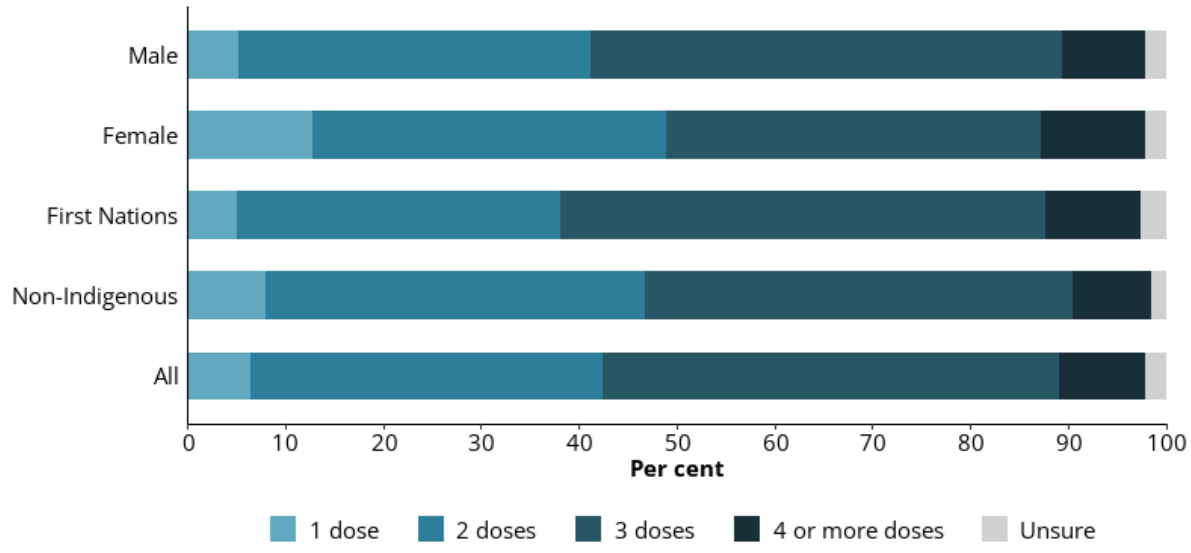
Prison entrants who received a COVID-19 vaccine

In 2022, almost 4 in 5 (79%) prison entrants reported receiving a COVID-19 vaccine; of those entrants, almost 1 in 2 (47%) reported they had received 3 doses. The proportion of prison entrants who reported receiving a COVID-19 vaccine ranged from 73% of those aged 25–34 to 85% of those aged 35–44.

Male entrants (79%) and female entrants (78%) were similarly as likely to report they had received a COVID-19 vaccine. Male entrants (48%) were more likely than female entrants (38%) to report they had received 3 doses of the COVID-19 vaccine (Figure 3.3).

First Nations entrants (85%) were more likely to report receiving a COVID-19 vaccine than non-Indigenous entrants (75%). Of First Nations entrants that reported receiving a COVID-19 vaccine, a half (50%) stated that they had received 3 doses (Figure 3.3).

Figure 3.3: Prison entrants, self-reported number of COVID-19 vaccine doses received, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Proportions are representative of 294 prison entrants who reported being vaccinated against COVID-19 only.
3. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Prison dischargees experiences with COVID-19

In 2022, more than 4 in 5 (84%) dischargees reported being quarantined or isolated due to COVID-19 while in prison. Dischargees aged 18–24 (71%) were least likely to report being quarantined or isolated due to COVID-19 while in prison. Male dischargees (83%) and

female dischargees (84%) were similarly as likely to report having been quarantined or isolated due to COVID-19 while in prison.

Almost 9 in 10 (85%) prison dischargees reported being offered a COVID-19 vaccine while in prison. Of those dischargees, almost 7 in 10 (69%) reported receiving the COVID-19 vaccine while in prison.

Dischargees aged 18–24 (90%) were most likely to report being offered the COVID-19 vaccine while in prison, and dischargees aged 25–34 (82%) were least likely.

Male dischargees (86%) were more likely to report being offered the COVID-19 vaccine while in prison than female dischargees (80%).

Almost three-quarters (73%) of First Nations dischargees and two-thirds (65%) of non-Indigenous dischargees reported receiving a COVID-19 vaccine while in prison.

Sexually transmissible infections

STIs are a continuing public health concern in Australia (Department of Health 2018), particularly for some groups of people, including those in prison.

The incidence of some STIs, such as human papillomavirus, has declined drastically in recent years, mostly due to the introduction of a human papillomavirus vaccine. But, other STIs – such as chlamydia, gonorrhoea and syphilis – have increased (Department of Health 2019).

The Australian Government monitors the prevalence of certain STIs through the National Notifiable Diseases Surveillance System. Notifiable STIs include chlamydial infection, donovanosis, gonococcal infection, and syphilis (Department of Health 2018).

In 2021, there were 121,793 notifications of STIs in Australia (Department of Health and Aged Care 2023b). The NPHDC collected data from jurisdictions on the number of notifications of STIs in prisons for these infections during the 2021 calendar year.

> During 2021, there were 18,650 notifications of STIs for people in custody in New South Wales, Queensland, Western Australia, South Australia, Tasmania and the Northern Territory (Indicator 1.2.2).

The rate of notifications of STIs for prisoners received into custody in 2021 was 53 per 100 prisoners received into custody.

Hepatitis C

The hepatitis C virus is an infection that causes liver inflammation; if left untreated, it can lead to complications such as cirrhosis (a chronic liver disease) and cancer (Wallace et al. 2018). It is the most commonly reported notifiable bloodborne disease in Australia (Department of Health and Aged Care 2023a).

The prison population is especially at risk of hepatitis C infection, due to the high proportion of people in custody with a history of injecting drug use; the at-risk behaviours associated with illicit and injecting drug use, including needle-sharing; and other at-risk behaviours, such as amateur tattooing and violence that can lead to blood-to-blood contact (Department of Health and Aged Care 2023c).

People in prison often come from marginalised groups, where medical care in the community is unavailable or not accessed, so are at risk of having undiagnosed hepatitis C before entering prison (Department of Health and Aged Care 2023c; Wallace et al. 2018).

Prison clinics are an ideal place to detect and treat people with undiagnosed hepatitis C. In recent years, new medications for the disease have led to an enormous increase in the treatment rate of people in prison with hepatitis C (Department of Health and Aged Care 2023c). For information on hepatitis C medication dispensed in prisons, see 'Medications'.

In the past, the NPHDC has reported on the proportion of prison entrants testing positive to hepatitis C using the National Prison Entrants' Bloodborne Virus & Risk Behaviour Survey. This survey has now been replaced by AusHep; however, AusHep data were not available when writing this report.

Hepatitis C surveillance

As part of the NPHDC, jurisdictions were asked to provide the number of tests performed for hepatitis C (antibody tests, polymerase chain reaction [PCR] tests and genotype tests) during the calendar year. Data on positive test results were not requested; however, the number of tests performed provides some surveillance data.

> During 2021, there were 37,181 tests performed for hepatitis C for people in custody in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory (Indicator 1.2.3).

Hepatitis C testing for prison dischargees

In 2022, prison dischargees were asked whether they had received a test for hepatitis C in prison and, if so, the test result.

> Almost 2 in 3 (64%) prison dischargees reported that they had been tested for hepatitis C in prison (Indicator 1.2.4).

One in 13 (8.1%) dischargees tested positive for hepatitis C in prison, while almost half (45%) tested negative. About one-third (32%) of dischargees were not tested for hepatitis C in prison.

Hepatitis B

Hepatitis B is a bloodborne virus that causes inflammation of the liver, and can lead to cirrhosis and cancer, conditions that can be fatal (Department of Health and Aged Care 2023b).

In 2020, over 220,000 people in Australia were living with a chronic hepatitis B infection. A vaccination for hepatitis B has been available since the 1980s, but the virus still disproportionately affects many disadvantaged populations, including people born overseas, First Nations peoples, and people in custody (Department of Health and Aged Care 2023b).

As part of the NPHDC, jurisdictions were asked to provide the number of tests performed for hepatitis B during the calendar year. Data on positive test results were not requested; however, the number of tests performed provides some surveillance data.

During 2021, there were 79,756 tests performed for hepatitis B for people in custody in New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory (Indicator 1.2.5).

Human immunodeficiency virus

Human immunodeficiency virus (HIV) is a bloodborne virus that weakens the immune system; if left untreated, it can eventually lead to acquired immunodeficiency syndrome (AIDS). While there is no effective cure available for HIV, treatment in the form of medication can prevent disease progression and transmission (Department of Health 2019).

Although prevalence is low in the prison population, transmission remains a risk due to higher levels of at-risk behaviours that people engage in (Butler and Simpson 2017).

As part of the NPHDC, jurisdictions were asked to provide the number of tests performed for HIV during the calendar year. Data on positive test results were not requested; however, the number of tests performed provides some surveillance data.

During 2021, there were 57,527 tests performed for HIV for people in custody in New South Wales, Queensland, Western Australia, South Australia, and the Northern Territory (Indicator 1.2.6).

Health conditions diagnosed in prison

Prison dischargees diagnosed with health conditions in prison

Prison dischargees were asked if they had ever been diagnosed with a health condition, and, if so, to specify its type. Dischargees were also asked if they had been diagnosed with a health condition for the first time in prison and, if so, the type of health condition.

Almost 1 in 4 (26%) prison dischargees reported they were first diagnosed with a health condition in prison (Indicator 1.2.7).

Almost 3 in 4 (74%) prison dischargees were diagnosed with a health condition at some stage of their lives.

Female dischargees (33%) were more likely than male dischargees (25%) to be diagnosed with a health condition in prison.

Non-Indigenous dischargees (27%) and First Nations dischargees (25%) were similarly as likely to say they had a health condition diagnosed in prison.

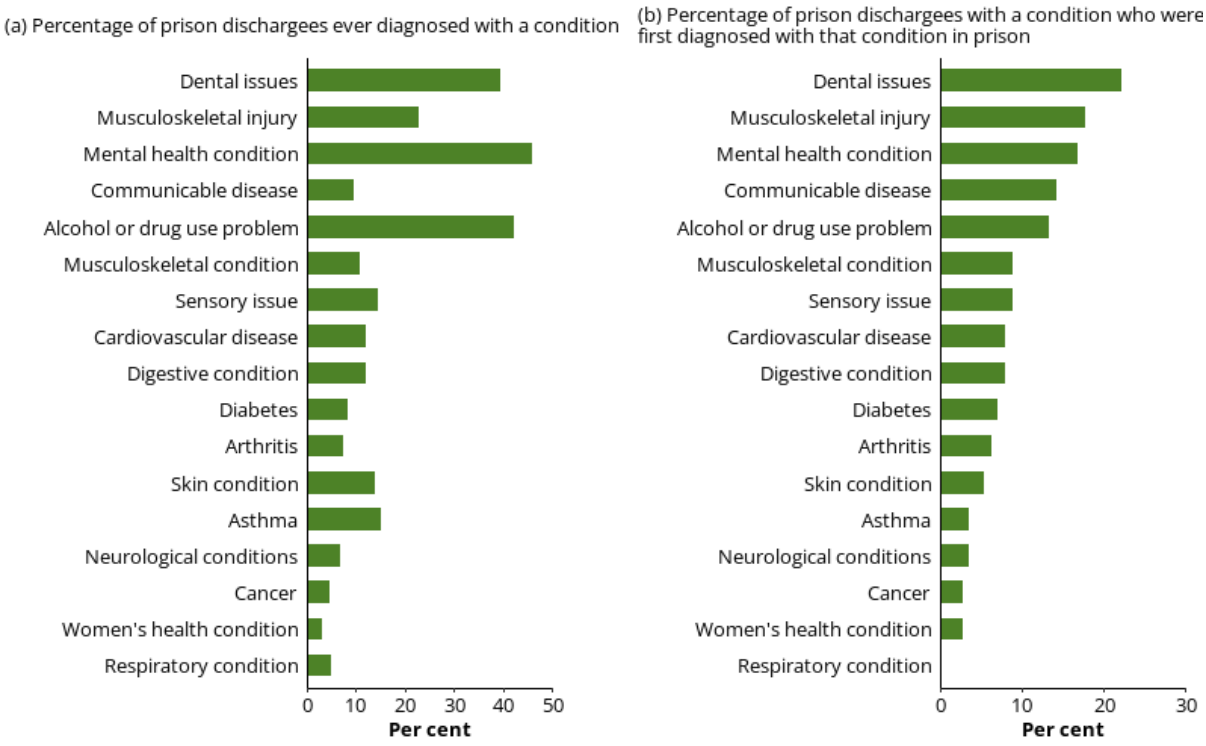
The health conditions that prison dischargees most commonly said they had been diagnosed with at some stage in their lives were:

- psychological/mental health condition (46%)
- alcohol or drug use problem (42%)
- dental issues (39%) (Figure 3.4).

The health conditions prison dischargees reported they were diagnosed with for the first time in prison were most likely to be:

- dental issues (22%)
- musculoskeletal conditions (18%)
- psychological/mental health condition (17%)
- communicable diseases (14%) (Figure 3.4).

Figure 3.4: Prison dischargees, self-reported health conditions ever diagnosed and diagnosed in prison, 2022



(a) Percentage of all prison dischargees in the data collection who had ever been diagnosed with a health condition.

(b) Percentage of prison dischargees in the data collection diagnosed with a health condition that was first diagnosed during current prison stay.

Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

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Human function and disability

The International Classification of Functioning, Disability and Health describes disability at an individual or population level, and covers:

- impairments – problems in body function or structure
- activity limitations – difficulties in executing activities
- participation restrictions – problems with involvement in life situations (WHO 2011).

Disability is best understood as a continuum – from having no impairment or limitation to the complete loss of functioning or ability to complete a task (AIHW 2022).

People with disability have lower rates of employment, incomes, educational attainment, and life participation rates than those without disability (AIHW 2022).

Currently, little is known about the prevalence of physical disabilities of people in prison. However, people with intellectual disability are understood to be over-represented in prisons globally (Hellenbach et al. 2017).

While the prevalence of intellectual disability in people in prison varies across studies, several studies have found that 25–30% of people in prison have borderline intellectual disability, and 10% have a mild intellectual disability (Hellenbach et al. 2017).

The NPHDC collected information about people in prison living with disability using 3 items from the AIHW's Standard Disability Flag:

- the 'activity and participation need for assistance cluster'
- the 'education participation restriction flag'
- the 'employment participation restriction flag'.

The Standard Disability Flag relies on self-reported impairment and restriction and does not require a medical diagnosis (AIHW 2017). See the Technical Notes for more information.

Health conditions or disabilities that affect everyday activities

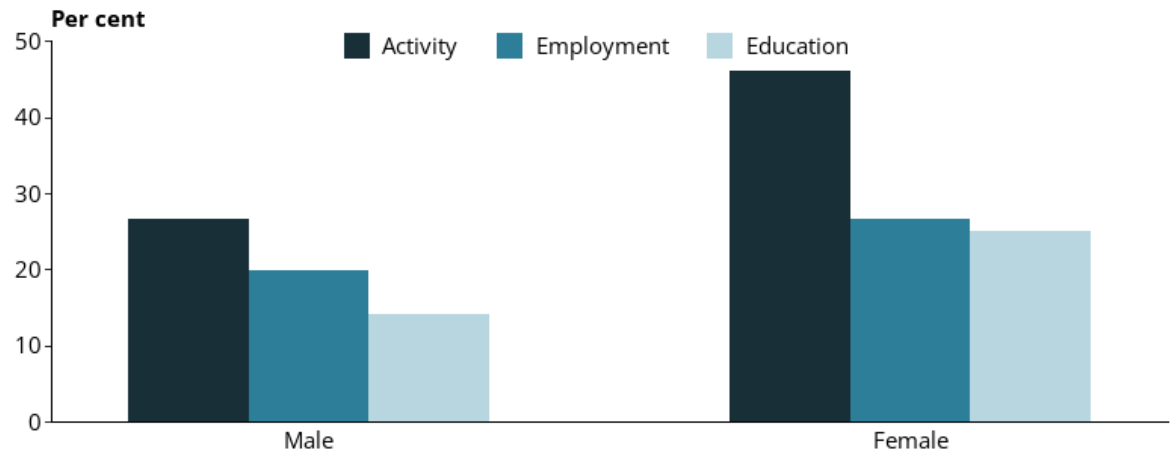
Any limitation

Prison entrants were asked whether they had a long-term health condition or disability that affected their participation in education, employment or everyday activities.

> Almost 2 in 5 (39%) prison entrants reported that a long-term health condition or disability affected their participation in everyday activities (30%), education (16%) or employment (21%) (Indicator 1.3.1).

Almost a half (47%) of female prison entrants reported a limitation in everyday activities, 25% in education, and 27% in employment, while more than one-quarter (27%) of male prison entrants reported a limitation in everyday activities, 14% in education and 20% in employment (Figure 4.1).

Figure 4.1: Prison entrants, self-reported chronic health condition or disability limiting their participation in activities, education or employment, by sex and type of limitation, 2022



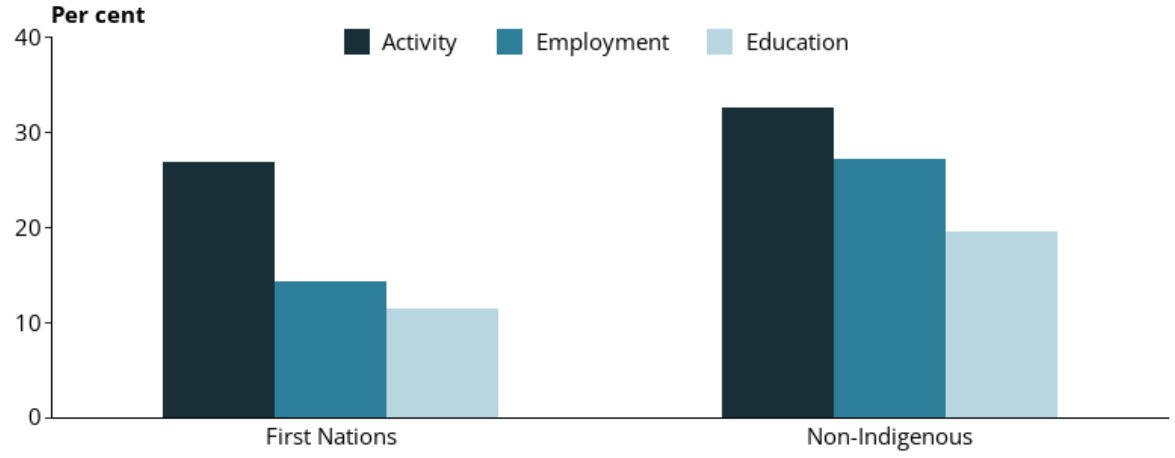
Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Non-Indigenous prison entrants were more likely to report restrictions to activity (33%), education (20%) and employment (27%) than First Nations prison entrants (27%,12% and 14%, respectively) (Figure 4.2).

Figure 4.2: Prison entrants, self-reported chronic health condition or disability limiting their participation in activities, education, or employment, by Indigenous identity and type of limitation, 2022



Notes

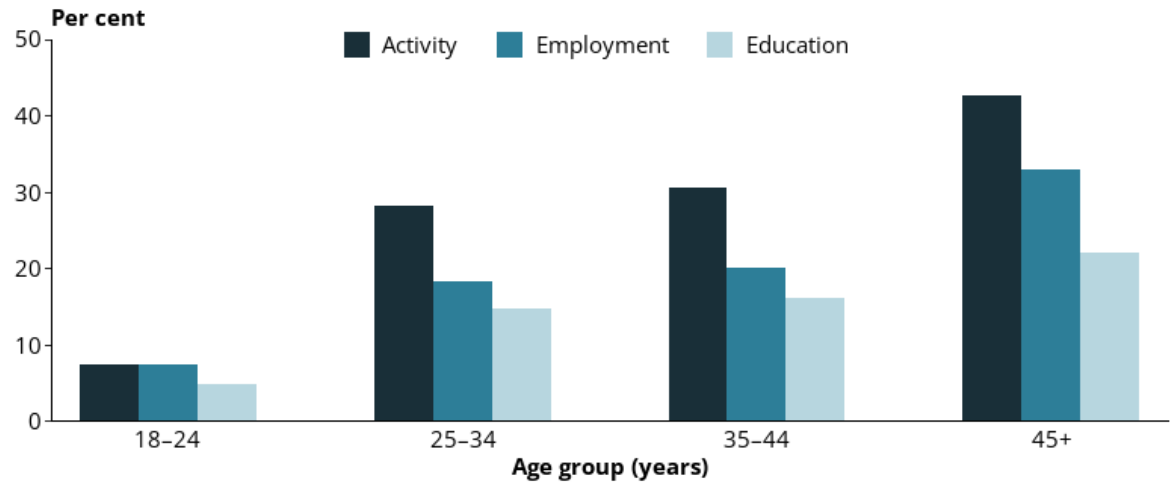
1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

The prevalence of self-reported limitations to everyday activities, education or employment increased with age, from 1 in 8 (12%) prison entrants aged 18–24 to over 1 in 2 (55%) for

entrants aged 45 and over. Increasing prevalence in limitations with age was consistent across everyday activities, education and employment (Figure 4.3).

Figure 4.3: Prison entrants, self-reported chronic health condition or disability limiting their participation in activities, education or employment, by age and type of limitation, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Comparisons with the general community

In 2018, nearly 1 in 5 (18%) Australians of all ages had disability (ABS 2019). This compares with almost 2 in 5 (39%) prison entrants aged 18 and over in the 2022 NPHDC.

Comparisons of the prevalence of disability between the prison population and adults in the general community are difficult, as people in prison are typically younger than those in the community, and the prevalence of many types of disability, particularly core activity limitations, increases with age. People in prison also experience accelerated ageing, which may predispose them to health conditions that are more prevalent among older populations (AIHW 2020).

Disability prevalence increases with age

The prevalence of disability among prison entrants is higher in each age bracket than in the general community:

- Of those aged 25–34, 1 in 14 (7.1%) people in the community, and 1 in 3 (36%) prison entrants reported a disability.
- Of those aged 35–44, 1 in 11 (9.0%) people in the community, and 2 in 5 (39%) prison entrants reported a disability.
- Of those aged 45–54, 1 in 6 (16%) people in the community, and half (49%) of prison entrants reported a disability (ABS 2019).

Core activity limitations

Core activity limitations are those that affect a person's ability to undertake the 'core activities' of self-care, mobility, and/or communication – activities deemed to be essential to normal everyday living.

Limitations in the areas of self-care, mobility and/or communication were combined to form the 'core activity limitation' indicator.

People living with disability can also be identified as having schooling and/or employment restrictions. If a person does not have any core activity limitations, or any schooling/employment restrictions, they can still be living with disability if they have identified limitations or restriction with other activities; in this case, they are classified as having the lowest severity of disability (ABS 2019).

> Of prison entrants surveyed, 9.4% reported profound or severe core activity limitations (Indicator 1.3.2).

About 1 in 20 (4.9%) prison entrants reported moderate core activity limitations and 1.3% reported mild core activity limitations.

Of the 16% of entrants reporting any core limitation, almost 2 in 3 (60%) rated the limitation as profound/severe, about 1 in 3 (31%) as moderate, and almost 1 in 10 (8.6%) as mild.

Comparisons with the general community

The prevalence of profound or severe core activity limitations among people aged 18–34 in the general community was 2.1% while the prevalence among people of the same age in prison was 4.9% (AIHW analysis of ABS 2022).

Among people aged 35–54 in the community, 2.8% reported having profound or severe core activity limitations while 13% of people of the same age in prison reported having profound or severe core activity limitations.

Female prison entrants aged 18 and over were more than twice as likely to report having profound or severe core activity limitations (17%) as females of the same age in the general community (7.0%).

Males prison entrants aged 18 and over were similarly as likely to report profound or severe core activity limitations (8.0%) as those of the same age in the community (5.7%). However, these results will be affected by the different age profile of prison entrants and people in the community. Prison entrants are predominantly younger (aged 25–44) than adults in the community. People in prison also experience accelerated ageing, meaning that people aged 45 and over can be considered elderly in prison (Baidawi et al. 2011; Turner and Trotter 2010).

Head injuries

Among the general adult population, about 17% of males and 9% of females have had a head injury leading to a loss of consciousness, an indication of possible traumatic brain injury (Frost et al. 2013). The prevalence of acquired brain injury among people in prison is much higher, at 40–90% (Alderman et al. 2018; Colantonio et al. 2014; Kelly et al. 2018). Acquired brain injury has been associated with an increase in aggression, impulsivity, impaired judgement, and reduced empathy – all of which are also associated with criminal behaviour.

Acquired brain injury refers to any damage to the brain that occurs after birth and/or due to fetal alcohol syndrome. The most common causes are stroke and other organic causes, accident, or trauma, known as traumatic brain injury (Alderman et al. 2018).

Acquired brain injury can cause difficulties with memory, attention, information processing, and mood regulation. It is a risk factor for criminal behaviour and for re-offending after prison release (Alderman et al. 2018).

Brain injury among people in prison has a substantial impact on prison health services, with an increased need for medical and psychological services (Piccolino and Solberg 2014).

Prison entrants who have had head injuries

Prison entrants were asked whether:

- they had ever had a head injury resulting in a loss of consciousness
- they had noticed symptoms such as headaches, memory changes, behavioural, and/or mood changes as a result of that head injury
- those symptoms had persisted.

> Almost 2 in 5 (38%) prison entrants reported a history of a head injury resulting in loss of consciousness (Indicator 1.3.3).

A similar number of males (39%) and females (37%) reported a history of head injury resulting in loss of consciousness. More non-Indigenous prison entrants (44%) than First Nations prison entrants (33%) had such an injury.

Of those who reported a head injury, 3 in 5 (59%, or 23% of all prison entrants surveyed) said they had noticeable symptoms following the head injury, and 1 in 2 (51%, or 20% of all prison entrants surveyed) were still experiencing symptoms.

Prison dischargees who have had head injuries

Prison dischargees were asked whether they had sustained a head injury resulting in loss of consciousness while in prison and, if so, whether they experienced symptoms such as headaches, memory loss, or behavioural and/or mood changes following the injury.

> About 1 in 13 (7.7%) prison dischargees reported having a head injury in prison that resulted in a loss of consciousness (Indicator 1.3.4).

Of those who reported a head injury in prison, almost 3 in 4 (70%, or 5.3% of all prison dischargees surveyed) said had noticeable symptoms following the head injury, and 3 in 5 (58%, or 4.4% of all prison dischargees surveyed) were still experiencing symptoms.

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Mental health and self-harm

Mental health is fundamental to emotional, psychological and social wellbeing, and affects individuals, families and the wider community (ABS 2018). Mental health conditions are chronic conditions such as depression, anxiety disorders, psychotic disorders, and alcohol and other drug use disorders. These conditions can influence thoughts, feelings, behaviour, stress levels, relationships and decision-making.

Mental health conditions, particularly severe conditions, are over-represented in the prison population. For example, the prevalence of psychosis in a London prison population was found to be more than 20 times that of the general community, and almost 70% of people in prison had more than one mental health disorder (Bebbington et al. 2017).

Unlike many other chronic conditions, mental health conditions do not increase in prevalence with age (ABS 2022). For some people, interacting with the justice system might be the first time a health professional has assessed their mental health.

An Australian population-based data linkage study of adults in their 20s and 30s found that 1 in 3 (32%) of those with a psychiatric illness had been arrested during a 10-year period, with the first arrest often occurring before their first contact with mental health services (Morgan et al. 2013).

People in prison have a high prevalence of self-reported mental health conditions (AIHW 2019) and, while they are often able to access mental health care during incarceration, their mental health can quickly deteriorate after release (Cutcher et al. 2014).

People in prison with a history of a mental health condition are more likely to experience alcohol and other drug use disorders, crime, and poor health outcomes after their release. A history of substance use, particularly injecting drug use, is linked to mental health conditions, self-harm and suicidal behaviour in people while in prison and after their release (Butler et al. 2018; Cossar et al. 2018; Stewart et al. 2018).

This section analyses the self-reported mental health of prison entrants and prison dischargees, covering:

- mental health condition
- self-assessed mental health status
- recent psychological distress
- reasons for psychological distress
- self-harm.

Mental health condition

Prison entrants reporting a mental health or behavioural condition

During the data collection period, prison entrants were asked if they:

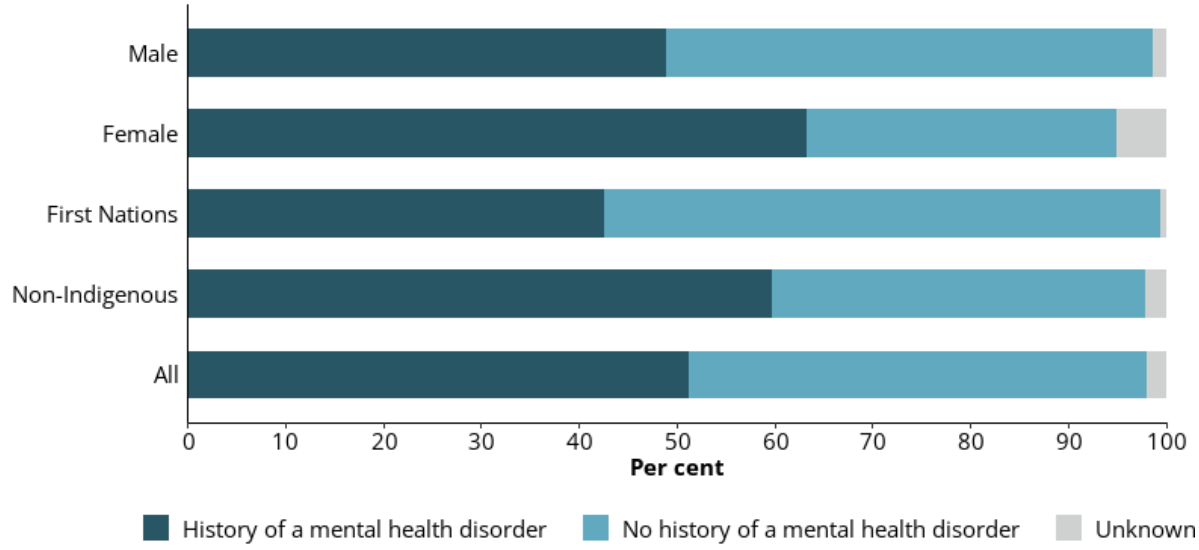
- had ever been told they had a mental health or behavioural condition (including drug and alcohol abuse) by a doctor, psychiatrist, psychologist or nurse
- were currently taking medication for a mental health condition, including those relating to alcohol and other drug use.

More than a half (51%) of prison entrants reported being told they had a mental health condition at some stage in their lives (Indicator 1.4.1).

Female prison entrants (63%) were more likely than male prison entrants (49%) to report a mental health condition at some stage in their lives (Figure 5.1).

Non-Indigenous prison entrants (60%) were more likely to report a mental health condition than First Nations prison entrants (42%) (Figure 5.1).

Figure 5.1: Prison entrants who had ever been told they had a mental health condition, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Prison entrants aged 25–34 were most likely to report a mental health condition (54%) at some stage of their lives, and those aged 18–24 were least likely (34%).

For information on medications dispensed in prison for mental health conditions see 'Medications'.

Self-assessed mental health status

Self-assessed health status is used extensively in public health research in the absence of more detailed objective health data. It is used in various data collections on numerous topics, making it useful for comparisons between different population groups (Wu et al. 2013).

Prison entrants and prison dischargees were asked to rate their mental health as being excellent, very good, good, fair or poor.

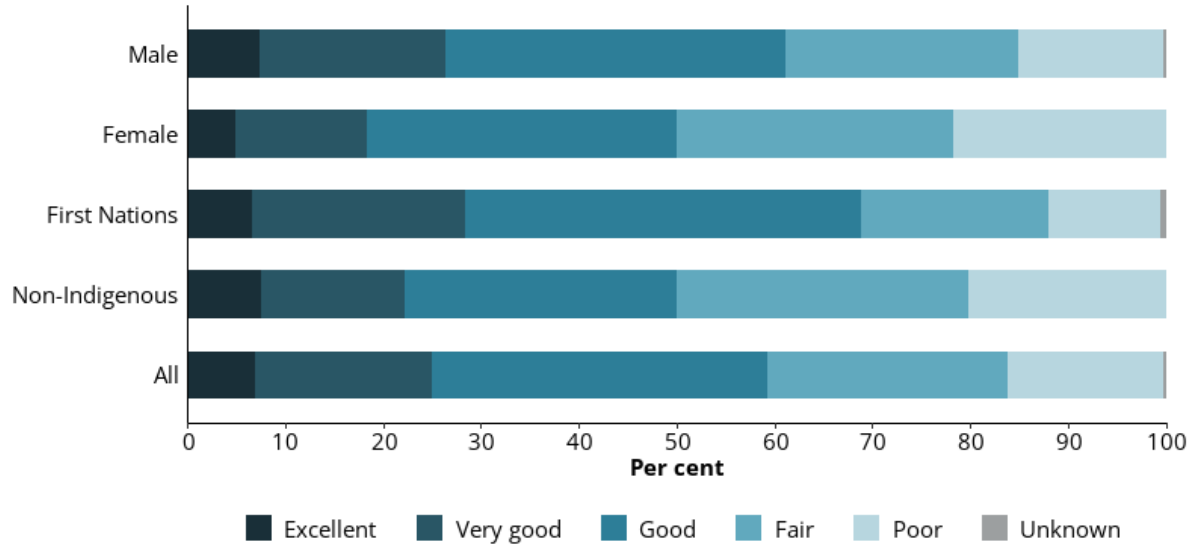
About 3 in 5 (59%) prison entrants described their mental health as good, very good, or excellent (Indicator 1.4.2).

Almost 3 in 4 (73%) prison dischargees described their mental health as good, very good or excellent (Indicator 1.4.3).

Male prison entrants were more likely (61%) than female entrants (50%) to report their mental health as good, very good or excellent (Figure 5.2). Overall, prison dischargees were more likely than prison entrants to report their mental health as being good or better, with more than 4 in 5 (81%) female dischargees, and almost 3 in 4 (72%) male dischargees, describing their mental health as good or better (Figure 5.3).

First Nations prison entrants (69%) were more likely than non-Indigenous prison entrants (50%) to describe their mental health as generally good or better (Figure 5.2). First Nations prison dischargees (80%) were also more likely than non-Indigenous prison dischargees (67%) to describe their mental health as generally good or better (Figure 5.3).

Figure 5.2: Prison entrants, self-assessed mental health status, by sex and Indigenous identity, 2022

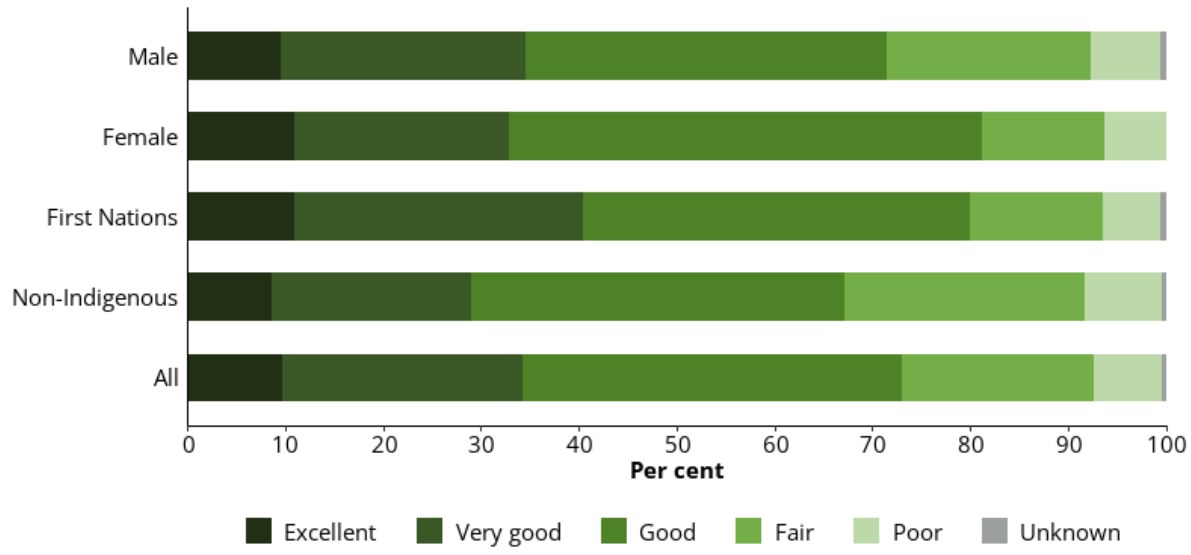


Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Figure 5.3: Prison dischargees, self-assessed mental health status, by sex and Indigenous identity, 2022



Notes

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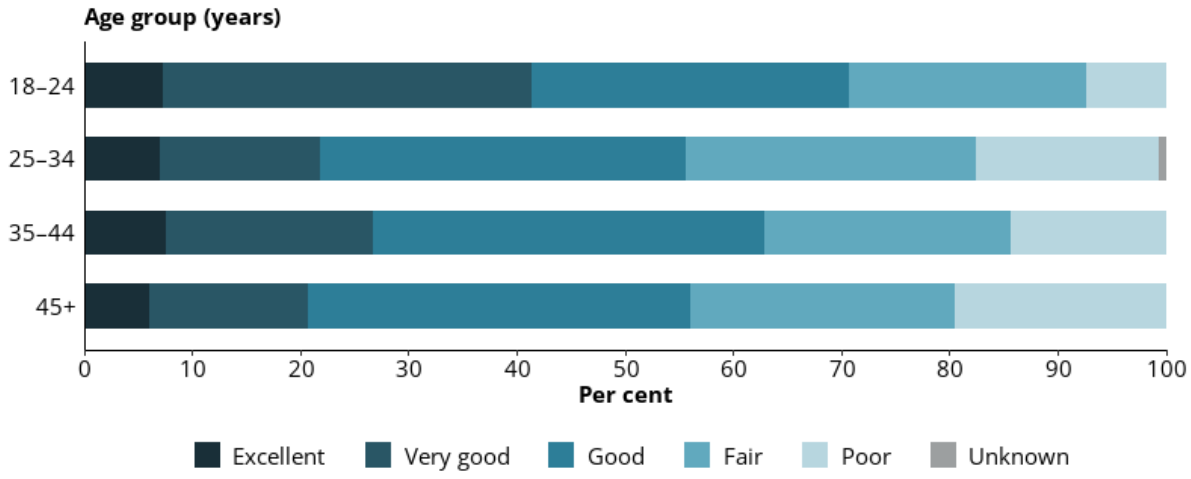
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Prison entrants aged 18–24 (71%) were more likely to describe their mental health as generally good or better and those aged 25–34 and 45 and over were equally the least likely to do so (56%) (Figure 5.4). Similarly, prison dischargees aged 18–24 (82%) were more likely to describe their mental health as generally good or better and those aged 45 and over were the least likely (65%) (Figure 5.5).

Figure 5.4: Prison entrants, self-assessed mental health status, by age, 2022

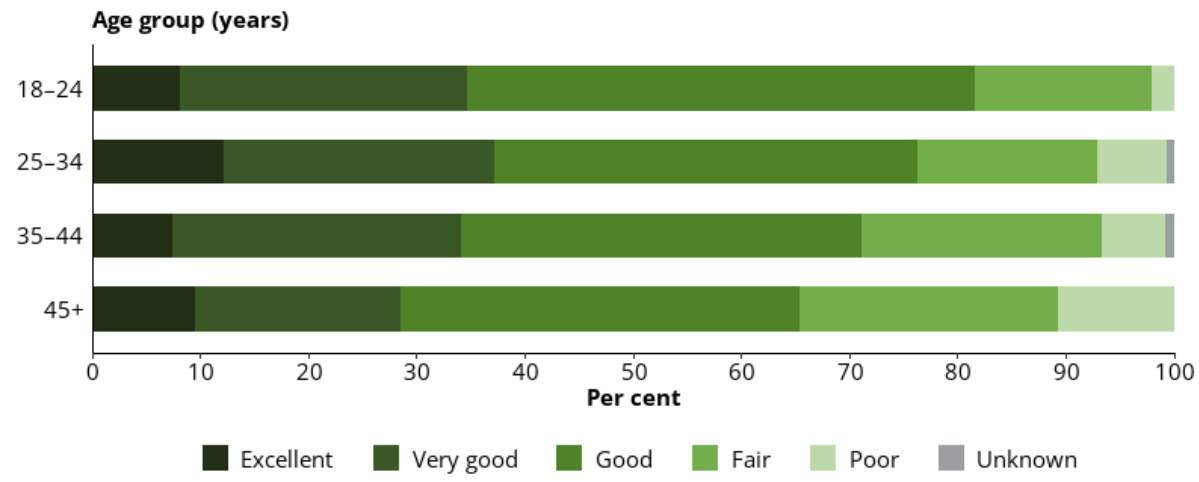


Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Figure 5.5: Prison dischargees, self-assessed mental health status, by age, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Prison dischargees change in mental health status while in prison

More than 4 in 5 (81%) prison dischargees reported their mental health improved or stayed the same while in prison (Indicator 1.4.4).

Prison dischargees were more likely to report that their mental health improved while in prison, with almost half (46%) reporting that it improved; one-third (34%) reported that it stayed the same and 1 in 5 (19%) that it worsened during their time in prison.

Males (47%) were more likely than females (39%) to report that their mental health improved while in prison. Females (44%) were more likely than males (33%) to report that it stayed the same, with females and males fairly similar in reporting that it had worsened in prison (16% and 20%, respectively).

Recent psychological distress

The Kessler 10 (K10) scale is a widely used and well-validated survey tool designed to measure participants' levels of psychological distress through questions about depression and anxiety symptoms over the preceding 4 weeks (Andrews and Slade 2001; Kessler et al. 2002). It has also been shown to be a good indicator of serious mental illness (Kessler et al. 2002).

In 2020–21, 15% of Australians aged 16 to 85 experienced high or very high levels of psychological distress. Females (19%) were more likely to score high or very high levels of psychological distress on the K10 than males (12%), although the differences between the sexes were smaller than those in prison populations (ABS 2022).

Entering and leaving prison can be highly stressful for people in the prison system. The experience of being in prison; the prison environment; relationships with other prisoners;

family, housing and employment issues; and alcohol and other drug use might all be potential causes of concern and distress for people in the prison system.

Prison entrants and dischargees were asked about their recent psychological distress levels, and their perceived reasons for any distress.

The K10 was included in the surveys completed by prison entrants (for distress levels before prison entry) and by prison dischargees (for distress levels leading up to release).

Prison entrants (43%) were more than 3 times as likely to score high or very high levels of psychological distress as the general population (15%) in 2020–21. Prison dischargees (26%) were also more likely to score high or very high levels of psychological distress than the general population (15%) in 2020–21 (ABS 2022).

More than 2 in 5 (43%) prison entrants scored high or very high levels of psychological distress (Indicator 1.4.5).

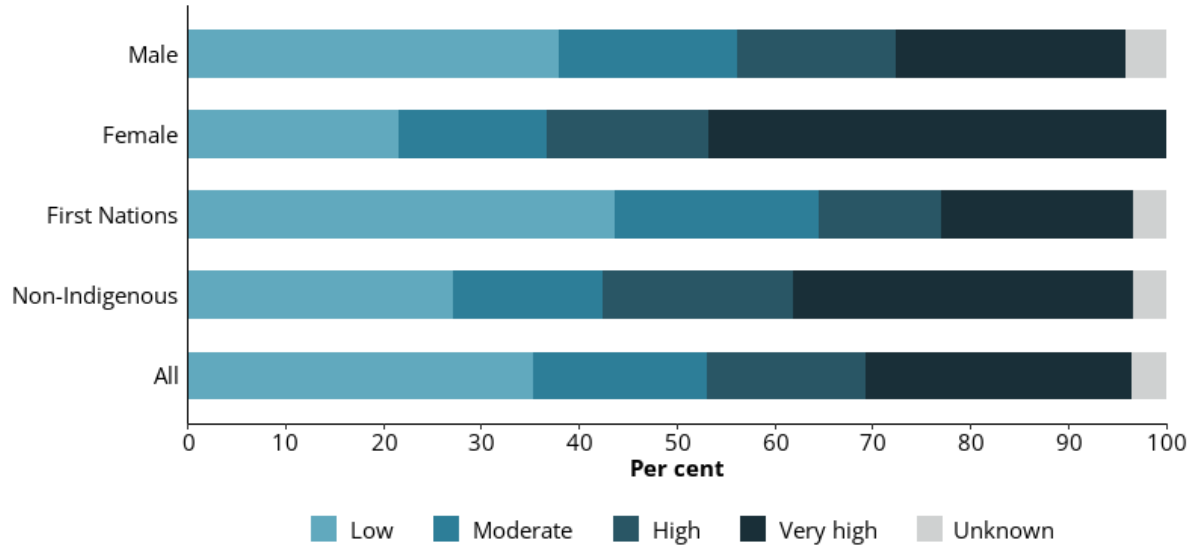
Over 1 in 4 (26%) prison dischargees scored high or very high levels of psychological distress (Indicator 1.4.6).

Using the K10 scale, more prison dischargees (51%) scored low levels of psychological distress than prison entrants (35%) (figures 5.6 and 5.7).

Female prison entrants (63%) were more likely than male prison entrants (40%) to score high or very high levels of psychological distress. However, male prison dischargees (27%) were more likely than female dischargees (17%) to score high or very high levels of psychological distress (figures 5.6 and 5.7).

More than a half of non-Indigenous prison entrants (54%) compared with almost one-third (32%) of First Nations prison entrants scored high or very high levels of psychological distress. Non-Indigenous prison dischargees (30%) were more likely than First Nations dischargees (21%) to score high or very high levels of psychological distress (figures 5.6 and 5.7).

Figure 5.6: Prison entrants, K10 level of distress, by sex and Indigenous identity, 2022

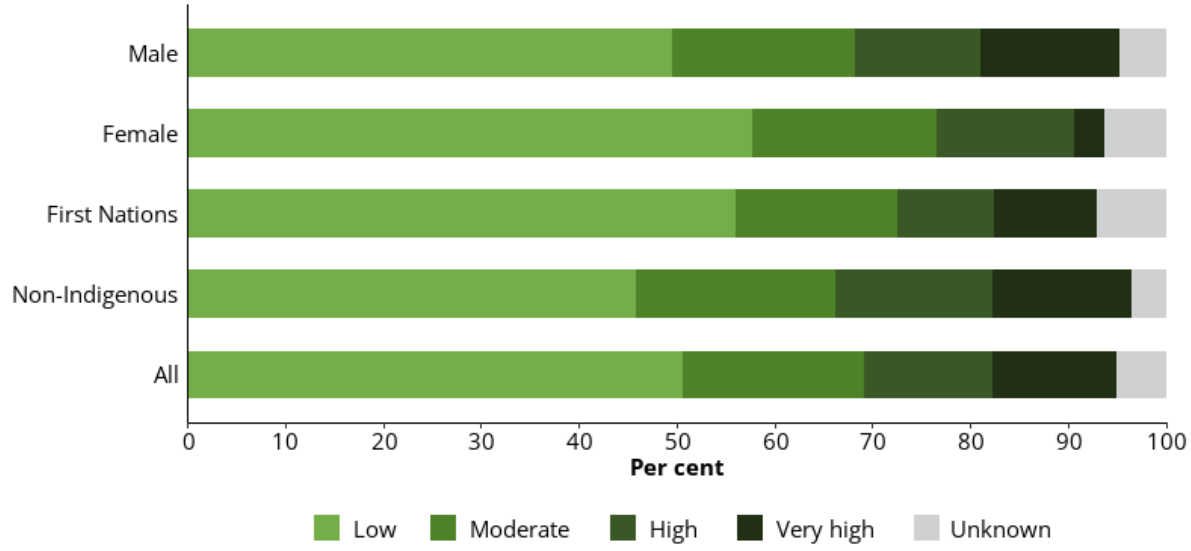


Notes

1. Proportions are proportions in this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.
3. K10 refers to the Kessler 10 scale to measure psychological distress.

Source: Entrants form, 2022 NPHDC.

Figure 5.7: Prison dischargees, K10 level of distress, by sex and Indigenous identity, 2022



Notes

1. Proportions are proportions in this data collection only, and not the entire prison population.
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3. K10 refers to the Kessler 10 scale to measure psychological distress.

Source: Dischargees form, 2022 NPHDC.

Reasons for psychological distress

Prison entrants and prison dischargees were asked to rate how concerned they were about:

- their current imprisonment
- family or relationships in the community
- relationships in prison
- mental health issues
- physical health issues
- tobacco, alcohol and/or other drugs
- any other particular issue.

Prison dischargees were also asked how concerned they were about their upcoming release.

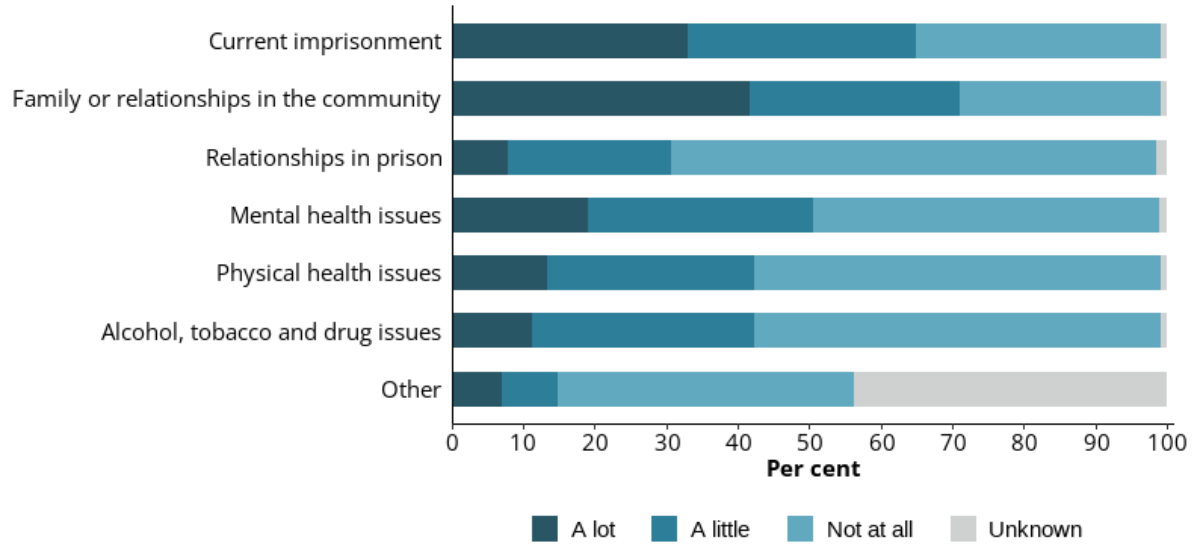
For prison entrants, the most common causes of a lot of distress were:

- family or relationships in the community (42%)
- current imprisonment (33%)
- mental health issues (19%)
- physical health issues (14%)
- issues around tobacco, alcohol and other drugs (11%)
- relationships in prison (7.8%) (Figure 5.8).

Results were generally lower for prison dischargees with the most common cause of a lot of distress being:

- family or relationships in the community (17%)
- upcoming release (15%)
- mental health issues (11%)
- current imprisonment (10%)
- physical health issues (10%)
- issues around tobacco, alcohol, and other drugs (10%)
- relationships in prison (3.2%) (Figure 5.9).

Figure 5.8: Prison entrants' level of distress, by reason for distress, 2022



Notes

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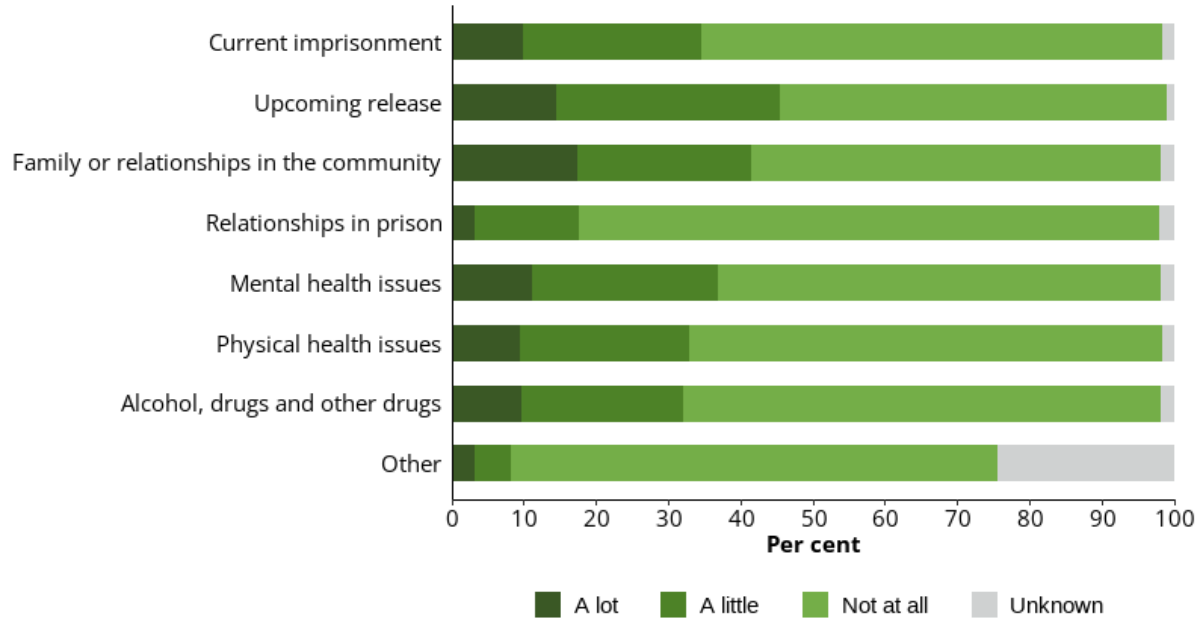
Source: Entrants form, 2022 NPHDC.

Figure 5.9: Prison dischargees' level of distress, by reason for distress, 2022



Notes

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Source: Dischargees form, 2022 NPHDC.

Self-harm

Self-harm is a broad term that refers to a person intentionally inflicting physical harm to their own body, an act that may or may not have been intended to cause death (AIHW 2022*)*.

Rates of self-harm and suicide in Australia differ between males and females. Crude rates of suicide rates in Australia were more than 3 times greater for males (19 per 100,000) than females (6 per 100,000) in 2019–20 (AIHW 2022).

Suicide rates were higher for:

- males than for females
- First Nations Australians than for non-Indigenous Australians
- those who were more socioeconomically disadvantaged.

All of these groups are over-represented in the prison population (AIHW 2022).

A history of self-harm is particularly common in the prison population where risk factors for self-harm – such as a history of childhood abuse, mental health conditions, or alcohol and other drug use disorders – are also more prevalent than in the general population (Barton et al. 2014; Stewart et al. 2018).

A recent study of the health and wellbeing of people in an Australian prison showed that people in prison were 10 times as likely as the general Australian population to report a history of suicide attempts and thoughts of suicide within the previous 12 months (Butler et al. 2018).

Prison entrants' experiences of self-harm

During the data collection period, prison entrants were asked if they:

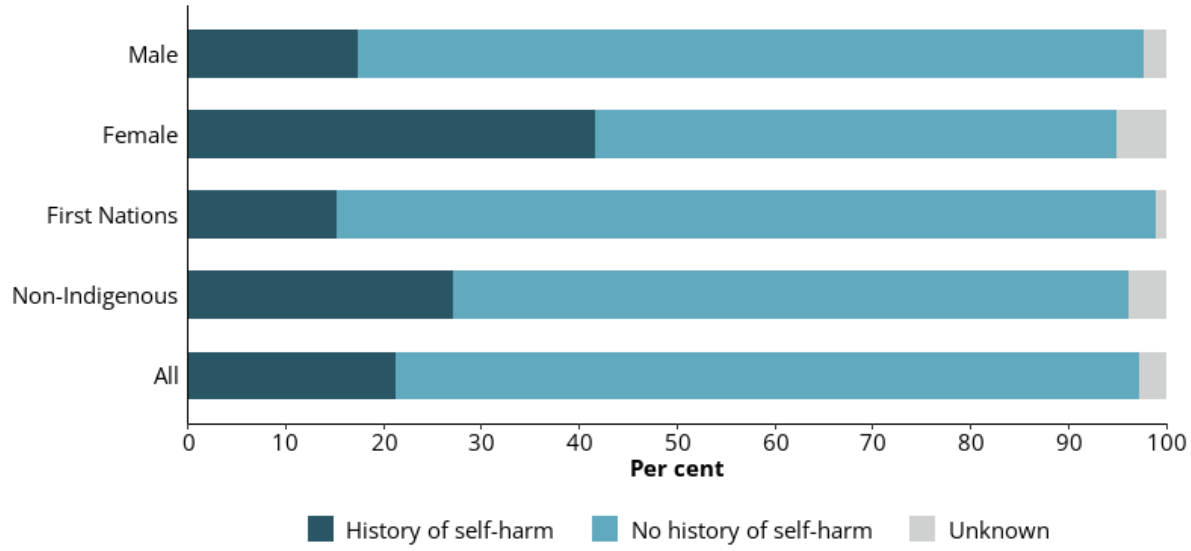
- had ever intentionally harmed themself
- had thoughts of harming themself in the last 12 months (referred to in this section as recent thoughts of self-harm).

> Over 1 in 5 (21%) prison entrants reported a history of self-harm (Indicator 1.4.7).

Female prison entrants (42%) were more than 2 times as likely to report a history of self-harm as male prison entrants (17%) (Figure 5.10).

Non-Indigenous prison entrants (27%) were more likely to report a history of self-harm than First Nations prison entrants (15%) (Figure 5.10). Prison entrants aged 18–24 (29%) were most likely to report a history of self-harm, and prison entrants aged 45 and over were least likely (15%).

Figure 5.10: Prison entrants, history of self-harm, by sex and Indigenous identity, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

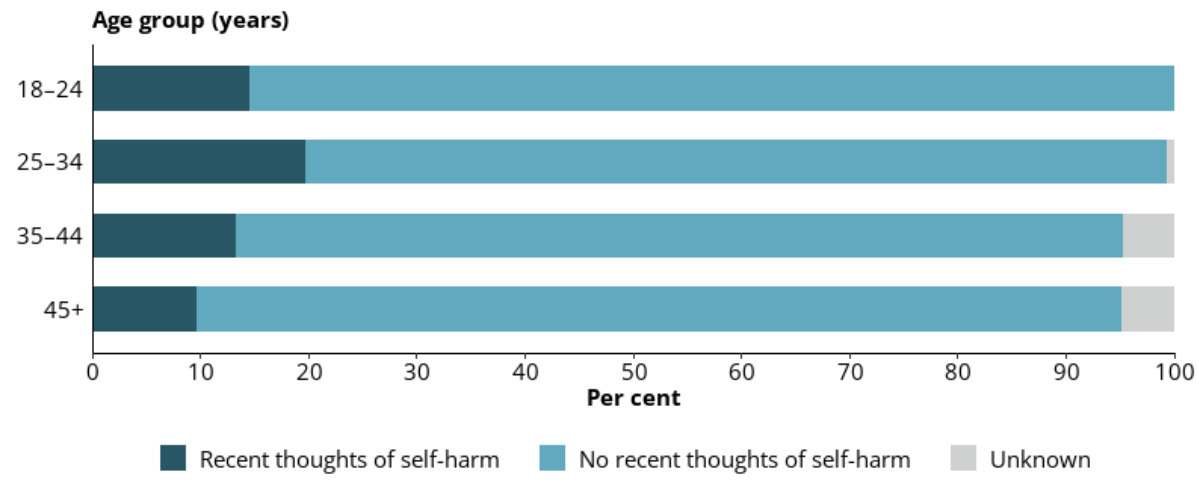
More than 1 in 7 (15%) prison entrants reported having thoughts of self-harm in the previous 12 months (Indicator 1.4.8).

Female prison entrants (30%) were over 2 times more likely to report recent thoughts of self-harm than male entrants (13%).

Non-Indigenous prison entrants (17%) were fairly similar to First Nations prison entrants (13%) in reporting recent self-harm thoughts.

Recent thoughts of self-harm were reported most in entrants aged 25–34 (20%), and least in entrants aged 45 and over (9.8%) (Figure 5.11).

Figure 5.11: Prison entrants, thoughts of self-harm in the previous 12 months, by age, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Identification of self-harm or suicide risk

At the end of the prison entrants' survey, staff administering the survey were asked if the participant was identified as currently at risk of self-harm or suicide (excluding at 4 prisons in New South Wales where researchers administered surveys).

Participants identified at risk of self-harm or suicide should be supported according to best practice at the prison.

> One in 16 (6.3%) prison entrants were identified by staff as being at risk of self-harm or suicide (Indicator 1.4.9).

Female entrants (28%) were 8 times more likely than male entrants (3.6%) to be identified as being at risk of self-harm. Non-Indigenous entrants (6.8%) were similarly as likely to be identified as at risk as First Nations entrants (5.4%).

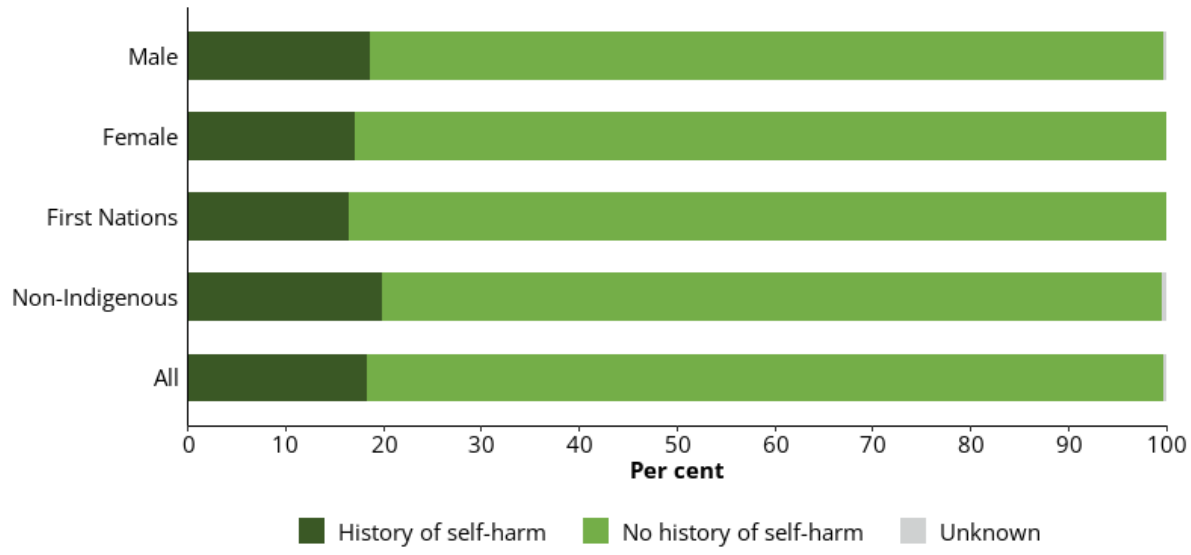
Prison dischargees experiences of self-harm

Prison dischargees were asked if they had ever intentionally harmed themselves before their current incarceration and if they had intentionally harmed themselves during their current period in prison.

Almost 1 in 5 (18%) prison dischargees reported a history of self-harm before their current incarceration.

Female prison dischargees (17%) were similar to male dischargees (19%) in reporting a history of self-harm. Non-Indigenous prison dischargees (20%) were similarly as likely to report a history of self-harm as First Nations dischargees (17%) (Figure 5.12).

Figure 5.12: Prison dischargees, history of self-harm before current incarceration, by sex and Indigenous identity, 2022



Notes

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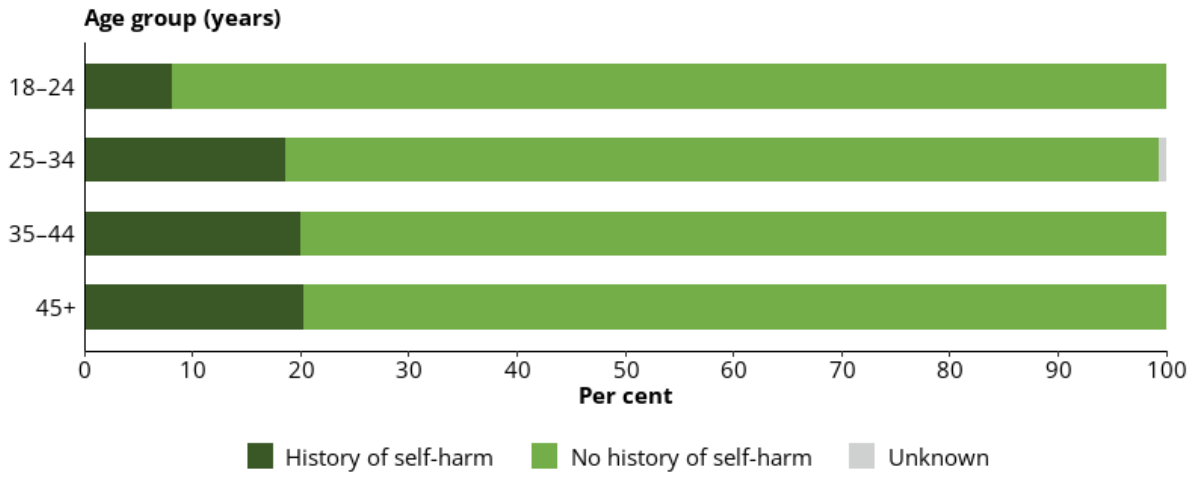
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

The likelihood of prison dischargees reporting a history of self-harm before their current incarceration increased with age – from 1 in 13 (8.2%) prison dischargees aged 18–24 to 1 in 5 (20%) dischargees aged 45 and over (Figure 5.13).

Figure 5.13: Prison dischargees, history of self-harm before current incarceration, by age, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

The proportion of prison dischargees reporting intentionally harming themselves in prison was lower than those reporting having self-harmed at some stage in their lives.

One in 20 (5.1%) prison dischargees reported having harmed themselves during their current period in prison (Indicator 1.4.10).

Male dischargees were similarly as likely to report intentional self-harm during their current period in prison (5.5%) as female dischargees (3.1%), and non-Indigenous dischargees (6.1%) were similarly as likely to do so as First Nations dischargees (4.0%).

Self-harm while in prison was most reported in prison dischargees aged 25–34 (7.7%) and least reported in dischargees aged 18–24 (2.0%).

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Reproductive health

Females in prison are a particularly vulnerable group (Breuer et al. 2021). They experience more challenges to their health and wellbeing than males in prison – and than females in the general community.

Compared with females in the general community, females in prison are far more likely to have been pregnant, to have been pregnant at a young age, and to have had multiple pregnancies – all of which take a substantial physical toll (Jones et al. 2018; Olsson et al. 2014).

Females in prison are more likely to be single parents, and more likely to be socioeconomically disadvantaged than those in the community (Earle 2018; Jones et al. 2018).

The vast majority of women in the criminal justice system are mothers, and many also have non-biological children who depend on them (Jones et al. 2018) (see 'Socioeconomic factors' for information on people in prison with dependent children).

The effects of separating mothers from their children, even for short periods of time, can be devastating for all individuals involved (Poehlmann 2005). Children of incarcerated mothers are more likely to be in out-of-home care (often permanently), and children in out-of-home care are more likely to have contact with the criminal justice system (Dowell et al. 2018; Dowell et al. 2019; Millar and Dandurand 2018; Paynter et al. 2019; Remond et al. 2023).

Pregnancies

Most females in prison are mothers – and, on average, had their first pregnancy at a much younger age than females in the general community (AIHW 2019, 2023).

When compared with females who become pregnant after prison, females in Australia who are pregnant either before or during incarceration are more likely to have poorer birth outcomes, including babies of low birthweight, and to have children placed in out-of-home care by the age of 2 (Dowell et al. 2018).

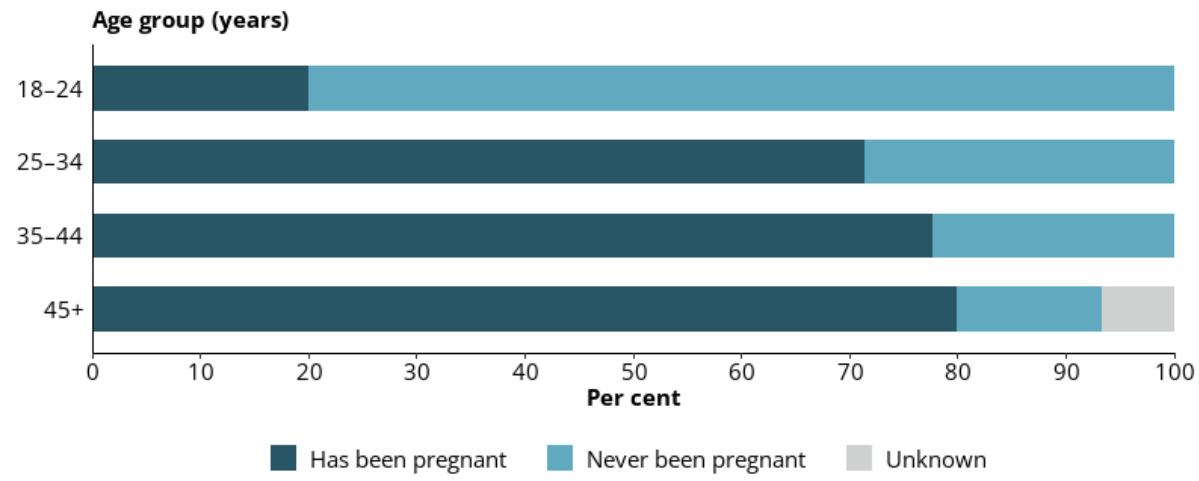
Prison entrants who have been pregnant

Female prison entrants were asked whether they had been pregnant at some stage in their lives, and their age at their first pregnancy.

> Over 7 in 10 (72%) female prison entrants reported they had been pregnant at some stage in their lives (Indicator 1.5.1).

Female entrants aged 18–24 were the least likely to report they had been pregnant at some stage in their lives (20%) (Figure 6.1). Female entrants aged 45 and over were the most likely to report being pregnant at some stage in their lives (80%).

Figure 6.1: Female prison entrants, history of pregnancy, by age, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

The average age at first pregnancy was 19.6 years (Indicator 1.5.2).

The average age at first pregnancy was 17.5 for Indigenous females, and 20.6 for non-Indigenous females.

Females in custody who were pregnant

When compared with pregnant females in the community, pregnant females in prison are likely to have more mental health issues, and are more likely to smoke tobacco and to have used alcohol and other drugs while pregnant before incarceration (Dowell et al. 2018; Dowell et al. 2019; Knight and Plugge 2005; Mukherjee et al. 2014).

Imprisonment during pregnancy can provide females with better access to medical care. However, this may not be enough to mitigate the poorer health outcomes for mother and child, given the existing disadvantages. As well, with many females on remand and incarcerated for short periods – sometimes multiple times during the pregnancy – perinatal care might be interrupted, risking poorer outcomes for mother and child (Dowell et al. 2018; Dowell et al. 2019).

About 7.0 per 100 females received into custody in 2021 were pregnant (Indicator 1.5.3).

In 2021, 164 females in custody in participating prisons were pregnant. This represented about 7% of the 2,348 females received into participating prisons during that year. However, as females cycle through the criminal justice system, the same pregnant female might be received into custody several times throughout her pregnancy, and some females will not yet know they are pregnant.

Cervical screening

The National Cervical Cancer Screening Program recommends a Cervical Screening Test for females aged 25–74 every 5 years, to check for the presence of human papillomavirus, a common virus that can cause cervical cancer. This renewed cancer screening program was introduced in December 2017 and replaced the Pap test every 2 years in females aged 18– 69 (Cancer Council Australia 2022; Department of Health and Aged Care 2022).

Prison entrants screened for cervical cancer

> More than a half (55%) of female prison entrants reported having received a screening for cervical cancer in the previous 5 years (Indicator 1.5.4).

Female prison entrants reported higher rates of cervical cancer screening than females in the general community (55% compared with 46%) (AIHW 2021). However, rates were lower among First Nations entrants (41%) than among non-Indigenous entrants (65%).

Prison dischargees screened for cervical cancer

> Nearly 2 in 5 (38%) female prison dischargees reported receiving a cervical cancer screening in prison (Indicator 1.5.5).

First Nations female dischargees were more likely to report receiving a cervical cancer screening in prison (46%) than non-Indigenous female dischargees (29%).

The majority of female dischargees had been in prison for less than 12 months. With cervical screening recommended every 5 years, many dischargees might not have been due for a cervical cancer screening during their period of incarceration.

Mammograms

Female dischargees were asked whether they had received a mammogram (a screening test for breast cancer) while in prison or in the past 2 years.

> Almost 1 in 33 (3.1%) female prison dischargees reported receiving a mammogram while in prison (Indicator 1.5.6).

Female prison dischargees aged 45–54 were the most likely to report receiving a mammogram (17%).

The Royal Australian College of General Practitioners recommends a mammogram every 2 years for females aged 50–74 who are at average, or only slightly higher, risk of breast cancer. Annual mammograms from age 40 may be recommended for females with a moderately increased, or a potentially high risk, of breast cancer, or for those carrying a mutation (RACGP 2021).

The prison population is young relative to the wider Australian population, and very few females in prison in Australia are aged 50 and over. These females were even less likely to be captured through the prison dischargee survey and might have had a mammogram on schedule in the community.

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Deaths

This chapter presents data on deaths that occur while in prison or after release from prison.

Deaths that occur in prison can happen for similar reasons to the deaths of people in the community, such as natural causes, illness or suicide. The Australian Institute of Criminology monitors deaths in prison (McAlister and Bricknell 2022).

Deaths that occur after release from custody are often due to preventable causes, such as suicide, injury or overdose. People who leave prison are at a higher risk of death than the general population, particularly in the first month after release (Bukten et al. 2022; Forsyth et al. 2018).

Deaths in custody

There are many reasons a person might die while in prison or in police custody. Similar to deaths in the community, people in prison die from illness, accidents and injuries, ageing and suicide. Over the past 2 decades, with the prison population ageing at a rapid rate, deaths from natural causes have increased.

Data on deaths in custody came from the Australian Institute of Criminology report *Deaths in custody in Australia 2021–22* (McAlister and Bricknell 2022).

Deaths in custody comprise deaths in prison custody and in police custody. Deaths in prison custody include deaths in prison or youth detention facilities, deaths that occur during transfer to or from these facilities, and deaths in medical facilities after transfer from these facilities (McAlister and Bricknell 2022). This section presents deaths in prison custody, unless otherwise specified.

The Australian Institute of Criminology monitors deaths in custody through the National Deaths in Custody Program, which was established in 1992 following the 1989 Royal Commission into Aboriginal Deaths in Custody.

The National Deaths in Custody Program found that:

- between 1979–80 and 2021–22, 3,310 people died in custody (including 2,157 in prison custody), of which 19% were First Nations people and 80% were non-Indigenous Australians
- between 1979–1980 and 2021–22, over half (58%) of First Nations people who died in prison custody were younger than 40, compared with 44% of non-Indigenous people who died in prison custody
- the most common causes of death since 2000–01 were natural causes (65% of all prison custody deaths since 2000–01)
- cause of death by hanging fell from 43% of deaths in prison in 2000–01 to 22% in 2021– 22
- between 2000–01 and 2021–22, non-Indigenous Australians were more likely to die in prison custody than First Nations people (McAlister and Bricknell 2022).

In 2021–22, 84 people died in prison custody (Indicator 1.6.1).

Of the 84 people who died in prison custody in 2021–22:

- 16 deaths were First Nations people (death rate of 1.2 per 1,000 First Nations people in prison)
- 68 were non-Indigenous people (death rate of 2.4 per 1,000 non-Indigenous people in prison) (McAlister and Bricknell 2022).

In 2021–22, 80 males (2.1 per 1,000 males in prison) and 4 females (1.3 per 1,000 females in prison) died in prison. Due to the relatively small number of females in prison, female death rates in prison were more likely to fluctuate over time.

The average (mean) age at death of people in prison in 2021–22 was 55 and the most common (median) age at death was 54.5.

The median age at death of people in prison in 2021–22 was lower for First Nations people in prison (43) than for non-Indigenous people in prison (57). This is consistent with the younger age of First Nations people in prison, and the lower life expectancy and higher mortality rate of First Nations people in the community, when compared with non-Indigenous Australians (Phillips et al. 2017).

In 2022, the mean age for First Nations people in prison was 34.4 (median age of 33), compared with 39.5 for non-Indigenous Australians (median age of 37) (ABS 2023). In 2021– 22, a half (50%) of the deaths in prison were people aged 55 and above.

In 2021–22, there were a total of 84 deaths in prison of which:

- 70% (59 people) were of people sentenced, and 30% (25 people) of people on remand
- less than a half (46%) occurred in a hospital setting, either in a public hospital (26%) or in a prison hospital (19%)
- less than a half (46%) died in their cell.

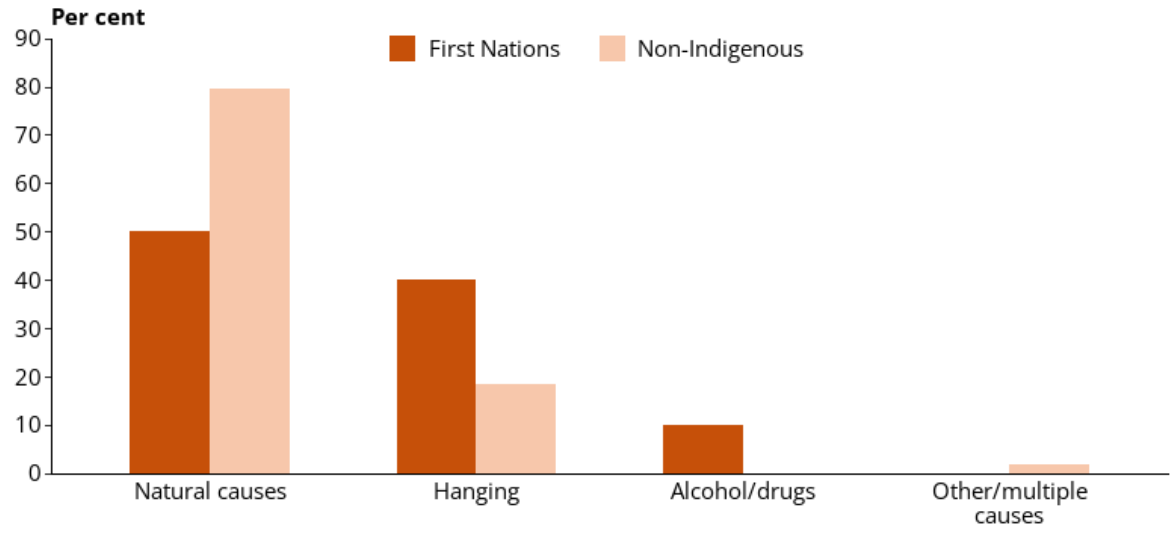
Of the 64 deaths in prison custody in 2021–22 where the cause of death was recorded:

- the majority (75%) were from natural causes
- a half (50%) of First Nations deaths and 4 in 5 (80%) non-Indigenous deaths were from natural causes (Figure 7.1).

Of the 63 deaths in prison custody in 2021–22 where the manner of death was recorded:

- one-quarter (25%) were deaths from suicide, or self-inflicted causes
- there were no deaths from homicide.

Figure 7.1: Deaths in prison custody, by Indigenous identity and cause of death, 2021–22



Source: Australian Institute of Criminology, 2022.

Deaths following release from prison

People recently released from prison are at a higher risk of illness and death than the general population (Zlodre and Fazel 2012).

The risk of death is especially high in the first month after release, and the causes of death during this time are usually preventable – they include suicide, injury and overdose (Binswanger et al. 2007; Bukten et al. 2022; Forsyth et al. 2018; Kariminia et al. 2007; Stewart et al. 2004).

The risk of suicide among people recently released from prison is more than 6 times as high as that for the general population (Jones and Maynard 2013).

The risk of suicide for those recently released from prison is about 14 times as high for females, and about 5 times as high for males, as for females and males in the general population (Spittal et al. 2014).

Among people recently released from prison, rates of deaths from suicide are similar to rates of drug-related deaths (Spittal et al. 2014; van Dooren et al. 2013).

On release from prison, most people are eligible to apply for a crisis payment from Centrelink. In the 2022 NPHDC, more than a half (53%) of prison dischargees reported that they expected to receive a crisis payment from Centrelink.

People released from prison may also continue to receive payments from Centrelink in the form of income support. If a death occurs, it is usually recorded as the reason for cessation of Centrelink benefits in Department of Social Services data, which were used to estimate the number of deaths after release from prison. This is a validated method of estimating deaths following release from prison (Kinner and Forsyth 2016). However, because some individuals do not receive a crisis payment from Centrelink, and because not all people who die after release from custody are receiving Centrelink benefits at the time of death, this method may underestimate deaths.

Crude death rates for people released from prison were calculated as the number of deaths recorded in the Centrelink data divided by the total number of people recorded in the Centrelink data who had received the post-release crisis payment.

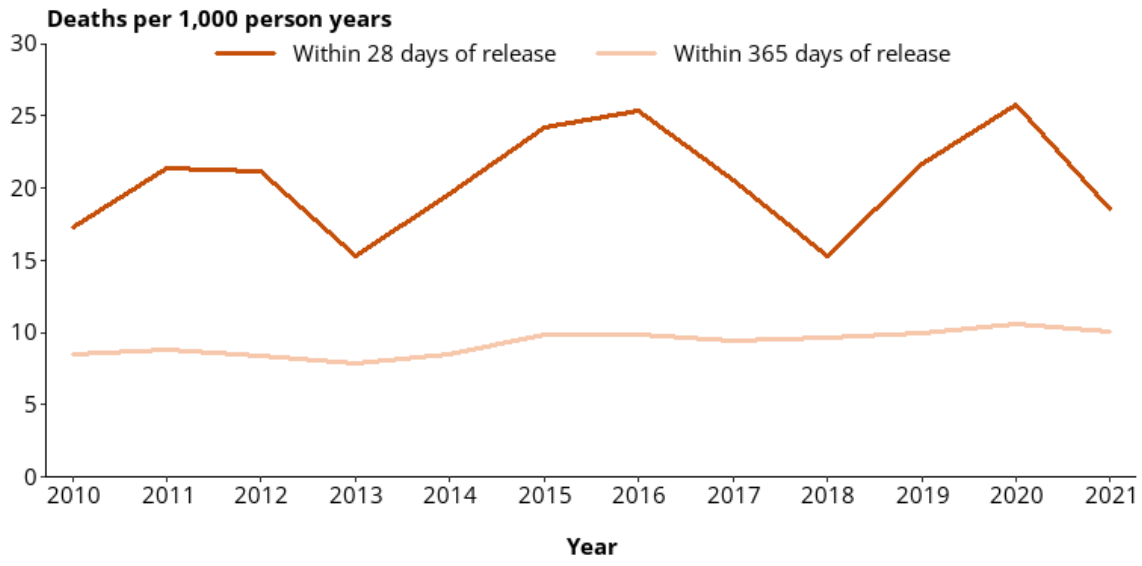
Since the 2018 NPHDC, people released from prison are counted once only, regardless of how many times they had been incarcerated over the previous month or year. This means that a single death is much less likely to be linked to multiple releases. As a result, the crude death rates have increased compared with those in previous calculations. As the method for death rate calculation has changed, current estimates in the NPHDC should not be compared with estimates before 2018.

Death rates were calculated for the first 28 days following prison release, and for the first year (365 days) following release.

Due to the relatively small numbers of the post-release prison population, and the small numbers of deaths within that population, the crude death rates vary from year to year (Figure 7.2).

In 2021, people released from prison were more likely to die within the first 28 days of release (18.5 per 1,000 person years) than within 365 days of release (10.1 per 1,000 person years) (Figure 7.2).

Figure 7.2: Trends in deaths within 28 days and 365 days of release from prison, per 1,000 person years, 2011–2021 (crude death rate)



Note: Calculations are based on the number of deaths released within the preceding 28 days or 365 days and the total number of people released.

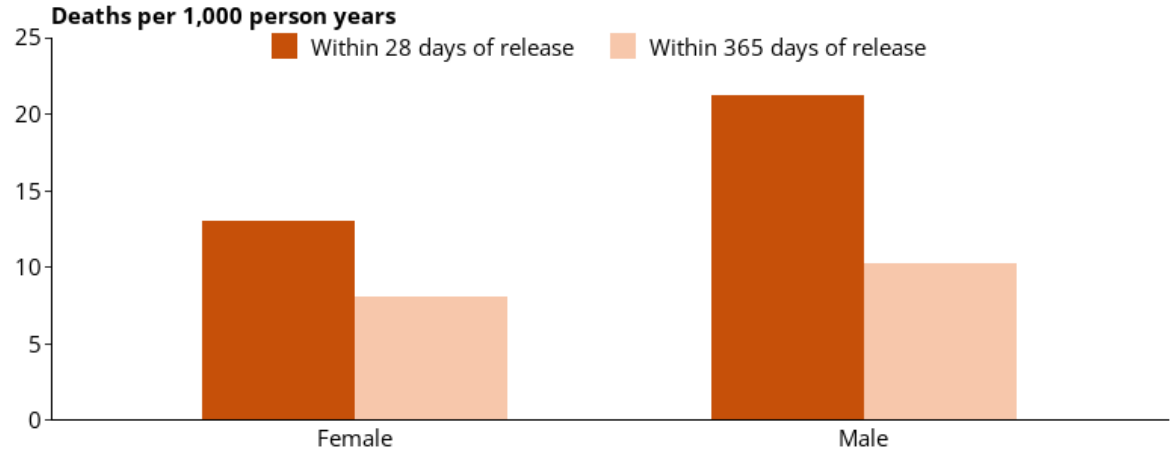
Source: AIHW calculations of data supplied by the Department of Social Services 2023.

In 2021, the crude death rate for people within 28 days of release from prison was 1.4 deaths per 1,000 people released from prison. This equates to 18.5 deaths per 1,000 person years (Indicator 1.6.2).

In the same year, the crude death rate for people within 365 days of release from prison was 10.1 deaths per 1,000 people released from prison. This equates to 10.1 deaths per 1,000 person years (Indicator 1.6.3).

Males were 1.6 times as likely to die within 28 days of release (1.6 per 1,000 males released, or 21.2 per 1,000 person years) as females (1.0 per 1,000 females released, or 13.0 per 1,000 person years). Males were similarly as likely to die within 365 days of release (10.2 per 1,000 males released, or 10.2 per 1,000 person years) as females (8.0 per 1,000 females released, or 8.0 per 1,000 person years) (Figure 7.3).

Figure 7.3: Deaths within 28 days and 365 days of release from prison, per 1,000 person years, by sex, 2021 (crude death rate)



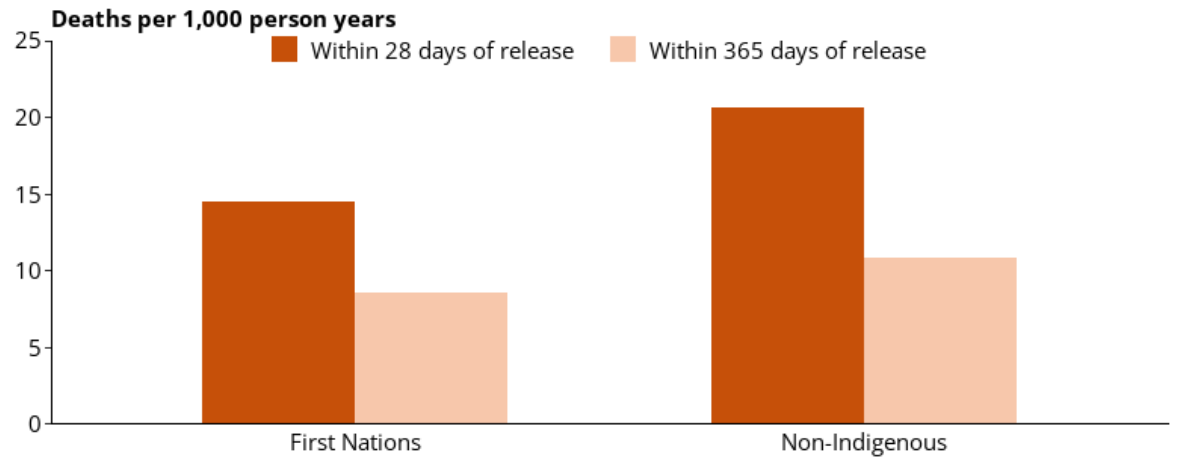
Note: Calculations are based on the number of deaths released within the preceding 28 days or 365 days and the total number of people released.

Source: AIHW calculations of data supplied by the Department of Social Services 2023.

Non-Indigenous Australians were more likely to die within 28 days of release (1.6 per 1,000 non-Indigenous people released, or 20.6 per 1,000 person years) than First Nations people (1.1 per 1,000 First Nations people released, or 14.5 per 1,000 person years).

Non-Indigenous Australians were also more likely to die within 365 days of release (10.9 per 1,000 non-Indigenous people released, or 10.9 per 1,000 person years) than First Nations people (8.6 per 1,000 First Nations people released, or 8.6 per 1,000 person years) (Figure 7.4).

Figure 7.4: Deaths within 28 days and 365 days of release from prison, per 1,000 person years, by Indigenous identity, 2021 (crude death rate)



Note: Calculations are based on the number of deaths released within the preceding 28 days or 365 days and the total number of people released.

Source: AIHW calculations of data supplied by the Department of Social Services 2023.

People aged 55 and over were more likely than younger people to die, both within the first 28 days of release and within 365 days of release.

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Socioeconomic factors

People in contact with the criminal justice system have higher rates of homelessness and unemployment and often come from socioeconomically disadvantaged backgrounds. People leaving prison are members of society needing employment, housing and other support services in the community to maintain and improve health and wellbeing, and reduce the likelihood of returning to prison (AIHW 2019).

This section reports on socioeconomic factors that might affect the health or wellbeing of prison entrants and dischargees, including detention history, parental imprisonment, family contact, cultural background, education, employment and access to housing.

Detention history

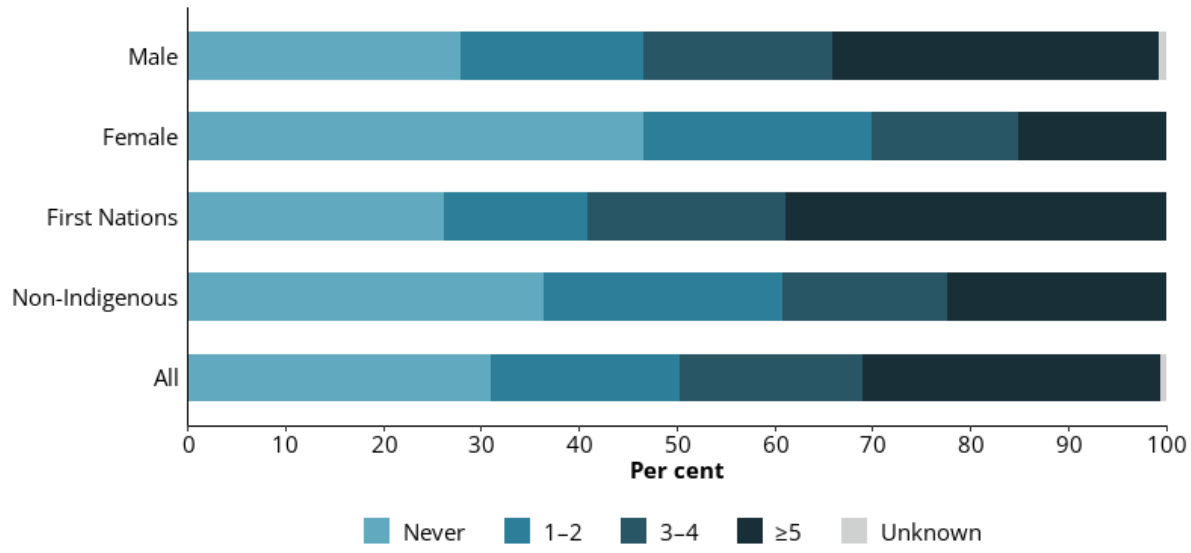
About 2 in 3 (68%) prison entrants reported they had previously been in an adult prison. Almost one-third (30%) had been in prison at least 5 times before, and 31% had never been previously incarcerated in the adult prison system (Figure 8.1).

Almost 1 in 5 (19%) prison entrants had previously been in youth detention. Of those previously in youth detention, almost two-thirds (64%) were in youth detention 1–2 times and just over one-quarter (26%) at least 5 times.

Male prison entrants were more likely to report extensive prison histories than female entrants (Figure 8.1). About one-third (33%) of male entrants had been in prison 5 or more times, compared with 15% of females. About one-third of male entrants (28%) and almost a half of female entrants (47%) had never been in prison before. Female entrants (88%) were more likely than male entrants (79%) to have never been in youth detention before.

One-quarter (25%) of First Nations prison entrants had never been in prison before, while almost 2 in 5 (39%) had been in prison at least 5 times before. One-quarter (25%) of First Nations prison entrants had been to youth detention at least once before.

Figure 8.1: Prison entrants, previous number of times in an adult prison, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which, did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Family

Family history of incarceration

When an individual is incarcerated, it affects their entire community (Besemer et al. 2018; Jardine 2018; Remond et al. 2023). Most people who enter prison leave a family, and often dependent children, in the community (Flynn et al. 2015). This can become an intergenerational problem; many people in prison had a parent in prison during their own childhood (Dennison and Besemer 2018; Troy et al. 2018).

Imprisonment of mothers and fathers can be harmful to the health and wellbeing of the parent and the child, particularly if the parent–child relationship is severed (Bartlett and Trotter 2019; Dennison and Smallbone 2015; McIntyre 2017; Wildeman et al. 2018).

Maintaining and improving family relationships results in a better transition from prison to the community, reduced re-offending, and better health and welfare outcomes for the person in the prison system and their children and families (Troy et al. 2018).

> One in 4 (25%) prison entrants reported that 1 or more of their parents or carers had been in prison during their childhood (Indicator 2.1.1).

Of 183 First Nations prison entrants, 1 in 3 (36%) reported having had parents or carers in prison during their childhood.

Of 184 non-Indigenous prison entrants, 1 in 7 (15%) reported having had parents or carers in prison during their childhood.

Younger prison entrants were almost 3 times more likely than older entrants to report having had a parent or carer in prison during their childhood (42% of entrants aged 18–24 and 16% of entrants aged 45 and over).

Female prison entrants were more likely to report having had a mother (17%) than a father (8.3%) in prison during their childhood. Conversely, male prison entrants were more likely to report having had a father (22%) than a mother (5.5%) in prison during their childhood.

Dependent children in the community

> Two in 5 (40%) prison entrants reported that they had children in the community who were dependent on them for their basic needs (Indicator 2.1.2).

Almost a half (47%) of First Nations prison entrants had dependent children, compared with one-third (34%) of non-Indigenous entrants.

Females (33%) were less likely than males (41%) to have dependent children.

Contact with family, friends and/or elders

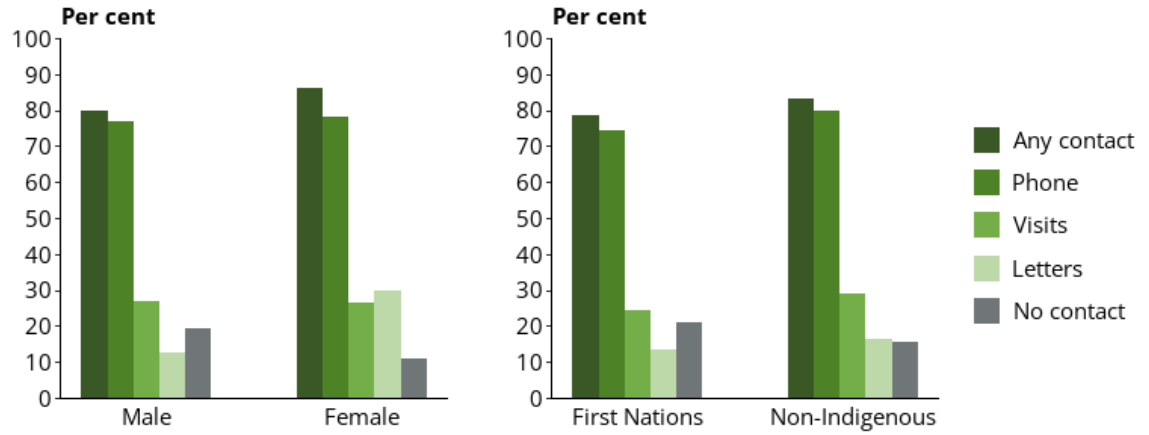
Transitioning from prison to the community can be challenging, and people released from prison make a more successful transition if they have culturally appropriate psychosocial support (Abbott et al. 2018).

Strong and supportive relationships with family, friends or elders in the community can help with the transition (Abbott et al. 2018; Besemer et al. 2018). Men and younger people are particularly vulnerable compared with females and older people transitioning from prison, having typically lower levels of social support in the community (Pettus-Davis et al. 2018).

> About 4 in 5 (81%) dischargees reported having contact with family, friends and/or elders in the community in the past 4 weeks (Indicator 2.1.3).

Non-Indigenous dischargees (83%) were fairly similar to First Nations dischargees (79%) in reporting recent contact with family, friends or elders in the community. Females (86%) were more likely than males (80%) to report having done so (Figure 8.2). Phone contact was most common (77%), followed by visits (27%) and receiving letters (15%). Almost 1 in 5 (18%) dischargees reported having had no recent contact with family, friends or elders.

Figure 8.2: Prison dischargees, type of contact with family, friends or elders in the previous 4 weeks, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of prison dischargees in this data collection, and not the entire prison population.
2. Multiple responses were allowed.
3. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Language and birthplace

People in prison who were born overseas or whose first language is not English face added challenges during imprisonment, such as additional isolation, discrimination and marginalisation (Shepherd 2016; Watt et al. 2018).

Prison entrants and prison dischargees were asked about their country of birth and the primary language they spoke. It was a condition of obtaining consent that participants had to be able to understand the process of consent. As a result, this group of people might be under-represented in this data collection.

Most prison entrants (90%) and dischargees (90%) surveyed were born in Australia. English was the main language spoken at home (84% of prison entrants, and 81% of dischargees). Australian Indigenous languages were the second most common language, with 8.7% of prison entrants and 9.4% of prison dischargees speaking an Indigenous language at home.

Education

Education is a recognised social determinant of health, with lower levels of education associated with poorer health (Mitrou et al. 2014).

In 2021, 58% of people in the general community aged 17 and over reported completing year 12. Almost 1 in 10 (9.7%) people in the general community aged 15 and over were completing vocational education or undertaking a university degree or other higher education (ABS 2022).

While the prison population cannot be directly compared with the general community due to differences in age structure and other factors, tertiary qualifications are more prevalent in the

community. In 2022, almost 2 in 5 (37%) people aged 20–64 in the general community reported attaining a bachelor's degree or higher (ABS 2022).

People in prison have lower levels of educational attainment and higher levels of learning difficulty and learning disability than people in the general community (AIHW 2019; Kendall and Hopkins 2019; Skues et al. 2019).

Lower levels of educational attainment are associated with poorer employment opportunities and outcomes, and unemployment is a risk factor for incarceration and for re-offending after release (Baldry et al. 2018).

Education completed by prison entrants

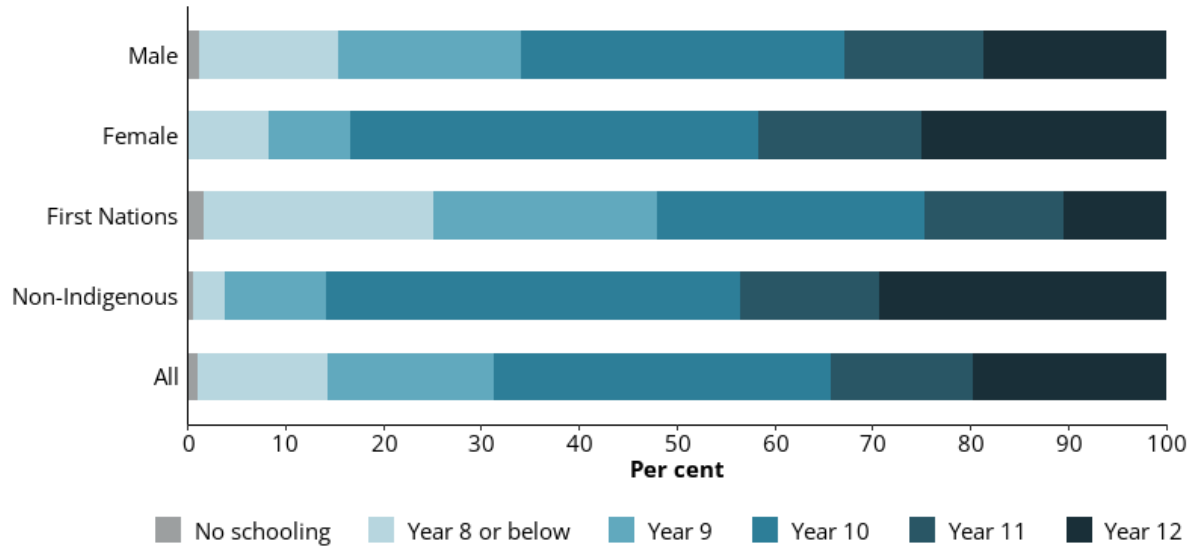
Prison entrants were asked about the highest level of schooling they had completed and about any qualifications they had attained other than school.

> For 1 in 3 (31%) prison entrants, the highest level of completed schooling was year 9 or under (Indicator 2.1.4).

Over two-thirds of prison entrants (69%) had completed schooling to year 10 or higher and 1 in 5 (20%) had completed the equivalent of year 12 (Figure 8.3).

For 13% of prison entrants, their highest level of schooling was year 8 or below.

Figure 8.3: Prison entrants, highest level of schooling completed, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of prison entrants in this data collection, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Of 183 First Nations prison entrants, over half (52%) reported completing year 10 or higher, while 1 in 10 (10%) completed year 12. About a quarter of First Nations prison entrants (24%) reported their highest level of completed schooling as year 8 or below.

Of 184 non-Indigenous prison entrants, 86% reported completing year 10 or higher, while one-third reported completing year 12 (29%). One in 30 non-Indigenous entrants (3.3%) reported their highest level of completed schooling as year 8 or under.

Almost 2 in 5 (37%) prison entrants had completed a trade certificate, while more than a half (54%) had no formal education other than schooling.

One in 20 (5.1%) prison entrants were studying, either full time or part time, during the 30 days before entering prison.

Education at the tertiary level was not common – the highest level of completed education for entrants was a diploma (4.6%), followed by a bachelor's degree (2.7%), and a postgraduate qualification (0.5%).

Education completed by prison dischargees

People in prison, particularly if sentenced, might be able to complete some study or a qualification. These educational attainments can improve self-confidence, have a positive impact on employment outcomes after release from prison, and reduce the likelihood of re-offending (Baldry et al. 2018).

Prison dischargees were asked if they had completed any qualifications while in prison.

> One in 4 (23%) prison dischargees reported completing a qualification while in prison (Indicator 2.1.5).

One in 5 (20%) prison dischargees reported that they finished a trade qualification while in prison, and 4.9% reported completing secondary school. Some dischargees completed more than one qualification while in prison.

First Nations dischargees (23%) and non-Indigenous dischargees (24%) were similarly as likely to report completing a qualification while in prison. Of First Nations dischargees, 4.5% reported completing secondary school, and 19% reported completing a trade certificate while in prison.

Of non-Indigenous dischargees, 5.2% reported completing secondary school, and 21% reported completing a trade certificate while in prison.

Employment

Employment is a social determinant of health, and unemployment is linked with a number of poor psychosocial outcomes, including mental health issues, alcohol and other drug use disorders, and crime (Fergusson et al. 2013; Winter et al. 2019).

People in contact with the criminal justice system already face difficulties in gaining employment, with lower educational attainment, lower socioeconomic status, higher levels of alcohol and other drug use disorders and higher levels of mental health conditions compared with the general community (Sullivan et al. 2019).

A history of detention adds another barrier to employment, particularly for those who have been in prison for longer than 6 months (Ramakers et al. 2014; Winter et al. 2019).

Employment before prison

Prison entrants were asked to describe their employment status in the 30 days before entering prison.

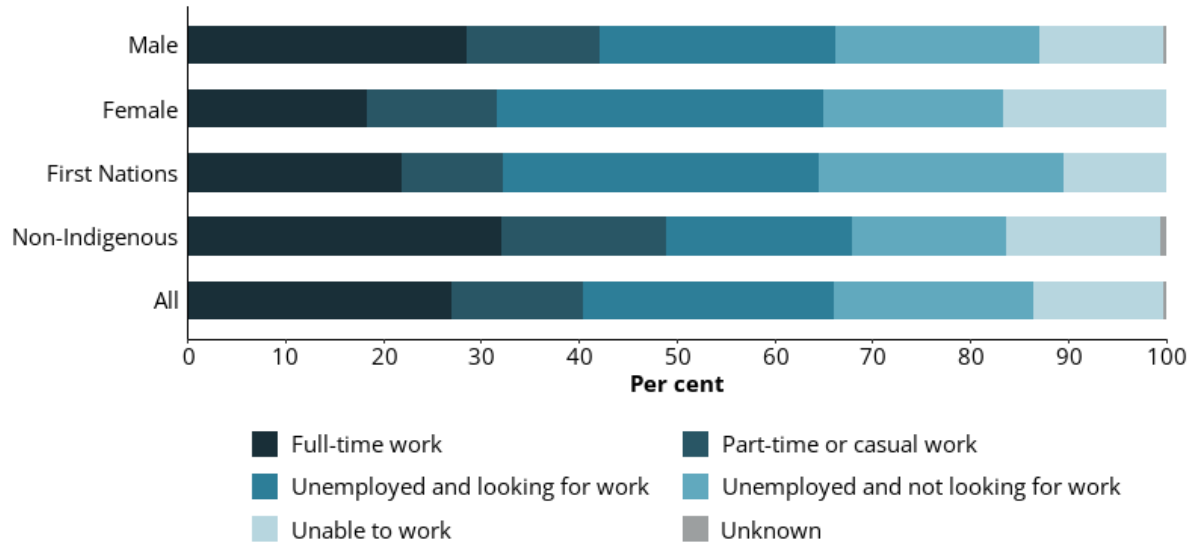
Less than a half (46%) of prison entrants reported they were unemployed during the 30 days before prison (Indicator 2.1.6).

Two in 5 (40%) prison entrants were employed in the 30 days before prison. About 1 in 8 (13%) entrants reported being unable to work due to disability, age, or health conditions (Figure 8.4). Of the 171 entrants who were unemployed, 56% were looking for work while 44% were not looking for work.

One in 3 First Nations entrants (32%) reported they were employed during the 30 days before entering prison, while over a half (57%) reported being unemployed. About 1 in 2 (49%) non-Indigenous entrants reported that they were employed during the 30 days before entering prison, while about 1 in 3 (35%) reported being unemployed (Figure 8.4).

Two in 5 (40%) prison entrants were working, either full time (27%) or part time (13%) before being imprisoned. More males (42%) reported being employed than females (32%), while females (33%) were more likely than males (24%) to report they were unemployed and looking for work (Figure 8.4).

Figure 8.4: Prison entrants, employment status in the 30 days before entering prison, by sex and Indigenous identity, 2022



Notes

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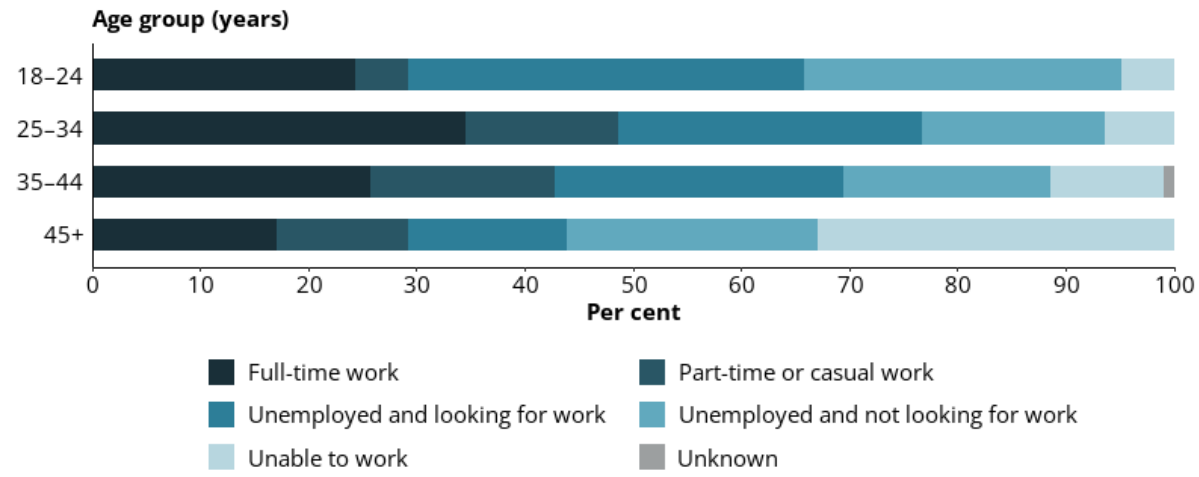
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Ability to work varied by age. One in 3 (33%) prison entrants aged 45 and over reported being unable to work, compared with 4.9% of those aged 18–24 (Figure 8.5).

Young prison entrants aged 18–24 were the group most likely to report being unemployed and looking for work (37%), compared with prison entrants aged 45 and over (15%) (Figure 8.5).

Figure 8.5: Prison entrants, employment status in the 30 days before entering prison, by age, 2022



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Source: Entrants form, 2022 NPHDC.

Employment in prison

Employment while in prison is an indicator of government objectives to provide programs and services that address the causes of offending and the limited vocational skills and the poor employment history of some people in prison (which is a key contributor to decreasing recidivism).

Data on prisoner employment came from the Productivity Commission Report on Government Services 2023 (Productivity Commission 2023). Prisoner employment is defined as the number of prisoners employed as a percentage of those eligible to work. Prisoners who are eligible to work exclude those who:

- are unable to work for reasons of ill health or their relatively short periods of imprisonment
- are in full-time education or other full-time programs
- have a protection status that precludes their access to employment
- are fine defaulters in custody for a few days only
- are hospital patients or unable to work due to old age
- are in centres where the jurisdiction's policy is not to provide work, or where work is unavailable
- are remandees who choose not to work.

Due to factors such as local economic conditions – which affect the capacity to attract commercially viable prison industries, causing employment rates to fluctuate – these results should be interpreted with caution.

Almost 4 in 5 (80%) people eligible to work in prison were employed in prison in 2021–22 (Indicator 2.1.7).

Between 2021–22, 80% of prisoners eligible to work were employed while in prison:

- 51% worked in service industries
- 29% worked in commercial industries
- 0.4% working in work release programs.

Prisoner employment was lower for First Nations people eligible to work (71%) than for non-Indigenous people eligible to work (84%).

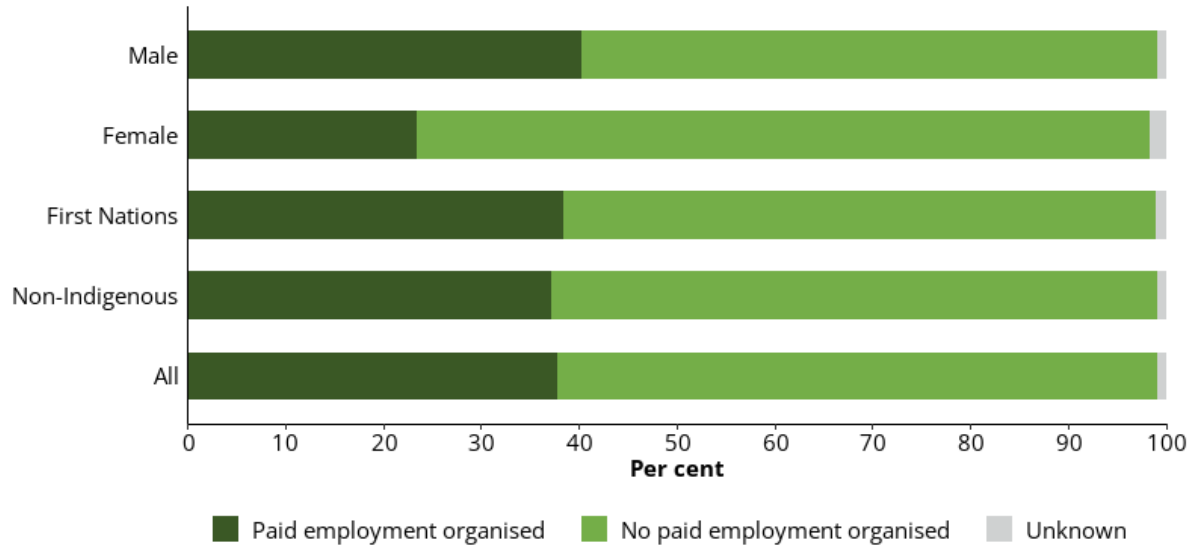
Employment status on release from prison

Almost 2 in 5 (38%) prison dischargees had paid employment organised to start within 2 weeks of release from prison (Indicator 2.1.8).

Of 431 prison dischargees, 19% said they had full-time employment organised within 2 weeks of release, 8.8% said they had part-time employment and 10% said they had casual/contract employment. About 3 in 5 (61%) prison dischargees said they did not have paid employment organised (Figure 8.6).

Male dischargees (40%) were more likely than female dischargees (24%) to have organised paid employment upon release (Figure 8.6).

Figure 8.6: Prison dischargees, employment status within 2 weeks of release, by sex and Indigenous identity, 2022



Notes

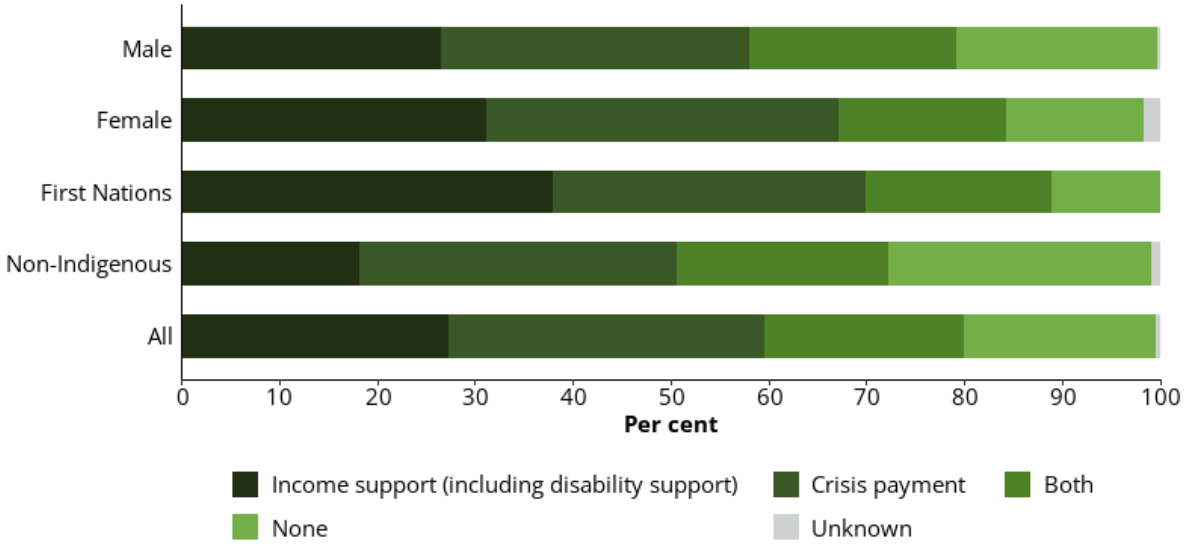
1. Proportions are representative of this data collection, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Almost 4 in 5 (80%) prison dischargees expected to receive a government payment through Centrelink on release (Indicator 2.1.9).

About one-quarter (27%) of prison dischargees expected to receive income support, including disability support; 32% expected to receive a crisis payment; and 20% expected to receive both payments (Figure 8.7).

Figure 8.7: Prison dischargees expecting to receive some form of financial assistance from Centrelink, by payment type, 2022



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Source: Dischargees form, 2022 NPHDC.

Homelessness

There are clear links between homelessness and health, with homeless people having mortality rates that are an estimated 2–5 times higher than for the general population, especially from suicide and unintentional injuries. Homeless people also have higher rates of infectious diseases, chronic conditions, mental health issues, and alcohol and other drug use disorders. Similar to people in prison, they also experience accelerated ageing (Fazel et al. 2014).

Homelessness not only refers to those sleeping on the streets, but also includes those with unstable housing – such as improvised dwellings or tents, supported accommodation, temporarily living with other households, and staying in boarding houses or other temporary lodging.

Data from the 2021 Australian Census of Population and Housing show that an estimated 122,500 people (0.5% of the general Australian population) were homeless on Census night (ABS 2023). Of these people, an estimated 7,600 (less than 0.1% of the Australian population) were sleeping rough in improvised dwellings or tents, or sleeping outside (ABS 2023).

Accommodation for prison entrants before prison

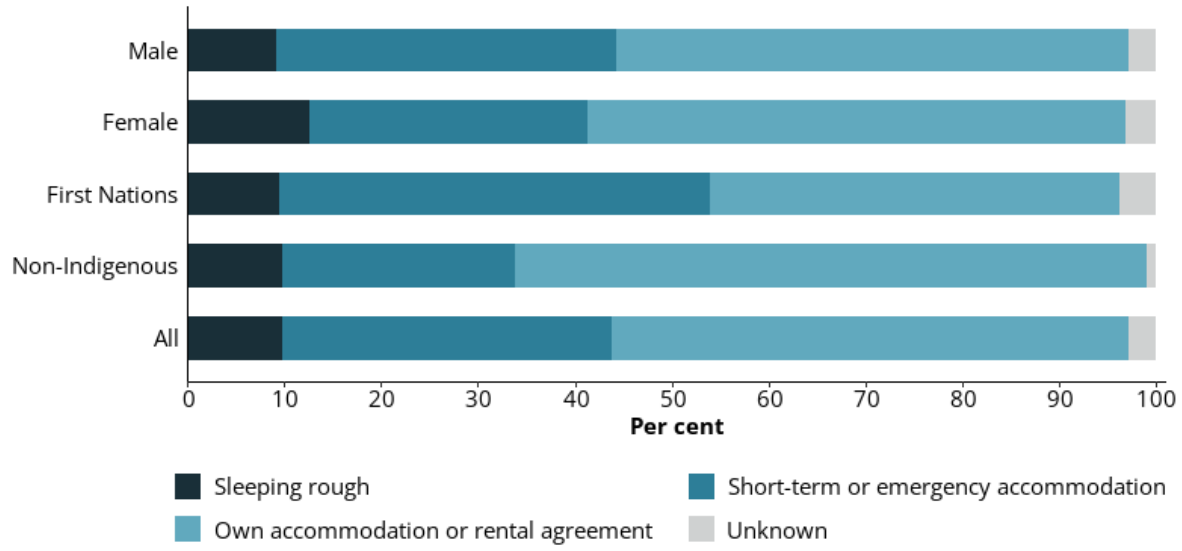
More than 2 in 5 (43%) prison entrants reported that they were homeless (including staying in short-term or emergency accommodation) during the 4 weeks before prison (Indicator 2.1.10).

Prison entrants were around 100 times more likely to be homeless than people in the general community. More than 1 in 3 (36%) prison entrants were in short-term or emergency accommodation, and 1 in 10 (10%) were in unconventional housing or sleeping rough (Figure 8.8).

Of 183 First Nations prison entrants, over a half (54%) had experienced homelessness in the 4 weeks before entering prison: 9.8% had experienced sleeping rough and 46% had experienced short-term or emergency accommodation in the 4 weeks prior to entering prison (Figure 8.8).

One-third (33%) of non-Indigenous prison entrants had experienced homelessness in the 4 weeks before entering prison while two-thirds (66%) had not experienced homelessness (Figure 8.8).

Figure 8.8: Prison entrants, accommodation type in the 4 weeks before prison, by sex and Indigenous identity, 2022



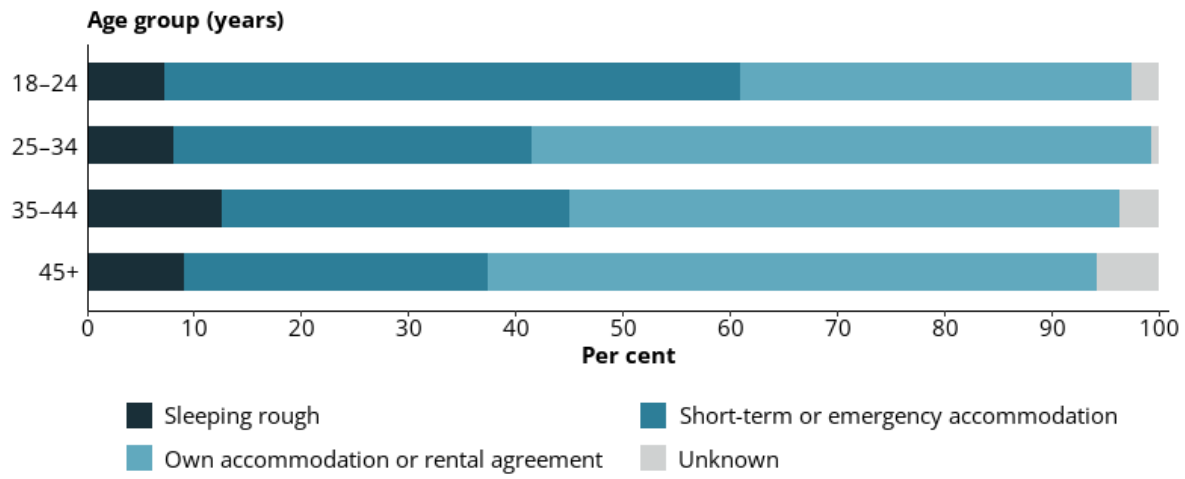
Notes

1. Proportions are representative of this data collection, and not the entire prison population.
2. Multiple responses were allowed.
3. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Prison entrants aged 18–24 were the group most likely to have experienced homelessness in the 4 weeks before entering prison (61%), while people aged 45 and over were the least likely to have experienced homelessness (37%) (Figure 8.9).

Figure 8.9: Prison entrants, accommodation type in the 4 weeks before prison, by age, 2022



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Source: Entrants form, 2022 NPHDC.

Accommodation expectations of prison dischargees once released

Finding suitable stable accommodation is a major concern for people about to be released from prison, especially for those with no family support.

In 2021–22, 2.4% of all adult clients of specialist homelessness services had come from a custodial setting (including prison), youth justice detention centres, and immigration detention centres. The majority were males (54%) aged 20–44 (59%). They were also more likely than other adult homelessness services clients to need assistance with drug and alcohol counselling (26% compared with 11% of all adult clients) (AIHW 2022).

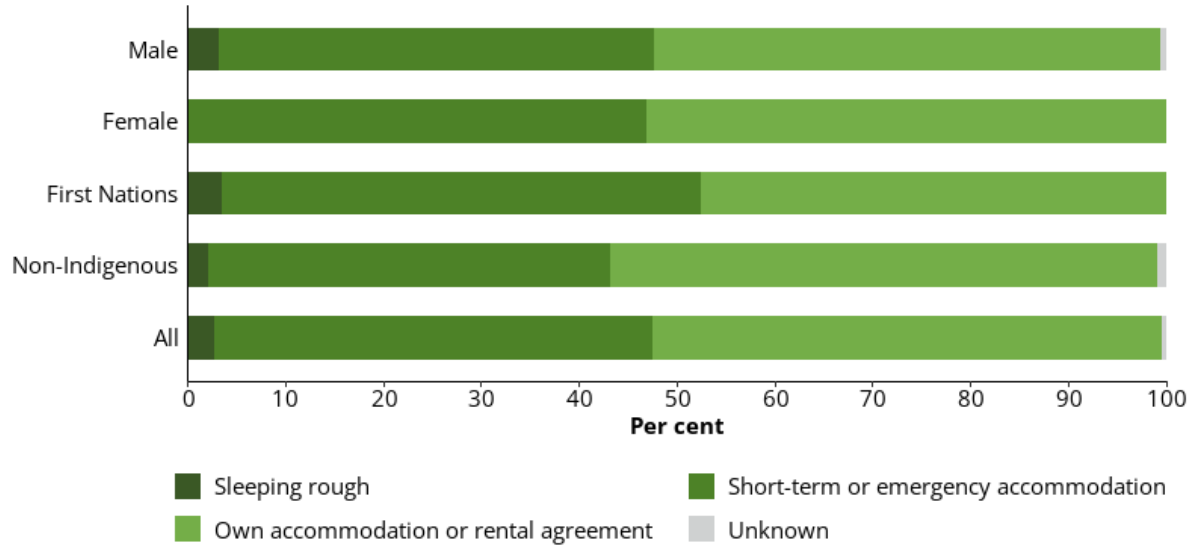
> Almost a half (48%) of prison dischargees expected to be homeless (including in short-term and emergency accommodation) once released (Indicator 2.1.11).

Almost a half of prison dischargees (45%) were planning to sleep in short-term or emergency accommodation and 2.8% expected to sleep rough on release from prison (Figure 8.10).

About a half (52%) of prison dischargees had their own stable accommodation arranged, where they were either the owners or named on a lease (Figure 8.10).

Prison dischargees aged 35–44 were the most likely age group to report having their own accommodation (61%) while those aged 25–34 were the least likely to report having their own accommodation (46%) (Figure 8.11).

Figure 8.10: Prison dischargees, accommodation type expected on release from prison, by sex and Indigenous identity, 2022



Notes

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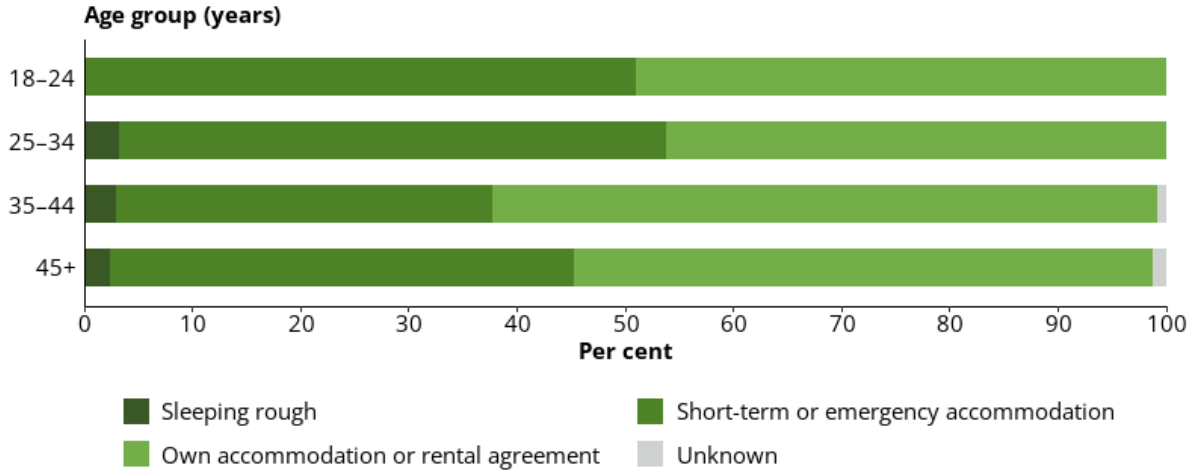
Source: Dischargees form, 2022 NPHDC.

Figure 8.11: Prison dischargees, accommodation type expected on release from prison, by age, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

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Health risk behaviours

Health behaviours can be defined as the actions taken by individuals that affect their health and mortality (Short and Mollborn 2015). While some behaviours can improve one's health – such as exercise and eating nutritious foods (see 'Physical health status') – others can have negative impacts on health, such as consuming alcohol, smoking cigarettes and using illicit drugs.

People who come in contact with the criminal justice system are more likely than the general population to engage in behaviours that are harmful to their health (AIHW 2019; Doyle et al. 2015; Porter 2014).

This section reports on alcohol consumption, smoking and vaping, illicit drug use, risky sexual behaviours – and other risky behaviours engaged in while in prison, such as tattooing and body piercing, and needle sharing.

Alcohol consumption

Alcohol use, particularly high-level consumption, is a major risk factor for death and disease and has been linked to numerous acute and chronic health conditions (GBD 2016 Alcohol Collaborators 2018). The consumption of alcohol also carries short-term risks of injuries and motor vehicle accidents due to intoxication (AIHW 2023).

There are strong and persistent links between alcohol use disorder and adverse psychosocial outcomes affecting physical and mental health, family violence, relationship instability, at-risk sexual behaviours, unemployment, violence, victimisation and criminal activity (Fergusson et al. 2013).

Alcohol consumption among prison entrants

The proportion of prison entrants who were at risk of alcohol-related harm over the previous 12 months was determined using questions on alcohol consumption from the World Health Organization's Alcohol Use Disorder Identification Test (AUDIT-C) screening instrument (Babor et al. 2001). The AUDIT-C is a screening tool only and is not used for diagnostics. Further, the AUDIT-C relies on self-reported personal estimates of alcohol intake, which are often lower than the actual number of standard drinks consumed, meaning underestimation of alcohol-related risk is common (Devos-Comby and Lange 2008; Gilligan et al. 2019).

The AUDIT-C alcohol harm risk profile does not align with the National Health and Medical Research Council's *Australian guidelines to reduce health risks from drinking alcohol* (the standard alcohol risk rating used in Australia) (NHMRC 2020). However, both guidelines recognise that alcohol-related harm can be caused by different patterns of consumption, such as from a single episode of consumption, or a cumulative effect often referred to as 'lifetime risk' (Babor et al. 2001; NHMRC 2020).

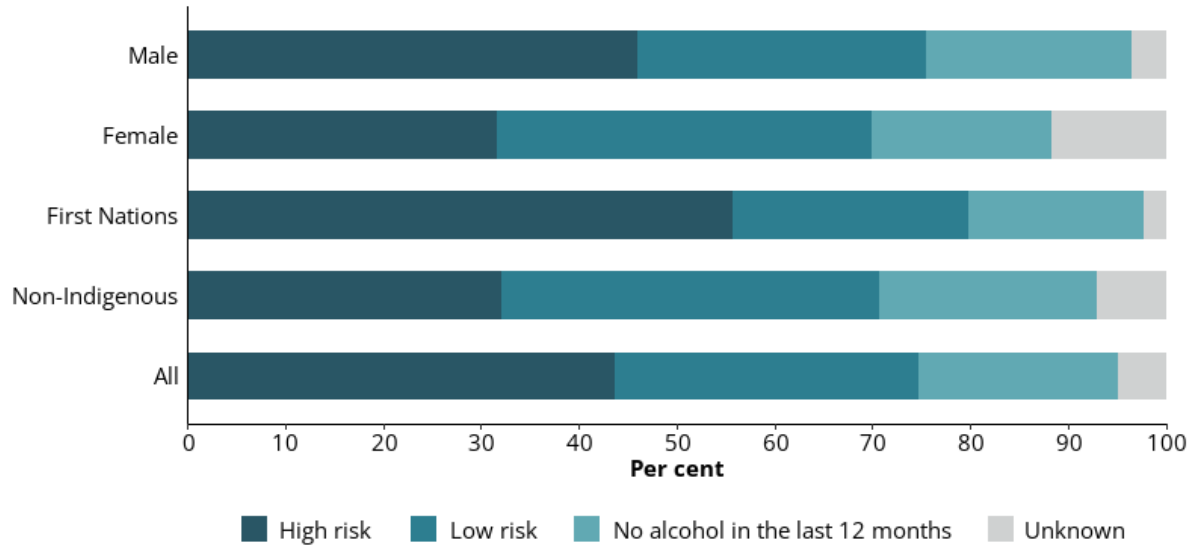
The AUDIT-C measures alcohol-related harm through a 12-point scoring system. A person is considered 'high-risk' if they score 6 points or more (Babor et al. 2001).

> About 2 in 5 (44%) prison entrants were considered to be at high risk of alcohol-related harm during the previous 12 months (Indicator 2.2.1).

Almost a half (46%) of male prison entrants and about one-third (32%) of female prison entrants were considered to be at high risk of alcohol-related harm.

Of 183 First Nations prison entrants, 56% were considered to be at high risk of alcohol-related harm, 24% were considered to be at low-risk and 18% reported no alcohol use in the last 12 months. Of 184 non-Indigenous prison entrants, 32% were considered to be at high risk of alcohol-related harm, 39% were considered to be at low-risk and 22% reported no alcohol use in the last 12 months (Figure 9.1).

Figure 9.1: Prison entrants, risk of alcohol-related harm in the previous 12 months, by sex and Indigenous identity, 2022



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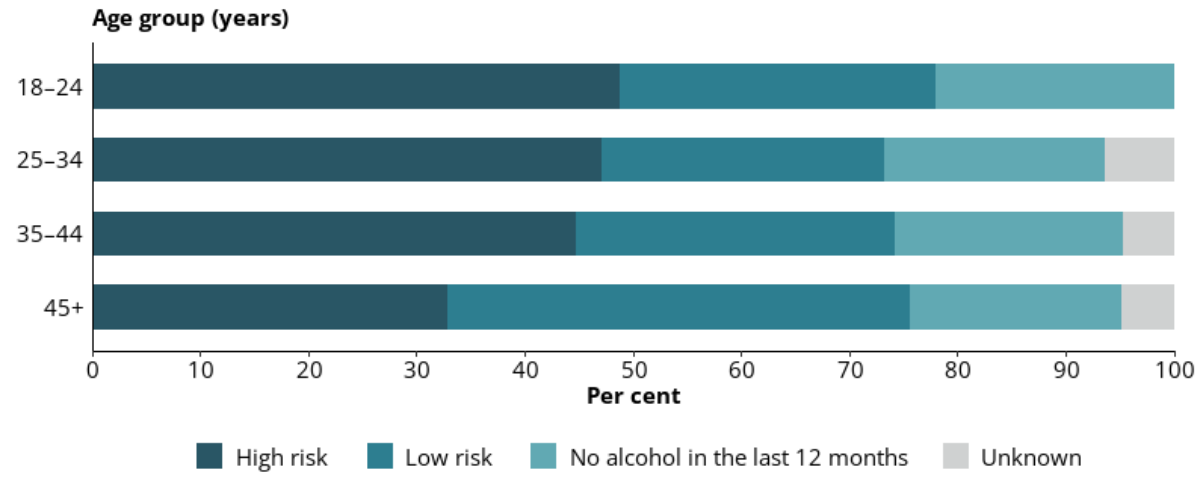
Source: Entrants form, 2022 NPHDC.

Prison entrants aged 18–24 (49%) were the most likely to be identified in the AUDIT-C as being at high risk of alcohol-related harm, and those aged over 45 (33%) were the least likely (Figure 9.2).

Figure 9.2: Prison entrants, risk of alcohol-related harm in the previous 12 months, by age, 2022



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Source: Entrants form, 2022 NPHDC.

Alcohol consumption among prison dischargees

Prison dischargees were asked whether they consumed alcohol while in prison. Of 431 dischargees, 8.6% reported that they drank alcohol in prison while 91% reported they did not.

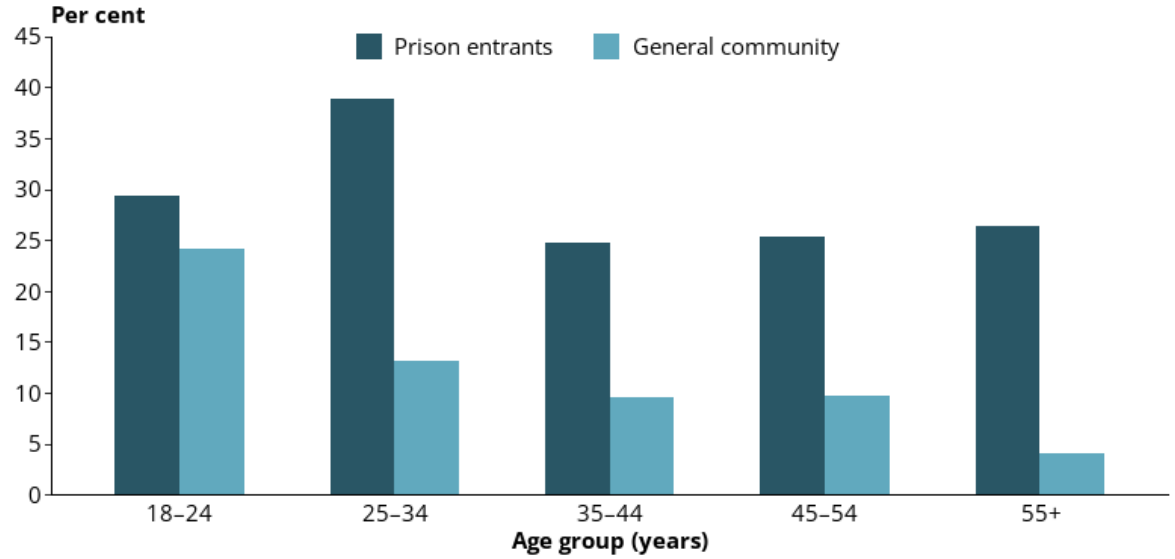
Alcohol consumption comparisons with general community

The proportion of prison entrants who had consumed at least one standard drink of alcohol in the previous 12 months were compared with that for people aged 18 and over in the AIHW's 2019 National Drug Strategy Household Survey. The proportion of prison entrants who consumed alcohol was similar to that in the general community, with 76% of prison entrants consuming at least one standard drink of alcohol in the previous year, compared with 79% of people age 18 and over in the general community.

Comparisons were made between prison entrants and people in the community who reported consuming at least 7 standard drinks on a typical day of drinking in the previous 12 months, by age and sex. For each age group, prison entrants were more likely to drink 7 standard drinks on a typical day of drinking than people of the same age in the community (Figure 9.3).

The likelihood of consuming at least 7 standard drinks on a typical day of drinking decreased with age for people in the general community – from 24% of those aged 18–24 to 9.6% of those aged 35–44. Among prison entrants, the proportion who consumed 7 standard drinks per day of drinking remained high across all age groups (between 25–39%) (Figure 9.3).

Figure 9.3: Prison entrants (2022) and the general community (2019), self-reported consumption of at least 7 standard drinks on a typical day of drinking in the previous 12 months, by age



Notes

1. Excludes those who reported not drinking in the previous 12 months.
2. Proportions are representative of this data collection only, and not the entire prison population.
3. Prison entrants excludes Victoria, which did not provide data for this item.

Sources: AIHW 2020; Entrants form, 2022 NPHDC.

Smoking

Tobacco smoking is one of the largest single preventable causes of death and disease in Australia. It is a major risk factor for many chronic conditions, including coronary heart disease, stroke, diabetes, chronic obstructive pulmonary diseases, multiple types of cancers, and asthma (AIHW 2019b). In 2019, 13% of males and 10% of females in Australia, aged 18 and over, smoked daily (AIHW 2020).

Smoking is common in groups over-represented in the prison population (AIHW 2013) – that is, smoking rates are much higher among people living in low socioeconomic areas, First Nations people, people with mental health disorders, people with substance use disorders, people who are unemployed and people experiencing homelessness (Department of Health and Aged Care 2023; Twyman et al. 2014).

While smoking has decreased over time in the general community in Australia, the same is not true for people in custody, whose smoking rates, in facilities that allow smoking, remain high.

Smoking bans have been implemented in most prisons across Australia. Of the 73 participating prisons in the 2022 NPHDC:

- 58 enforced smoking bans
- 15 allowed smoking.

Banning smoking in prison can reduce mortality rates among people in prison from smoking-related causes, particularly cardiovascular and pulmonary disease, and cancer (Binswanger et al. 2014).

The National Tobacco Strategy 2023–2030 recognises the high smoking rates in the prison population, and that prisons are an important setting for tobacco control efforts. It recommended that people in prison be provided more support to quit, including access to nicotine replacement therapy and other pharmacotherapies (Department of Health and Aged Care 2023). However, the majority of ex-smokers released from smoke-free prisons resume smoking, so smoking cessation support and policy attention are also required for people after their release from prison, and to ensure continuity of care (Puljević et al. 2018).

Smoking among prison entrants

Prison entrants were asked whether they had ever smoked tobacco, whether they currently smoked, and how old they were when they had their first full cigarette.

Of 371 prison entrants, 86% said they had smoked a full cigarette at some stage in their lives and 13% said they had never smoked a full cigarette.

> The average age that prison entrants reported smoking their first full cigarette was 14.2 (Indicator 2.2.2).

Almost 3 in 4 (71%) prison entrants reported that they currently smoked tobacco. About 4 in 5 (79%) First Nations prison entrants and almost 2 in 3 (64%) non-Indigenous entrants reported they were current smokers.

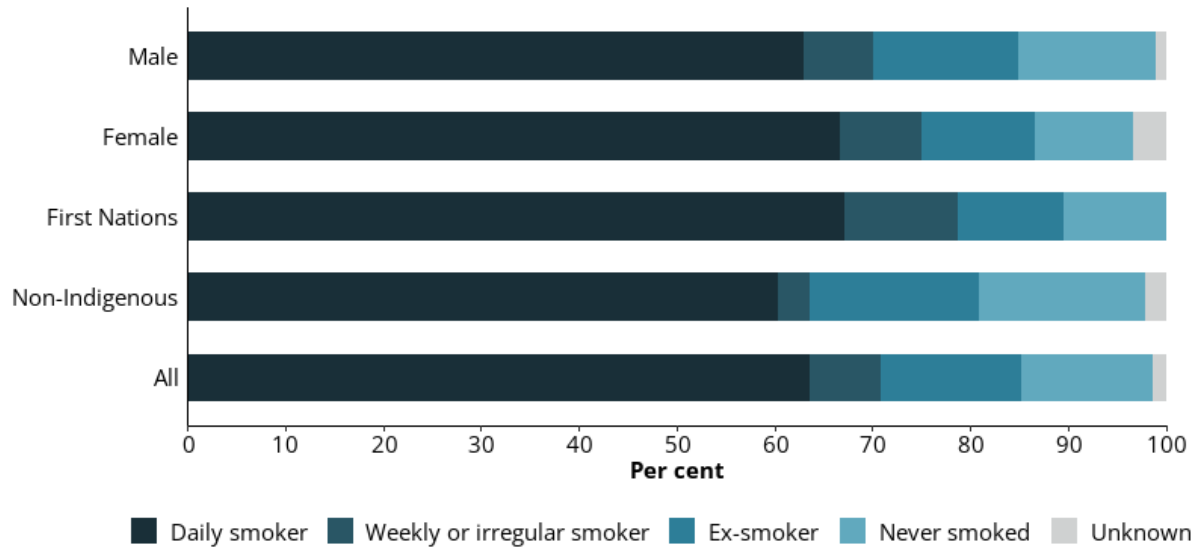
Female prison entrants (75%) were more likely than male prison entrants (70%) to report they were current smokers. Entrants aged 35–44 were the most likely group to report being current smokers (76%), and those aged 45 and over were least likely (61%).

> Almost 2 in 3 (64%) prison entrants reported they smoked tobacco daily (Indicator 2.2.3).

Rates of daily smoking were similar among females and males, with 67% female entrants and 64% male entrants reporting they smoked daily (Figure 9.4).

First Nations entrants (67%) were more likely than non-Indigenous entrants (60%) to report they smoked daily (Figure 9.4).

Figure 9.4: Prison entrants, frequency of tobacco smoking, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Prison entrants were asked about their household's exposure to smoke in the last 12 months. Over a half of prison entrants (55%) reported that someone in their home smoked daily inside the home. About one-quarter (28%) of entrants reported that people in the household would only smoke daily outside and 14% reported that no one in the home regularly smoked.

Smoking among prison dischargees

Prison dischargees were asked whether they had smoked tobacco on their current prison entry, whether they smoked in prison, and their intentions to smoke on release.

Almost 3 in 4 (72%) dischargees reported they smoked tobacco on entry to prison.

Of 200 First Nations dischargees, 78% reported they smoked on entry to prison while 23% reported they did not.

Of 231 non-Indigenous dischargees, 68% reported they smoked on entry to prison while 32% reported they did not.

Prison dischargees aged 35–44 (80%) were the group most likely to report they were current smokers on prison entry, and those aged 18–24 (63%) were the least likely.

Of prison dischargees in all participating prisons, about one-third (35%) reported being current smokers, down from the 72% of all dischargees who said they smoked on entry to prison.

> In prisons that allowed smoking, 4 in 5 (82%) prison dischargees reported they currently smoked tobacco (Indicator 2.2.4).

Smoking bans in prison have an impact on the proportions of people in custody who reported they currently smoked. Smoking bans have been implemented in most prisons across Australia. Of the 73 prisons which participated in the NPHDC, 58 had complete smoking bans. About 1 in 4 (29%) dischargees from prisons that banned smoking said they were current smokers.

In prisons that allowed smoking:

- almost 3 in 4 (71%) dischargees aged 45 and over said they were current smokers, while 100% of dischargees aged 25–34 said they were current smokers
- almost 9 in 10 (88%) First Nations dischargees, and 3 in 4 (75%) non-Indigenous dischargees said they were current smokers
- one-quarter (23%) of dischargees reported they smoked less at discharge.

Smoking comparisons with the general community

Smoking rates among people entering prison were much higher than in the general community. Comparisons were made between prison entrants in the 2022 NPHDC with people aged 18 and over in the 2019 National Drug Strategy Household Survey (AIHW).

Striking differences were found between the proportions of prison entrants and the general population who were daily smokers or who had never smoked.

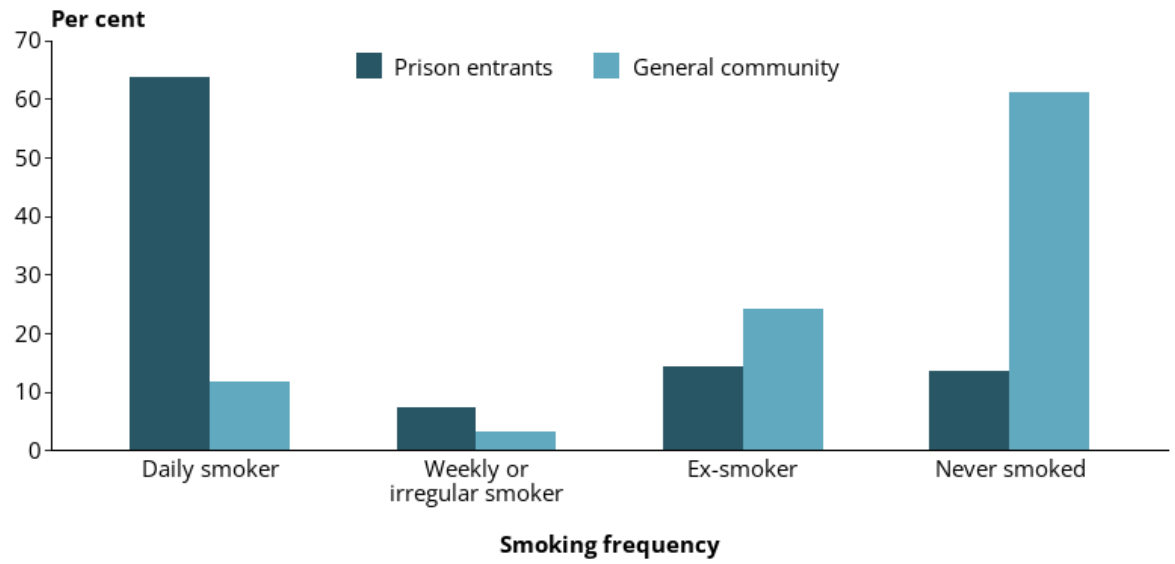
Over a half (64%) of prison entrants were daily smokers, compared with about 1 in 8 (12%) people in the general community (AIHW 2020) (Figure 9.5).

About 1 in 8 (13%) prison entrants said they had never smoked, compared with 61% in the community (AIHW 2020) (Figure 9.5).

Two-thirds (67%) of First Nations prison entrants reported they were a daily smoker compared with 28% of First Nations people in the general community. Of all non-Indigenous prison entrants, 60% reported they were a daily smoker compared with 11% of non-Indigenous people in the general community.

The proportion of people in the community who reported never having smoked was highest among younger people (80% of those aged 18–24 in 2019), suggesting that fewer young people in the general population were trying and taking up smoking (AIHW 2020). In contrast, only 15% of prison entrants aged 18–24 had never smoked.

Figure 9.5: Prison entrants (2022) and the general community (2019), frequency of tobacco smoking



Notes

1. Proportions of prison entrants are representative of this data collection only, and not the entire prison population.
2. Prison entrants excludes Victoria, which did not provide data for this item.

Sources: AIHW 2020; Entrants form, 2022 NPHDC.

Quitting smoking

Quitting smoking is difficult, and people released from smoke-free prisons often relapse (Jin et al. 2018). Commonly perceived barriers to quitting successfully include:

- poor stress management
- lack of professional support
- the high prevalence and acceptability of smoking in vulnerable communities (Twyman et al. 2014).

Most prisons offer programs for those who wish to stop smoking, or to cope with quitting in a smoke-free facility. But, relapse upon release is common, and smoking cessation support is required for people transitioning to the community (Brose et al. 2018; Puljević et al. 2018).

Quitting smoking among prison entrants

Prison entrants who reported they were current smokers were asked whether they wanted to quit smoking, and which resources they would find helpful.

> About a half (48%) of prison entrants who were current smokers wanted to quit (Indicator 2.2.5).

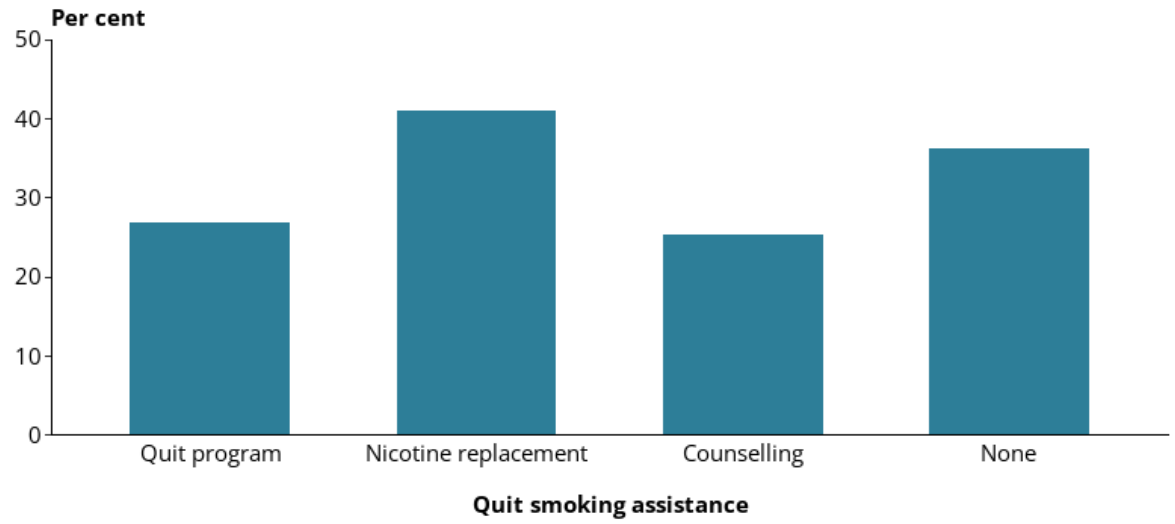
Older prison entrants were more likely than younger entrants to report they wanted to quit smoking. Almost 3 in 5 (57%) entrants aged over 45 reported they wanted to quit smoking compared with 2 in 5 (39%) of those aged 18–24.

Female prison entrants were more likely (53%) than male prison entrants (46%) to report that they wanted to quit smoking.

Of prison entrants who wanted to quit smoking:

- about 2 in 5 (41%) said nicotine replacement therapy would help
- about one-quarter (27%) said a quit program would help
- one-quarter (25%) said counselling would help
- about one-third (36%) said they did not want any help (Figure 9.6).

Figure 9.6: Prison entrants, current smokers, by support required to quit smoking, 2022



Notes

1. Entrants could select multiple answers.
2. Proportions are representative of this data collection only, and not the entire prison population.
3. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Quitting smoking among prison dischargees

Prison dischargees were asked about the resources they knew were available in prison to help them quit smoking, and whether they had used any of these.

Of those who knew assistance was available, nicotine replacement therapy was most commonly used – with about 1 in 10 (11%) prison dischargees who were current smokers on entry to prison choosing this option.

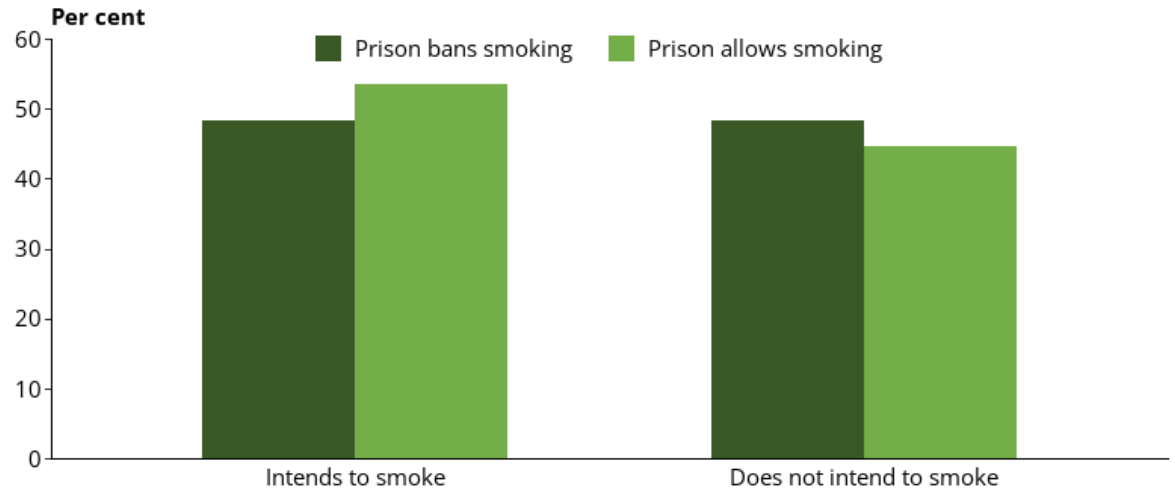
Smoking intentions on release

Prison dischargees were asked about their intention to smoke on release from prison.

> About a half (49%) of prison dischargees who were current smokers on prison entry intended to smoke on release (Indicator 2.2.6).

There was little difference in prison dischargees' intention to smoke on release – 48% of dischargees from 60 prisons that banned smoking, and 54% from 15 prisons that allowed smoking intended to smoke on release (Figure 9.7).

Figure 9.7: Prison dischargees, intention to smoke on release, by smoking ban status of prison, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

E-cigarette (vaping) use

E-cigarettes, or vapes, are electronic devices containing a chemical liquid that is heated to produce an aerosol vapour. This vapour is inhaled by the user, which may have harmful consequences for their health (NHMRC 2022).

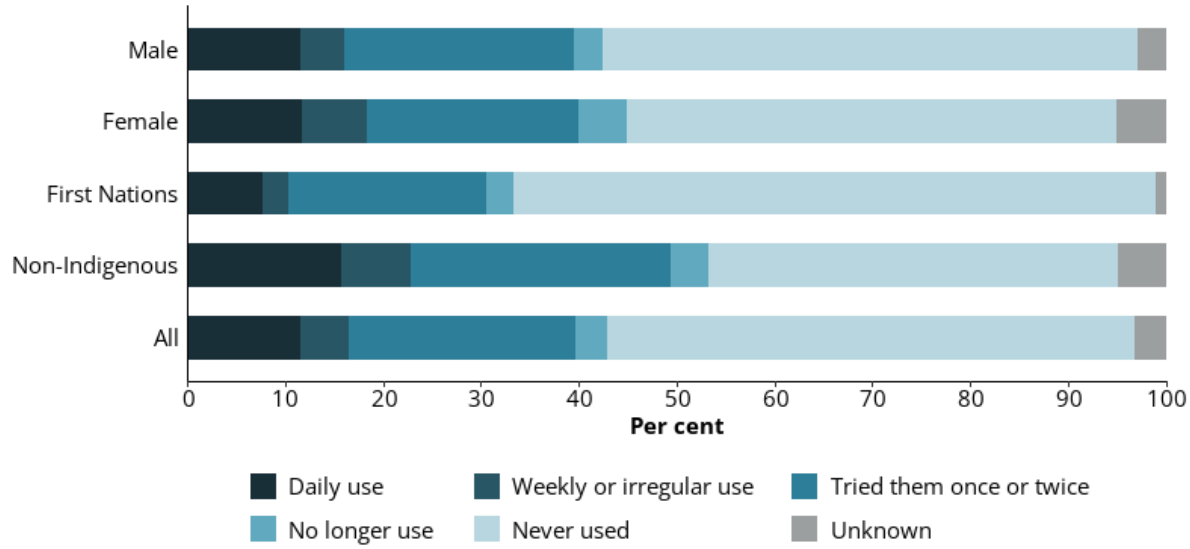
Prison entrants were asked about their e-cigarette use. Of 371 prison entrants, 43% reported they had used an e-cigarette at least once. Of those who had used an e-cigarette, 7.5% reported they no longer used them. Prison entrants were considered to be ‘current users’ of e-cigarettes if they reported using them on a weekly or irregular, or daily basis.

About one-quarter (23%) of prison entrants reported trying e-cigarettes once or twice, while about 1 in 8 (12%) reported they used e-cigarettes daily (Figure 9.8).

Two-thirds of First Nations prison entrants had never used an e-cigarette (66%). About 1 in 5 (20%) of First Nations prison entrants reported they had used them once or twice and 7.7% reported they used e-cigarettes daily (Figure 9.8).

More than a half (53%) of non-Indigenous prison entrants had used e-cigarettes at least once. About 1 in 4 (27%) non-Indigenous prison entrants reported they had tried e-cigarettes once or twice and 16% reported they used e-cigarettes daily (Figure 9.8).

Figure 9.8: Prison entrants, frequency of e-cigarette use, by sex and Indigenous identity, 2022



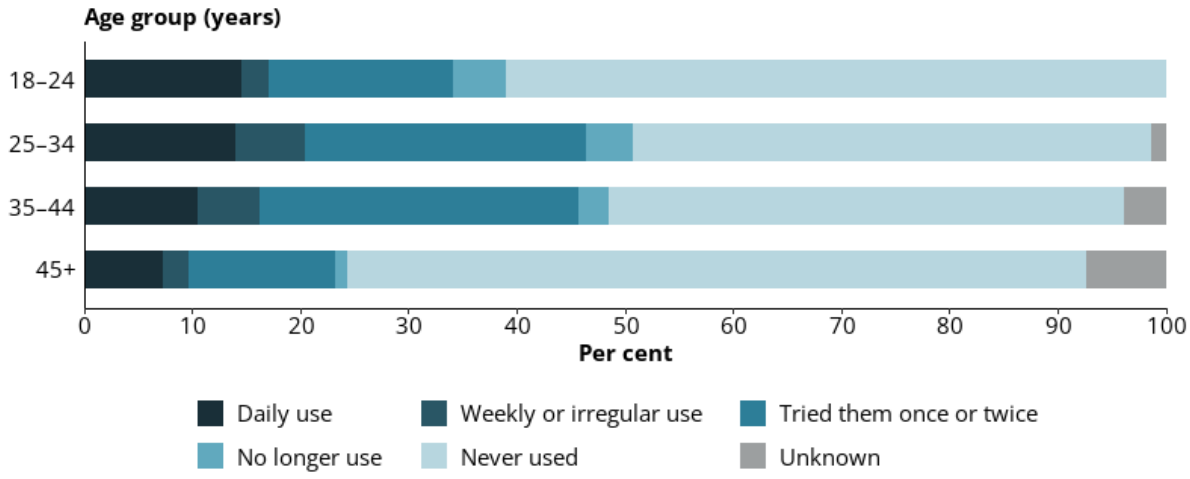
Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Young people were more likely to report daily use of e-cigarettes than those in older age groups. About 1 in 7 (15%) prison entrants aged 18–24 reported using e-cigarettes daily while about 1 in 14 (7.3%) prison entrants aged 45 and over reported using e-cigarettes daily (Figure 9.9).

Figure 9.9: Prison entrants, frequency of e-cigarette use, by age, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Vaping comparisons with general community

About 2 in 5 (43%) prison entrants reported they had used an e-cigarette at least once compared with 1 in 11 (9.3%) adults in the general community (ABS 2022). Consistent with e-cigarette usage among prison entrants, the proportion of those in the community who had ever used an e-cigarette was higher in those aged 18–44 than in those aged over 45.

Male prison entrants were almost 4 times as likely to report ever using an e-cigarette (43%) than males in the community (11%).

Female prison entrants were 6 times more likely to report ever using an e-cigarette (45%) than females in the community (7.5%).

About 1 in 6 prison entrants reported currently using e-cigarettes (16%) while 3.2% reported that they no longer use them. By contrast, people in the community were more likely to report that they no longer used e-cigarettes (7.1%) than current e-cigarette use (2.2%).

In the community, and among prison entrants, those aged 18–24 were the group most likely to report currently using e-cigarettes; however, prison entrants aged 18–24 were more than 3 times as likely to report currently using e-cigarettes (17%) than people of the same age in the community (4.8%) (ABS 2022).

Illicit drug use

Illicit drug use is the use of illegal drugs, volatile substances, and prescription drugs for non-medical purposes. Like many other chronic conditions, drug use disorder requires long-term management, often with a combination of medication and psychosocial services, and treating any co-morbidities (Goodwin and Sias 2014).

This is especially important for people in custody who are more likely than people in the general population to have co-occurring alcohol and other drug use disorders, mental health conditions, and physical health conditions (Forsyth et al. 2018).

Illicit drug use is a primary motivating factor in many crimes – including non-violent property offences such as burglary and theft – particularly for those who have drug dependence (Kopak and Hoffmann 2014).

Among people with heroin dependence, criminal involvement is associated with unemployment, mental health issues, a criminal history, greater severity of dependence, and more extensive heroin use (Marel et al. 2013).

Methamphetamine use is highly addictive and can lead to antisocial behaviour, such as crime, to facilitate the drug use (Goldsmid and Willis 2016; Tait et al. 2018). It is also associated with major physical and mental health conditions, with the death rate from methamphetamine use doubling between 2009 and 2015 (Darke et al. 2017).

The likelihood of injecting drug use decreases with incarceration, but high-risk injecting behaviours increase, particularly among young people, as does the risk of hepatitis C and other bloodborne virus transmissions (Cunningham et al. 2018).

Illicit drug use, particularly injecting drug use, influences physical and mental health. The majority of people in custody have a history of illicit drug use.

Drug use before prison

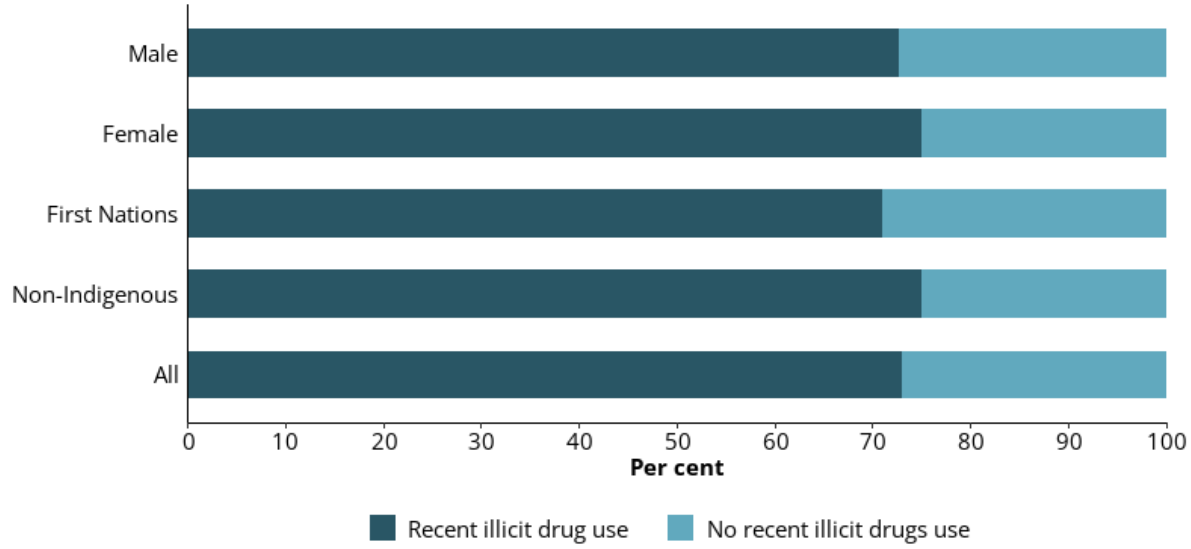
Illicit drug use among prison entrants

Prison entrants were asked about their drug use in the previous 12 months, also referred to as ‘recent’ drug use.

> Almost 3 in 4 (73%) prison entrants reported using illicit drugs in the previous 12 months (Indicator 2.2.7).

Illicit drug use in the previous 12 months was reported similarly for females and males. Of 60 female entrants, 75% reported using illicit drugs in the previous 12 months, while 73% of 311 male entrants reported recent illicit drug use (Figure 9.10).

Figure 9.10: Prison entrants, illicit drug use in the previous 12 months, by sex and Indigenous identity, 2022



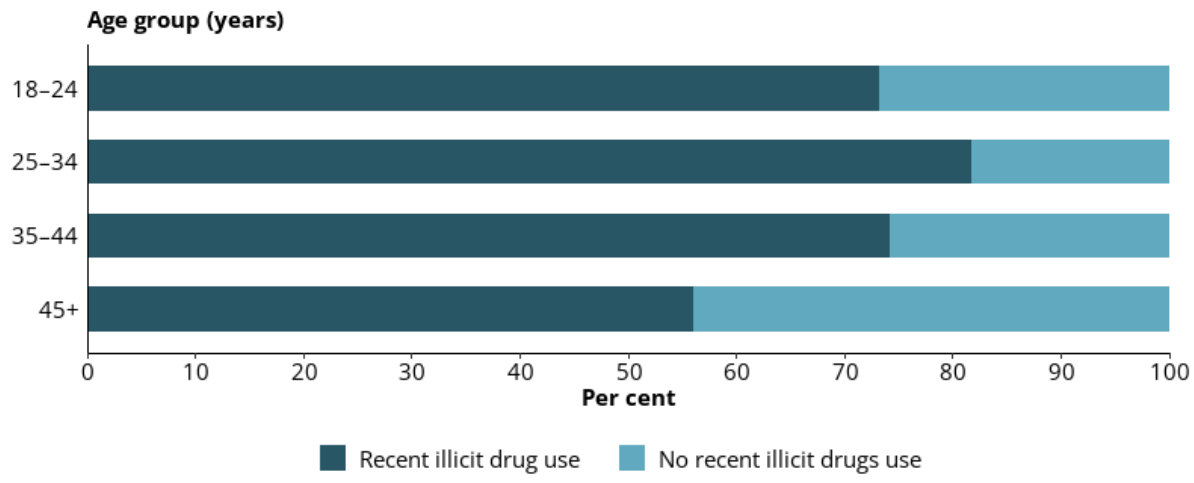
Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Prison entrants aged 25–34 were most likely to report using illicit drugs in the previous 12 months (82%) while those aged 45 and over were the least likely (56%) (Figure 9.11).

Figure 9.11: Prison entrants, illicit drug use in the previous 12 months, by age, 2022



Notes

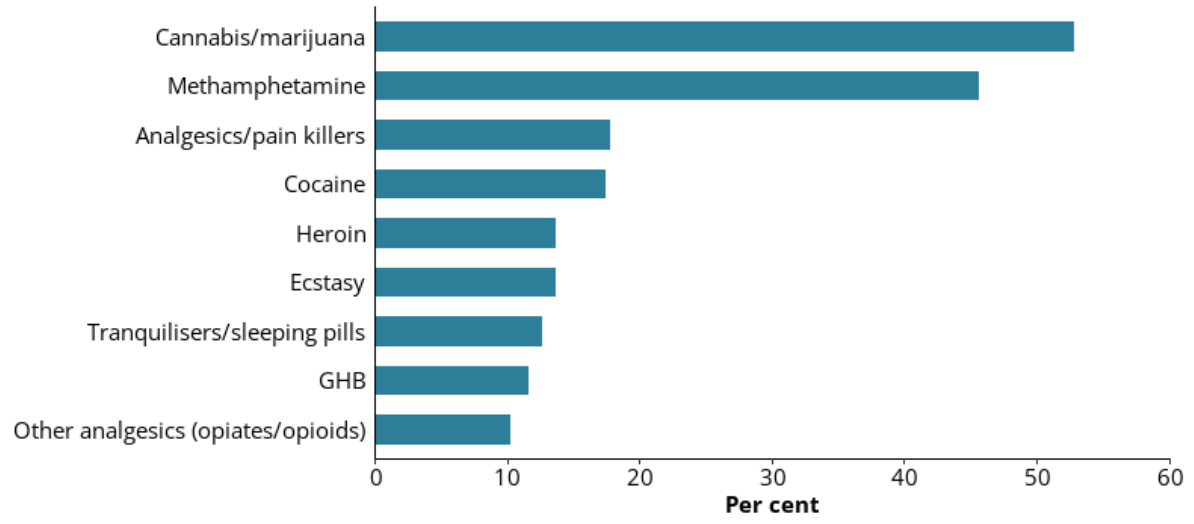
1. Proportions are representative of this data collection only, and not the entire prison population
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

The most commonly reported drug used by prison entrants for non-medical purposes – or that was not supplied to them medically – was cannabis, with more than a half (53%) reporting having used it at least once in the previous 12 months (Figure 9.12).

Methamphetamines/amphetamines were also commonly used with 46% of prison entrants reporting using them at least once in the previous 12 months.

Figure 9.12: Prison entrants, illicit drug use in the previous 12 months, by drug type, 2022



Notes

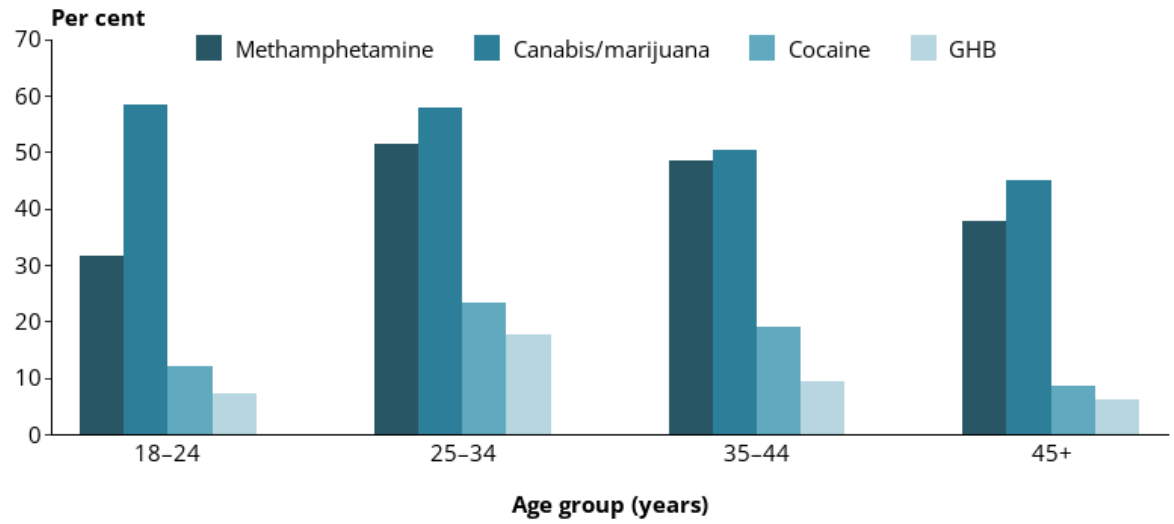
1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Younger prison entrants were more likely to report using illicit drugs in the past 12 months than older entrants. Recent use of methamphetamine before prison entry was lowest for those aged 18–24 (31%) and highest for those aged 25–34 (51%), before decreasing with age.

Recent cannabis use decreased across age groups, from 59% of those aged 18–24, to 45% of entrants aged 45 and over. Recent illicit use of methamphetamine, cocaine, analgesics, GHB, and heroin were most commonly reported by entrants aged 25–34 (Figure 9.13).

Figure 9.13: Prison entrants, illicit drug use in the previous 12 months, by age and drug type, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Illicit drug use among prison dischargees

Prison dischargees were asked if they had used illicit drugs before entering prison. Over a half (55%) of dischargees reported having done so.

Injecting drug use

Injecting drug use among prison entrants

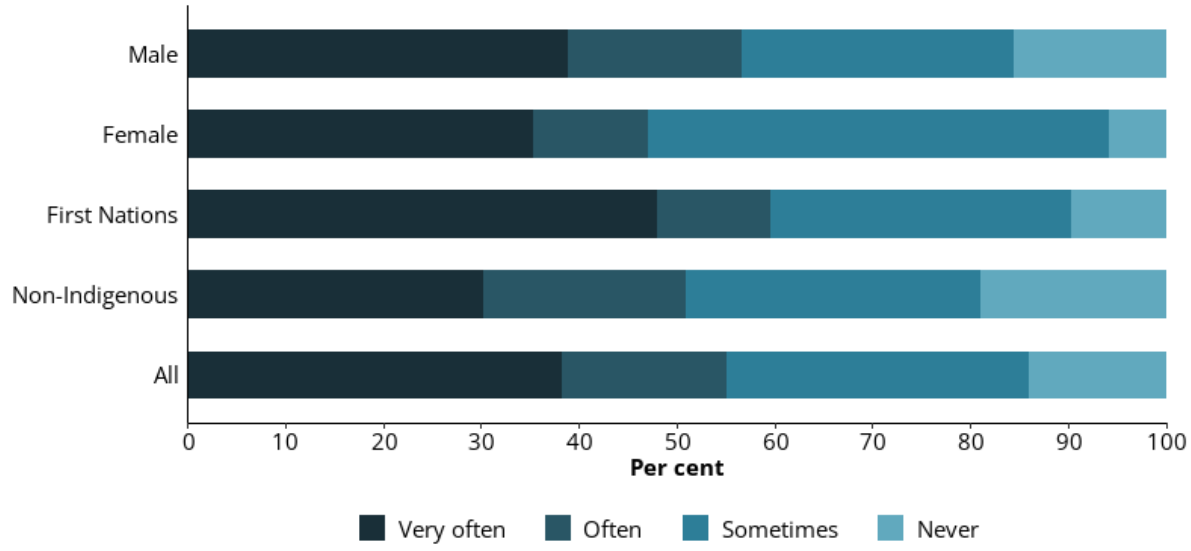
Almost one-third (29%) of prison entrants reported they had injected drugs at some stage in their lives (Indicator 2.2.8).

Fewer than 1 in 5 (17%) prison entrants aged 18–24 reported they had injected drugs at some stage in their lives, while more than 1 in 3 (35%) prison entrants aged 35–44 reported having done so.

Of those prison entrants who reported injecting drugs at some stage in their lives, 38% reported they had injected drugs very often in the last 12 months, 17% reported they injected drugs often and 31% reported injecting drugs sometimes (Figure 9.14).

First Nations entrants (48%) reported injecting drugs very often in the last 12 months, with only 9.6% reporting never injecting in the same period. Nearly 1 in 3 (30%) non-Indigenous entrants reported injecting very often in the last 12 months, with nearly 1 in 5 (19%) reporting never injecting in the same period.

Figure 9.14: Prison entrants, frequency of injecting drug use in the previous 12 months, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Proportions are representative of 107 prison entrants who reported ever injecting drugs.
3. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Illicit drug use comparisons with general community

People entering prison were more than 4 times as likely to report illicit drug use in the preceding 12 months as people in the general community (73% and 17%, respectively) (AIHW 2020).

In the general community, males (20%) were more likely than females (13%) to report illicit drug use in the previous 12 months (AIHW 2020). These differences were not observed in the prison population as males and females both had higher rates of illicit drug use in the previous 12 months (73% and 75%, respectively).

Males entering prison were almost 4 times as likely to report recent illicit drug use as males in the community, and females were almost 6 times as likely to do so as females in the community.

Prison entrants were consistently more likely to report recent illicit drug use than people of the same age in the general community.

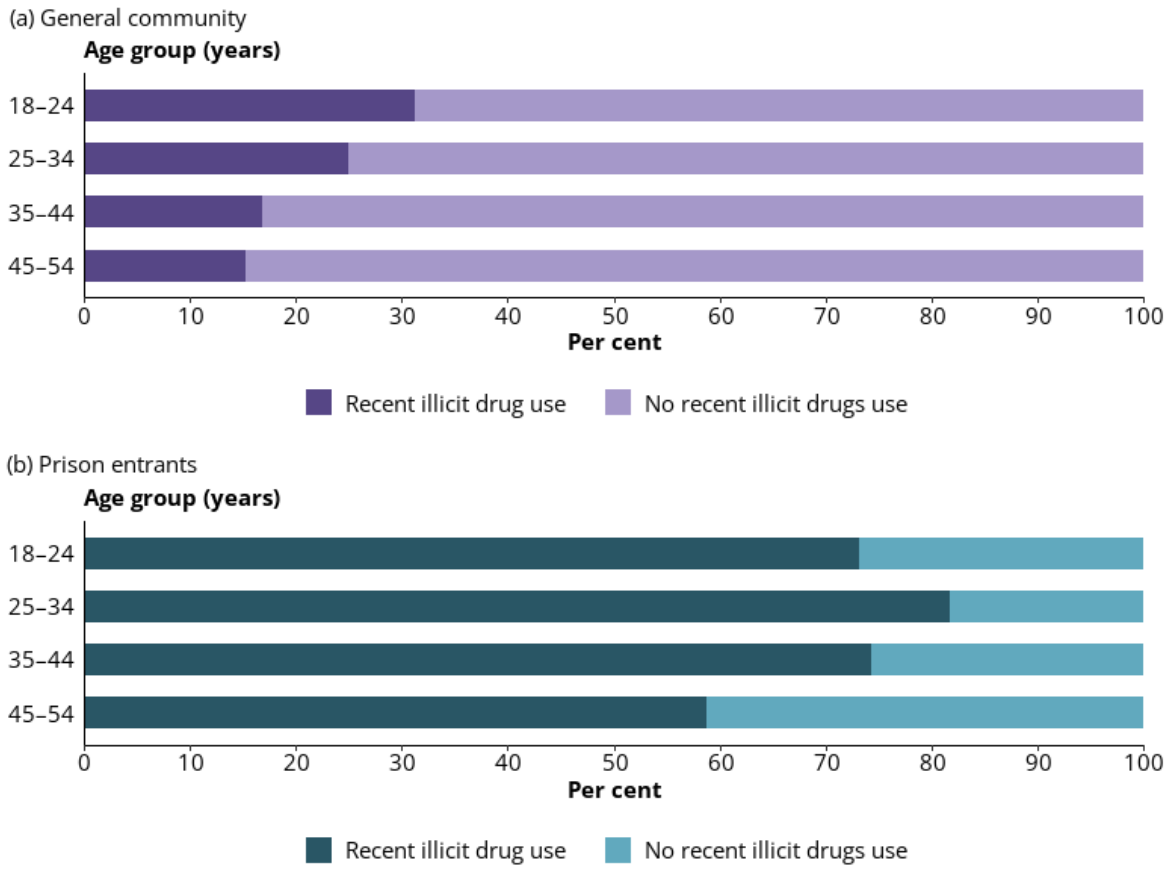
Almost three-quarters (73%) of prison entrants aged 18–24 reported using illicit drugs in the previous 12 months, while about 1 in 3 (31%) people of the same age in the community reported doing so (AIHW 2020). Recent illicit drug use remained high among prison entrants aged 18–54, while in the community the proportions declined. About 3 in 5 (59%) prison entrants aged 45–54 reported using illicit drugs in the previous 12 months while 15% of people of the same age in the community reported doing so (Figure 9.15).

Cannabis was the most common illicit drug people in the community had recently used, at 12% (15% of males and 8.7% of females).

Male prison entrants were more than 3 times as likely as males in the community to report recent cannabis use, and female prison entrants were 6 times as likely as females in the community.

Prison entrants (46%) were more than 30 times as likely to report recent methamphetamine use as people in the community (1.4%) (AIHW 2020).

Figure 9.15: General community (2019) and prison entrants (2022), illicit drug use in the previous 12 months, by age



Notes

1. Proportions of prison entrants are representative of this data collection only, and not the entire prison population.
2. Prison entrants data excludes Victoria, which did not provide data for this item.

Sources: AIHW 2020; Entrants form, 2022 NPHDC.

Substance use in prison

There are fewer opportunities in prison to obtain and use illicit drugs than in the general community as prisons use multiple strategies to reduce the supply of illicit drugs, including drug detection dogs and urinalysis (Dolan and Rodas 2014). Compared with people in the community who can access sterile injecting equipment more readily, people in prison are at increased risk of contracting bloodborne viruses as a result of sharing injecting equipment, particularly hepatitis C (Cunningham et al. 2018).

Substance use among prison dischargees

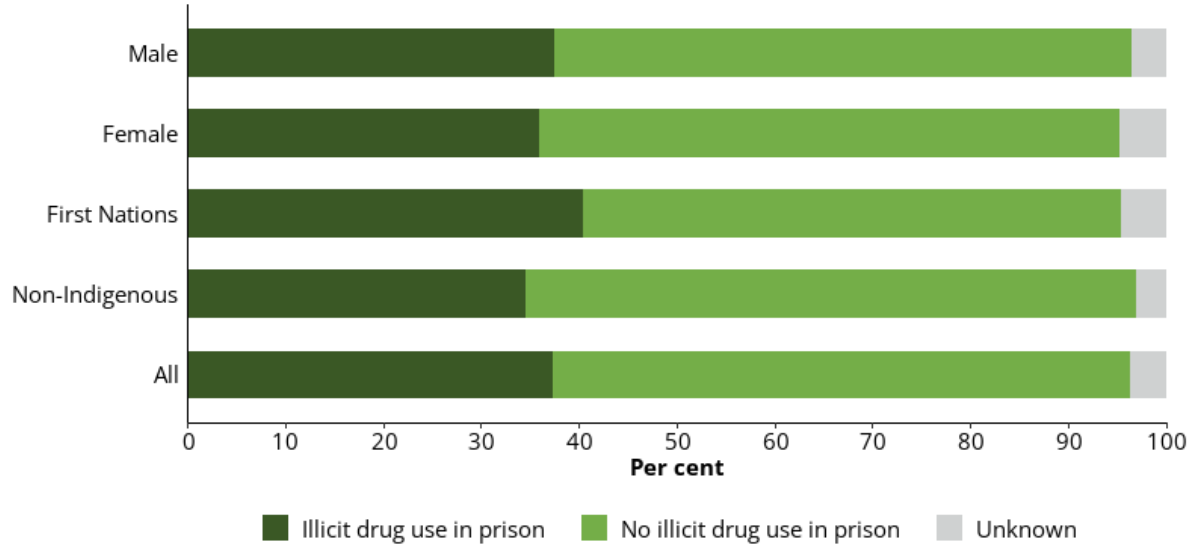
Prison dischargees were asked whether they had used substances in prison, and whether they had injected substances in prison.

> Almost 2 in 5 (37%) prison dischargees reported using illicit drugs in prison (Indicator 2.2.9).

Over a half (55%) of First Nations dischargees reported they had not used substances in prison while 41% had.

Of 231 non-Indigenous prison dischargees, 62% reported they had not used substances in prison while 35% had (Figure 9.16).

Figure 9.16: Prison dischargees, illicit drug use while in prison, by sex and Indigenous identity, 2022



Notes

1. Proportions of prison entrants are proportions in this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Prison dischargees aged 25–34 (40%) were the group most likely – and dischargees aged 45 and over (32%) the least likely – to report using substances for non-medical purposes, or that were not supplied to them medically while in prison.

Injecting substances among prison dischargees

> About 1 in 7 (14%) prison dischargees reported injecting substances in prison (Indicator 2.2.10).

Prison dischargees were asked if they had injected substances during their current time in prison.

About 1 in 7 (15%) male dischargees and about 1 in 20 (6.2%) female dischargees reported injecting substances in prison.

Dischargees aged 18–24 were the group most likely to inject substances in prison (18%) while those aged 45 and over were the least likely (8.3%).

More than 4 in 5 First Nations dischargees (82%) reported not injecting substances while in prison while about 1 in 6 (16%) reported injecting substances in prison.

Almost 9 in 10 non-Indigenous dischargees (87%) reported never injecting substances in prison while about 1 in 10 (12%) reported injecting substances in prison.

Tattooing and body piercings in prison

As well as for injecting drugs, needle sharing in prison might occur when people receive amateur tattoos or body piercings from other people in prison. Without sterilised equipment, tattooing and body piercing are risk behaviours for contracting bloodborne viruses (Butler et al. 2010).

> About 1 in 14 (7.2%) prison dischargees reported receiving a tattoo or body piercing while in prison (Indicator 2.2.11).

Prison dischargees were more likely to report receiving a tattoo (6.7%) than a piercing in prison (0.7%).

Over 1 in 5 (22%) of young prison dischargees (aged 18–24) reported receiving a tattoo or body piercing while in prison; every age group thereafter was less likely to report receiving a tattoo or body piercing while in prison (7.1–0%).

Needle sharing in prison

Sharing needles and syringes carries the risk of transmitting communicable diseases, most notably hepatitis C (Butler and Simpson 2017). Community needle and syringe exchange programs have been shown to be a cost-effective way to reduce infections, such as hepatitis C (Abdul-Quader et al. 2013; Iversen et al. 2013; Kwon et al. 2012). In some countries, needle and syringe exchange programs have been extended to prisons, resulting in decreased needle sharing practices and bloodborne virus transmissions, with no evidence of major negative consequences (Lazarus et al. 2018; Moazen et al. 2018; Schwitters 2014).

> About 1 in 8 (13%) prison dischargees reported sharing injecting equipment in prison (Indicator 2.2.12).

At-risk sexual behaviours

Engaging in at-risk sexual behaviours, particularly with new or casual sexual partners, increases the risk of sexually transmissible diseases (STIs).

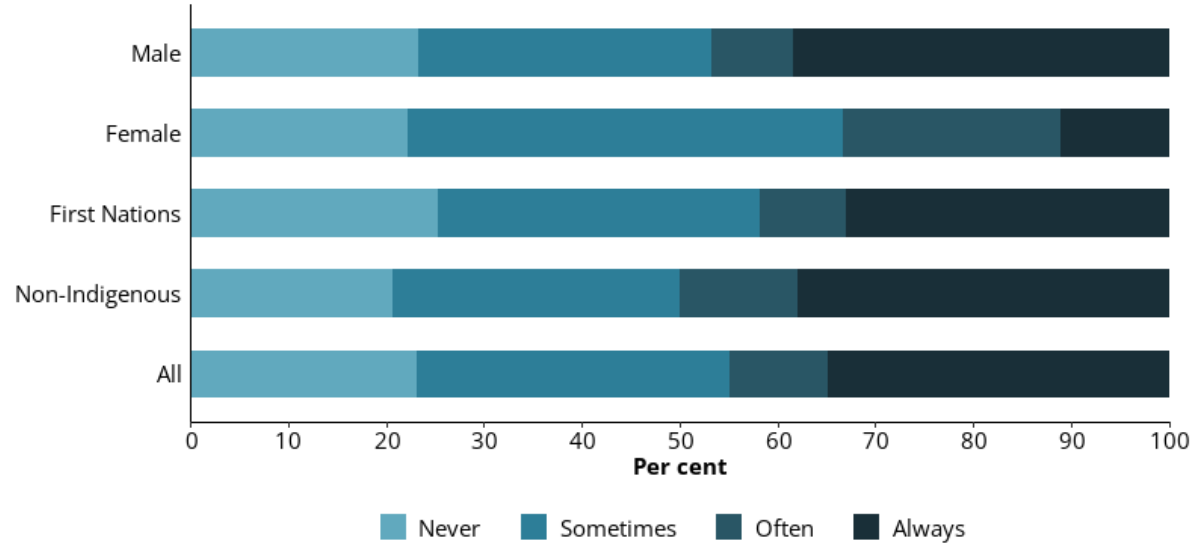
> About 1 in 3 (35%) prison entrants reported having a casual sexual partner in the previous 3 months and never used a condom (Indicator 2.2.13).

Of 138 prison entrants who had a casual sexual partner in the previous 3 months:

- 35% reported they always had unprotected casual sex in the previous 3 months
- 42% reported they often or sometimes had unprotected casual sex

- 23% reported they never had unprotected sex (Figure 9.17).

Figure 9.17: Prison entrants, self-reported unprotected sex frequency, by sex and Indigenous identity 2022



Notes

1. Percentages exclude participants reporting no casual sex partner in the previous 3 months and those who did not report their sexual behaviour.
2. Excludes Victoria, which did not provide data for this item.
3. Proportions are representative of this data collection only, and not the whole prison population.

Source: Entrants form, 2022 NPHDC.

Males (38%) were over 3 times more likely than females (11%) to report always having unprotected sex. Females were more likely to report sometimes (67%) or often having unprotected sex than males (38%).

Non-Indigenous Australians (38%) were fairly similar to First Nations people (33%) in reporting always having unprotected sex. First Nations people (25%) were fairly similar to non-Indigenous Australians (21%) in reporting never having unprotected sex.

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Health services

There are high levels of health problems among people in prison;however, it can be difficult for some people to access health services in the community. Health can be a lower priority for some people, particularly when they have concerns about housing, employment, dependants, alcohol and other drug issues, and other stressful life events. Prison may provide an opportunity to access some required health-care services (Plugge et al. 2014).

The NPHDC provided information from prison entrants on their health-seeking behaviours. Data were collected about visits to health professionals, both in the community and in prison (for those prison entrants who reported being in prison on a prior incarceration in the previous 12 months). Information was also collected about when prison entrants did not seek health-care services, and their reasons for not seeking health care when needed.

Health-care referrals

Transport to a health professional for someone in prison is more problematic than in the community if that health professional is outside the prison. Some consultations require transfer through another prison before attending, and, if having to transfer through a prison perceived as dangerous, people in prison might elect to forego a necessary appointment, rather than go through the transfer process.

Prison entrants' referral to mental health services

Entrants receive an initial health assessment on entry to prison which is similar to a screening assessment that might include history taking and/or a mental health screening tool (Dean et al. 2017; Martin et al. 2018). The initial health assessment is separate from the NPHDC survey.

After administering the prison entrants survey, clinic staff were asked – after completing the health assessment – if the participant was deemed at risk of self-harm and had been referred to mental health services for observation and/or further assessment. See 'Mental health and self-harm' for further information.

In 4 prisons in New South Wales, researchers administered surveys and did not provide data on this item.

> One in 7 (15%) prison entrants were referred to the prison mental health service after their reception assessment (Indicator 3.1.1).

Female prison entrants (28%) were more likely than male prison entrants (13%) to be referred to prison mental health services.

These patterns were generally consistent with prison entrants reporting on their mental health status; that is, female entrants were more likely than male entrants to rate their mental health as poor or fair (see 'Self-assessed mental health status').

Prison dischargees attending external medical appointments

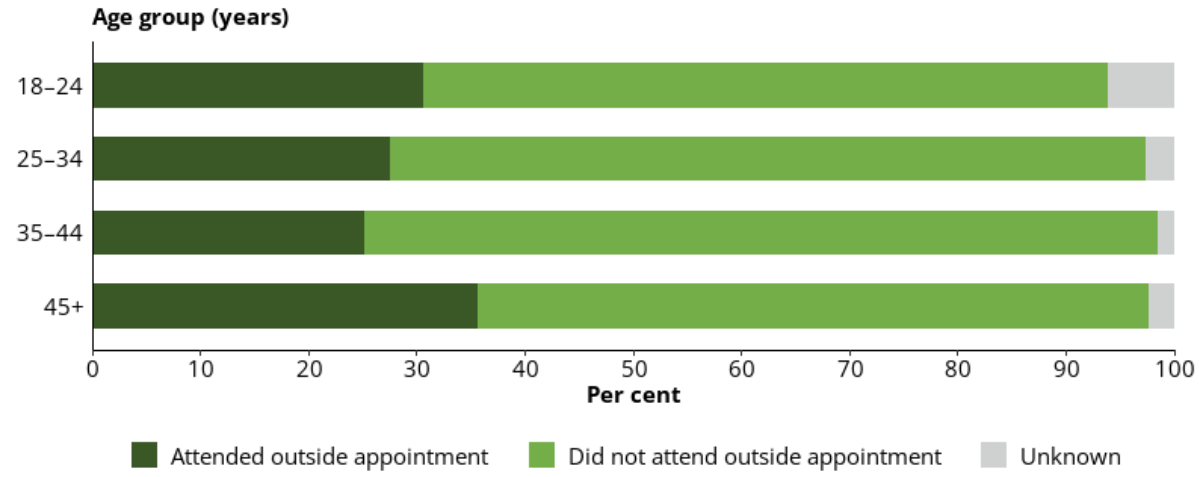
Prison dischargees were asked whether they had attended a medical appointment outside the prison during their incarceration period.

About 1 in 3 (29%) prison dischargees reported attending a medical appointment outside the prison during their incarceration (Indicator 3.1.2).

Female prison dischargees (38%) were more likely to report attending an outside appointment than male prison dischargees (28%).

Prison dischargees aged 45 and over (36%) were the most likely to report attending a medical appointment outside the prison, and those aged 35–44 were the least likely (25%) (Figure 10.1).

Figure 10.1: Prison dischargees, attendance at a medical appointment outside prison during current prison term, by age, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

People in custody using community health facilities

In some jurisdictions, people in prison who are hospitalised, or need highly specialised health care, can be managed within the prison system, as larger prisons might contain inpatient beds.

Alternatively, people in custody might be transferred to community facilities or secure wards in community hospitals for specialised treatment. Transfers to hospital might be planned – such as scheduled surgery and specialist outpatient appointments – or unplanned, in emergency situations.

A total of 73 participating prison clinics reported the number of hospital transfers that occurred during the 2-week data collection period.

In 2022, there were 844 hospital transfers in the 2-week collection period (Indicator 3.1.3).

Of the 844 hospital transfers reported by participating clinics in 2022, 31% were acute (or unplanned) transfers to hospital for emergencies, and 70% were non-acute or planned hospital transfers.

People in custody using telehealth

The term ‘telehealth’ is used to describe the delivery of appointments with a health professional via a video or telephone call. Implementing telehealth consultations in correctional settings provides people in prison with greater access to health-care professionals (Tian et al. 2021).

Participating prisons were asked how many telehealth consultations took place during the 2-week data collection period. A total of 2,038 telehealth consultations took place across 75 prison clinics who provided data for this item.

Health professionals consulted

Health professionals consulted in the community

> Almost 3 in 4 (71%) prison entrants reported they had seen a health professional in the community in the previous 12 months (Indicator 3.1.4).

Females (88%) were more likely than males (67%) to report consulting a health professional in the community in the previous 12 months.

Almost 2 in 3 (63%) First Nations prison entrants reported that they consulted a health professional in the community in the previous 12 months, while 1 in 3 (37%) did not.

About 3 in 4 (78%) non-Indigenous prison entrants reported consulting a health professional in the community in the previous 12 months.

The likelihood of prison entrants reporting that they had seen a health professional in the community in the previous 12 months increased with age. Prison entrants aged 18–24 (49%) were the least likely to report seeing a health professional in the community, and those aged 45 and over (83%) were the most likely.

Health professionals seen in prison

> Over 2 in 3 (70%) prison entrants who had been in prison in the previous 12 months reported seeing a health professional in prison during that time (Indicator 3.1.5).

Of 371 prison entrants, 41% reported they had been in prison in the previous 12 months. Of these entrants, females (70%) and males (70%) were equally as likely to report consulting a health professional while in prison.

First Nations prison entrants (75%) were more likely to report consulting a health professional in prison than non-Indigenous prison entrants (65%).

Type of health professional seen

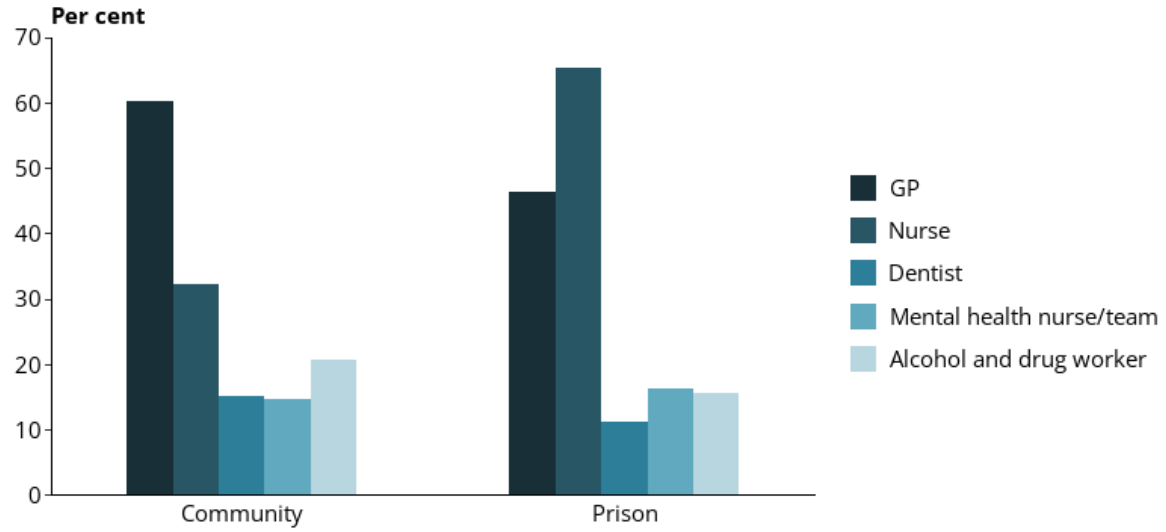
Of 371 prison entrants, 60% reported seeing a doctor or general practitioner (GP) in the community in the previous 12 months, and 32% reported seeing a nurse (Figure 10.2).

More than a half (53%) of First Nations prison entrants reported seeing a doctor or GP in the community in the previous 12 months, 32% reported seeing a nurse and 20% reported seeing an alcohol or drug worker.

About 2 in 3 (67%) non-Indigenous prison entrants reported seeing a doctor or GP in the community in the previous 12 months, 33% reported seeing a nurse and 22% reported seeing an alcohol or drug worker.

Of 153 prison entrants who had been in prison in the previous 12 months, 46% reported seeing a doctor or GP, while 65% reported seeing a nurse in prison (Figure 10.2).

Figure 10.2: Prison entrants, self-reported consultation with a health professional in the community or in prison in the previous 12 months, by type of health professional, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire population.
2. Proportions of prison entrants who saw a health professional in prison in the past 12 months are proportions of prison entrants who reported being in prison in the past 12 months and not all prison entrants in this data collection.
3. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Comparisons with the general community

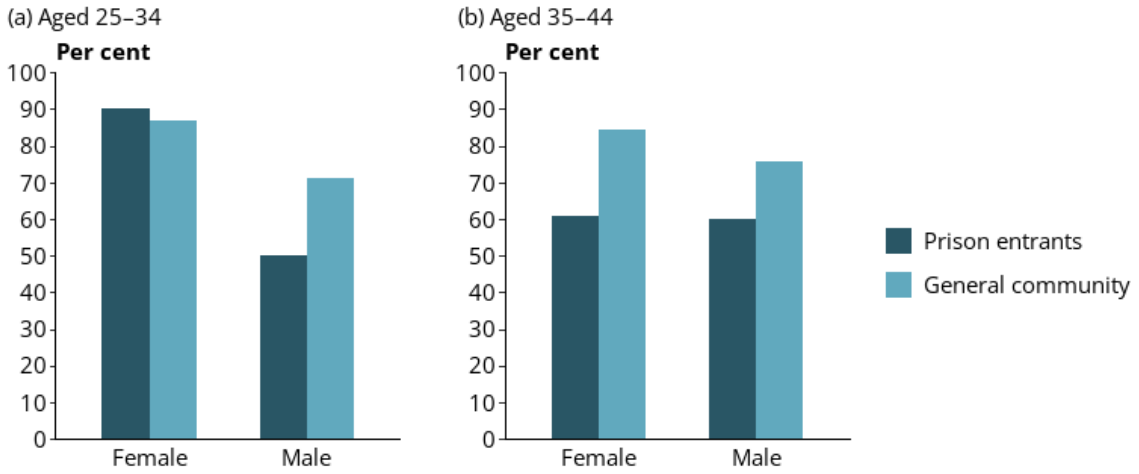
In 2021–22, most people aged 15 and over (84%) in Australia reported seeing a GP in the preceding 12 months, and nearly a half (49%) said they had seen a dentist (ABS 2022).

These proportions were higher than the 60% of prison entrants who reported seeing a GP in the community, and the 15% who said they saw a dentist in the past 12 months; however, the prison population is younger than the general Australian population, and health care needs tend to increase with age.

Nine in 10 (90%) female prison entrants aged 25–34 reported seeing a GP in the previous 12 months as did almost 9 in 10 (87%) females of the same age in the community. Among female prison entrants aged 35–44, 61% reported seeing a GP in the previous 12 months compared with 84% of females of the same age in the community.

A half (50%) of male prison entrants aged 25–34 reported consulting a GP in the previous 12 months as did almost 3 in 4 (71%) males of the same age in the community. Among male prison entrants aged 35–44, 60% reported seeing a GP in the previous 12 months compared with 76% of males of the same age in the general community (Figure 10.3).

Figure 10.3: Prison entrants (2022) and the general community (2021–22), self-reported consultation with a GP in the community in the previous 12 months, by age and sex



Notes

1. Proportions of prison entrants are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Sources: ABS 2022; Entrants form, 2022 NPHDC.

Alcohol treatment in prison

Given the high proportion of people in custody who reported that, while in the community, they consumed alcohol at levels considered high risk for alcohol-related harm (see 'Alcohol consumption'), there is a clear need for alcohol-treatment services to be available in prison, and then continued into the community after release.

> One in 10 prison dischargees (9.7%) reported accessing an alcohol treatment program in prison (Indicator 3.1.6).

Accidents or injuries in prison

Accidents and injuries can have substantial health consequences and might require the temporary or ongoing care and resources of a prison health clinic.

Prison dischargees were asked if they had an accident or sustained an injury while they were in prison that required medical attention.

> About one-third (34%) of prison dischargees reported they had an accident or injury in prison that required medical attention (Indicator 3.1.7).

Accidents or injuries in prison occurred more often for males (37%) than females (16%), and for non-Indigenous dischargees (35%) than Indigenous dischargees (33%).

Barriers to use of health services

Improving the health of people in prison is a part of improving public health overall, so barriers to the use of health services by people in prison need to be minimised wherever possible. Barriers might be:

- physical – such as not being able to attend a consultation due to time constraints, lack of transport or lack of services
- psychosocial – where an individual feels stigmatised or intimidated, where culturally appropriate care is unavailable, or where an individual feels discouraged from seeking treatment.

Barriers to receiving specialist treatment might be particularly problematic for people in prison, especially if the person is required to travel out of the prison.

Prisons entrants needing to see a health professional in previous 12 months

Prison entrants were questioned about seeing a health professional in the previous 12 months, either in the community or in prison for those who said they had been incarcerated at some stage in the previous year.

Entrants were asked if, during the previous 12 months, they needed to see a health professional but did not. If this was the case, they were asked why.

> About a half (52%) of prison entrants reported needing to see a health professional in the community in the previous 12 months but not doing so (Indicator 3.1.8).

About one-third (36%) of prison entrants reported they did not see a GP in the previous 12 months despite needing to – similar to the proportion of people aged 15 and over in the general community who also did this (28%) (ABS 2022).

When asked why they did not see a health professional in the community when needed, prison entrants were able to select multiple reasons. The most common reasons cited were that:

- they felt they didn't need to, they didn't want to or they couldn't be bothered (46%)
- the waiting time was too long or the health professional was not available at the time required (34%)
- they were too busy (30%)
- they were affected by alcohol or other drugs (27%)

> One-quarter (25%) of prison entrants reported needing to see a health professional in prison in the previous 12 months, but not doing so (Indicator 3.1.9).

Despite needing to, about 1 in 7 (15%) prison entrants said they did not see a GP in prison, and 1 in 20 (4.6%) reported not seeing a dentist in prison.

Use of prison clinics

People entering prison are routinely given an initial health assessment to provide clinicians with an indication of the health, and health needs, of the individual and whether referral for further assessment or treatment is required.

Use of prison clinics by prison dischargees

Prison dischargees were asked if they had received a health assessment on entry to prison and whether they were referred for further assessment or treatment as a result.

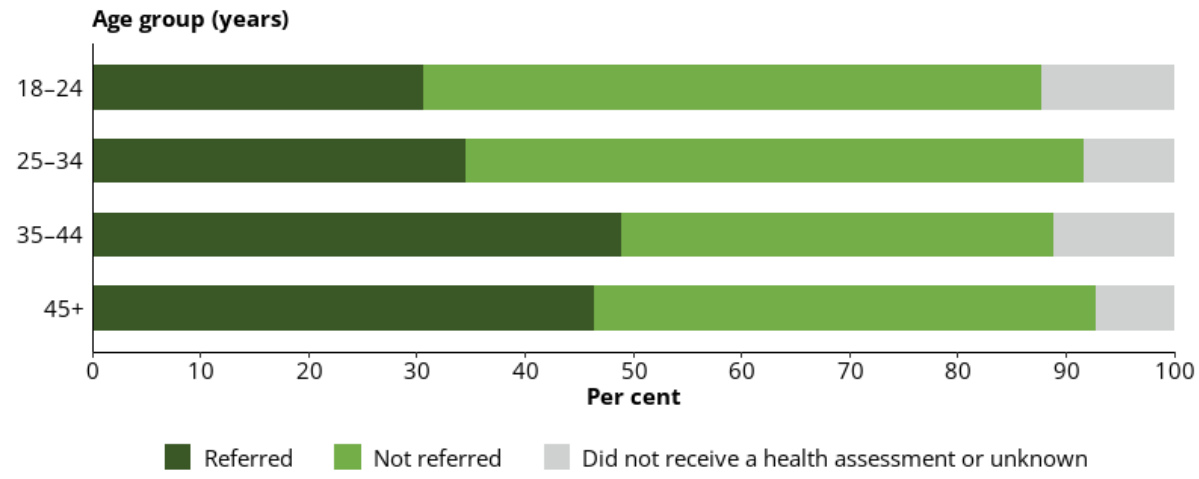
> About 9 in 10 (90%) prison dischargees reported they received a health assessment when they entered prison (Indicator 3.1.10).

Prison dischargees aged 45 and over were the most likely to report they had received an initial health assessment on prison entry (92%), and those aged 35–44 were the least likely (87%).

Around 2 in 5 (41%) dischargees had been referred for further assessment or treatment following their initial health assessment on entry. Females (53%) were more likely to report receiving a referral than males (39%).

Dischargees aged 35–44 (49%) were the most likely to report receiving a referral on prison entry, followed by those aged 45 and over (46%); dischargees aged 18–24 were the least likely (31%) (Figure 10.4).

Figure 10.4: Prison dischargees, self-reported referral after initial health assessment on prison entry, by age, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

The health professionals to whom dischargees reported most commonly being referred to after an initial health assessment on entering prison were doctors/GPs (65%), nurses (52%), mental health nurse or team (32%) and alcohol and drug counsellors (25%).

Prison dischargees were asked if they could easily see a doctor/GP and/or nurse when required while they were in prison.

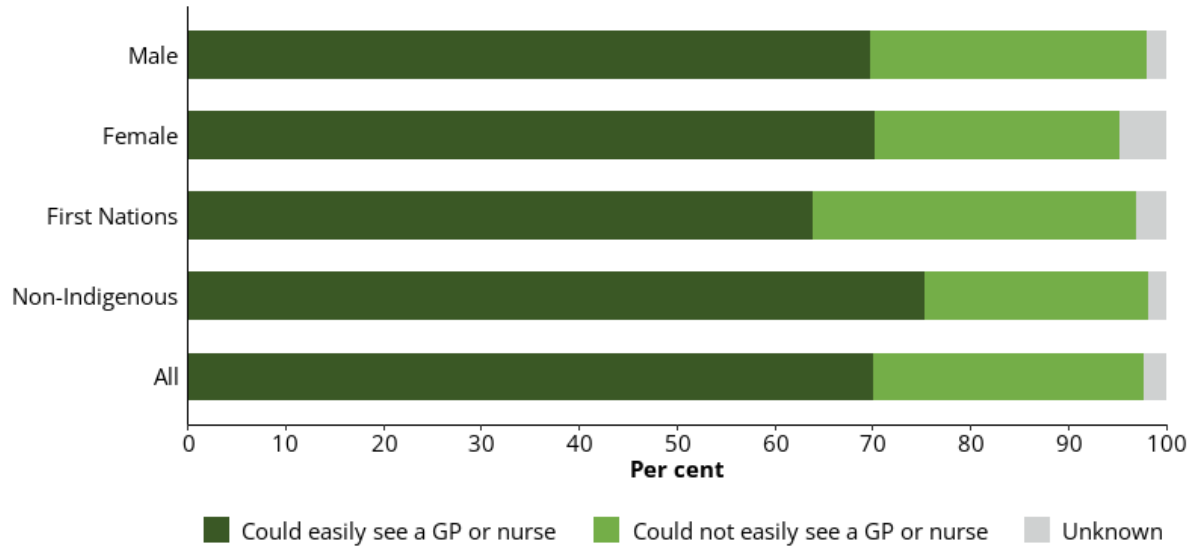
> More than two-thirds (70%) of prison dischargees reported they could easily see a medical professional (GP or nurse) while in prison (Indicator 3.1.11).

More than two-thirds (69%) of prison dischargees said they could easily see a nurse in prison, but fewer than a half (46%) said they could easily see a doctor or GP. Prison clinics are usually a nurse-led system of care, so this finding is consistent with this practice.

About two-thirds (64%) of First Nations prison dischargees reported they could easily see a medical professional while in prison, while one-third (33%) reported they could not (Figure 10.5).

Three-quarters (75%) of non-Indigenous prison dischargees reported they could easily see a medical professional while in prison, while almost one-quarter (23%) reported they could not (Figure 10.5).

Figure 10.5: Prison dischargees, self-reported, ease of access to a GP or nurse in prison, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Younger prison dischargees found it more difficult to see a doctor/GP or nurse in prison than older prison dischargees. About a half (53%) of prison dischargees aged 18–24 said they could easily see a GP or nurse in prison. Over two-thirds of prison dischargees aged 25–34 (69%) and 35–44 (70%) could easily see a GP or nurse while in prison. Those aged 45 and over (81%) were the group most likely to report they could easily see a GP or nurse.

Prison dischargees were asked whether they had visited the prison clinic during their time in prison.

About 9 in 10 (93%) prison dischargees reported visiting the prison clinic while in prison (Indicator 3.1.12).

All (100%) female prison dischargees and 9 in 10 (92%) male prison dischargees reported visiting the prison clinic while in prison.

Older dischargees were more likely to report visiting the prison clinic than younger dischargees. Over 9 in 10 (96%) prison dischargees aged 45 and over reported visiting the prison clinic, as did 4 in 5 (82%) dischargees aged 18–24.

Of 431 prison dischargees, 6.0% reported they did not visit the prison clinic while in prison. The most common reasons cited by dischargees for not visiting the prison clinic were:

- they felt at the time they didn't need to or want to (27%)
- other (23%)
- they were refused access to the clinic (15%).

Use of prison clinic by people in custody

Information about how people in prison used the clinic was collected as part of the 2022 NPHDC. Health professionals completed a clinic visit form for every consultation attended by a person in custody who provided consent during the 2-week data collection. The form included demographic information about the patient, the problem managed, and the type of health professional the patient saw.

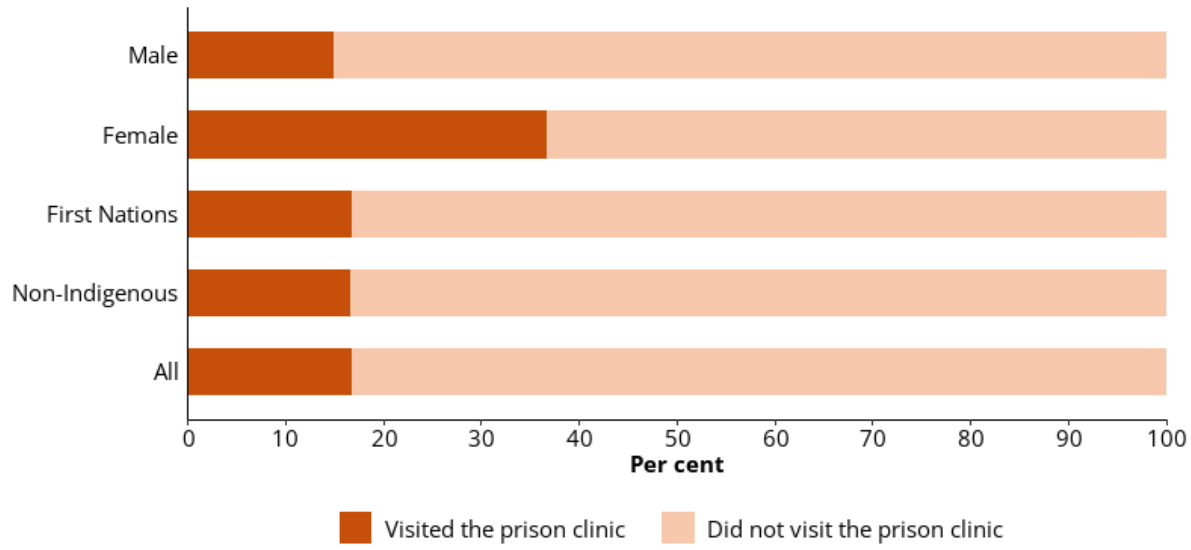
Not all clinic visits were able to be recorded and the following results are likely an underestimate of the true proportions of people accessing the clinics. Proportions were calculated as a percentage of all people in participating prisons on a snapshot day, 30 June 2022, provided by the ABS.

> About 1 in 6 (17%) people in custody attended the prison clinic during the 2-week data collection period (Indicator 3.1.13).

Females were more likely (37%) than males (15%) to visit the prison clinics during the 2-week data collection period (Figure 10.6).

First Nations people in custody (17%) and non-Indigenous Australians in custody (17%) were equally as likely to visit the prison clinics (Figure 10.6).

Figure 10.6: People in custody, visits to the prison clinic in the 2-week data collection period, by sex and Indigenous identity, 2022



Notes

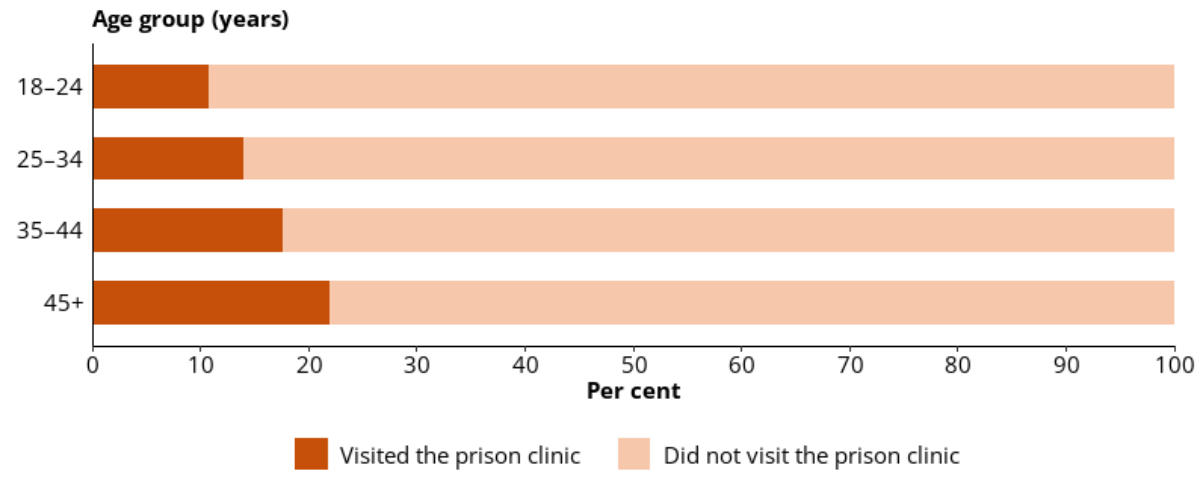
1. Proportions are representative of this data collection only, and are likely an underestimate of the true proportions of people who visited the prison clinics in the 2-week data collection period.
2. Excludes Victoria, which did not provide data for this item.

Source: Clinic form, 2022 NPHDC.

The proportion of people in custody who visited the prison clinic during the 2-week data collection period increased with age (Figure 10.7).

People aged 18–24 (11%) were the least likely group to have visited the prison clinic during the 2-week data collection period, while those aged 45 and over (22%) were the group most likely to have done so (Figure 10.7).

Figure 10.7: People in custody, visits to the prison clinic in the 2-week data collection period, by age, 2022



Notes

1. Proportions are representative of this data collection only, and are likely an underestimate of the true proportions of people who visited the prison clinics in the 2-week data collection period.
2. Excludes Victoria, which did not provide data for this item.

Source: Clinic form, 2022 NPHDC.

Number of visits per patient

There were 6,651 clinic visits, attended by 4,489 people in custody (or patients) recorded on the clinic visit forms, or 1.5 clinic visits per patient.

Females (1.7 visits per female patient) typically attended more clinic visits during the 2-week data collection period than males (1.4 visits per male patient).

The rate of clinic visits per patient increased with age, with patients aged 18–24 attending an average of 1.3 visits, and those aged 45 and over attending an average of 1.6 visits.

Number of problems managed per patient

During the 2-week data collection period in 2022, 1.5 problems, on average, were managed per visit.

Females (1.6 problems per patient) had slightly more problems managed, on average, than males (1.4 per patient).

The number of problems managed per visit increased with age. Patients aged 18–24 had an average of 1.4 problems managed per patient, and those aged 45 and over had an average of 1.5 problems managed.

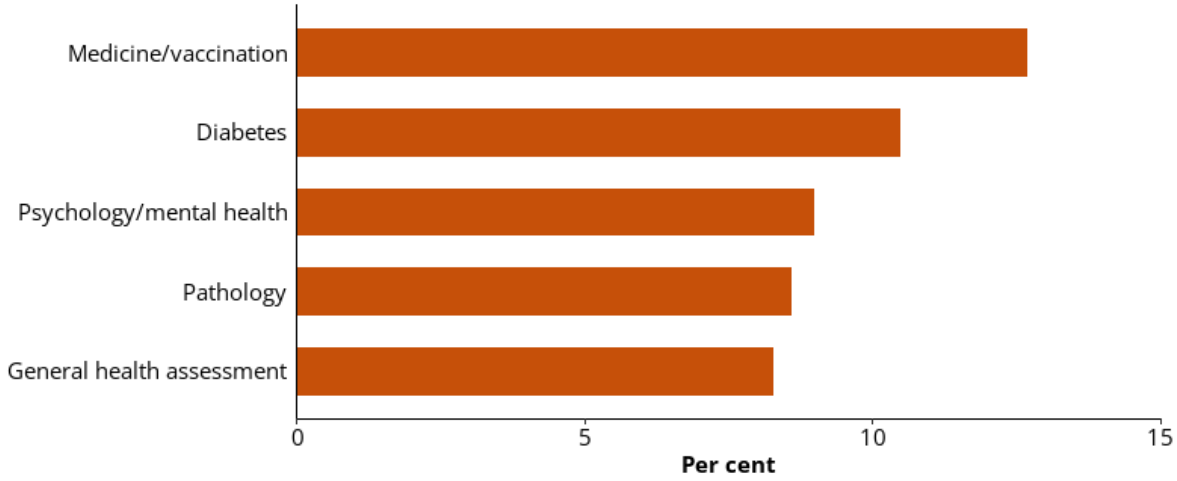
Conditions managed at the prison clinic

Health professionals in the prison clinics recorded the problem or condition managed at the clinic visits during the 2-week data collection period. Multiple conditions were recorded per visit, where necessary.

During the data collection period, 9,686 specified conditions were managed during 6,651 clinic visits. Of those specified conditions:

- 13% were related to medication or vaccination
- 11% were diabetes related
- 9.0% were mental health related
- 8.6% were related to pathology
- 8.3% were general health assessments (Figure 10.8).

Figure 10.8: Conditions managed at clinic visits, by type of condition, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Clinic form, 2022 NPHDC.

The types of conditions managed, as specified on the clinic visit form, differed according to the sex of the patient.

Males were more than 5 times as likely as females to be managed for a condition related to diabetes, 2 times as likely to be managed for wound care and twice as likely to be managed for cardiovascular disease or a respiratory condition.

Females were 10 times more likely than males to be managed for a condition related to a communicable disease; almost 3 times as likely to be managed for pathology; and equally as likely to be managed for alcohol or drug use, dental conditions, asthma, neurological conditions and malignancies.

The types of conditions managed in the clinic also varied with age. The likelihood of conditions like diabetes, cardiovascular disease, musculoskeletal conditions and arthritis being managed at the clinic increased with age.

Management of conditions like psychological/mental health conditions and musculoskeletal injuries decreased with age.

Services received during prison clinic visits

For each clinic visit recorded on the clinic visit form during the 2-week data collection period, clinicians reported the service(s) a patient received.

Of the 6,651 clinic visit forms completed, 10,073 services were provided – an average of 1.5 services per visit. The services administered were:

- treatment (55% of all services)
- assessment only (48%)
- advice and education (38%)
- referrals (9.8%).

Males (60%) were more likely than females (37%) to receive treatment during a prison clinic visit. But females (60%) were more likely than males (45%) to receive an assessment only (Figure 10.9).

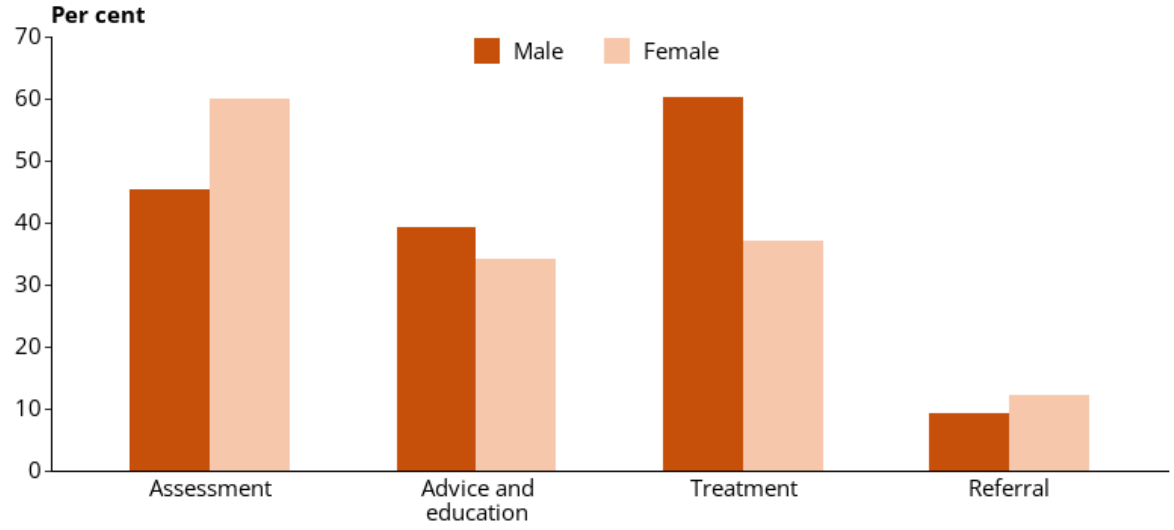
Younger people in prison were more likely than older people in prison to attend for advice or education during a clinic visit:

- 40% of those aged 18–24
- 41% of those aged 25–24
- 38% of those aged 35–44
- 35% of those aged 45 and over.

Older people in prison were more likely than younger people in prison to attend for treatment during a clinic visit:

- 52% of those aged 18–24
- 53% of those aged 25–24
- 57% of those aged 35–44
- 57% of those aged 45 and over.

Figure 10.9: Type of service provided during clinic visit, by sex, 2022



Notes

1. Multiple types of services could be provided during a single clinic visit.
2. Proportions are representative of services provided at clinic visits in this data collection only, and not the entire prison population.
3. Excludes Victoria, which did not provide data for this item.

Source: Clinic form, 2022 NPHDC.

Initiator of clinic visits

As happens in general practice in the community, a visit to the prison clinic may be initiated by the patient or by clinic staff.

A patient initiating a clinic contact indicates health-care-seeking behaviour. A health professional may initiate clinic contacts, for example, to monitor a health condition, to follow up a pathology test, or for health intervention. During the 2-week data collection period, clinicians indicated on the clinic visit form whether the visit had been initiated by the patient or by staff.

> More than 1 in 3 (36%) clinic visits were initiated by the patient (Indicator 3.1.14).

About 3 in 5 (63%) clinic visits recorded during the data collection period were initiated by clinic staff.

Patient-initiated visits were similar for males and females (36%), as well as for non-Indigenous (37%) and First Nations patients (35%).

All age groups were similarly as likely to initiate a clinic visit. Patients aged 25–34 (38%) were the most likely to initiate a clinic visit, and those aged 45 and over were the least likely (34%).

Type of health professional seen

Prison clinics usually have nurse-led health care, with nurses responsible for providing most of a patient's primary health care through the prison clinic. If nursing staff are unable to help a patient, they can refer them to a doctor, allied health professional, or other health specialist, either in the prison clinic, or outside the prison.

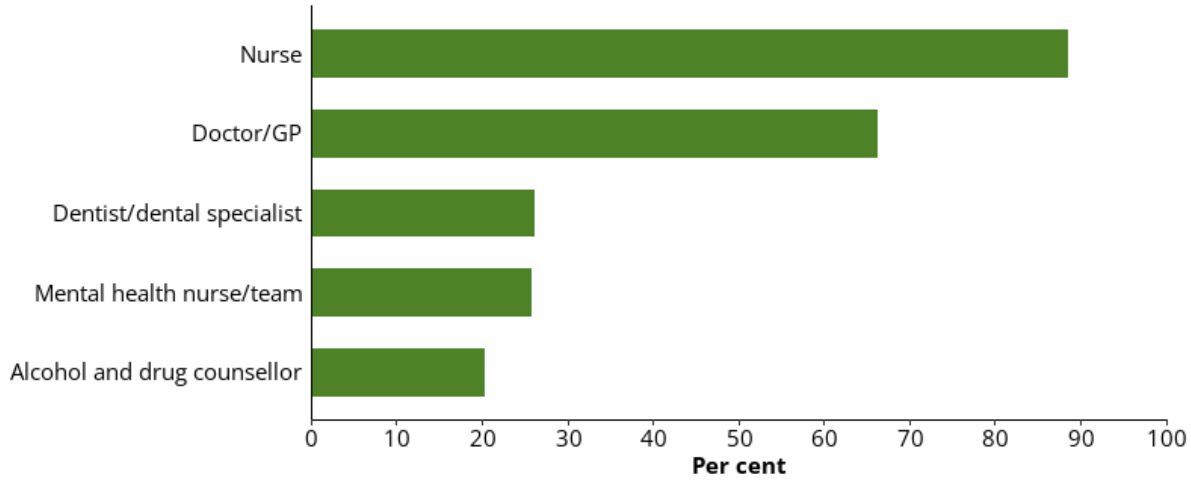
Most prison clinics have doctors/GPs who either work at the prison or visit regularly. Prisons often offer other health services, such as dental services, mental health services, and alcohol and other drug treatment services.

Type of health professionals seen by prison dischargees

Prison dischargees were asked which type of health professionals they had seen in prison. Of prison dischargees who saw a health professional in the prison clinic:

- almost 9 in 10 (89%) reported seeing a nurse
- 2 in 3 (66%) reported seeing a doctor/GP
- about one-quarter (26%) reported seeing a dentist
- about one-quarter (26%) reported seeing a mental health team
- 1 in 5 (20%) reported seeing an alcohol and other drug counsellor (Figure 10.10).

Figure 10.10: Prison dischargees, self-reported type of health professional seen in the prison clinic, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC

Type of health professional seen by people in custody

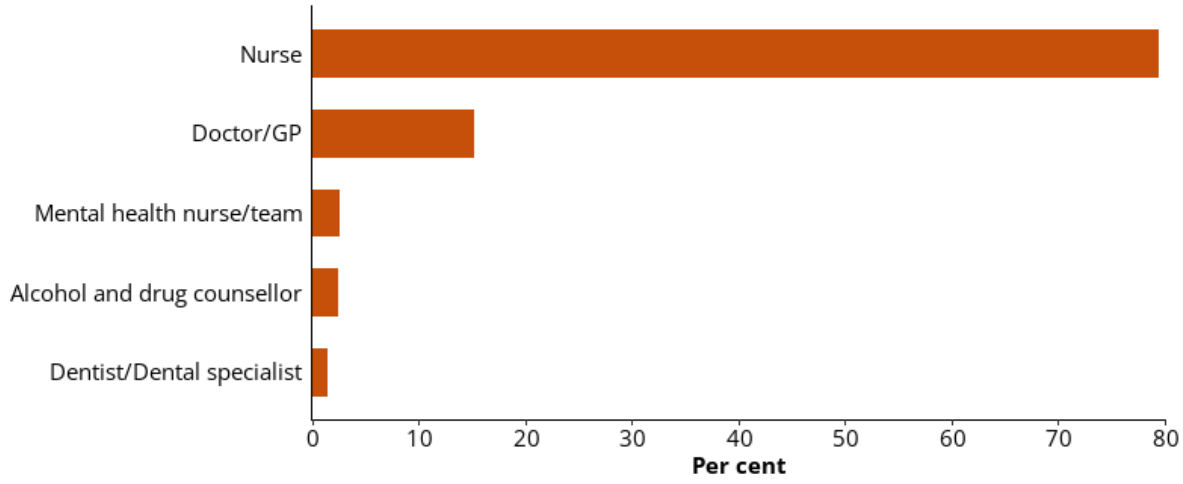
The type of health professional who provided the service for each clinic visit was recorded on the clinic visit form.

The clinic visit form was completed for clinic visits attended by all consenting people in custody during the 2-week data collection period – not just for clinic visits by prison dischargees. So information from this form provided types of health professionals seen by a larger proportion of the prison population.

The majority of clinic visits recorded during the 2-week data collection period (80%) were consultations with nurses. One in 7 (15%) clinic visits were consultations with a doctor/GP, 2.6% with a mental health nurse/team, 2.5% with an alcohol and drug counsellor and 1.5% with a dentist/dental specialist (Figure 10.11).

Psychologists, psychiatrists, physiotherapists, Indigenous health workers, medical imaging professionals, social workers and other health professionals combined accounted for about 1 in 13 (8.0%) of all clinic visits recorded during the data collection period.

Figure 10.11: Type of health professionals conducting clinic visits, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes New South Wales, which did not provide data for this item.

Source: Clinic form, 2022 NPHDC.

Full-time equivalent staffing

People in custody often require more medical attention than the general population.

People in prison are more likely than those of the same age in the community to have mental health disorders or chronic physical health conditions, and are less likely to have sought, or have had access to, clinical health services in the community (Young et al. 2015).

For many, prison provides the opportunity to see health professionals, and to receive the treatment they require. When healthier people are released from prison, the entire community benefits (Kinner and Young 2018).

The provision of health-care services to people in prison depends on the availability of suitably qualified staff. People in custody should have access to health care that is equivalent to that in the community, taking into consideration the need for health-care professionals that specialise in mental health, and in alcohol and other drug use disorders. Medical and allied health services should be provided onsite, wherever possible (Australian Medical Association 2012; United Nations 1990).

The number of health-care staff required in a prison depends on factors such as:

- whether the prison is a reception centre where complete medical examinations are performed
- whether the prison is a females's prison, as medical requirements for males and females differ
- requirements for drug and alcohol detoxification.

Staffing discussed in this report is restricted to doctors and nurses, for which there is more consistent reporting across jurisdictions.

In 2021, there were 3.81 full-time equivalent doctors and nurses working within the correctional system per 100 people in custody (Indicator 3.1.15).

In 2021, there were 0.39 full-time equivalent (FTE) doctors and 3.42 FTE nurses practising in prison clinics per 100 people in custody (from a total of 35,722 people in custody on 30 June 2021 in participating facilities and jurisdictions) (Figure 10.12).

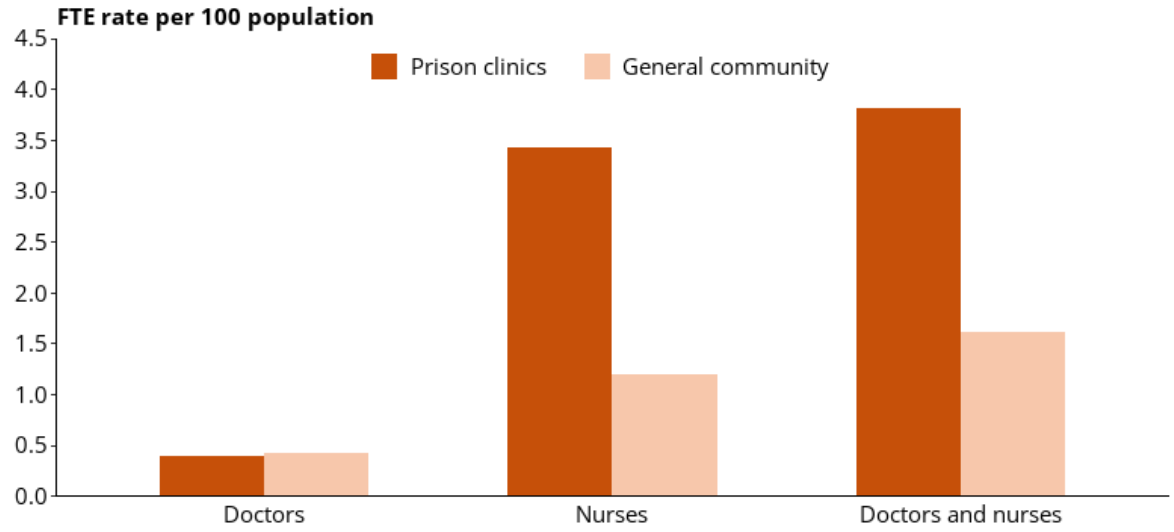
In the 2022 collection, jurisdictions were asked to provide a standard FTE of doctors and nurses in all prison clinics for the 2021 calendar year. So, any comparisons with previous versions of this data collection should not be made.

The FTE rate of doctors and nurses in prison clinics (3.81 FTE per 100) was over twice that of the equivalent rate in the general population (1.61 FTE per 100) (Figure 10.12).

For doctors, the rate in prison clinics (0.39 FTE per 100 persons) was similar to that in the general community in Australia (0.42 FTE per 100 persons). But the rate of nurses in prison clinics (3.42 FTE per 100 persons) was more than 2.5 times that in the general Australian population in 2020 (1.19 FTE per 100 persons) (AIHW 2022).

This likely reflects the greater need for health-care services in prisons, and the nurse-led primary health-care model provided in prison clinics, along with medication administration models that differ from those in the community due to the secure prison environment.

Figure 10.12: FTE health professionals in Australian prisons (2021) and in Australia (2020) (rate)



Note: Excludes Victoria, which did not provide data for this item.

Sources: 2022 NPHDC; AIHW 2022.

Vaccination

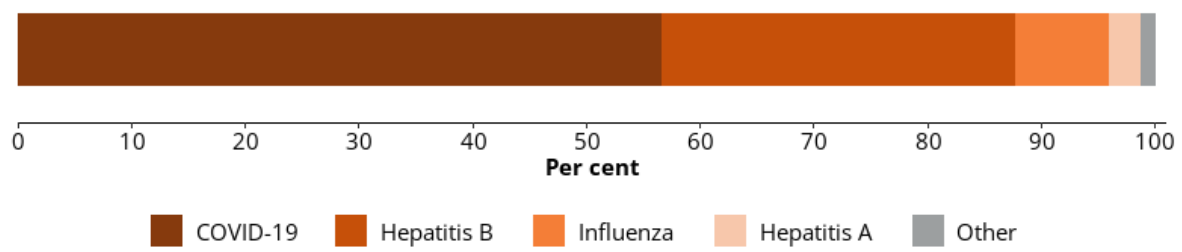
The prison population is at high risk of vaccine-preventable and other communicable diseases, and prison can provide the opportunity to access vaccinations (Butler and Simpson 2017).

During the 2-week data collection period, prison clinics administered 833 vaccinations to people in custody (Indicator 3.1.16).

COVID-19 vaccinations were the most prevalent vaccination type administered (472 or 57% of all vaccinations), followed by hepatitis B (258 or 31% of vaccinations). There were also 69 vaccinations for influenza; 23 for hepatitis A; 10 for measles, mumps, and rubella; and 1 for human papilloma virus (Figure 10.13).

The influenza vaccinations are seasonal; hence, as jurisdictions collected data at various 2-week time periods throughout the year, the number of influenza vaccines provided are an underestimate of the total.

Figure 10.13: Vaccinations provided by prison clinic services during the 2-week data collection period, by vaccination type, 2022



Notes

1. 'Other' includes vaccinations for measles, mumps, rubella, and human papilloma virus.
2. Influenza vaccinations were under-recorded, as they are usually administered according to a seasonal schedule and data collection took place at various times of the year in different jurisdictions.
3. Proportions are representative of this data collection only.
4. Excludes Victoria and one Queensland prison, which did not provide data for this item.

Source: Establishment form, 2022 NPHDC.

Continuing care

Continuity of care is necessary to maintain any health improvements achieved by people in prison. Many people lose any health gains they made in prison within a few months of release, which affects not only the individual, but the entire community (Kouyoumdjian et al. 2018; Wang et al. 2010).

Some barriers to continuity of care can be overcome by ensuring that everyone released from prison has immediate access to health care, with:

- a valid Medicare card or number, where eligible, from the day of their release
- immediate access to required medications or treatment
- immediate access to accommodation and support services.

Compliance with a treatment plan depends on the person's knowledge of their health conditions, including the medications and other treatments they require. This knowledge has been found to be lacking for many people released from prison (Carroll et al. 2014).

Health-related discharge planning

People in prison often have multiple and complex health needs, making their return to the community a time of increased risk to their health and wellbeing (Thomas et al. 2016; Young et al. 2015).

Discharge planning supports the continuity of health care between prison and the community, and is necessary for a successful transition (Kinner et al. 2012). A discharge summary provides an individual plan for the continuity of care of a person from prison to the community. It incorporates referrals to appropriate community-based services and ensures medications, health services and other support services are accessible.

With an increasingly high proportion of prisoners on remand (70% of prison entrants and 44% of prison dischargees were on remand in the 2022 NPHDC), the timing of release from prison is often uncertain. It is relatively common for a person on remand to leave prison to attend court, and then be released directly from court into the community.

Sentenced prisoners might also experience an unplanned release, such as from a parole hearing or appeal proceeding in court. So, it can be difficult for clinic staff to know when to begin discharge planning for many of the people in prison.

Discharge summaries on file when released

Prison clinics in New South Wales, Queensland, Tasmania and the Australian Capital Territory provided information on how many remand and sentenced prisoners were released during the 2-week data collection period, and whether, for sentenced prisoners, these releases were planned or unplanned.

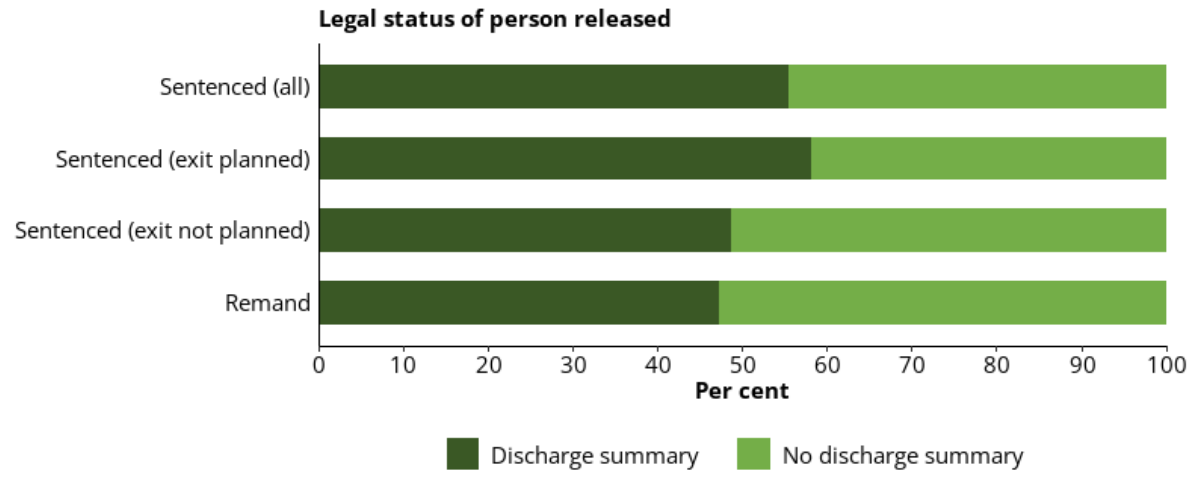
These prison clinics also provided information on how many people had a written discharge summary on file at the time of their release.

> More than a half (56%) of sentenced prisoners had a discharge summary on file when they were released (Indicator 3.1.17).

Of the 731 sentenced prisoners who were released during the 2-week data collection period, 528 had a planned exit and 203 had an unplanned exit. Of those who had a planned exit, 58% had a health-related discharge summary on file at the time of their release. Of those who had an unplanned exit, 49% had a discharge summary on file (Figure 10.14).

Of the 477 people who were released while on remand, 47% had a discharge summary on file (Figure 10.14).

Figure 10.14: Proportion of people released from prison who had a health-related discharge summary in place, by legal status, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, South Australia, Western Australia, Northern Territory and one Queensland prison, which did not provide data for this item.

Source: Establishment form, 2022 NPHDC.

Prison clinics were asked to provide information on their typical prisoner release procedures. Release procedures and the health-related discharge summary varied according to the facility, and according to the health needs of the person in custody.

People released from prison were more likely to have a detailed health-related discharge summary if they had a history of a mental health condition, other chronic health condition, or an alcohol and other drug use disorder, or if they were on regular medication.

Prison clinics reported that, in general, the process for health-related discharge planning included:

- a review at the prison clinic of the person due to be released
- advice and education for the patient regarding health conditions, medications, upcoming appointments, as well as on safe drug use and overdoses for patients with substance use disorders
- a discharge summary or discharge health report and letter for the patient's GP being prepared, and either given to the person due for release or forwarded to their GP, community clinic, or health service
- a discharge summary being prepared, containing the patient's medical history, current problems, allergies, dietary requirements or other needs, future appointments scheduled, relevant pathology and radiology tests, any current medication, vaccination record, and clinic contact details for further information
- a referral to appropriate community services such as GPs, community health clinics, Aboriginal medical services or health clinics, mental health services, psychologists, and/or accommodation support, as required
- a referral or appointment to a specialist, hospital, or program for services such as opioid substitution therapy, to ensure continuity of care
- for some clinics, a limited supply of ongoing medication (1–2 weeks), or arrangements for these to be collected from a pharmacy in the community.

Referral to health professionals after release for prison dischargees

More than 2 in 5 (42%) prison dischargees reported they had a referral or an appointment to see a health professional after release (Indicator 3.1.18).

Females (55%) were more likely than males (40%) to report having a referral or appointment scheduled with a health professional after release from prison.

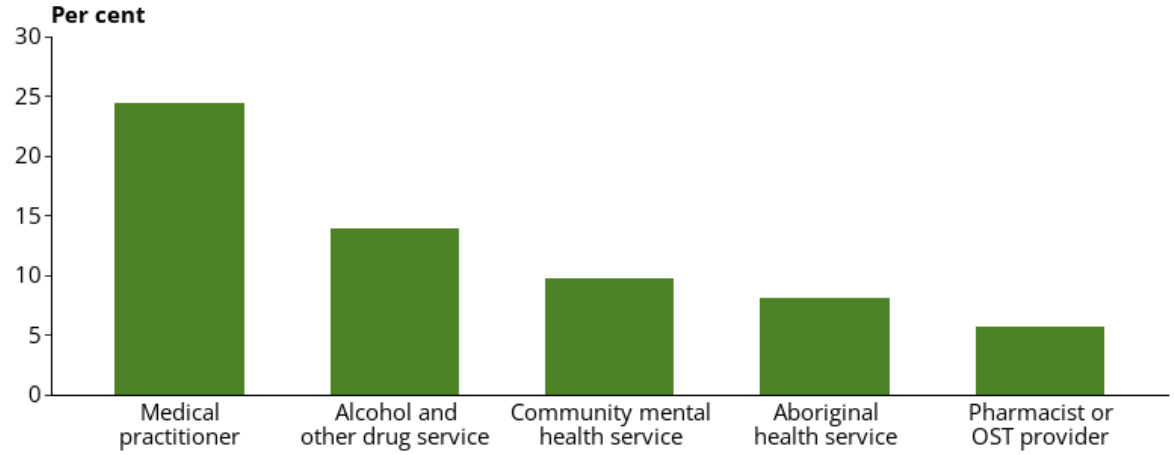
Non-Indigenous dischargees (43%) were similarly as likely as First Nations dischargees (41%) to report having a referral or appointment scheduled with a heath professional after release.

Dischargees aged 45 and over (46%) were the most likely to have a referral or appointment scheduled with a health professional after their release from prison, and those aged 18–24 were the least likely (22%).

Of all prison dischargees:

- about 1 in 4 (24%) had a referral or appointment scheduled to see a medical practitioner after release
- about 1 in 7 (14%) had a referral or appointment to an alcohol and drug treatment or counselling service
- about 1 in 10 (9.7%) had a referral or appointment to a community mental health service
- 8.1% had a referral or appointment to an Aboriginal medical service
- 5.6% had a referral or appointment to a pharmacist or opioid substitution therapy provider (Figure 10.15).

Figure 10.15: Prison dischargees, self-reported referral or appointment to see a health professional after release, by type of health professional or service, 2022



Notes

1. Multiple options could be selected.
2. Proportions are representative of this data collection only, and not the entire prison population.
3. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Medicare access

People in prison are currently ineligible to use Medicare and most Pharmaceutical Benefits Schemes. One reason for this is that Medicare and Pharmaceutical Benefit Schemes are federally funded, while prison clinics are funded and operated by the states and territories.

Having affordable, bulk-billed or subsidised health services and medications is necessary for the continuity of care of people leaving prison (Cumming et al. 2018; Kinner et al. 2012). So having access to Medicare services immediately on release is critical for the health of the person and the community. Prison dischargees were asked whether they would be enrolled in Medicare and able to access health services in the community on the first day of their release from prison.

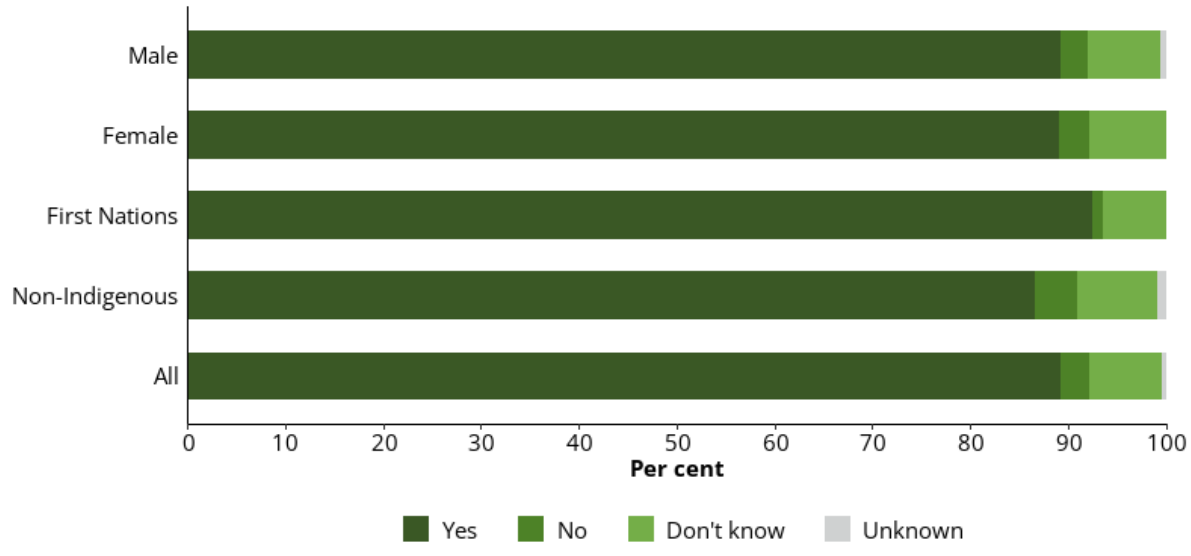
> Almost 9 in 10 (89%) prison dischargees reported they would be able to use Medicare services from the day of their release (Indicator 3.1.19).

One in 10 dischargees were either unsure (7.4%) or reported they would not (2.8%) be able to use Medicare services from the day of their release (Figure 10.16).

Male and female prison dischargees (both 89%) were equally as likely to report they would be enrolled in, and have access to, Medicare services immediately on their release from prison (Figure 10.16).

First Nations prison dischargees (93%) were more likely than non-Indigenous dischargees (87%) to report they would be enrolled in, and have access to, Medicare services from the first day of release from prison (Figure 10.16).

Figure 10.16: Prison dischargees, self-reported access to Medicare on first day of release, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

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Appropriateness of health services

Satisfaction with health services

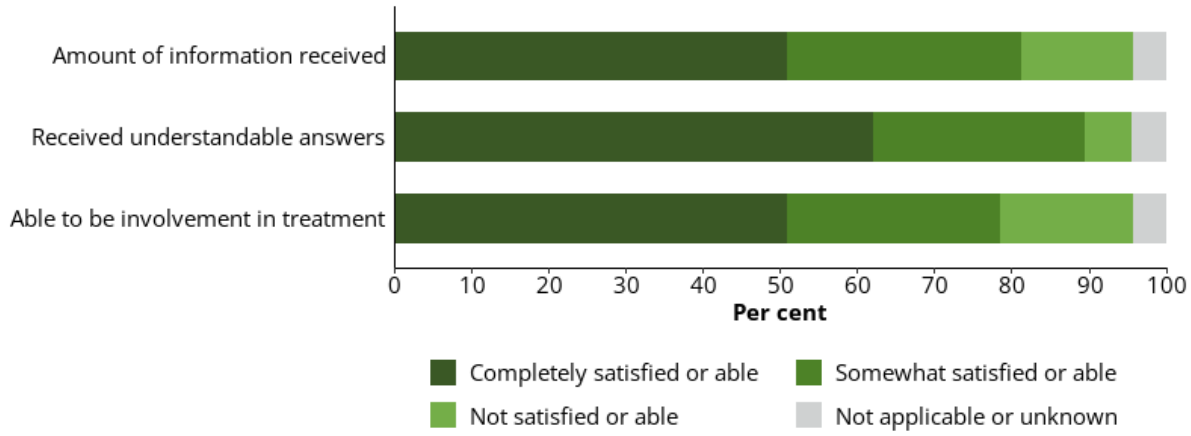
Amount of information received

Prison dischargees were asked questions about their experiences with prison health services during their time in prison. They were asked to rate their level of satisfaction with the amount of information about their condition they received during their clinic visits.

> More than 4 in 5 (81%) prison dischargees reported they were satisfied with the amount of information on their condition they received at the clinic (Indicator 3.2.1).

More than a half (51%) of dischargees reported they were completely satisfied with the amount of information they received at the prison clinic, and more than one-quarter (30%) reported they were somewhat satisfied (Figure 11.1).

Figure 11.1: Prison dischargees, self-reported level of satisfaction with aspects of prison clinic visits, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Answers could be understood

Prison dischargees were asked how satisfied they were that the answers they received at their clinic visits were easy to understand.

> Most (90%) prison dischargees reported they received answers they could understand at the clinic (Indicator 3.2.2).

Nearly two-thirds (62%) of dischargees reported they were completely satisfied that they could understand the answers given to them at the prison clinic, and over one-quarter (27%) reported they were somewhat satisfied (Figure 11.1).

Females (64%) were slightly more likely than males (62%) to report that they were completely satisfied with the answers they received.

Involvement in treatment decisions

Prison dischargees were asked how involved they were able to be in their treatment decisions at the prison clinic.

> Nearly 4 in 5 (79%) prison dischargees reported they were able to be involved in their treatment decisions at the clinic (Indicator 3.2.3).

Just over a half (51%) of dischargees reported they were able to be completely involved in their treatment decisions at the prison clinic, and more than one-quarter (28%) said they were able to be somewhat involved (Figure 11.1).

Non-Indigenous dischargees (21%) were more likely than First Nations dischargees (13%) to report they were unable to be involved in their treatment decisions.

Time spent at clinic visits

Prison dischargees were asked to rate whether they had enough time with clinicians during their clinic visits.

> Nearly three-quarters (71%) of prison dischargees reported they always or mostly had enough time during their clinic visits (Indicator 3.2.4).

Nearly a half (48%) of dischargees reported they always had sufficient time during their clinic visits, and nearly one-quarter (23%) reported they mostly had enough time. Almost 1 in 7 (15%) reported they rarely or never had enough time during clinic visits.

Patient rating of health care received at prison clinic

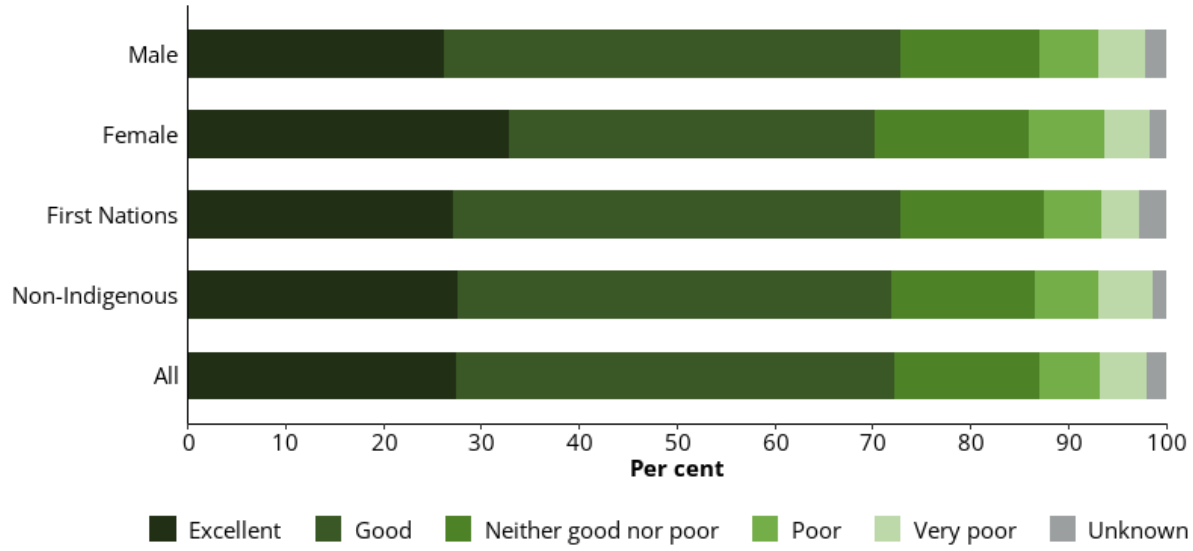
Prison dischargees were asked to rate the level of health care they received at the prison clinic.

> Nearly three-quarters (72%) of prison dischargees rated the health care they received in the prison clinic as good or excellent (Indicator 3.2.5).

Male dischargees (73%) were slightly more likely than female dischargees (70%) to give a positive rating of their health care in prison (Figure 11.2).

First Nations dischargees (73%) were similarly as likely as non-Indigenous dischargees (72%) to rate their health care as good or excellent and slightly less likely than non-Indigenous dischargees (10%) to rate their health care as poor or very poor (12%) (Figure 11.2).

Figure 11.2: Prison dischargees, rating of the quality of health care received at the prison clinic, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Nutritional value of food in prison

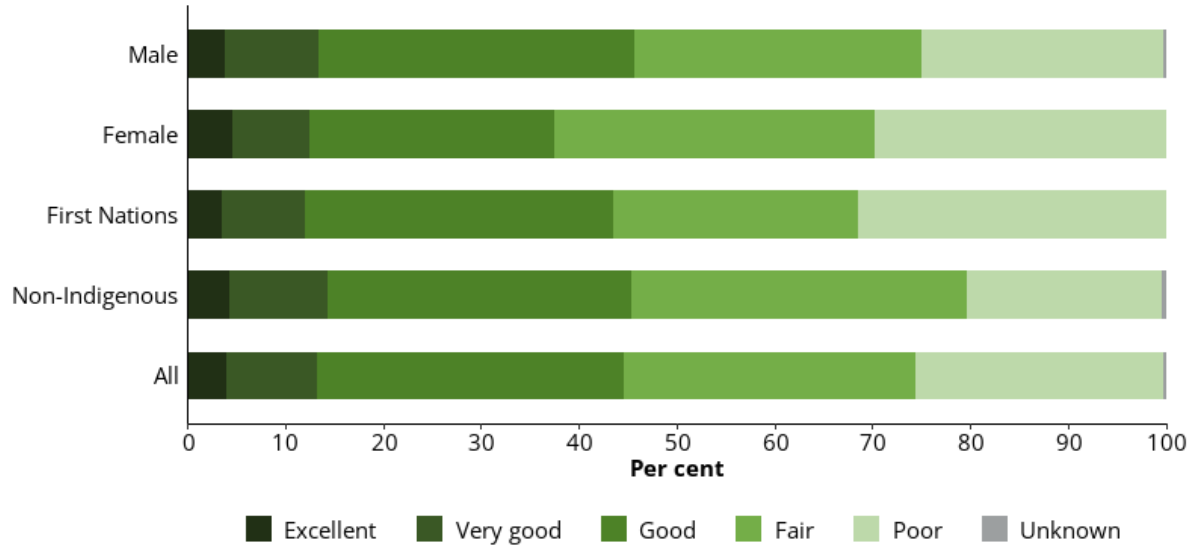
Prison dischargees were asked to rate the nutritional value of their diet in prison.

> Nearly a half (45%) of prison dischargees rated their diet in prison as excellent, very good or good (Indicator 3.2.6).

Male dischargees were more likely (46%) to rate their diet as good, very good or excellent than female dischargees (38%). Female dischargees were more likely (63%) to rate their diet as fair or poor than male dischargees (54%) (Figure 11.3).

Nearly a half of First Nations dischargees (44%) rated their diet as good, very good or excellent, while 32% rated their diet as poor. Nearly a half (46%) of non-Indigenous dischargees rated their diet as good or better, while 20% rated their diet as poor (Figure 11.3).

Figure 11.3: Prison dischargees, self-reported nutritional value rating of prison diet, by sex and Indigenous identity, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

Cultural safety of health care for First Nations people in prison

The *Cultural Respect Framework 2016–2026* defines cultural safety by the experience of the health consumer with regards to the care they are given, and their ability to access services and raise concerns (AHMAC 2016). This includes the treatment of care by the health professional and the client's feelings of cultural safety.

Cultural safety is about how care is provided, rather than what care is provided. It requires health-care providers to deliver safe, accessible and responsive health care that is free of racism by:

- recognising and responding to the power imbalance between practitioner and patient
- reflecting on their knowledge, skills, attitudes, practising behaviours and conscious and unconscious biases (Department of Health 2021).

Objective 3.2 of the *National Aboriginal and Torres Strait Islander Plan 2021–31* also outlines that health-care providers must have cultural safety values, behaviours and standards embedded in the workplace culture (Department of Health 2021).

Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services in prisons

An Aboriginal Community Controlled Health Organisation (ACCHO) is a primary health-care service initiated and operated by the local Aboriginal community. An Aboriginal Medical Service (AMS) is a health service funded principally to provide services to First Nations people. It may be either an ACCHO or a state or territory government-run service. Currently

in Australia, there are more than 140 ACCHOs and more than 200 AMSs and other Aboriginal and Torres Strait Islander health services (NACCHO n.d [b]).

These services deliver holistic, comprehensive and culturally appropriate health care to the community that controls them through a locally elected Board of Management (NACCHO n.d [a]).

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended that corrective services, in conjunction with Aboriginal health services and other such bodies, should review and report on health service provision to First Nations people in correctional institutions (RCIADIC 1991).

It was recommended that this review include the involvement of Aboriginal health services in providing mental and physical health care for First Nations people in custody (RCIADIC 1991). This could be achieved through visits to prisons by ACCHOs and AMSs, and by employing Aboriginal health practitioners as members of the clinic staff.

However, ACCHOs in Australia are subject to funding shortages and are often over-stretched in their ability to service the people in their communities (Moran et al. 2014; NACCHO n.d [a]). This limits their capacity to reach all communities in need, including prisons where First Nations people make up a substantial portion of the population. Currently, there are only a few prisons in Australia that facilitate visits by ACCHOs.

Culturally appropriate care reported by prison dischargees

First Nations prison dischargees were asked whether they received a visit from an ACCHO or an AMS while in prison.

> Of 200 First Nations prison dischargees, 26% reported receiving treatment or consultation in prison from an ACCHO and/or an AMS (Indicator 3.2.7).

Many prison facilities have First Nations health practitioners and other First Nations professionals or staff to provide culturally appropriate health care.

For those First Nations dischargees who received them in prison, 18% of ACCHO or AMS services were for health care, 7.5% for access to legal support, 7.0% for alcohol and other drugs support, 7.0% for social and emotional wellbeing, 5.0% for housing support, 4.0% for child, family or community services and 2.5% for quitting smoking.

Culturally appropriate care happens in many ways, not just through the ACCHOs and AMSs. Therefore, people in prison were also asked whether they had received culturally appropriate care in prison.

> Of 200 First Nations prison dischargees, nearly two-thirds (65%) reported they received culturally appropriate health care in prison (Indicator 3.2.8).

First Nations male dischargees were less likely to report receiving culturally appropriate health care (63%) than First Nations female dischargees (76%).

First Nations dischargees aged 25–34 were the group most likely to report that they received culturally safe health care in prison (68%), while those aged 18–24 were the least likely (61%).

Visiting health professionals from Aboriginal health services

> Fifteen per cent of participating prisons received visits by ACCHO and/or AMS health professionals daily, weekly or monthly (Indicator 3.2.9).

Of the 11 prisons that reported receiving visits from ACCHO and/or AMS health professionals, the visits occurred at least weekly in nearly a half of the facilities (45%), at least monthly in 36% of them and daily in 18% of them.

Visiting health professionals from ACCHOs and/or AMSs were most likely to be Aboriginal health practitioners (at 7 prison facilities), but also included counsellors (at 4 facilities), doctors (at 3 facilities), psychologists (at 3 facilities), social workers (at 2 facilities) and alcohol and other drug practitioners (at 2 facilities).

Seventy-six per cent of participating prisons reported never receiving visits from ACCHO and/or AMS health professionals.

Preparedness for release

People who have been incarcerated are often at their most vulnerable on release, and many of the health improvements made during their time in prison can quickly erode.

Release from prison might cause trauma and emotional distress, and increase the likelihood of harmful substance use, and other risk behaviours. So death rates from most causes of death, but particularly preventable causes, increase dramatically on release (Binswanger et al. 2013; Bukten et al. 2017; Forsyth et al. 2018; Spitall et al. 2019; Thomas et al. 2016).

The rapid churn of people through the prison system means that prisoner health is public health (WHO 2012). This is particularly true with short-term incarceration, and most people in prison are in prison for relatively short periods (ABS 2023). As well, the risk of re-offending is often higher when people are released from prison without medical and support plans in place (Phillips and Lindsay 2011).

Instituting comprehensive and consistent release procedures, and ensuring continuity of health care between prison clinic and community service providers, are essential for the health of people leaving prison, as well as for the health of the community.

Prison dischargees were asked how prepared they felt about their upcoming release from prison.

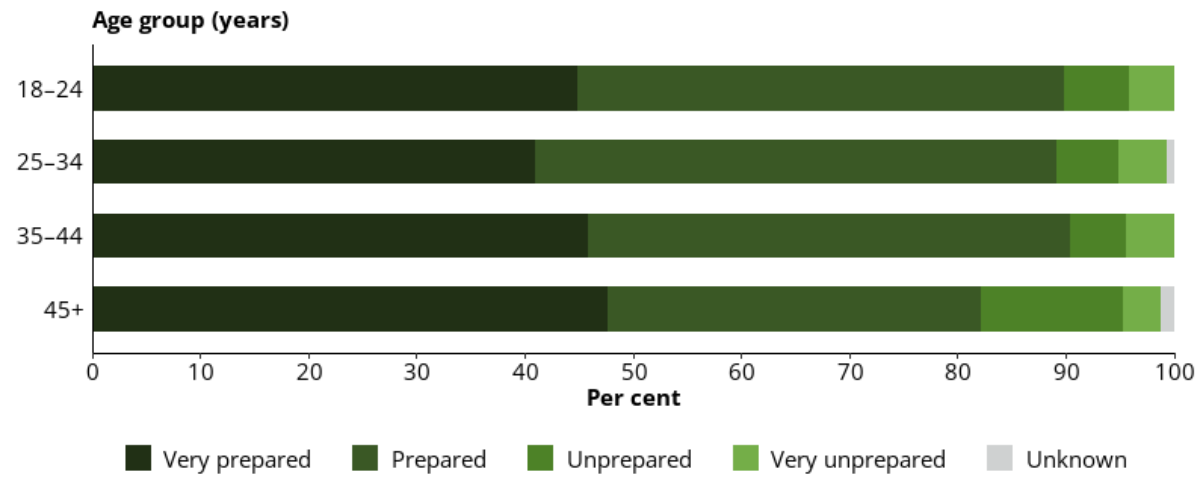
> Almost 9 in 10 (88%) prison dischargees said they were prepared for their upcoming release from prison (Indicator 3.2.10).

The majority (88%) of dischargees reported that they felt either prepared (44%) or very prepared (44%), with only 12% reporting they felt unprepared or very unprepared for release from prison.

First Nations dischargees (90%) were slightly more likely than non-Indigenous dischargees (87%) to report feeling prepared or very prepared for their upcoming release.

Prison dischargees aged under 45 were more likely to report feeling prepared or very prepared for release from prison (90%) than those aged 45 and over (82%) (Figure 11.4).

Figure 11.4: Prison dischargees, self-reported level of preparedness for release, by age, 2022



Notes

1. Proportions are representative of this data collection only, and not the entire prison population.
2. Excludes Victoria, which did not provide data for this item.

Source: Dischargees form, 2022 NPHDC.

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Medication

People in prison generally have poor health and complex health needs, reflected in the number and types of medications they take. These medications can differ from those taken in the general community, particularly medications for mental health problems, addictions and chronic conditions – areas in which people in prison are known to have poorer health than the general community (AIHW 2016).

Certain aspects of the prison environment may influence prescribing practices. Prisoners have limited access to over-the-counter medications, and are usually not allowed to keep medications in their possession; hence, some medications that may be purchased without prescription in the community are likely to be prescribed in prison.

The choice of prescribed medications may be influenced by security considerations, such as the daily prison schedule, and the 'direct administration' of medications whereby prisoners are provided with, and take, medications under supervision. As in the general community, some medications – such as antipsychotics and benzodiazepines – are considered to be 'tradeable', and the prescription, possession and taking of these medications are closely monitored (AIHW 2016).

Medications are an important element in treating many physical and mental health conditions. This section presents data on medications dispensed in custody, including opioid substitution therapy, mental health medication, hepatitis C treatment, and intentions to continue taking medications after release.

Medications dispensed in custody

The National Prisoner Health Data Collection (NPHDC) medication form was used to obtain data on prescription medications given to incarcerated individuals on a single day during the data collection period in 2022. This provided a snapshot of the medications typically dispensed by prison clinics.

To calculate the proportion of people dispensed medication in custody, a snapshot of prison population data for the facilities that participated in the 2022 NPHDC was obtained from the ABS for use as a denominator.

However, the results may underestimate the true proportions of incarcerated individuals taking prescription medication, as not all prison clinics were able to capture all dispensed medications.

> Around 1 in 4 (27%) people in custody were dispensed prescription medication on a snapshot day in prison (Indicator 3.3.1).

Nearly one-third (31%) of females in prison, and nearly one-quarter (22%) of males in prison, were dispensed prescription medication in 2022 on a snapshot day (Table 12.1).

On average, each person in custody who received medication was dispensed 2.93 medications, with females receiving more on average (3.32 medications) than males (2.96 medications). In total, approximately 20,896 medications were dispensed to 7,130 individuals in custody on a single snapshot day during the 2022 NPHDC (Table 12.1).

Table 12.1: People in custody dispensed prescription medication, by sex, 2022

Measure	Males	Females	People
Number of people in custody dispensed medication	5,263	659	7,130
Number of medications dispensed	15,567	2,185	20,896
Number of people in custody	24,515	2,148	26,663
Percentage of people in custody dispensed medication (%)	21.5	30.7	26.7
Average number of medications dispensed per person dispensed any medication	2.96	3.32	2.93

Notes

1. Totals include unknowns.
2. Excludes Victoria, which did not provide data for this item.
3. Numbers are representative of this data collection only, and not the entire prison population.

Source: Medication form, 2022 NPHDC; data supplied by the ABS.

Medications dispensed by prison clinics were assigned to 23 categories. The most commonly dispensed medication types were:

- antidepressants/mood stabilisers (for example, sertraline, fluoxetine) (18%)
- analgesics (for example, paracetamol, codeine or oxycodone) (13%)
- anti-inflammatories/anti-rheumatic agents (for example, ibuprofen, aspirin) (9.0%)
- drugs associated with digestive system disorders, such as antiemetics, anti-nauseants, laxatives, and anti-diarrhoeals (8.1%)
- antihypertensive and beta-blocking medications (for example, perindopril, ramipril) (7.4%) (Table 12.2).

Table 12.2: Prescription medication dispensed to people in custody, by type of medication, 2022

Medication category	Number	%
Antidepressants/mood stabilisers	3,770	18.0
Analgesics	2,677	12.8
Anti-inflammatories/anti-rheumatic agents	1,881	9.0
Drugs used in acid-related disorders, antiemetics, anti-nauseants, laxatives, antidiarrhoeals	1,684	8.1
Antihypertensives, beta blocking agents	1,550	7.4
Antipsychotics	1,423	6.8
Vitamins and mineral supplements	1,386	6.6
Cholesterol-lowering drugs (lipid modifying agents)	1,134	5.4
Asthma relievers, preventers, symptom controllers (drugs for obstructed airway)	738	3.5
Drugs used in diabetes	920	4.4
Dermatologicals (skin, including antifungals)	553	2.6
Drugs used in opioid dependence	485	2.3
Antihistamines	476	2.3
Antiepileptics, anti-Parkinson drugs	391	1.9
Antibiotics	270	1.3
Hepatitis, antivirals for HIV, infectious diseases	245	1.2
Diuretics	172	0.8
Hypnotics and sedatives	132	0.6
Thyroid therapy	103	0.5
Anti-anxiety (anxiolytics)	87	0.4
Drugs used in benign prostatic hypertrophy (prostate)	73	0.3
Drugs used in nicotine dependence	33	0.2
Other	713	3.4
Total prescription medications dispensed	**20,896**	**100.0**

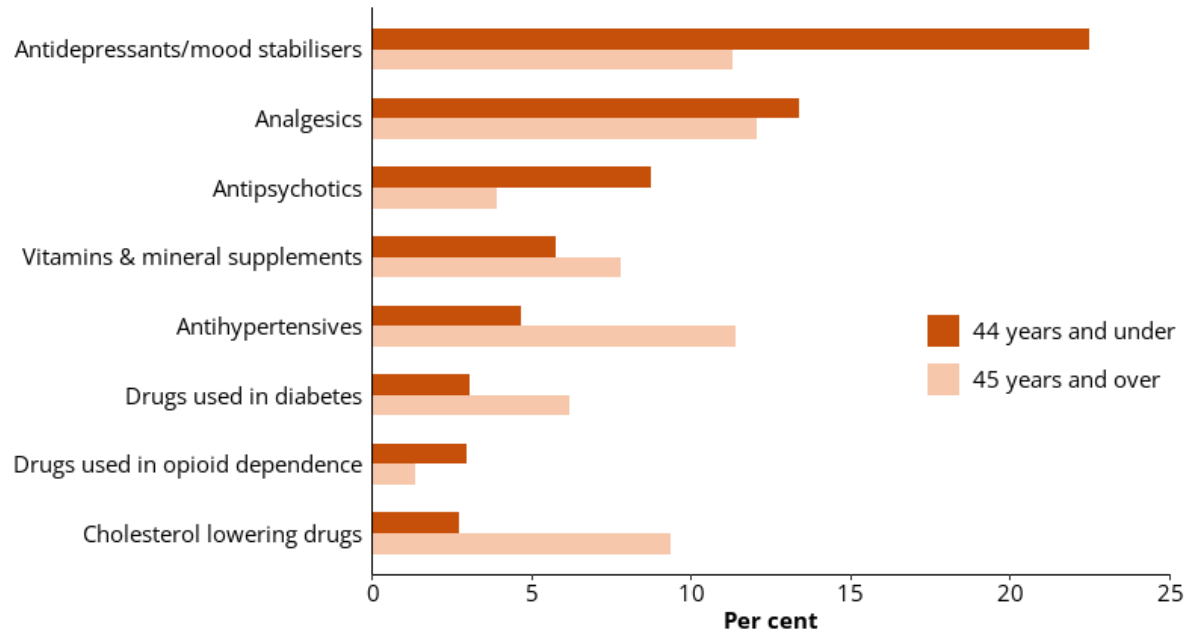
Notes

1. Excludes Victoria, which did not provide data for this item.
2. Percentages may not sum to the total due to rounding.
3. Numbers are representative of this data collection only, and not the entire prison population.

Source: Medication form, 2022 NPHDC.

The proportions of medications dispensed to people in prison differed by age, reflecting the differing conditions that affect each population (Figure 12.1). Indigenous identity and sex were not factors that greatly influenced the types of medications dispensed.

Figure 12.1: Prescription medications dispensed to people in custody, by age group and type of medication, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Medication form, 2022 NPHDC.

Differences in age accounted for the greatest difference in medications dispensed. Certain medications – such as antihypertensives, cholesterol lowering drugs, drugs used in diabetes, and vitamins and mineral supplements – were dispensed more frequently to people in prison aged 45 and over due to age-related conditions (Figure 12.1).

People in prison aged 44 and under were more likely to be dispensed antidepressants, analgesics and antipsychotics (Figure 12.1).

Opioid substitution therapy

Opioid drugs such as heroin, morphine, oxycodone and fentanyl, are linked to various health and social problems.

Treatment with opioid substitution therapy (OST) – such as methadone, buprenorphine and suboxone – can reduce cravings, lessen withdrawal symptoms, improve physical and mental health, and reduce drug-related crime and demand for illicit drugs (Scott et al. 2015).

On a snapshot day in 2022, 55,700 people were receiving pharmacotherapy treatment for their opioid dependence across Australia. Of these people, 5,100 (9.1%) received this treatment in a correctional facility (AIHW 2023).

Periods of transition into prison provide an important opportunity to engage people in OST who may not otherwise receive and engage in treatment (Gisev et al. 2014).

People entering prison may need detoxification (for withdrawal) and longer term treatment due to sudden withdrawal from drugs. Availability of OST in prison has been linked to a

reduction in drug injection and thus lower associated harms such as needle sharing and infections (Kinner et al. 2013; Lafferty et al. 2018; Schwitters 2014).

Opioid substitution therapy for prison entrants

Prison entrants were asked whether they were currently, or had ever been, on OST.

> About 1 in 13 prison entrants (7.5%) reported they were currently on OST (Indicator 3.3.2).

About 1 in 6 (16%) prison entrants reported they had been on OST at some stage in their lives.

Opioid substitution therapy for people in custody

> About 1.8% of people in custody were dispensed OST medication (Indicator 3.3.3).

Medications for opioid dependence were reportedly dispensed to nearly 1.8% of people in custody. But this was likely an underestimate of the true value, as not all medications typically dispensed were captured in the NPHDC.

Opioid substitution therapy for prison dischargees

> About 1 in 8 (13%) prison dischargees on OST while in prison plan to continue after release (Indicator 3.3.4).

One in 13 (7.5%) prison dischargees reported currently being on OST.

Mental health medication

Medications for mental health conditions, known as psychotropic medications, include antidepressants and mood stabilisers, anti-anxiety medications, antipsychotics, sedatives and hypnotics. People in prison are more likely to be prescribed psychotropic medications than people in the general community (Spittal et al. 2019).

A study of people in prison in the United States found that 18% were taking psychotropic medication at the time of their admission to prison (Gonzalez and Connell 2014). Rates of psychotropic medication prescribing in prisons in England were found to be 5.5 times as high for males, and 5.9 times as high for females as rates for the general population of a similar age (Hassan et al. 2014).

Females in contact with the prison system in Australia are more likely than males to have been prescribed psychotropic medication. A study of female dischargees in New South Wales found that around a half had a current prescription for psychotropic medication (Abbott et al. 2016).

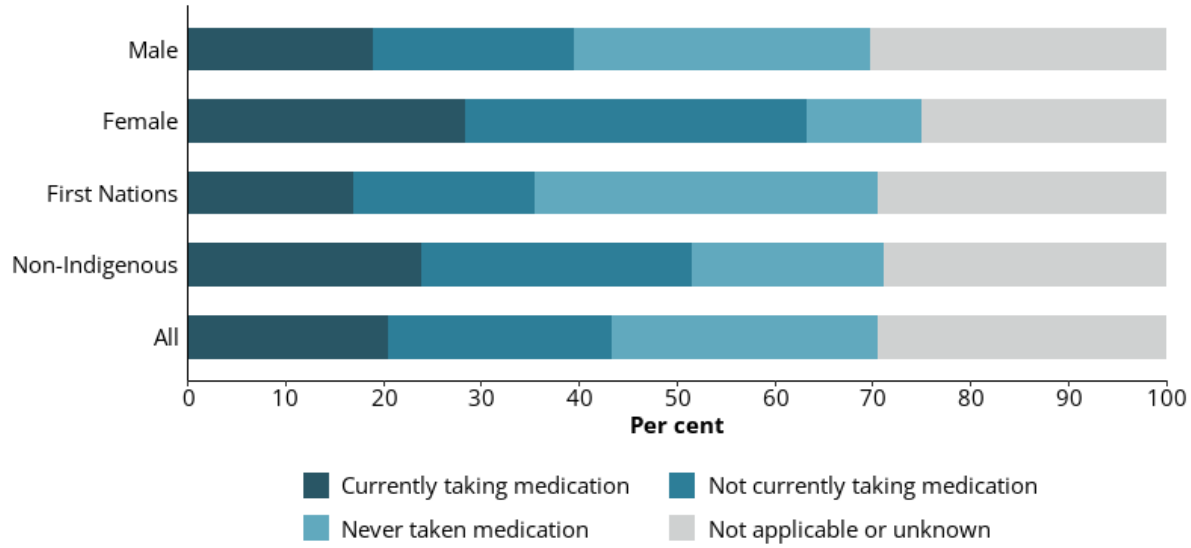
Mental health medication for prison entrants

Prison entrants were asked whether they currently have a mental health or behavioural condition (see ‘Mental health and self-harm’ for more information). They were then asked if during the past 12 months they received treatment for a mental health or behavioural condition, and if they have ever taken medication for a mental health disorder.

One in 5 (20%) entrants reported currently taking medication related to mental health. Female entrants (28%) were more likely than male entrants (19%) to report taking mental health related medication (Figure 12.2).

Non-Indigenous entrants (24%) were more likely than First Nations entrants (17%) to report currently taking medication for a mental health condition (Figure 12.2).

Figure 12.2: Prison entrants currently taking mental health related medication, by sex and Indigenous identity, 2022



Notes

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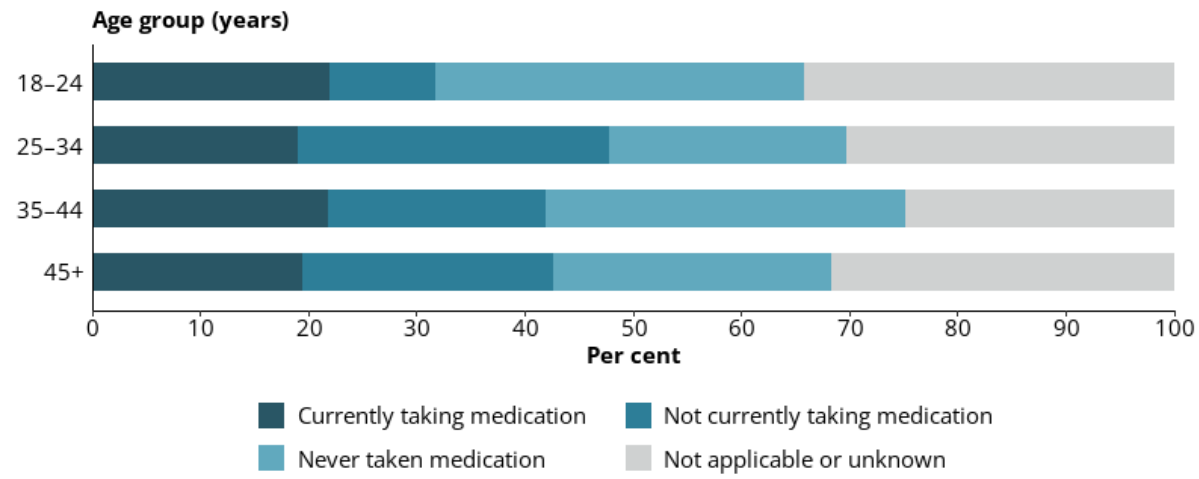
2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2018 NPHDC.

Prison entrants aged 18–24 and 35–44 (22%) were equally as likely to report currently taking medication for a mental health condition, and those aged 25–34 (19%) were the least likely (Figure 12.3).

Figure 12.3: Prison entrants currently taking mental health related medication, by age, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: Entrants form, 2022 NPHDC.

Mental health medication dispensed to people in custody

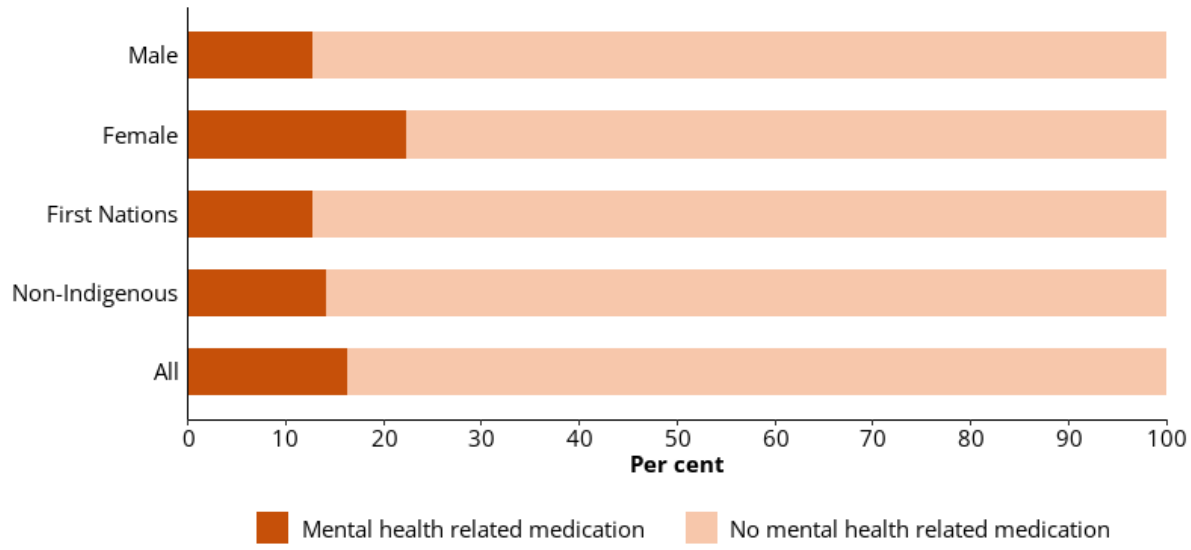
Due to the many comorbidities in the area of mental health alone, some people were dispensed medications from multiple categories.

Some medications may also be prescribed for conditions other than the primary condition for which the medication was originally designed to treat. For example, some antipsychotic medications may be prescribed in low doses to treat insomnia while some antiepileptic medications are commonly prescribed to treat neuropathic pain (Murnion 2018; Thompson et al. 2016). As well, not all medications regularly dispensed were reported, so the proportions are likely under-representative of the true values.

About 1 in 6 (16%) people in custody were dispensed mental health related medication. Females in prison (22%) were more than 1.5 times as likely as males (13%) to be dispensed mental health related medication (Figure 12.4).

There was no difference in the proportion of First Nations people in custody (13%) and non-Indigenous people in custody (14%) taking prescribed mental health related medication.

Figure 12.4: People in custody, dispensed mental health related medication, by sex and Indigenous identity, 2022



Notes

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2. Excludes Victoria, which did not provide data for this item.

Source: ABS 2023; Medication form, 2022 NPHDC.

People in custody aged 35–44 (18%) were the most likely to be dispensed mental health related medications, while those aged 18–24 (10%) were the least likely.

The majority of mental health related medications dispensed were antidepressants, regardless of age, sex or Indigenous status. Antidepressants accounted for almost 1 in 5 (18%) of all mental health related medications dispensed during the 2022 collection period.

One in 15 (6.8%) mental health related medications dispensed were antipsychotics, while hypnotics and sedatives (0.6%) and anti-anxiety medications (0.4%) were dispensed in small amounts only.

Females in custody (20%) were slightly more likely to be dispensed antidepressant medications than males in custody (18%). Similarly, females (7.6%) were slightly more likely than males (6.5%) to be dispensed antipsychotic medications.

Hepatitis C treatment

The Department of Health and Aged Care has outlined strategies to eliminate hepatitis C as a public health threat by 2030 (Department of Health and Aged Care 2023).

From March 2016, direct-acting antivirals were subsidised by the Australian Government, leading to a much higher uptake of hepatitis C treatment in Australia – and in priority groups such as the prison population (Department of Health and Aged Care 2023).

Direct-acting antivirals replaced the interferon-based treatments for hepatitis C infection, and are shorter in course duration, more effective and have fewer side effects for patients (Lafferty et al. 2018).

The Department of Health and Aged Care's *Sixth National Hepatitis C Strategy 2023–2030* reports that Australian prisons, currently, do not offer regulated access to sterile injecting

equipment, despite prisons being primary settings of hepatitis C transmission. Subsequent National Hepatitis C Strategies should prioritise actions to respond to this unmet need (Department of Health and Aged Care 2023).

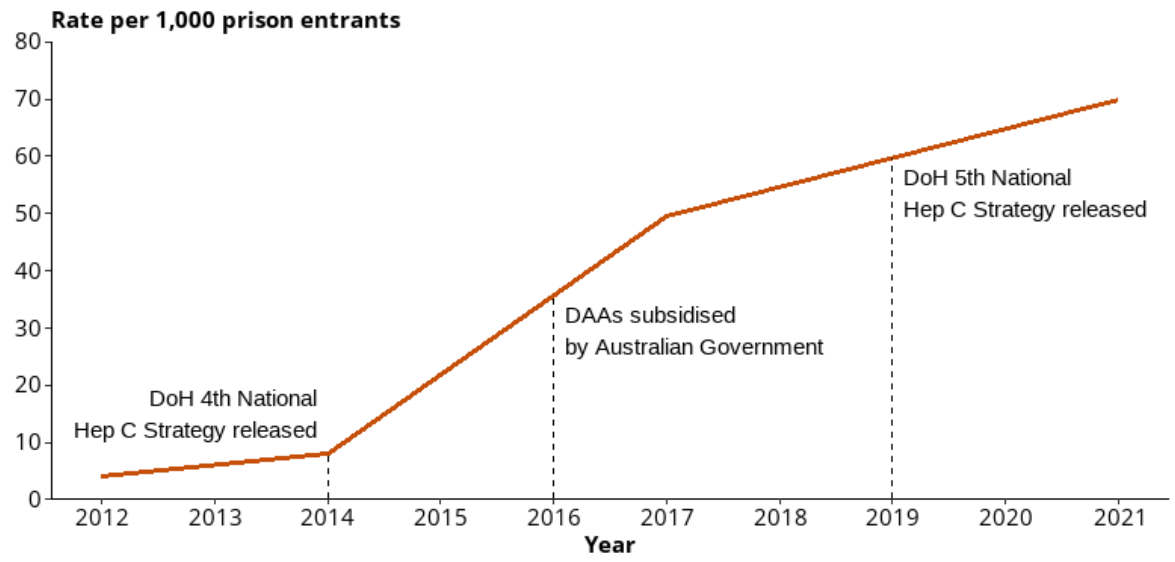
People in prison remain a priority group for testing and treating hepatitis C, and diagnoses and treatments need to be accompanied by education and support.

The introduction of direct-acting antivirals to treat hepatitis C has been revolutionary in the prison population. Before these were available, the rate of uptake of hepatitis C treatment was 4 courses of treatment per 1,000 people received into custody in 2012, 8 courses of treatment per 1,000 in 2014, and 50 courses of treatment per 1,000 received into custody in 2017 (Figure 12.5).

> In 2021, the rate of hepatitis C treatment was 70 courses of treatment per 1,000 people received into custody (Indicator 3.3.5).

For more information on Hepatitis C, see 'Communicable diseases'.

Figure 12.5: Trends in hepatitis C treatment courses per 1,000 people received into prison, by year, 2012–2021



DAA = Direct-acting antiviral agents; DoH = Department of Health; hep = hepatitis.

Notes

1. Rates of hepatitis C treatment courses are representative of this data collection and not the entire prison population.
2. The Department of Health 4th (2014–2017), 5th (2018–2022) and 6th (2023–2030; not shown on graph) National Hepatitis C Strategy identifies the prison population as a priority group.

Source: Establishment form, NPHDC 2012, 2015, 2018, 2022.

Continuation of medications

Prison dischargees intending to continue taking medication

Prison dischargees were asked if they were taking regular medication, and whether they intended to continue the medication after release.

Over 9 in 10 (91%) prison dischargees who were taking regular medication intended to continue the medication after release (Indicator 3.3.6).

Substantial variations in intentions to continue medication after prison existed among different age groups, with 62% of people aged 18–24 intending to continue medication compared with 98% of people aged over 45.

There was little difference in the proportion of dischargees intending to continue their medication based on sex or Indigenous identity.

Medication comparisons with the general community

The prison population differs from the general community in terms of age, sex and Indigenous identity, and this affects the types of medications typically prescribed and/or dispensed to people in prison and in the community.

In the community, Australians are entitled to subsidised medications under the Pharmaceutical Benefits Scheme (PBS). Due to the lack of access to Medicare services in prison, medications provided to people in prison are generally not covered by the PBS and are instead funded through the state and territory governments. Medications prescribed to people in prison may therefore differ from those prescribed to people in the community with the same health needs.

Using the World Health Organization's Anatomical Therapeutic Chemical Classification, comparisons were made between medications dispensed in the NPHDC and medications prescribed under the PBS in the community (WHO Collaborating Centre for Drug Statistics Methodology 2023).

About 2 in 5 (43%) medications dispensed to people in prison were those to treat the nervous system (including mental health); in the community, medications for the nervous system accounted for 21% of the total medications prescribed under the PBS (DHAC 2022).

About 1 in 10 (9.0%) medications dispensed to people in prison were those to treat the musculoskeletal system; in the community, medications for the musculoskeletal system accounted for 3.2% of the total medications prescribed under the PBS (DHAC 2022).

Medicines to treat the cardiovascular system accounted for 32% of the total medications prescribed under the PBS; in prison, they accounted for 14% of total medications dispensed (DHAC 2022).

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Technical notes

All data contained in the 2022 NPHDC (National Prisoner Health Data Collection) report are based on information obtained from people aged 18 and over from participating prisons from all states and territories, except Victoria –which did not participate in the 2022 NPHDC.

Terminology

Accelerated ageing and age profiles

Various definitions of an ‘older prisoner’ exist in academic and government research. The threshold for what constitutes an older person in prison varies between 45 to 65 years and above and no consensus currently exists in the evidence base.

Accelerated ageing is common among people in prison who may experience a life expectancy gap of 10 years or more compared with the general Australian population (Baidawi et al. 2011; Turner and Trotter 2010). This means that a person in prison in their 50s may have the physical appearance and health problems of someone at least 10 years older in the general community and, so, are functionally older than their chronological age (Codd 2018).

Accelerated ageing occurs to a greater extent among people in prison because they are more likely to live in poverty, achieve a lower standard of education, and experience housing instability and a lack of employment (Turner and Trotter 2010). As well, having risky lifestyles and behaviours, being unable to access health-care services and experiencing incarceration are associated with poorer physical and mental health and can contribute to age-related illnesses and conditions (AIHW 2020; Codd 2018).

The 2022 NPHDC report therefore uses the threshold of 45 years and above to define an older person in prison (compared with 65 years and above in the general community). This lower age threshold (of 45+ years) was chosen to allow the report to better capture data on the health of older people in prison, as the sample size of older people in prison, particularly older females, restricts some detailed analyses. The national supplementary data tables are disaggregated by 5 age groups (18–24, 25–34, 35–44, 45–54 and 55+) where appropriate, so individual breakdowns can be viewed.

Disability

Standardised Disability Flag

The NPHDC collects information about people in prison with self-reported disability or long-term health conditions using a version of the AIHW Standardised Disability Flag. The flag derives from a standard set of questions that assess a person’s level of functioning and need for support in everyday activities. The set is based on the International Classification of Functioning, Disability and Health, and is broadly consistent with the short disability questions that the Australian Bureau of Statistics (ABS) uses in a number of its social surveys. The Standardised Disability Flag includes 3 components:

- activity and participation need for assistance cluster
- education participation restriction flag
- employment participation restriction flag.

The activity and participation need for assistance cluster collects data on individuals' perception of whether a long-term health condition or disability restricts their everyday activities. This component involves assigning the degree of assistance and/or supervision required to perform 8 everyday activities. For each of the 8 activities, there is a 5-level response scale. Data are then used to derive an activity limitation flag, the extent of activity limitation and an optional extent of core activity limitation (see 'Core activity limitation' below).

The education participation restriction flag and the employment participation restriction flag are derived from 2 separate questions; these are, in turn, independent from the activity limitation extent and flag items.

The Standard Disability Flag relies on self-reported impairment and restriction and does not require respondents to have a medical diagnosis. The flag does not include a question on disability type (AIHW 2016).

Core activity limitation

Core activities are everyday activities in communication, mobility, and self-care. These are activities deemed to be essential to normal everyday life. The extent of an individual's core activity limitation is derived from the activity and participation need for assistance cluster from the Standardised Disability Flag (see 'Standardised Disability Flag' above).

Four levels of core activity limitation are determined based on whether a person needs help and/or supervision with, has difficulty with, or uses aids, equipment or medications for any of the 3 core activities. A person's overall level of core activity limitation is determined by their highest level of limitation in these activities. The 4 levels of limitation are:

- profound limitation (people with the greatest need for help – who always need help, or who are unable to do an activity)
- severe limitation (people who sometimes need help and/or have difficulty)
- moderate limitation (people who need no help but have difficulty)
- mild limitation (people who need no help and have no difficulty, but use aids, equipment, or medications).

In the NPHDC, a profound or severe core activity limitation or restriction is defined as those who sometimes, or always need help and/or supervision with core activities of daily living (mobility, self-care, or communication).

Kessler Psychological Distress Scale-10

Psychological distress data presented in this report and supplementary tables are scored using the Kessler Psychological Distress Scale-10 (K10). The K10 was developed as a short dimensional measure of non-specific psychological distress in the anxiety-depression spectrum (Kessler et al. 2002; Andrews and Slade 2001). The K10 involves 10 questions about emotional states experienced in the previous 4 weeks. For each question, there is a 5-level response scale. Scores for each item are summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Individuals must answer all 10 questions to be given a valid K10 score.

Results are grouped into the following 5 levels of psychological distress scoring categories:

- low (indicating little, or no psychological distress) – indicated by a score of 10–15
- moderate – indicated by a score of 16–21
- high – indicated by a score of 22–29

- very high – indicated by a score of 30–50.

Slightly different scoring for the K10 is sometimes used in other surveys and research (for example, low 10–19, moderate 20–24, high 25–29, very high 30–50), so caution should be used when comparing results. The K10 scoring used in this report is the same scoring used in ABS surveys to enable comparisons between the prison and general Australian populations (ABS 2012).

AUDIT-C

The data on alcohol consumption and alcohol-related harm presented in this report and supplementary tables were determined using questions on alcohol consumption from the World Health Organization's Alcohol Use Disorder Identification Test (AUDIT) screening instrument (Babor et al. 2001). The AUDIT was developed as a simple method of screening for people with hazardous and harmful patterns of alcohol consumption.

The consumption component of this instrument (AUDIT-C) contains 3 consumption questions from the AUDIT, with each question scoring 0–4 points. Scores for the 3 questions are summed, with a minimum possible score of 0 (reflecting no alcohol use) and a maximum possible score of 12. Individuals must answer all 3 questions – or answer '0' for question 1 only (reflecting no alcohol use) – to be given a valid AUDIT-C score.

Results are grouped into risk categories of low, moderate, high, and very high depending on an individual's sex. Generally, the higher the score, the more likely it is that a person's drinking is affecting his or her safety. For both males and females, a score of 6 of more indicates a high risk of alcohol-related harm.

It should be noted that the questions included in the 2022 NPHDC have additional wording added at the start of each AUDIT-C question relating to a time frame of 'over the past 12 months', so caution should be used when comparing other AUDIT-C results with those for the NPHDC.

Illicit drug use

The NPHDC collects self-reported data on the use of drugs for non-medical purposes in people entering and leaving prison. The term 'illicit drugs' in this report includes the following:

- illegal drugs (such as cocaine, heroin, and amphetamine type stimulants)
- pharmaceutical drugs (such as opioid-based pain relief medications, benzodiazepines and steroids) when used for non-medical purposes
- other substances, legal or illegal, used inappropriately, such as inhalants from petrol, paint or glue.

Presentation of data

Most data in this report have been rounded for readability. The following rounding rules have been applied:

- Numbers over 100,000 and under a million are rounded to the nearest multiple of 1,000.
- Numbers between 1,000 and 100,000 are rounded to the nearest multiple of 100.
- Numbers between 500 and 999 are rounded to the nearest multiple of 10.
- Numbers between 100 and 499 are rounded to the nearest multiple of 5.
- Numbers between 10 and 99 are rounded to the nearest whole number.

- Numbers under 10 are rounded to one decimal place.

Proportions presented in the report are shown as percentages, rounded to 1 decimal place when less than 10% and to whole numbers when over 10%.

While the NPHDC report focuses on national level data, supplementary data tables for national and state and territory data are available on the AIHW website. State and territory data tables are available for indicators only; however, due to the low response rates in some states and territories, data should be interpreted with caution. Readers should satisfy themselves if the data are fit for purpose if they intend to use it where response rates are low.

No data have been age standardised.

Mean, median, and age range

Two measures of central tendency are sometimes used for reporting data in the NPHDC:

- Average (mean) – the average, or mean, is calculated by summing all the values for a particular data item, and dividing by the total number of observations. In the NPHDC, averages are used for some indicators that report age at which an event occurred, or as a summary statistic for survey sample data sets.
- Median – the median is the middle value of a set of observations, when arranged in ascending order. As a result, the median is not affected greatly by small or large outlier numbers. In the NPHDC, the median is often used in conjunction with the mean as a summary statistic for survey sample data sets, or where data are not normally distributed, or include extreme values that would distort the mean – for example, the median time that those sentenced could expect to serve.

Other measures of location sometimes used for reporting in the NPHDC reports and supplementary data tables include the minimum and maximum. In the NPHDC, this is often used to present the upper and lower bounds of ages (in years) for a particular indicator or data item. All means, medians and age ranges in the report and supplementary data tables have been indicated.

Standard deviation

One measure of spread – standard deviation – is sometimes used in the supplementary tables for reporting data in the NPHDC. The standard deviation measures how dispersed a set of observations are in relation to the mean.

In the NPHDC, the standard deviation is reported in conjunction with the mean as a survey sample data set summary statistic and/or for indicators reporting average age at which an event occurred.

All standard deviations reported in the supplementary data tables have been indicated.

Population rates

Population rates allow different groups to be compared while taking into account differences in population sizes.

In the NPHDC, rates are used for some indicators which report the number of events occurring in the population over a specified period of time. Rates derived from NPHDC data are expressed as the number per 100, or 1,000, people in or received into custody in 2021. All rates reported have been indicated.

Denominators for population rates for people in prison aged 18 and over are sourced from the ABS, unless otherwise stated.

Crude mortality rates

Data on deaths following release from prison came from the Department of Social Services, and are expressed as crude mortality rates (crude death rates). In the NPHDC, crude death rates are calculated both:

- as a proportion of the number of deaths occurring per 1,000 people released in the preceding 28 days (days 0–28 post-release) or 365 days (0–365 days post-release) (incidence proportion)
- as a proportion of per 1,000 person years (incidence rate).

Readers should keep in mind that incidence proportions are not adjusted for the amount of time the group spent at risk of the event's (death) occurring. Hence, the incidence proportion for a group calculated using the number of deaths in the first 28 days post-release will always be lower than, or equal to, the proportion for the same group calculated using the number of deaths in the first 365 days post-release.

Incidence rates, however, take into account the amount of time a group spent at risk of an outcome (death) and so allow for comparison, with the effect of differing times at risk removed. Incidence rates are presented in this report to assist in comparing crude death rates within 28 days and 365 days post-release.

Person-time crude death rates were calculated by dividing the number of deaths observed during the period (either 28 or 365 days post release) by the amount of time those released spent at risk of dying within the period.

Data cautions

Significance testing

Significance testing for the NPHDC was not undertaken due to the sample design and method of data collection. The collection was designed to be a census, capturing data on the entire population of interest at a given point in time. However, to date, this has not been achieved, as not all people in prison (especially entrants and dischargees) could be involved in data collection for various reasons. Of those who could be approached, some do not provide consent to participate.

The sample is therefore not probabilistic sampling, but rather nonprobability sampling using a convenience sample. In future NPHDC collections, the AIHW will aim to incorporate deeper levels of analysis where feasible.

Comparability of data in the 2022 NPHDC

Comparability of data between each NPHDC

There have been changes between each NPHDC collection – with indicators being added or deleted, and some changes made to definitions and data collection methods. Structural changes to questions and response options in the survey forms have also been made between collections in the NPHDC – meaning that certain aspects of the data may not be comparable between collections.

As the data in the NPHDC are based on a convenience sample, the coherence of the data across collection periods is difficult to assess, due to sampling and non-sampling biases present in each collection period.

Time-series analyses of data have been avoided in the 2022 NPHDC, except for certain data items from coherent external collections or that have good coherence across NPHDC collections.

For these reasons, caution should be used in comparing data for different years of the collection.

Comparability of NPHDC and general community data

This report compares NPHDC data with data for the general Australian community (where available) to provide additional context. These comparisons are made by sex, Indigenous identity, or age group where possible.

It should be noted, however, that the data are not directly comparable due to the different survey sampling or data collection techniques used, and to the substantial differences in the demographic profile of people in prison compared with those in the general community. For example, the age structure of the general prison population is lower than that of the general community, and the prison population has a higher proportion of males and First Nations people than the general community. No significance testing has been undertaken, so caution is advised when interpreting results.

Comparisons with the general community are at a national level, and include all states and territories, in line with the national focus of the NPHDC report. However, Victoria did not participate in the 2022 NPHDC, and data for that state are therefore not captured in 2022 data. Victorian data are, however, included in NPHDC indicators sourced from external data sources, including:

- the Productivity Commission (for prisoner employment)
- the Australian Institute of Criminology (for deaths in custody)
- the Department of Social Services (for deaths following custodial release).

Caution should therefore be used in interpreting comparisons between the NPHDC sample and the general community, and should be used as a guide only.

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This report cannot be considered as either endorsed by state and territory departments or an expression of the policies or views of state and territory departments. Any errors of omission or commission are the responsibility of the AIHW.

Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AIDS	acquired immunodeficiency syndrome
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AUDIT	Alcohol Use Disorder Identification Test
AUDIT-C	Alcohol Use Disorder Identification Test – Consumption
COPD	chronic obstructive pulmonary disease
FTE	full-time equivalent
GP	general practitioner
HREC	Human Research Ethics Committee
HIV	human immunodeficiency virus
K10	Kessler Psychological Distress Scale
NPHDC	National Prisoner Health Data Collection
OST	opioid substitution treatment
PBS	Pharmaceutical Benefits Scheme
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
STI	sexually transmissible infection

Glossary

Aboriginal and/or Torres Strait Islander health practitioner: An Aboriginal and/or Torres Strait Islander person (see **First Nations people**) who has gained a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

Aboriginal Community Controlled Health Organisation or Service (ACCHO, ACCHS): An organisation operated by the local First Nations community, and controlled through a locally elected board, to deliver comprehensive, holistic and culturally appropriate health care to the community. ACCHOs vary in size and composition – from large organisations with multiple medical and other practitioners who provide a range of services, through to small organisations that rely on nurses and/or Aboriginal health workers to provide most services.

Aboriginal Medical Service (AMS): A health service funded principally to provide services to Aboriginal and Torres Strait Islander individuals that is not necessarily community controlled. AMSs that are not community controlled are government health services run by a state or territory government. Non-community controlled AMSs mainly exist in the Northern Territory and the northern part of Queensland.

Aboriginal or Torres Strait Islander: A person who identifies themselves as being of Aboriginal or Torres Strait Islander origin. See also **First Nations people** and **Indigenous**.

acute: A term used to describe something that comes on suddenly and is often brief, intense and severe.

adult prison: A place administered and operated by a justice department, where individuals are detained while under the supervision of the relevant justice department on a pre-sentence or sentenced detention episode.

arthritis: A group of disorders for which there is inflammation of the joints – which can then become stiff, painful, swollen or deformed. The 3 most common forms of arthritis are osteoarthritis, rheumatoid arthritis and gout.

asthma: A common, chronic inflammatory disease of the air passages that presents as episodes of wheezing, breathlessness and chest tightness due to widespread narrowing of the airways and obstruction of airflow.

back problems: A range of conditions related to the bones, joints, connective tissue, muscles and nerves of the back. These conditions can affect the neck (cervical spine), upper back (thoracic spine) and lower back (lumbar spine) as well as the sacrum and tailbone (coccyx). Back problems are substantial causes of disability and lost productivity.

bloodborne virus: A virus that lives in the blood and is transmitted by blood-to-blood contact. Examples of bloodborne viruses include hepatitis C and human immunodeficiency virus (HIV).

bulk-billing: The process where a medical practitioner or other health practitioner sends the bill for eligible services directly to **Medicare**, so the patient pays nothing. Also known as direct billing.

burden of disease: The quantified impact of a disease, injury or risk factor on a population, using the disability-adjusted life year (DALY) measure. One DALY is 1 year of 'healthy life' lost due to illness and/or death. The more DALYs associated with a disease or injury, the greater the burden. The DALY is produced by combining the years lived with disability and years of life lost together. People generally experience more burden as they age.

cancer: A group of several hundred diseases in which abnormal cells are not destroyed by normal metabolic processes, but instead proliferate and spread out of control (after being affected by a carcinogen, or after developing from a random genetic mutation) and form a mass called a tumour or neoplasm. In this data collection, cancer includes leukaemia, lymphoma, kidney cancer, bladder cancer, digestive system cancer, stomach cancer, bowel cancer, breast cancer, genital cancer, head and neck cancers, liver cancer, lung cancer, nervous system cancers and skin cancer (excluding non-melanoma skin cancer).

cardiovascular disease: Any disease that affects the circulatory system, including the heart and blood vessels. Examples include coronary heart disease, heart failure, rheumatic fever and rheumatic heart disease, congenital heart disease, stroke and peripheral vascular disease.

chronic conditions: A diverse group of diseases/conditions, such as heart disease, cancer and arthritis, which tend to be long lasting and persistent in their symptoms or development. Although these features also apply to some **communicable diseases**, the term is usually confined to non-communicable diseases.

chronic kidney disease: Abnormalities of kidney structure or function that are present for 3 months or more. It may be caused by several conditions – such as diabetes, high blood pressure or congenital conditions.

clinic visit: A face-to-face consultation for which an entry is made in the health service record.

communicable disease: Diseases that are capable of being transmitted between individuals, including acquired immunodeficiency syndrome (AIDS), HIV, hepatitis, malaria, meningitis, sexually transmitted infections, and vaccine-preventable diseases such as chickenpox and influenza.

COVID-19 (Coronavirus disease 2019): An infectious disease caused by the SARS-CoV-2 virus.

diabetes: A chronic condition where the body cannot properly use its main energy source – the sugar glucose. This is due to a relative or absolute deficiency in insulin, a hormone produced by the pancreas, which helps glucose enter the body's cells from the bloodstream and be processed by them. Diabetes is marked by an abnormal build-up of glucose in the blood; it can have serious short- and long-term effects. The 3 main types of diabetes are type 1 diabetes, type 2 diabetes and gestational diabetes.

digestive system disorders: Disorders that include abdominal pain, diarrhoea, gallstones, gastroenteritis, hernias, incontinence, indigestion, intestinal diseases, liver disease, malabsorption syndromes, oesophageal disease, pancreatic disease and peptic ulcer. Excludes digestive system cancers such as bowel, liver and stomach cancer.

dischargee: A person aged at least 18 who is expected to be released from custody during the data collection period, or due to be released within 4 weeks following the data collection period. People who were being transferred from one facility to another were not included as dischargees.

e-cigarette (electronic cigarette): Personal vaporising device, often referred to as a vape, where users inhale vapour rather than smoke. The vapours usually contain flavourings and may also contain nicotine or other chemical constituents.

entrant: A person aged at least 18, who is entering full-time custody, either on remand or a sentence. People currently in prison who were transferring from one prison to another were not included as entrants.

First Nations people: People of **Aboriginal or Torres Strait Islander** descent who identify as an Aboriginal or Torres Strait Islander.

full-time equivalent (FTE): On-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are excluded. Contract staff employed through an agency are included where the contract is for the supply of labour (for example, nursing) rather than of products (such as maintenance). A full-time equivalent of 1.0 means a person is equivalent to a full-time worker, while a full-time equivalent of 0.5 indicates that the person works half time.

health-related discharge plan: A plan that supports the continuity of health care between the prison health service and the community, based on the individual needs of the patient leaving prison.

Illicit drug use: Includes use of:

- any drug that is illegal to possess or use
- any legal drug used in an illegal manner, such as
  - a drug obtained on prescription, but given or sold to another person to use
  - glue or petrol that is sold legally, but used in a manner that is not intended, such as inhaling fumes
  - stolen pharmaceuticals sold on the black market (such as pethidine)
  - any drug used for 'non-medical purposes', which means drugs used either alone or with other drugs to induce or enhance a drug experience for performance enhancement (for example, athletic) or for cosmetic purposes (for example, body shaping).

Indigenous: Used interchangeably with **Aboriginal and Torres Strait Islander**. See **Aboriginal and/or Torres Strait Islander** and **First Nations**.

Kessler Psychological Distress Scale – 10 items (Kessler-10; K10): A survey device used to measure non-specific psychological distress in people. It uses 10 questions about negative emotional states that participants in the survey may have had in the 4 weeks leading up to their interview. The designers recommend using it only for people aged 18 and over.

median: A measure based on the value(s) of the observation(s) at the midpoint of a list of observations, ranked from the smallest to the largest.

Medicare: A national, government-funded scheme that subsidises the cost of personal medical services for all Australians and aims to help them afford medical care. The Medicare Benefits Schedule (MBS) is the listing of the Medicare services subsidised by the Australian Government. The schedule is part of the wider Medicare Benefits Scheme (Medicare).

mental health: A state of wellbeing in which the person realises his or her own abilities, can cope with the normal stresses of life, can work productively and can contribute to the community. Mental health is the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development and the use of cognitive, affective and relational abilities.

mental illness/mental health disorder: The range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. Mental health disorders are

diagnosable by certain criteria, and include depression, anxiety, substance use disorders, personality disorders, and psychoses.

musculoskeletal condition: A long-term condition affecting a skeletal muscle, tendon, ligament, joint or blood vessel that services skeletal muscles and any related tissues. Includes back injuries, back pain, bone disease, bursitis, joint diseases, muscular disease, spinal diseases and tendonitis. Excludes arthritis, injury or cancer in this data collection.

musculoskeletal injury: Recent/short-term injuries to a skeletal muscle, tendon, ligament, joint or blood vessel that services skeletal muscles and any related tissues.

non-Indigenous: A term used to describe people who have indicated that they are not of **Aboriginal or Torres Strait Islander origin** (see also **First Nations people**).

nutritional value of diet: The rating of the nutritive quality of food eaten – in this report, in a prison.

opiate/opioid substitution treatment (OST): A form of health care for heroin and other opiate-dependent people using prescribed opioid agonists, which have some similar or identical properties to heroin and morphine on the brain and which alleviate withdrawal symptoms and block the craving for illicit opiates. OST includes methadone, buprenorphine, and buprenorphine-naloxone, buprenorphine long-acting injection and naltrexone.

osteoporosis: A condition that causes bones to become thin, weak and fragile.

pathology: A general term for the study of disease, but often used more specifically to describe diagnostic services that examine specimens, such as samples of blood or tissue.

pharmacotherapy: The treatment of disease and illnesses using pharmaceutical drugs.

pregnancy: The carrying of one or more offspring that has been confirmed by medical test with or without the assistance of a medical professional. Pregnancy includes babies carried to full term, abortions and miscarriages.

prisoner: Somone aged 18 and over who is held in custody and whose confinement is the responsibility of a correctional services agency. Comprises of sentenced individuals and people held in custody awaiting trial or sentencing (remandees or people on **remand**). Youth offenders, people in psychiatric custody, police cell detainees, those in periodic detention, asylum seekers or Australians held in overseas prisons are not included.

prison mental health service: A health service that provides screening of prisoners at intake, does psychiatric assessments, provides therapy or counselling by mental health professionals and distributes psychotropic medication. This may be part of, or separate to, the prison heath service.

psychosis: A mental disorder in which the person has strange ideas or experiences that are unaffected by rational argument and are out of keeping with the views of any culture or group to which that the person belongs.

pulmonary disease/ chronic obstructive pulmonary disease (COPD): A preventable and treatable lung disease characterised by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

reception: The formal process whereby sentenced people are received into prison, either on **remand** or sentence.

rate: One number (numerator) divided by another number (denominator). The numerator is commonly the number of events in a specified time. The denominator is the population ‘at risk’ of the event. Rates (crude, age-specific and age-standardised) are generally multiplied by a number such as 100,000 to create whole numbers. In some instances, for example with

prescription volumes or expenditure amounts in magnitude, a multiplier of 100 is used to aid comprehension.

regular medication: Prescribed medication regularly taken by the prisoner, including depot and oral medications. Excludes routine household-type medications, such as paracetamol, which are taken on an as-needed basis.

remand: A term that describes when a person is placed in custody while awaiting the outcome of a court hearing.

respiratory conditions: Conditions of the respiratory system, including airways, lungs and the respiratory muscles, such as respiratory disease (chronic respiratory disease, lung disease and respiratory tract infections), bronchitis, diphtheria, influenza, colds, croup, pneumonia, sinusitis, legionnaires' disease, severe acute respiratory syndrome, tuberculosis and whooping cough. Excludes asthma and cancer.

risk factor: Any factor that represents a greater risk of a health disorder or other unwanted condition or event. Some risk factors are regarded as causes of disease, other are not necessarily so.

sexual assault: A sexual act carried out against a person's will through the use of physical force, intimidation or coercion. Includes rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in penetration, and attempts to force a person into sexual activity. These acts are an offence under state and territory criminal law.

social worker: Someone with a bachelor's degree in social work who provides counselling and support – in the case of this study, to prisoners.

telehealth: Health services delivered using information and communication technologies, such as videoconferencing or through other communication technologies.

transgender: A general term for a person whose gender identity is different from their sex at birth. A trans person may take steps to live in their nominated sex with or without health intervention(s).

youth detention centre: A place administered and operated by a department responsible for youth justice, where young people under the age of 18 are detained while under the supervision of the department on a pre-sentence or sentenced detention episode.

List of tables

List of figures

Related publications

This report, *The health of Australia's prisoners 2022*, is part of a series. The 5 earlier editions and any published subsequently can be downloaded for free from the AIHW website https://www.aihw. gov.au/reports-data/population-groups/prisoners/overview. The website also includes information on ordering printed copies.

The following AIHW publications relating to the health and wellbeing of people in Australia might also be of interest:

- Australian Institute of Health and Welfare (2023) Alcohol, tobacco & other drugs in Australia, [web report], catalogue number PHE 221, AHIW, Australian Government.
- Australian Institute of Health and Welfare (2023) 'Australia's welfare 2023: data insights' [PDF 11.1 MB], Australia's Welfare Series, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2023) Chronic disease, [AIHW website], AIHW, Australian Government.
- Australian Institute of Health and Welfare (2022) Australian Burden of Disease Study 2022 [PDF 597 KB], catalogue number BOD 27, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2022) 'Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018' [PDF 12.5 MB], Australian Burden of Disease Study Series 26, catalogue number BOD 32, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2022) 'Australia's health 2022: data insights' [PDF 16.9MB], Australia's Health Series 18, catalogue number AUS 240, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2022) Specialist homelessness services annual report 2021–22, [web report], catalogue number HOU 331, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2021) 'Cancer in Australia 2021' [PDF 3.1 MB], Cancer Series 133, catalogue number CAN 144, AIHW, Australian Government.
- Australian Institute of Health and Welfare (2020) 'National Drug Strategy Household Survey 2019' [PDF 2.7MB], Drug Statistics Series 32, catalogue number PHE 270, AIHW, Australian Government.

People in prison usually come from disadvantaged backgrounds, with poorer physical and mental health outcomes than the general population. They are less likely to have accessed health-care services, and more likely to have a history of risk behaviours that can affect health and wellbeing. Most people in prison are there for short periods, and many enter and exit the system multiple times. The health of people in prison is public health.

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