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The mental health of prison entrants in Australia

2010

Summary

This bulletin presents results from the 2010 National Prisoner Health Census, and focuses on the associations between mental health and a range of characteristics and behaviours reported by prison entrants. Generally, prison entrants with mental health issues have relatively poor socioeconomic and health characteristics and are more likely to engage in risky health behaviours. They also are more likely to use prison health services and use them more frequently.

Summary continued overleaf

bulletin 104

Contents

Mental health issues are common among prison entrants

In 2010, 31% of prison entrants reported that they had been told by a doctor, psychiatrist, psychologist or nurse that they had a mental health disorder (including drug and alcohol abuse) in their lifetime. This is about 2.5 times higher than the general population (ABS 2010). Sixteen per cent of prison entrants were currently on medication for a mental health disorder and 14% reported experiencing very high levels of distress.

Prison entrants with a mental health disorder have relatively poor socioeconomic and health characteristics

Compared with entrants without a history of a mental health disorder and the general population, prison entrants with a history of a mental health disorder have poorer socioeconomic and health characteristics. Two out of five prison entrants in Australia with a mental health disorder did not complete Year 10 at school and 2 out of 3 were either unemployed or unable to work due to disability, age or condition. Further, this group had extensive criminal histories, with about 1 in 3 having been incarcerated 5 or more times in an adult prison. Also, half of this group had received a head injury that resulted in a loss of consciousness or blacking out.

Prison entrants with a mental health disorder are more likely to report risky health behaviours

Many prison entrants in Australia report engaging in risky health behaviours such as illicit drug use, drinking alcohol at extreme levels and smoking tobacco. Some of these behaviours are even more extensive in prison entrants currently taking medication for a mental health disorder than those not taking medication. Three in 4 prison entrants currently taking medication for a mental health disorder have used illicit drugs in the last 12 months, more than half consumed alcohol at risky levels and nearly 90% smoked.

A high proportion of prison entrants with mental health issues accessed mental health services at the prison clinic

More than half of prison entrants who experienced very high psychological distress in the past 4 weeks were referred to a prison mental health clinic. Further, about a third of prison entrants taking medication for a mental health disorder visited the clinic for a mental health issue and nearly half (48%) of this group visited the clinic 3 or more times during the 2-week National Prisoner Health Census.

Introduction

Prisoners are more likely to have complex health needs and poor mental health, as well as higher use of illicit drugs and alcohol consumption than the general population. In addition, the prison environment, including crowded conditions, may have a further detrimental effect on prisoners' physical and mental health (Velamuri & Stillman 2007; SCRGSP 2012). This bulletin focuses on the mental health needs of prison entrants, the relationships with other health issues, and how prisoners' mental health needs are addressed in prison.

Previous research has found a higher prevalence of mental health problems in the Australian prison population than in the general population. According to one diagnostic study in New South Wales, the overall prevalence of at least one mental health disorder, including drug and alcohol abuse, was 80% in the prison population compared with 31% in the general population (based on the 1997 National Survey of Mental Health and Wellbeing) (Butler et al. 2006). However, a self-report study in New South Wales found that 49% of prisoners self-reported having ever been assessed or treated by a doctor or psychiatrist for an emotional or mental problem (including drug and alcohol abuse) (Indig et al. 2010), suggesting that some prisoners may be unaware of their mental health condition or that self-report data might underestimate the extent of mental health problems in prisoners.

The high rate of mental health disorders in prisoners may reflect, among other things, a lack of adequate diversion options in the community. These schemes, which aim to divert offenders with mental health issues from prison to mental health treatment, are often under-developed, poorly resourced and badly managed (WHO 2008). Diversion programs in Australia are not widely used because they require a person to plead guilty which may result in a criminal record (AIC 2011). Further, there is often a reluctance for psychiatric services to accept mentally ill patients from courts; a misconception that all people with mental health problems are a danger to the public; an intolerance of many societies to difficult or disturbing behaviour; and a failure to promote treatment, care and rehabilitation (WHO 2008; Butler et al. 2006).

The National Justice Chief Executive Officers' Group's best practice guidelines for providing treatment to offenders with a mental illness outlines that prisoners should receive recovery-oriented programs that focus on changing attitudes, values, feelings, goals, skills and roles. The guidelines outline that the prisons should have early screening and assessment tools to identify prisoners with mental illness and any associated problems, and establish effective communication between the community-based care and the prison environment to ensure appropriate continuation of care and medication on entry and discharge from prison (NJCEOG & Vic DoJ 2010). The National Statement of Principles for Forensic Mental Health (AHM 2003) further affirms that health services in prison should be appropriate and equivalent to those in the general community.

The best practice guidelines and the goal of having equivalent health care can be difficult to achieve. Full psychiatric assessments may not be available in prisons due to a lack of resources or the prison clinic being understaffed (UN 2009). Therefore, prisoners who are unaware of their mental health disorder and who do not request an assessment or treatment may not receive a diagnosis (Coid & Ullrich 2011). Further, there can be delays in establishing communication with a prisoner's community-based practitioner to confirm existing prescribed medication and treatment, which can lead to disruptions or changes to established practices (Bowen et al. 2009). These factors, combined with the relationship between mental health, illicit drug use and alcohol consumption, make the provision of services such as access to treatment, medication and rehabilitation and the use of discharge summaries (to allow for the continuation of care) complex and challenging.

Method

Data in this bulletin are sourced from the 2010 National Prisoner Health Census conducted by the Australian Institute of Health and Welfare (AIHW). Data were collected from prison entrants and prisoners in custody who used the prison clinic over 2 weeks in October and November 2010 in six states and territories (excluding New South Wales and Victoria). There were 610 prison entrants. They were predominately male (86%) with a median age of 31; and a disproportionate number were Indigenous (43%) compared with the general population. For further information, see *The health of Australia's prisoners 2010* (AIHW 2011a).

The prevalence of mental health disorders among prison entrants is determined through three main indictors (see Box 1 for a description). As information on the prevalence of mental health disorders is based on a number of self-report indicators, these may be underestimated. Some prison entrants may have difficulties in recalling that they have ever been told that they have a mental health disorder or that the medication they are currently taking is for a mental health disorder. Further, these indicators will only capture people who have visited a medical professional, and research has shown that prisoners typically make less use of health services in the community than the general population (Condon et al. 2007) and therefore may be unaware that they have a mental health condition.

To explore the use of prison clinics by prison entrants participating in the National Prisoner Health Census, forms were completed for new prison entrants who visited the prison clinic in the Census time frame. All prison entrants have an opportunity to appear in the clinic data during the 2-week Census period, but given the nature of the data collection, all prison entrants do not have an equal opportunity to appear in the data. For example, if prisoner A completes an entrant's form on day 1 of the Census they have 14 days to visit the clinic and complete a clinic form, however, if prisoner B completes an entrant's form on day 14 of the Census they only have 1 day to appear in the clinic data.

Box 1: Mental health indicators from the National Prisoner Health Census

Mental health history indicator: During the Census period prison entrants were asked whether they had ever been told that they had a mental health disorder (including drug and alcohol abuse) by a doctor, psychiatrist, psychologist or nurse. This data item reflects a history of a mental health disorder and does not specify whether it is a current condition. This indicator is used to look at relationships with historical factors. As a self-report data item, it could be an underestimate.

Current mental health medication indicator: During the Census period prison entrants were asked whether they were currently taking medication for a mental health disorder. This data item reflects current medication use and therefore may be used as a proxy for those who are currently suffering from a mental health disorder. This indicator is used to look at relationships with current factors. As a self-report data item, it could be an underestimate.

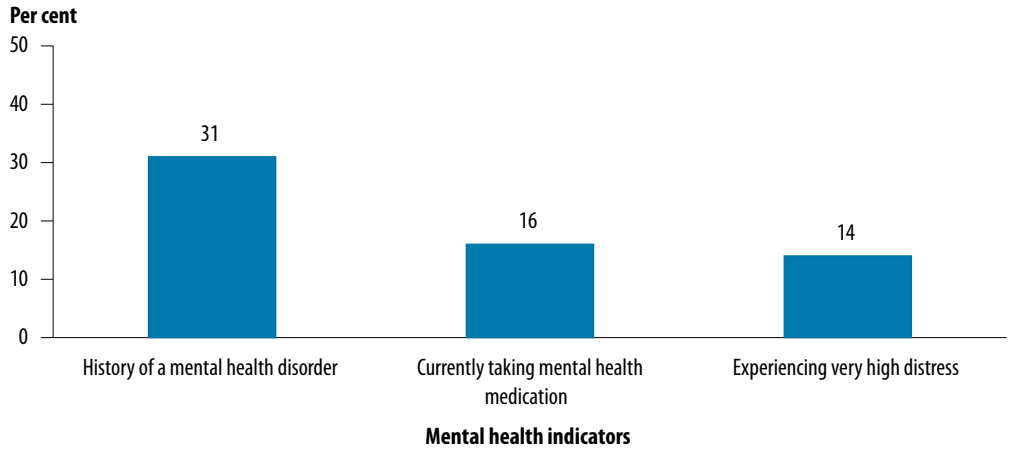
Current psychological distress indicator: During the Census period prison entrants' psychological distress in the 4 weeks before entry to prison was measured by the Kessler 10 (K10) scale. The K10 is a 10-item questionnaire intended to yield a global measure of 'psychological distress' based on questions about levels of anxiety and depression in the most recent 4 weeks. This data item can be used to identify those suffering from high psychological distress, which could be a proxy for a mental health disorder. This indicator is used to look at relationships with current factors. As a screening data item, it may provide more accurate information than self-report.

Findings

Prevalence of mental health issues among prison entrants

The 2010 National Prisoner Health Census found that 31% of prison entrants reported having ever been told that they had a mental health disorder (including drug and alcohol abuse). The number currently taking medication for a mental health disorder or experiencing psychological distress (measures of current mental health issues) is lower. Overall, 16% of all prison entrants surveyed reported that they were taking mental health related medication on entry to prison and 14% reported experiencing very high distress (Figure 1).

When compared with similar Australian community self-report studies, the proportion of prison entrants with a history of a mental health disorder was about 2.5 times higher than the general population (31% compared with 11–12%) (AIHW 2011a; ABS 2010). For more details, see *The health of Australia's prisoners 2010* (AIHW 2011a).



Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Table A1.

Figure 1: Proportion of prison entrants, by selected mental health related indicators, states and territories, 2010

Consistent with findings within the general population (ABS 2008), female prison entrants (41%) were more likely to have a history of a mental health disorder than males (30%). Females were also more likely to be experiencing very high psychological distress (26% compared with 12% of males). In contrast, the same proportions of male and female entrants (16%) were currently taking mental health medication on entry to prison (Table 1).

Non-Indigenous prison entrants were more likely to have a history of a mental health disorder than Indigenous prison entrants (38% and 23% respectively). They were also more likely to be currently taking medication for a mental health condition (19% and 12%) and experiencing very high psychological distress (17% and 9%) (Table 1). A similar pattern was found in the Victoria Prisoner Health Study (Deloitte Consulting 2003). These results are different to what is found in the general population (AIHW 2009).

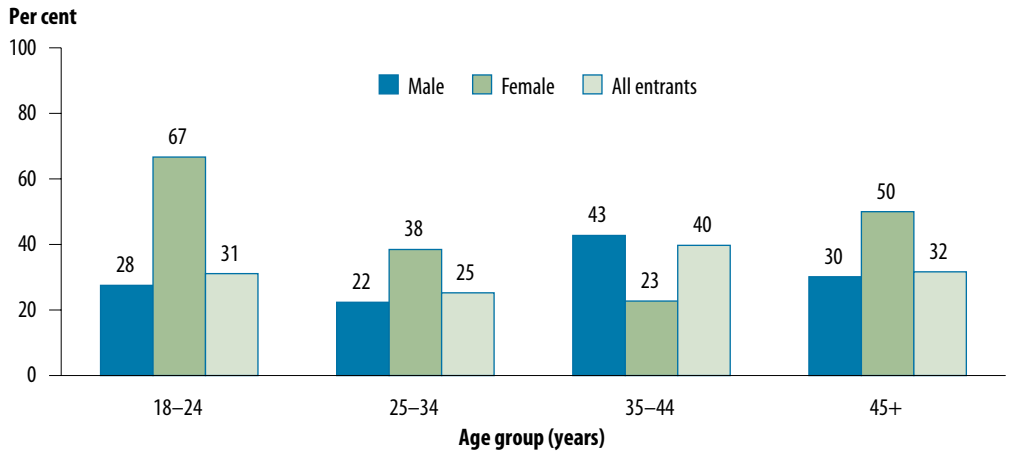
Table 1: Number and proportion of prison entrants, by selected mental health related indicators, by sex and Indigenous status, 2010

	History of a mental health disorder		Currently on mental health medication		Very high psychological distress		All entrants
	Number	Per cent	Number	Per cent	Number	Per cent	
Sex							
Male	157	30	83	16	63	12	524
Female	35	41	14	16	22	26	85
Indigenous status							
Indigenous	61	23	31	12	23	9	262
Non-Indigenous	124	38	61	19	56	17	327
All	**192**	**31**	**97**	**16**	**85**	**14**	**610**

Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Heath Census.

Source: Entrant form, National Prisoner Health Census 2010.

In terms of age, 43% of male prison entrants aged 35–44 had a history of a mental health disorder, followed by 30% of those aged 45 and over. Females showed a different age pattern. The highest proportion of female prison entrants with a history of a mental health disorder was those aged 18–24 (67%), with numbers decreasing for those aged 25 and older (Figure 2). Similar results by age and sex were found for prison entrants who were currently taking medication for a mental health condition and those experiencing very high psychological distress (Table A2).



Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Table A2.

Figure 2: Proportion of prison entrants ever told they have a mental health disorder, by sex and age groups, 2010

Associations between poor mental health and other factors

The mental health needs of prisoners can be complex due to relationships with factors such as low levels of education and employment, a history of incarceration, a history of head injury, substance use and high levels of self-harm (Coid & Ullrich 2011; Friestad & Kjelsberg 2009). This section explores the associations of a number of these characteristics and behaviours with the mental health of prisoners.

Completed education and employment status

Generally, people with relatively lower levels of education and literacy also tend to have poorer health (AMA 2007). Research has found that prisoners who have been incarcerated multiple times have, on average, lower levels of education (Rawnsley 2003). Further, a higher level of schooling is associated with a lower probability of arrest and incarceration (Lochner & Moretti 2004).

The level of educational attainment among prison entrants was lower than the general population, with 35% having not completed Year 10 compared with 14% of the general population (AIHW 2010). There were small differences in the educational attainment of prison entrants with and without mental health issues. Those with a history of a mental health disorder were slightly less likely to have completed Year 10 or above than those with no history of a mental health disorder (61% compared with 65%).

Prison entrants with a history of a mental health disorder were more likely to be unable to work due to disability, age or condition (20%) than those without a history of a mental health disorder (10%). Further, prison entrants with a history of a mental health disorder who were unemployed at the time of incarceration were less likely to be looking for work than those without a history of a mental health disorder (24% and 30% respectively) (Figure 3).

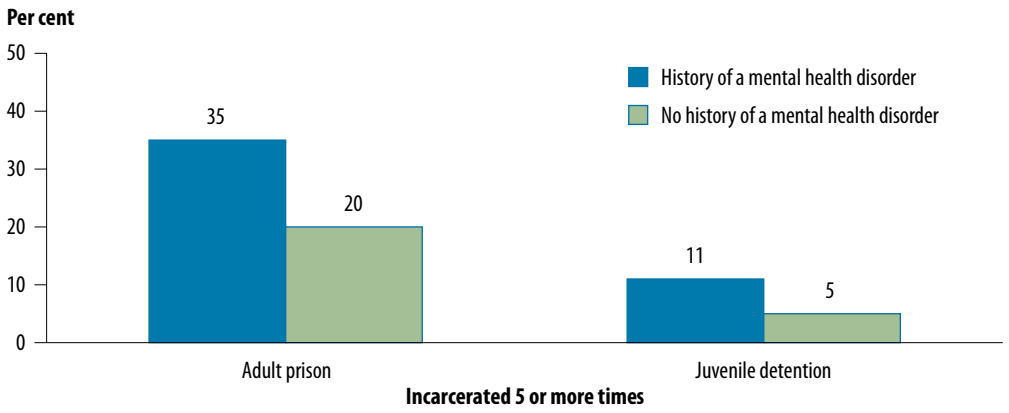
Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
Source: Table A3.

Figure 3: Proportion of prison entrants currently unemployed or unable to work, by mental health status, 2010

History of incarceration

Previous research has found a higher incidence of any mental health disorder in people who had been incarcerated at some point. The 2007 National Survey of Mental Health and Wellbeing found that of those who had been incarcerated, 41% reported a mental health disorder in the previous 12 months compared with 19% of those who had never been incarcerated (ABS 2008).

In the National Prisoner Health Census, a very similar proportion of prison entrants with and without a history of a mental health disorder had been previously incarcerated (75% compared with 74%). However, prison entrants with a history of a mental health disorder tended to have more extensive criminal histories. They were more likely to have been incarcerated 5 or more times in adult prison (35%) and in juvenile detention (11%) than prison entrants with no history of a mental health disorder (20% and 5%) (Figure 4).



Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
Source: Table A3.

Figure 4: Proportion of prison entrants incarcerated 5 or more times, by mental health status, 2010

Traumatic brain injury

Traumatic brain injury (TBI) is defined as an acquired brain injury caused by external force applied to the head which results in damage to the brain and/or an alteration in brain functioning (Rushworth 2011). Aggressive and socially unacceptable behaviours, poor self-monitoring, disability and mood disorders may be a direct consequence of these changes (Rushworth 2011; Andelic et al. 2010).

Research has consistently found higher levels of TBI among prisoners than in the general population, suggesting that there are some links between TBI, offending behaviour and mental health (Schofield et al. 2006). The 2010 NSW Inmate Survey found that 49% of prisoners reported a history of a head injury resulting in a loss of consciousness. Of these, 22% reported anxiety or depression and 14% reported personality changes after the injury (Indig 2010). Further, research in the United Kingdom found that juvenile offenders who had three or more self-reported TBIs were more likely to commit violent crimes.

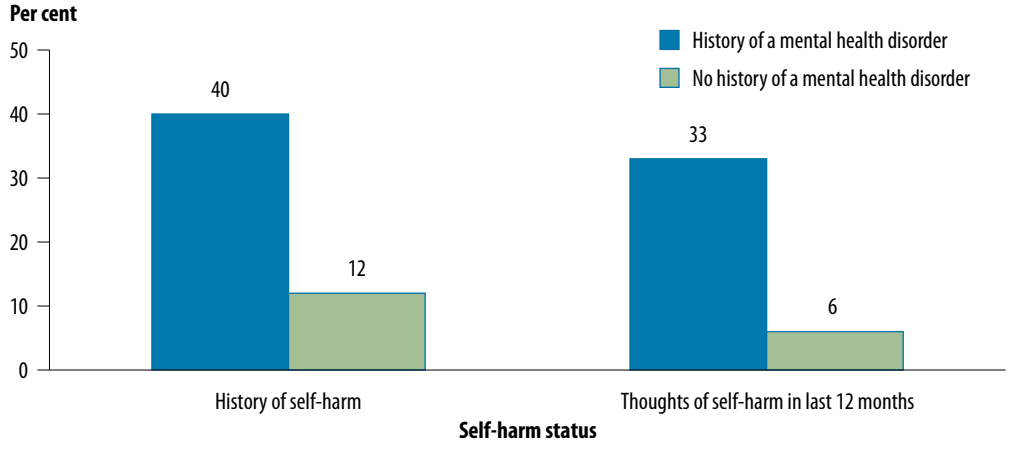
During the National Prisoner Health Census, prison entrants were asked whether they had ever received a blow to the head that resulted in a loss of consciousness; a proxy for TBI. Half (50%) of prison entrants with a history of a mental health disorder had received a head injury compared with about one-third (34%) with no history of a mental health disorder.

Self-harm

Self-harm is when a person deliberately inflicts physical harm to themselves, usually as an extreme way of trying to cope with distressing or painful feelings. It is not necessarily a suicide attempt, although it may include suicidal behaviour. The ABS National Survey of Mental Health and Wellbeing found that of the people who reported suicidal thoughts in the last 12 months, almost three-quarters (72%) had reported a mental health disorder in the previous 12 months (ABS 2008).

The prison population has been found to exhibit high levels of self-inflicted harm, suicidal thoughts and suicide attempts (Webb et al. 2011; Kirchner et al. 2008). Risk factors for self-harm are common for prisoners and include mental health problems, drug and alcohol abuse and previous suicide attempts (Fliege et al. 2008; Kenny et al. 2008).

Prison entrants with a history of a mental health disorder were more likely to have intentionally self-harmed (40%) and had thoughts of self-harm in the last 12 months (33%) than those with no history of a mental health disorder (12% and 6%, respectively) (Figure 5).



Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Table A3.

Figure 5: Proportion of prison entrants with a history of self-harm and thoughts of self-harm, by mental health status, 2010

Substance use

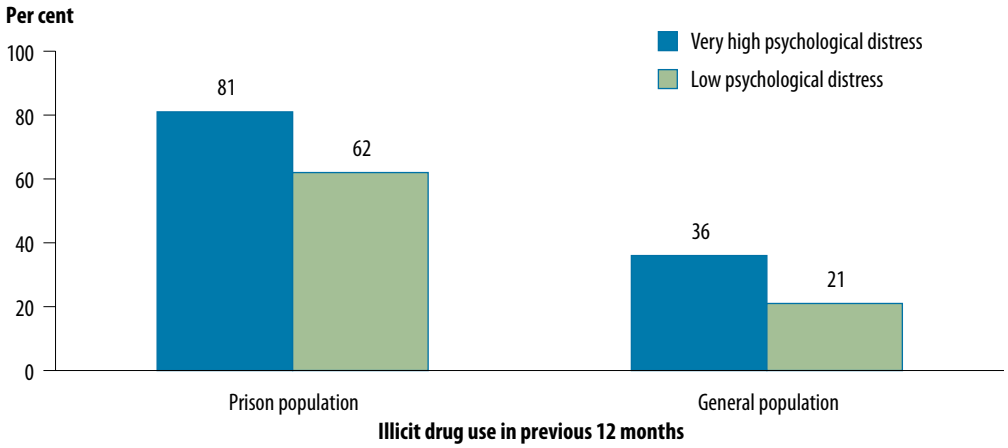
A co-occurrence between poor mental health and substance misuse has been found in a number of national diagnostic and self-report surveys. The ABS National Survey of Mental Health and Wellbeing (diagnostic based) found that of those who misused illicit

substances in the previous 12 months, 63% reported having a mental health disorder during the same period. Further, smoking was found to be twice as prevalent in persons who reported having a mental health disorder in the previous 12 months—almost one-third (32%) of current smokers reported a disorder (ABS 2008). The 2010 National Drug Strategy Household Survey (self-report based) found that nearly 1 in 5 (19%) of those who had used illicit drugs in the previous 12 months and 14% of those who consumed alcohol at risky levels weekly reported a mental health disorder (AIHW 2011b). This suggests that the self-report data might underestimate the extent of substance use in people with mental health problems compared with the diagnostic based survey.

There are a number of explanations as to why poor mental health and substance use might co-occur. Some research suggests that people with poor mental health begin to use substances to alleviate the symptoms of their illness. Others suggest that the underlying brain structures for poor mental health and the tendency for risky alcohol and drug use are the same. A third explanation is that factors such as social disadvantage, parental psychiatric illness and family dysfunction can place a person more at risk of developing poor mental health and a tendency for risky alcohol and drug use (Degenhardt et al. 2003).

Illicit drug use

Rates of illicit drug use were much higher in the prison population than the general population, with 66% of prison entrants using illicit drugs in the previous 12 months compared with 15% in the general population (AIHW 2011a; AIHW 2011b). Further, for both prison entrants and the general population aged 18–44, illicit drug use was more common in those with very high psychological distress (81% and 36% respectively) than those with low psychological distress (62% and 21%) (Figure 6).



Note: Excludes New South Wales and Victoria from both the prison and the general population as they did not participate in the 2010 National Prisoner Health Census.

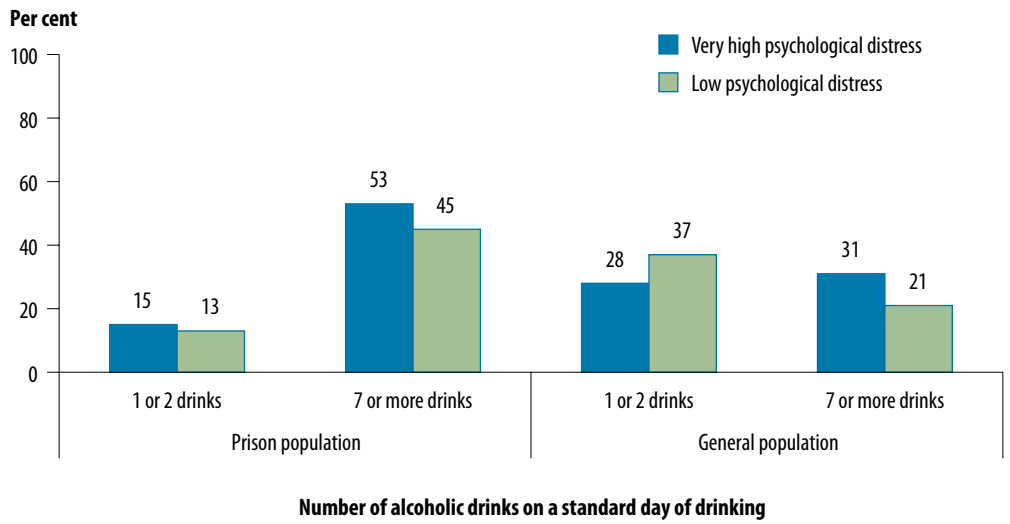
Source: Table A5, AIHW analysis of National Drug Strategy Household Survey 2010.

Figure 6: Proportion of prison entrants and general population aged 18–44 using illicit drugs in the previous 12 months, by level of psychological distress, 2010

For the prison population, illicit drug use in the previous 12 months was also more common among prison entrants currently taking medication for a mental health disorder (75%) than those not taking medication (66%) (Table A4).

Alcohol

Risky alcohol consumption was more prevalent among prison entrants than the general population (AIHW 2010). This was even more extensive for those with very high levels of psychological distress. More than half (53%) of prison entrants aged 18–44 with very high psychological distress consumed 7 or more alcoholic drinks on an average day of drinking (before entering prison) compared with about one-third (31%) of the general population (Figure 7).



Note: Excludes New South Wales and Victoria from both the prison and the general population as they did not participate in the 2010 National Prisoner Health Census.

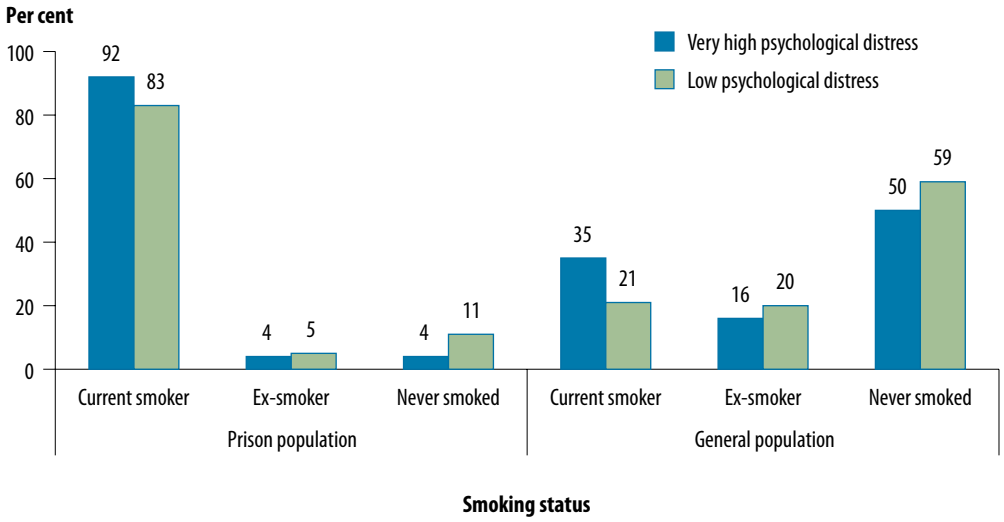
Source: Table A5, AIHW analysis of National Drug Strategy Household Survey 2010.

Figure 7: Proportion of prison entrants and general population aged 18–44 consuming multiple alcoholic drinks on a standard day of drinking, by level of psychological distress, 2010

However, looking at current medication use for a mental health disorder presents a different result. The National Prisoner Health Census found that prison entrants not currently taking any medication for a mental health disorder were slightly more likely to be at risk of alcohol-related harm as determined by the World Health Organization's Alcohol Use Disorder Identification Test (AUDIT) than those currently taking medication (59% and 53% respectively) (Table A4). Mental health medication may play a role in moderating distress levels.

Smoking

Overall, smoking rates are considerably higher among prison entrants than the general population (AIHW 2010; AIHW 2011b). This was even more extensive for those with very high levels of psychological distress. Prison entrants aged 18–44 experiencing very high psychological distress were much more likely to be current smokers than those in the general population experiencing the same level of distress (92% compared with 35%) (Figure 8).



Note: Excludes New South Wales and Victoria from both the prison and the general population as they did not participate in the 2010 National Prisoner Health Census.

Source: Table A5, AIHW analysis of National Drug Strategy Household Survey 2010.

Figure 8: Proportion of prison entrants and general population aged 18–44 by smoking status and level of psychological distress, 2010

For the prison population, prison entrants currently taking medication for a mental health disorder were more likely to be current smokers (89% compared with 82%) and less likely to have never smoked (5% compared with 12%) than those not taking medication (Table A4). High rates of smoking are reflective of the prison population in general.

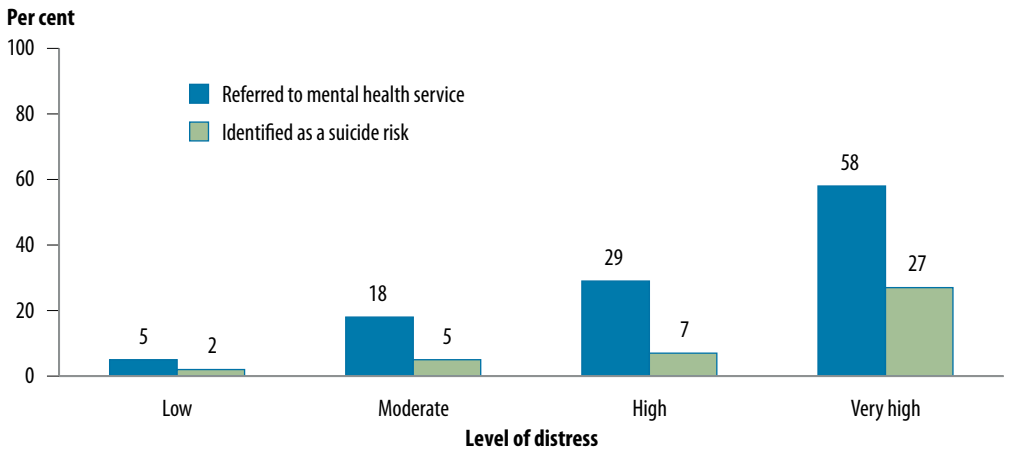
Prison mental health services

Health care services in prison are provided by the states or territories, which each provide and fund mental health services differently. Services can be provided through corrective or health departments, outsourced to a third party, or a combination of all approaches used (AIHW 2011a). During 2010, 22 full-time equivalent psychologists and 10 psychiatrists were employed in Australian prison clinics (excluding New South Wales and Victoria) at the time of the National Prisoner Health Census. However, this is likely to be an underestimate, as details on staff employed by contract are not captured in the National Prisoner Health Census data.

Prisoners typically underutilise health care services when in the community, therefore prison provides an opportunity to receive services (Condon et al. 2007). However, prison clinics are often unable to cope with the large number of prisoners with complex health needs (UN 2009), and often rely on prisoners to self-report health conditions. Therefore, if the prisoner is unaware of their mental health disorder, does not request treatment or does not display severe enough symptoms, they are unlikely to receive attention from prison clinic staff (Coid & Ullrich 2011). Delays may also occur in establishing communication with a prisoner's community-based care provider, which can lead to disruptions in treatment and even stoppages in medication. Delays in medication can mean that a prisoner's wellbeing may be compromised during the critical time of adjusting to the prison environment and their mental health can further deteriorate (Bowen et al. 2009; Edgar & Richford 2009).

Referral to mental health services

On entry to Australian prisons, entrants have a health assessment from which they may be referred to a mental health service and/or identified as a suicide risk. The proportion of entrants referred and/or identified increased with increased levels of distress (Figure 9). Nearly three-fifths (58%) of prison entrants who reported experiencing very high distress on entry to prison were referred to a mental health service and more than one-quarter (27%) were identified as a suicide risk, while only 5% of prison entrants who reported a low level of psychological distress were referred and 2% identified as a suicide risk.



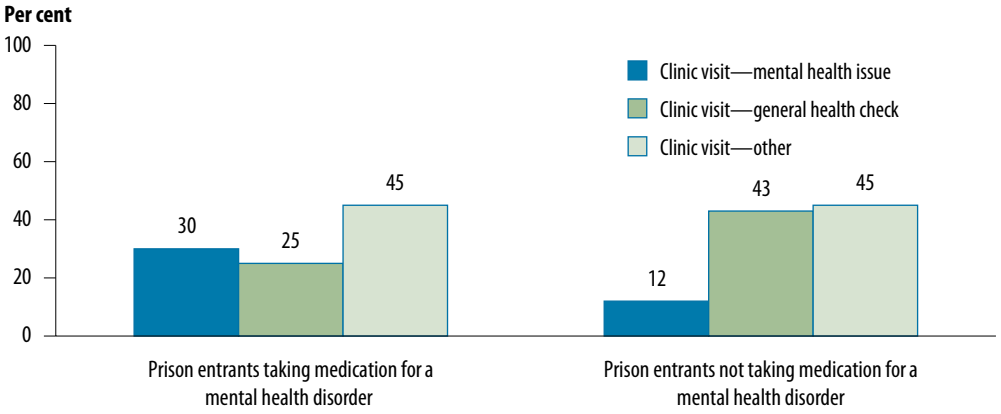
Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
Source: Table A6.

Figure 9: Proportion of prison entrants referred to mental health service and/or identified as a suicide risk upon entry to prison, by level of distress, 2010

Clinic visits for a mental health reason

Of the 610 prison entrants who participated in the National Prisoner Health Census, about half (54%) visited the clinic for some reason during the same period. Similar results were found for prison entrants with and without a history of a mental health disorder (53% and 55% respectively) and for those currently and not currently taking medication for a mental health disorder (58% and 54%). This is likely to underestimate visits due to the Census methodology—see 'Method'.

Overall, 15% of prison entrants who visited the prison clinic attended for a mental health reason. Prison entrants who were taking medication for a mental health disorder on entry to prison were considerably more likely to visit the clinic for a mental health issue than those not taking medication (30% and 12%) (Figure 10). Further, prison entrants currently taking medication for a mental health disorder were more likely to be a persistent user of the clinic. This group was more likely to make 3 or more visits during the 2 weeks of the Census than entrants not currently taking medication (48% and 29%) and less likely to only make 1 visit (23% and 42%).



Notes

1. Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
2. Clinic visit — 'other' includes visits for diabetes, pathology, skin condition, alcohol or drug use, medicine/vaccination, musculoskeletal injury, musculoskeletal condition, cardiovascular disease, respiratory conditions, communicable disease, dental, digestive condition, wound care, asthma, sensory, neurological, malignancy, arthritis and women's health.

Source: Table A7.

Figure 10: Proportion of prison entrants who visited the clinic during the National Prisoner Health Census period, by clinic visit type, 2010

Prison entrants who visited the clinic for a mental health reason were mostly seen by a nurse or a general practitioner (37% each) or a mental health nurse (20%). No prison entrant who visited the clinic for a mental health issue during the National Prisoner Health Census period was seen by a psychologist. While there were some psychologists and psychiatrists employed during the Census period, they did not provide mental health treatment for new entrants during that time. This simply demonstrates the referral process, where prison entrants first have a clinic visit with a nurse before being referred to a psychologist.

Conclusion

Mental health issues are common among prison entrants, with 1 in 3 having a history of a mental health disorder, 16% of prison entrants currently taking medication for a mental health disorder and 14% reporting very high levels of distress. This bulletin found that relative to other prison entrants, those with poor mental health also had more extensive imprisonment histories, poorer school attainment, higher unemployment rates and higher rates of substance use. Further, the association between substance use and mental health disorders was stronger in the prison population than in the general population. On entry to prison, prison entrants with higher levels of psychological distress were more likely to be referred to a mental health service than those with lower levels; or identified as a suicide risk than those with lower levels. Further, prison entrants currently taking medication for a mental health disorder were more likely to visit the clinic for a mental health reason than entrants not taking medication and more likely to make multiple visits. The 2012 National Prisoner Health Census will be expanded to include information on prisoners just before their release and will provide further insight into mental health services prisoners receive in prison.

Appendix

Table A1: Prison entrants, ever told they have a mental illness, current medication and high psychological distress, states and territories, 2010

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Ever told they have a mental illness									
Number	n.a.	n.a.	61	44	39	26	8	14	192
Per cent	n.a.	n.a.	32	25	33	60	67	19	31
Currently on mental health medication									
Number	n.a.	n.a.	42	17	21	9	3	5	97
Per cent (all)	n.a.	n.a.	22	10	18	21	25	7	16
Per cent (ever told)	n.a.	n.a.	57	39	51	35	38	39	46
High psychological distress									
Number	n.a.	n.a.	22	30	17	7	6	3	85
Per cent	n.a.	n.a.	12	17	14	16	50	4	14
Total	**n.a.**	**n.a.**	**189**	**173**	**118**	**43**	**12**	**75**	**610**

Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Entrant form, National Prisoner Health Census 2010.

Table A2: Number and proportion of prison entrants ever told they have a mental health disorder, by sex and age groups, 2010

	History of a mental health disorder		Currently on mental health medication		Very high psychological distress		All entrants
Age group (years)	Number	Per cent	Number	Per cent	Number	Per cent	
Male							
18–24	41	28	18	12	18	12	149
25–34	38	22	16	9	12	7	170
35–44	53	43	34	27	23	19	124
45+	22	30	<15	<21	<15	<21	73
Female							
18–24	10	67	6	40	7	47	15
25–34	15	38	5	13	10	26	39
35–44	5	23	—	—	3	14	22
45+	3	50	<5	<83	<3	<50	6
All people							
18–24	51	31	24	15	25	15	164
25–34	53	25	21	10	22	10	210
35–44	58	40	34	23	26	18	146
45+	25	32	16	20	11	14	79
All	**192**	**31**	**97**	**16**	**85**	**14**	**610**

Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Entrant form, National Prisoner Health Census 2010.

Table A3: Number and proportion of prison entrants ever told they have a mental health disorder and background factors, 2010

	History of a mental health disorder		No history of mental health disorder		All entrants	
Factors	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Completed Year 10 or above	118	61	269	65	390	64
Unemployed, looking for work	47	24	125	30	172	28
Unemployed, not looking for work	40	21	53	13	95	16
Unable to work do to disability, age or condition	38	20	40	10	78	13
Incarcerated 5 or more times in prison: adult prison	68	35	84	20	152	25
Incarcerated 5 or more times in prison: juvenile detention	21	11	21	5	42	7
Received a head injury	96	50	140	34	236	39
History of self-harm	77	40	50	12	127	21
Thoughts of self-harm in last 12 months	63	33	23	6	86	14
All entrants	**192**	**100**	**412**	**100**	**610**	**100**

Notes

1. Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
2. Per cents do not add up to 100%, as prisoners can be in multiple factors.

Source: Entrant form, National Prisoner Health Census 2010.

Table A4: Number and proportion of prison entrants currently on medication for a mental health disorder, by risk factors, 2010

	Currently taking medication for a mental health disorder		Not currently taking medication for a mental health disorder		All entrants	
Factors	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Used drugs in the previous 12 months	73	75	325	66	405	66
High alcohol risk	51	53	294	59	355	58
Low alcohol risk	30	31	122	25	156	26
Does not drink	15	15	78	16	97	16
Current smoker	86	89	408	82	506	83
Ex-smoker	4	4	28	6	33	5
Non smoker	5	5	57	12	64	10
Referred to a mental health services	49	51	63	13	113	19
Identified as a suicide risk	14	14	26	5	41	7
All entrants	**97**	100	**495**	100	**610**	100

Notes

1. Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
2. Per cents do not add up to 100%, as prisoners can be in multiple factors.

Source: Entrant form, National Prisoner Health Census 2010.

Table A5: Number and proportion of prison entrants aged 18–44, by level of psychological distress and risk factors, 2010

	Low psychological distress		Very high psychological distress		All entrants aged 18–44	
Factors	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Used drugs in the previous 12 months	161	62	59	81	365	70
1 or 2 drinks	33	13	11	15	65	13
7 or more drinks	117	45	39	53	244	47
Current smoker	215	83	67	92	446	86
Ex-smoker	14	5	3	4	22	4
Non smoker	28	11	3	4	46	9
All entrants	**259**	100	**73**	100	**520**	100

Notes

1. Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.
2. Per cents do not add up to 100%, as prisoners can be in multiple factors.

Source: Entrant form, National Prisoner Health Census 2010.

Table A6: Number and proportion of prison entrants, by current distress, referred to mental health services and/or identified as a suicide risk upon entry to prison, 2010

	Referred to mental health service		Identified as a suicide risk		All entrants	
Level of distress	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Low	15	5	7	2	306	100
Moderate	18	18	5	5	99	100
High	26	29	6	7	90	100
Very High	49	58	23	27	85	100
All entrants	**113**	19	41	7	610	100

Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Entrant form, National Prisoner Health Census 2010.

Table A7: Number of prison entrants visiting the clinic, by risk factors, 2010

	Prison entrants taking medication for a mental health disorder		Prison entrants not taking medication for a mental health disorder		All entrants who visited the clinic	
Clinic visit	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Clinic visit—mental health	17	30	31	12	50	15
Clinic visit—general health check	14	25	115	43	133	40
Clinic visit—other	25	45	123	46	149	45
All entrants who visited the clinic	56	100	269	100	332	100

Note: Excludes New South Wales and Victoria as they did not participate in the 2010 National Prisoner Health Census.

Source: Entrant form and Clinic form, National Prisoner Health Census 2010.

References

ABS (Australian Bureau of Statistics) 2008. National survey of mental health and wellbeing: summary of results, 2007. ABS cat. no. 4326.0. Canberra: ABS.

ABS 2010. National Health Survey: summary of results, 2007–2008 (Reissue). Retrieved 31/08/2011 <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.02007-2008%20 (Reissue)?OpenDocument>

AHM (Australian Health Ministers) 2003. National Mental Health Plan 2003–2008. Canberra: Australian Government.

AIC (Australian Institute of Criminology) 2011. Court-based mental health diversion programs. Research in Practice Tipsheet No. 20. Canberra: AIC.

AIHW (Australian Institute of Health and Welfare) 2009. Measuring the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. Cat. no. IHW 24. Canberra: AIHW.

AIHW 2010. The health of Australia's prisoners 2009. Cat. no. PHE 123. Canberra: AIHW.

AIHW 2011a. The health of Australia's prisoners 2010. Cat. no. PHE 149. Canberra: AIHW.

AIHW 2011b. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

AMA (Australian Medical Association) 2007. Social determinants of health and the prevention of health inequities—2007. Viewed 31/08/2011 < http://ama.com.au/node/2723>

Andelic N, Sigurdardottir S, Schanke A, Sandvik L, Sveen U, Roe C 2010. Disability, physical health and mental health 1 year after traumatic brain injury. Disability and Rehabilitation; 32:1122-1131.

Bowen RA, Rogers A & Shaw J 2009. Medication management and practices in prison for people with mental health problems: a qualitative study. International Journal of Mental Health Systems 3:34.

Butler T, Andrew G, Allnutt S, Sakashita C, Smith N, Basson J 2006. Mental disorders in Australia prisoners: a comparison with a community sample. Australian and New Zealand Journal of Psychiatry 40:272-276.

Coid J & Ullrich S 2011. Prisoners with psychosis in England and Wales: diversion to psychiatric inpatient services? International Journal of Law and Psychiatry 34:99–108.

Condon L, Hek G & Harris F 2007. A review of prison health and its implications for primary care nursing in England and Wales: the research evidence. Journal of Clinical Nursing 216:1201–9.

Degenhardt L, Hall W & Lynskey M 2003. What is comorbidity and why does it occur? Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment. Edited by Teesson M & Proudfoot H National Drug and Alcohol Research Centre: Sydney.

Deloitte Consulting for the Department of Justice—Corrections Victoria 2003. Victorian Prisoner Health Study. Melbourne: Department of Justice—Corrections Victoria.

Fliege H, Lee J, Grimm A & Klapp B 2008. Risk factors and correlates of deliberate self-harm behavior: a systematic review. Journal of Psychosomatic Research 66(6):477–93.

Friestad C & Kjelsberg E 2009. Drug use and mental health problems among prison inmates—results from a nation-wide prison population study. Nordic Journal of Psychiatry 63:237-245.

Indig D, Topp L, Ross B, Mamoon H, Border B, Kumar S, McNamara M 2010. 2009 NSW Inmate Health Survey: key findings report. Sydney: Justice Health.

Lochner L & Moretti E 2004. The effect of education on crime: evidence from prison inmates, arrests, and self-reports. American Economic Association.

Kenny D, Lennings C & Munn O 2008. Risk factors for self-harm and suicide in incarcerated young offenders: implications for policy and practice. Journal of Forensic Psychology Practice 8(4):358–82.
Kirchner T, Forns M & Mohino S 2008. Identifying the risk of deliberate self-harm among young prisoners by means of coping typologies. Suicide and Life-threatening Behaviour 38(4).
NJCEOG (National Justice Chief Executive Officers' Group) and Vic DoJ (Victoria Government Department of Justice) 2010. Diversion and support of offenders with a mental illness: guidelines for best practice. Victoria: Department of Justice.
Rawnsley T 2003. Dynamics in repeat imprisonment: utilising prison census data working papers in Econometrics and Applied Statistics: No 2003–02, ABS cat. no. 1351.0. Canberra: ABS.
Rushworth, N. 2011. Out of sight, out of mind: people with an acquired brain injury and the criminal justice system. Sydney: Brain Injury Australia.
Schofield P, Butler T, Hollis S, Smith N, Lee S, Kelso W 2006. Traumatic brain injury among Australian prisoners: rates, recurrence and sequelae. Brain Injury 20:499–506.
SCRGSP (Steering Committee for the Review of Government Service Provision) 2012. Report on government services 2012. Canberra: Productivity Commission.
UN (United Nations) 2009. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Viewed 14/12/2011 http://www.unhcr.org/refworld/category,REFERENCE,,MISSION,,4a1d0af22,0.html.
Velamuri M & Stillman S 2007.Longitudinal evidence of the impact of incarceration on labour market outcomes and general well–being. HILDA Survey Research Conference. Melbourne: Melbourne Institute of Applied Economic and Social Research.
Webb R, Qin P, Stevens H, Mortensen P, Appleby L & Shaw J 2011. National study of suicide in all people with a criminal justice history. Archive of general psychiatry 68(6):591–599.
WHO (World Health Organization) 2008. Trencin Statement on prisons and mental health. Copenhagen: WHO Europe.

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bulletin 104

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