OUTLINE OF EVIDENCE OF PROFESSOR STUART KINNER

DECEMBER HEARINGS 2022
(CRIMINAL JUSTICE & CHILD PROTECTION)

16 DECEMBER 2022

I BACKGROUND

1. Professor Kinner has a PhD in forensic psychology and more than two decades of research experience in public health. His research focuses on the health of marginalised and justice-involved people, with a current focus on young people moving through the youth justice system. He has been involved in justice health research in Victoria, Queensland, Western Australia, New South Wales, ACT, and the Northern Territory, and internationally.

2. He currently holds positions as:

   a. Head of the Justice Health Group at the Murdoch Children's Research Institute;

   b. Head of the Justice Health Unit in the Melbourne School of Population and Global Health, University of Melbourne;

   c. Professor of Health Equity at Curtin University; and

   d. Adjunct Professor in the Griffith Criminology Institute.

3. Professor Kinner serves on the Steering Group for the World Health Organization (WHO) Health in Prisons Programme (WHO HIPP), and the Steering Committee for the Worldwide Prison Health Research and Engagement Network (WEPHREN). He is a Technical Advisor to the WHO HIPP and is inaugural Chair of Australia's National Youth Justice Health Advisory Group.

II CHARACTERISTICS OF FIRST NATIONS PEOPLE IN THE CRIMINAL JUSTICE SYSTEM

General

4. Australian studies have found that among people in prisons the prevalence of risky alcohol use is higher among Indigenous people than non-Indigenous people, with a national survey finding that 73% of Indigenous prison receptions were at risk of alcohol-related harm.[1] Among Indigenous people in prison, alcohol dependence was associated with having an income below the poverty line.[2]

5. There was also an association between alcohol dependence and mental illness.[3] Indigenous people are less likely to report a diagnosed mental disorder on reception into prison, linked to the fact that they are also less likely to report engagement with health services prior to incarceration.[4] Among Indigenous Australians in prison, the 12-month prevalence of anxiety, depression and psychotic disorders has been estimated at 15%, 14% and 10% respectively.[5]

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[1] Attachment 1: *Prevalence and correlates of alcohol dependence in adult prisoners vary according to Indigenous status*, p 329.

[2] Attachment 1, p 333.

[3] Attachment 1, p 333.

[4] Attachment 2: *The pivotal role of primary care in meeting the health needs of people recently released from prison*. p 3.

[5] Attachment 3: Submission to the Productivity Commission's Issues paper on the Social and Economic Benefits of Improving Mental Health: *The role of incarceration in addressing inequalities for people with mental illness in Australia,* p 3.

Women

6. Indigenous women released from prison are at approximately 13 times higher risk of death compared to their counterparts from the general population.[6]

7. Women in prison who have been victims of violence, including sexual violence, are disproportionately Indigenous women, who are more likely than their non-Indigenous counterparts to be incarcerated and to be victims of violence.[7]

Men

8. Indigenous men released from prison are at approximately 5 times higher risk of death compared to their counterparts from the general population. Their absolute risk of death after release from prison is higher than that of Indigenous women released from prison.[8]

Children

9. Young people and children in detention have almost inevitably been exposed to some trauma, so trauma-informed policy and practice (including with respect to healthcare) is a necessity.[9] Indigenous youth are disproportionately represented among people who have experienced violence and have been involved in the criminal justice system.[10]

10. Aboriginal and Torres Strait Islander children are disproportionately impacted by the criminal justice system, as are children with current or prior involvement with the out-of-home care system. One reason for this is that behaviours that would typically be dealt with privately in a family home (e.g., acting out, verbal aggression, minor damage to property) can involve police when they occur in residential out-of-home care facilities. In this way, children involved in the out-of-home care system are, purely by virtue of being in that system, at increased risk of being 'criminalised'.[11]

11. The timeliness of initial assessments of children entering detention is of critical importance. Among incarcerated children, there is a high prevalence of conditions that require immediate attention, such as drug withdrawal and self-harming behaviour, and provision of essential medications. The high prevalence of mental disorder in these children also makes timely assessment especially pertinent.[12]

12. The limited evidence suggests that young people entering youth detention are likely to have under-utilised health services in the community.[13] However, given the often very short periods of time children spend in detention (for Indigenous children, the median time on remand is 8 days, and 61 days if sentenced)[14], detention at best provides an opportunity to identify unmet health needs and initiate care that can (and should) continue once these children return to the community.

13. Evidence from a recent global review of the evidence demonstrates that children in youth detention – in Australia and elsewhere -- are distinguished by a high prevalence of comorbid health problems: in other words, complexity is normative.[15] One implication of this reality is that coordinated, multisectoral, and continuous service provision is pivotal to achieving sustained improvements in their health and social outcomes.

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[6] Attachment 3, p 5.

[7] Attachment 4: *Submission to the Victorian Law Reform Commission Inquiry on Improving the Response of the Justice System to Sexual Offences: Reducing trauma among victim-survivors of sexual offences who are involved in the criminal justice system,* p 2.

[8] Attachment 3, p 5; see *Increased mortality among Indigenous persons during and after release from prison in New South Wales.*

[9] Attachment 5: *Transcript of Evidence of Professor Stuart Kinner and Mick Creati (Don Dale)*, p 1751 to 1752.

[10] Attachment 4, p 3.

[11] Attachment 6: *Submission to Council of Attorneys-General: Age of Criminal Responsibility Working Group*, p 2.

[12] Attachment 7: *Precis of Evidence of Professor Stuart Kinner (Don Dale)*, p 1.

[13] Attachment 7, p 3.

[14] See *Youth justice in Australia 2020-2021*.

[15] See *The health of adolescents in detention: a global scoping review*.

III HEALTHCARE STANDARDS, QUALITY, FUNDING, GOVERNANCE AND FINANCING

Lack of Quality Research

14. Importantly, there is a lack of quality evidence around the impacts of incarceration on children especially. When I was involved with the UN Global Study of Children Deprived of Liberty, we concluded that the evidence available was consistent with incarceration being harmful for children, but there was little evidence to rely on, and much of that evidence was poor quality. Incarceration is clearly not a desirable experience for children, but there is remarkably little evidence to either quantify or tease out its impacts.

15. There is a two-tier system for obtaining approval for research projects involving DCJS in Victoria. The first stage is submitting a proposal to the Corrections Victoria Research Committee (**CVRC**) which is a somewhat opaque process. Although CVRC purports to review proposals for feasibility, security considerations, resource implications, and alignment with DJCS priorities, I am not aware of any oversight of this process. Proposals approved by CVRC then come to the Justice Human Research Ethics Committee (**JHREC**), of which I am a member (noting that my evidence to the Yoorrook Justice Commission is in my own capacity, not on behalf of JHREC). I have been lobbying for CVRC to provide JHREC with a list of all of the proposals that they knock back, as it is my experience that undertaking independent justice research and/or obtaining DJCS data for research purposes is particularly difficult in Victoria. Although JHREC is bound to act in accordance with the NHMRC National Statement on Ethical Conduct in Human Research (and in my experience, does a good job of this), JHREC only ever 'sees' the subset of proposals that make it past the CVRC filter.

16. One specific concern with the process by which research involving DJCS is approved in Victoria is that CVRC first considers whether the proposed research aligns with DJCS strategic priorities. Given an abundance of evidence that outcomes for people exposed to the criminal justice system are a 'whole-of-government' problem, and therefore requirement whole-of-government solutions, it seems myopic at best to consider research proposals exclusively or even primarily through a justice lens. For example, if a research project aims to improve health outcomes after incarceration, with no necessary impacts on the criminal justice system, should this be knocked back because it's not a priority for DJCS?

17. Corrections Victoria needs to recognise that their own strategic interests are not the only matter for consideration when making decisions on the type of research to support. There needs to be a culturally capable, holistic, multi-disciplinary review of the process by which they consider research. The default position should be that the department supports independent research – particularly data-linkage research, where the resource impacts on the system are marginal. If, for example, I want to link prison records with hospital records to study cancer outcomes for people released from prison, CVRC can prevent this research from proceeding because it isn't in line with their strategic interests. This seems perverse to me.

18. Although (as noted above) I am in no way purporting to represent JHREC for the purposes of this Commission, as a member of JHREC, I am aware that JHREC has found it challenging to recruit and retain Indigenous persons to serve on the Committee. In my view, rectifying this remarkable gap in the expertise of JHREC is a major concern that warrants urgent attention, and, if necessary, increased investment. I am somewhat surprised that DJCS has, over such a longer period of time, been unable to successfully recruit an Indigenous person to reliably serve on JHREC.

Healthcare Standards, Quality and Financing

19. In my view Victoria's heavily disaggregated and privatised prison healthcare system has been disastrous for justice health. I am aware of at least one instance in which a private provider has attempted to restrict DJCS access to prison health data, based on the view that under the prevailing contract the private provider 'owns' these data. Although this seems to reflect some failures of contract management, in my view the larger issue is that sensitive data on the health of people held against their will by the state should *never* become the property of the private sector.

20. The conversation around privatisation should distinguish between private (for-profit) companies and subcontracting to community providers. I am a big supporter of having community providers involved and providing culturally safe healthcare, but that is distinct from outsourcing to profit-focused private companies. Nevertheless, a balance must be struck between contracting (a potentially large number of) services to locally-based community providers, and avoiding excessive disaggregation of service delivery that creates inefficiencies, complicates coordination across the sector, or impedes quality maintenance and improvement.

Challenges with Medicare and PBS

21. People in prisons and youth detention centres are excluded from Medicare and PBS subsidies, despite this being a notionally 'universal' scheme. Section 19(2) of the *Health Insurance Act 1973* (Cth) operates to prevent double-dipping, so if someone else is picking up the tab for provision of healthcare, then Medicare subsidies do not apply. However, in some instances this can compound inequities. The Health Minister is able to grant exemptions to this clause and there has been long-standing action to try to grant that exemption for people in prisons and youth detention centres. However, to date this has not occurred.

22. In my view, one key reason for the lack of progress on this issue is political. I suspect that there is a perception within state and territory governments that if people in prisons are given access to Medicare and PBS subsidies, the Federal Government will take money away from other state-based initiatives and organisations. In addition, in order to trigger Medicare subsidies under the Act, state and territory governments would arguably need to first acknowledge there are important gaps in the prison healthcare services they provide, such that the additional Commonwealth funding would not constitute 'double dipping'.

23. Having an agreement particular to specific Medicare item numbers and particular medications under the PBS, which are not currently adequately available in custody, would likely be the most practical way to make progress on this issue while mitigating fears of cost-shifting. Among the most critical MBS item numbers would be those relating to Indigenous health checks (MBS items 715, 228, 93470, 93479, 92004, 92016, 92011, 92023) prior to release from prison, and the various items related to mental healthcare plans and services. Regarding the PBS, one key class of medications that is currently very difficult to access in prisons is biologics, which are indicated for the treatment of some autoimmune conditions. These drugs can cost up to $40,000 per year, but on the PBS patients will, from 1 Jan 2023, only pay $30 per month to access these drugs. It is my understanding that, presumably due to the cost, biologics are very difficult for clinicians providing care in prisons to access.

24. In 2018, I chaired a meeting in Darwin on this Medicare/PBS issue and each jurisdiction had a senior health and justice bureaucrat attend. Victoria was the only state without a justice (or justice health) bureaucrat in attendance. Based on this and other meetings with senior bureaucrats in these systems, it is my impression that most jurisdictions are supportive of ending the exclusion of people in custody from Medicare and PBS subsidies. The debate is primarily with regard to details of implementation, rather than whether it is a good idea. I am less sure of the Victorian government's position.

IV HUMAN RIGHTS DIMENSIONS OF HEALTH CARE

25. I am leading a NHMRC-funded study in Queensland looking at rates and causes of death among young people who have had contact with the youth justice system. We found that the rate of death among those who had contact with the system was more than 4 times higher than in the age- and sex-matched general population, with one third of deaths due to suicide. Although the risk of death was greatest for those who had been in detention, it was dramatically elevated even for children who had only ever been charged with an offence. Our findings confirm that the poor health outcomes seen in children after youth detention are not necessarily caused by detention, and that many enter the system with significant pre-existing risk and disadvantage. For these children, custody is a regrettable opportunity to improve health outcomes. Unfortunately, at present this opportunity is largely missed.

V LACK OF CONTINUITY OF CARE UPON RELEASE TO GENERAL COMMUNITY

26. Although it is important to consider reforms to the criminal justice system, this system is in many ways the 'end point' that people reach when other systems have failed: family support, education, housing, mental health, disability services, etc. As such, both preventing incarceration and improving outcomes after incarceration require a system-wide, life course approach. Incarceration is a large, state-funded institution through which typically disadvantaged people pass. Almost all return to the community. Time in detention presents a rare (albeit regrettable) opportunity to identify unmet or underserved needs and initiate care. However, achieving sustained improvements in these outcomes requires close cooperation with community providers, to ensure a smooth transition from custodial to community services.[16]

27. To ensure that any health gains realised during episodes of detention are not lost, it is critical that treatment continue in an appropriate way after people are released from detention[17]

VI TRAJECTORY OF FIRST PEOPLES CHILDREN & YOUNG PEOPLE FOLLOWING RELEASE FROM CRIMINAL JUSTICE SYSTEM

28. Not enough is known about the health-related trajectories of people – including First Peoples – after release from incarceration. What we do know is that rates of preventable death are markedly elevated. In the weeks immediately after release from custody fatal overdose is a key driver of preventable death. Over the medium term, other key preventable causes of death in this population include suicide, unintentional injury, and violence. In the longer term, rates of premature death due to chronic diseases including cancer, asthma, and heart disease are also elevated. Evidence from the Australian Institute of Health and Welfare indicates that the rate of death among Indigenous people released from prison is similar to that for non-Indigenous people.[18] However, given the much higher rates of incarceration among Indigenous people, the elevated rates of mortality seen after release from custody apply disproportionately to Indigenous people.

VII TRANSPARENCY, ENGAGEMENT & ACCOUNTABILITY

29. Having led research in this sector for more than 20 years, and in most Australian jurisdictions as well as internationally, it is my experience and view that Victoria is a particularly challenging environment in which to undertake independent, rigorous research involving the criminal justice system. Victoria's DJCS seems uniquely reluctant to share data about the health of those in custody, or permit independent research or monitoring of these matters. One might argue that 'plausible deniability' is the lesser of two evils: in other words, the criticism levelled at DJCS for its apparent lack of transparency may be less consequential than the criticism that would be levelled if a full and unadulterated view of the system were possible.

30. In a recent national prison benchmarking exercise across Australia that I led, every state provided data. Victoria, after initially providing their data via the Chief Psychiatrist, subsequently withdrew their data at the direction of DJCS. Not long after this, I sat on a panel with the then Deputy Commissioner of Offender Management in Victoria, who extolled the benefits of Victorian prison mental health services. This opacity, and capacity to make such assertions unchecked, distinguishes the Victorian criminal justice system from other states and allows rhetoric to prevail.

[16] Attachment 5, p 1743.

[17] Attachment 7.

[18] See *The health of Australia's prisoners 2018*.

List of documents referred to in outline

- Attachment 1: *Prevalence and correlates of alcohol dependence in adult prisoners vary according to Indigenous status*
- Attachment 2: *The pivotal role of primary care in meeting the health needs of people recently released from prison*
- Attachment 3: Submission to the Productivity Commission's Issues paper on the Social and Economic Benefits of Improving Mental Health*: The role of incarceration in addressing inequalities for people with mental illness in Australia*
- Attachment 4: *Submission to the Victorian Law Reform Commission Inquiry on Improving the Response of the Justice System to Sexual Offences: Reducing trauma among victim-survivors of sexual offences who are involved in the criminal justice system*
- Attachment 5: *Transcript of Evidence: Professor Stuart Kinner and Dr Mick Creati in the Royal Commission into the Child Protection and Youth Detention Systems of the Northern Territory*
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