COMMUNITY COALITION ON CORRECTIONS

AMENDMENTS PROPOSED TO THE *CORRECTIONS MANAGEMENT BILL 2006*

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The following are amendments that the Community Coalition on Corrections proposes should be made to the *Corrections Management Bill* 2006[1] to rectify a lengthy list of serious defects that the Coalition has identified.

The community has been told to expect a family friendly, human rights compliant prison. As it stands, proposed legislation casts a shadow of deep doubt that this will be so. In important respects, the legislative framework of the Bill is inferior even to the inhuman and ineffective NSW system that it was intended to improve upon. The reality of the ACT system must balance the rhetoric.

- We are concerned that citizens who have been detained in the ACT prison should not be returned to the community in a more damaged state; that they will not be more likely to reoffend and cause us to fear them.
- We fear that the opportunity to bring the spirit of Alexander Maconochie to the ACT will be lost and the recidivist rate of 2% he achieved will remain at the present 43%, unless we look afresh at what we are doing.
- We have closed many schools because of the cost and are building the first ACT prison at $130m in order to create a safer ACT. We will pay some $70,000 a year to keep each prisoner incarcerated. For that sacrifice we expect something far better than the NSW system.

The Community Coalition on Corrections was established in 2000 to examine corrective service issues in the ACT, including the establishment of an ACT prison and the functioning of the existing remand system. It is made up of about 20 non-governmental organisations involved in service provision, advocacy or both, for or on behalf of people incarcerated in correctional centres. The organisations are from a cross-section of the community, including church groups, the health sector, alcohol and other drug services, prisoner's support groups and youth representatives.

The following amplifies amendments proposed in the submission dated April 2007 on the Bill by the ACT Council of Social Service. The Coalition endorses that submission. In particular, it supports the following recommendations in that submission of issues that this paper does not consider.

Section 40 on food and drink:

- Inclusion of a legislative right to nutritious and varied food and continuous access to drinking water.

1. The Corrections Management Bill 2006 is available at http://www.legislation.act.gov.au-/b/db_27985/current/pdf/db_27985.pdf and its explanatory statement at http://www.legislation.act.gov.au/es/db_27988/current/pdf/db_27988.pdf.

Regarding cl. 41 on clothing:

- Legislative right of remandees to wear their own or other inconspicuous clothing;
- Legislative right of prisoners to wear their own or other inconspicuous clothing when permitted to be outside.

Regarding cl. 47 on telephone calls:

- A right to more than one telephone call a week;
- Removal of requirement that telephone calls to family be "necessary";
- Placing right of detainees to have telephone contact with their support network on the same level as their right to have contact with their family;
- Extending the definition of family to include indigenous family networks.

Regarding cl. 50 on contact with accredited people:

- Need for clarification on the qualifications and appointments of official visitors;
- Right of inspections not to be confined to "reasonable times";
- Elimination of grounds for denial of contact with accredited people;
- Legislative guarantee of right of detainees to private telephone access to accredited people.

1 HEALTH SERVICES ARE ANSWERABLE TO THE CORRECTIONAL AUTHORITIES AND NOT TO THE DEPARTMENT OF HEALTH

Health services in the prison should be appointed by and answerable to the Department of Health and not the Department responsible for corrections as the Bill provides.

> It is the "the chief executive" of the Department of Justice and Community Safety and not of the Department of Health who, under cl. 21(1) "must appoint a doctor for each correctional centre." The terms of conditions of the appointment of the doctor, including powers of dismissal and reappointment, are thus in the hands of an authority that may have an interest in not accepting the doctor's professional advice.
>
> Nurses and other medical professionals whose role in maintenance of health treatment in the prison will also be crucial are in an even more subservient position to the correctional authorities. There is not the guarantee that they are to be employed in only therapeutic duties as cl. 21(1) provides for the doctor. Indeed, the only reference to the appointment of other health professionals is in cl. 22 in connection with their performance of non-therapeutic functions like body searching under cls. 115-16 and in future regulations made under cl. 52(4).

On the other hand, the Corrections Coalition welcomes the obligations in cl. 52 on the correctional authorities to ensure that detainees have access to those health services.

The importance of separately administered prison health systems is widely recognised. It flows from the poor health status of prison populations and the tension that can exist between the physical and mental well-being of this population and the general administration of the prison.

The AMA has an unequivocal position on the subject.

> "Every correctional facility health care service in Australian states and territories should be a part of the general health system and independent of Departments of Corrective Services or their equivalent" (AMA 1998 §2.1)

The Bill would place the ACT prison system behind rather than in front of New South Wales. In New South Wales, prison health services are provided by Justice Health which is separate from NSW Corrections. The principle of independent health services for prisons is reflected in human rights instruments and reports. Examples include:

(a) Rule 22 of the Standard Minimum Rules provides that 'The medical services should be organised in close relationship to the general health administration of the community or nation.'

(b) The European Committee for the Prevention of Torture has stressed that 'it is important that [medical] personnel should be aligned as closely as possible with the mainstream of health care provision in the community at large.'

(c) The Nagle Royal Commission in NSW recommended that health services to inmates be provided by the NSW Health Department, rather than the NSW prison authorities. Justice Health (NSW) was subsequently established in NSW as an independent statutory health corporation. In NSW, medical practitioners are appointed by the CEO of Justice Health, and are under the direction and control of the CEO. The corporation is answerable to the Minister for Health.

(d) The most important recent Australian statement of the need for separation of health from corrections is found in recommendation 13 of the first report of the Senate Select Committee on Mental Health of March 2006. Because of the high percentage of the general prisoner population with mental disorders, that committee recommends that state and territory governments "Transfer responsibility for mental health in general prisons to the department within each state or territory with portfolio responsibility for health" (Senate 2006).

2 NO PROVISION FOR THE REVIEW OF DECISIONS OF CORRECTIONAL AUTHORITIES HAVING ADVERSE IMPACTS ON THE HEALTH OF DETAINEES

The Bill contains no realistic means for the resolution of differences of opinion on health issues between health professionals and correctional authorities. Such issues can arise in the context of a particular prisoner (e.g. the prisoner's segregation under cl. 91) or of the impact of a prison practice on the health of detainees generally.

The correctional authorities may, for example, disregard a direction of the doctor "to protect the health of detainees (including preventing the spread of disease at correctional

centres)" if he or she "believes, on reasonable grounds, that compliance would undermine security or good order at the correctional centre" (cl. 21(5)).

Theoretically, administrative review of a decision of the correctional authorities may be sought by a person affected by the decision or a complaint may be made to the Human Rights Commission or Ombudsman. That course is unlikely to be a timely or effective means of resolving the concerns of a health professional. An administrative procedure should be in place to resolve promptly disputes between health professionals and correctional authorities or ultimately for them to be resolved at Cabinet level.

Provision should be thus be made in the Bill for a standing consultative arrangements to resolve differences of professional opinion relating to health matters.

3 ACCESS BY HEALTH PROFESSIONALS NOT GUARANTEED

There is no general right of access of the medical staff to the prison and detainees. As the Bill stands, the doctor appointed under cl. 21 for the care of the prisoners would be subject to directions of the correctional authorities.

There is no provision equivalent to s. 236B of the Crimes (Administration of Sentences) Act 1999 (NSW) giving a right of access by the prison doctor etc:

> the Chief Executive Officer, Justice Health, is to have free and unfettered access at all times to all parts of the correctional centre, to all medical records held at the correctional centre and to all offenders held in custody in the correctional centre.

4 HEALTH WORKER-PATIENT CONFIDENTIALITY NOT SECURED

There seems to be no provision to ensure that health records of prisoners are kept confidential from the prison authorities. Those delivering health services should follow professional standards of patient confidentiality. Without this being openly recognised and respected by the correction authorities, health care within the prison will be severely compromised because prisoners will be reluctant to communicate with prison medical staff. The example of New South Wales should be followed where the prison health service is by statute entrusted with "keep[ing] medical records of offenders and other persons in custody" (s. 236A(d), *Crimes (Administration of Sentences) Act* 1999 (NSW)).

The Bill creates a situation whereby the medical staff would be operating in an ethical nightmare. By virtue of health services being placed under the authority of corrections, the Bill puts them under the direction of the custodial staff who are thus in a position to demand that medical staff ignore the basic principles of confidentiality in health care. They will be able to threaten medical staff with dismissal if they do not comply with requests to report on or collect information of a personal nature which the custodial staff desire to obtain for intelligence for corrections.

The obligation to protect confidentiality should be recognised as applying to all who provide health services and not just medical practitioners.

There is explicit provision in clause 76 for correctional authorities to access health records from outside the prison and no provision for the confidentiality of medical records made by the doctor appointed under cl. 21.

> Clause 76:
>
> (1) For this Act, the chief executive may ask a relevant chief executive for a written report about a detainee's health.
>
> (2) The relevant chief executive must comply with the request as soon as practicable.
>
> Compliance with a request for information is an obligation, not a discretion. The government intends this clause to be a lawful authority for health agencies to provide health records about detainees without having to decide compliance with the privacy principles (Explanatory statement, p. 36).

The lack of confidentiality is justified on the ground of coroners' reports:

> Over many years coroners and courts have expressed the need for corrections agencies to know about the health of detainees in order to avert a crises [sic], or to respond to one. (Explanatory statement, p. 36)

The therapeutic doctor appointed under cl. 21 is required to prepare from the medical records a "health schedule" about the detainee (cl. 76(4)).

The only confidentiality requirements in the Bill applying to medical records relate to:

(i) the power in the correctional authorities to limit access within the correctional setting: i.e. to limit "the people who may access the health schedule and the circumstances for access" (cl. 76(6)(b)).

(ii) the general obligation in cl. 221 not to disclose "protected information" outside the correctional setting. This is subject to a power in the chief executive to authorise "the divulging of protected information about a person if the chief executive believes, on reasonable grounds, that divulging the information is—

> (a) necessary to protect someone whose life or safety is in danger; or
>
> (b) otherwise in the public interest. (cl. 221(5)).

4.1 The health schedule

For the safety of the detainees themselves, there is a need for certain medical information about detainees to be made known to security staff. Diabetes and epilepsy are examples given in cl. 76 of the Bill. Likelihood of self harm is another example. There is no doubt that specific conditions and assessments of this sort should be included in the health schedule but what the Bill specifies should be included in the schedule goes well beyond these matters. The schedule is to include a summary of "the detainee's conditions" which would negate medical confidentiality across the board.

Cl. 76(5) states that the health schedule should contain "a summary" of:

> (a) the detainee's condition and health risks, including any likelihood of the condition resulting in a medical emergency or the onset of significant health problems and any associated symptoms; and
>
> (b) a treatment regime for the detainee.

4.2 Case management plans

Like health schedules, the correctional authorities may require under cl. 77(3)(e) that case management plans include a statement of "the detainee's health condition" which could well be far in excess of what is relevant for the purpose that the plan is intended to serve. A statement of risks and associated treatment regime that is also specified in cl. 77(3)(e) would seem to be sufficient.

4.3 Amendments proposed:

(a) external medical records should be provided to the therapeutic doctor not to correctional authorities;

(b) contents of health schedules and case management plans should be limited to what in the opinion of the therapeutic doctor the correctional staff need to know to ensure the safety of the detainee. (Note that the power of the doctor under cl. 21(2)(b) to give directions "to protect the health of detainees" may also be relevant to promote this same objective and reduce the need for some detail to be included in the health schedule and case management plan);

(c) statutory protection of the confidentiality of both the medical records provided to the therapeutic doctor and those records assembled by the medical staff; and

(d) medical staff including the doctor to be appointed by health, not correctional authorities.

4.4 Background

The disclosure of complete medical records to the correctional authorities is unnecessary and was not recommended by the Royal Commission into Aboriginal Deaths in Custody. Privacy and confidentiality of detainees is to be compromised only "so far as is consistent with their proper care".

At the same time confidentiality needs to be qualified in the interests of inmates to ensure that those delivering health services share information with corrective services so as to provide appropriate care. This may extend to information about medication, those with behavioural problems and, in particular, inmates at risk of self-harm. In the words of the Royal Commission into Aboriginal Deaths in Custody:

> "The private right of the prisoner in maintaining the confidentiality of such information must be balanced against the public interest in corrections authorities being granted access to medical information which directly affects their ability to adequately discharge their duties towards the prisoner. This public duty of care may extend beyond the provision of adequate medical attention to the individual prisoner concerned. If a particular prisoner has a medical condition pre-disposing him or her to epileptic seizures or sudden outbursts of violence, such matters would potentially affect the well-being of other prisoners and prison officers. They would properly be taken into account in assigning work to that prisoner and in the general matters of classification and supervision" (RCIADIC §24.4.71).

Under present arrangements in the ACT this is done. There are weekly meetings of a detainee review committee which monitors all inmates for risk of self harm. The

following from rec. 152 of the Royal Commission into Aboriginal Deaths in Custody should be implemented for all inmates:

> e. The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care;
>
> f. The establishment of detailed guidelines governing the exchange of information between prison medical staff, corrections officers and corrections administrators with respect to the health and safety of prisoners. Such guidelines must recognise both the rights of prisoners to confidentiality and privacy and the responsibilities of corrections officers for the informed care of prisoners. Such guidelines must also be public and be available to prisoners; and
>
> g. The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:
>
> i. persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;
>
> ii. intoxicated or drug affected persons, or persons with drug or alcohol related conditions;
>
> iii. persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or heart disease;
>
> iv. persons who have made any attempt to harm themselves or who exhibit, or are believed to have exhibited, a tendency to violent, irrational or potentially self-injurious behaviour;
>
> v. apparently angry, aggressive or disturbed persons;
>
> vi. persons suffering from mental illness;
>
> vii. other serious medical conditions;
>
> viii. persons on medication; and
>
> ix. such other persons or situations as agreed.

5 CORRECTIONAL AUTHORITIES CAN OVERRIDE MEDICAL ADVICE ON TRANSFER TO EXTERNAL HEALTH FACILITIES

By clause 53, the correctional authorities have power to override the advice of the prison doctor that a detainee should be transferred to an external health facility:

> (1) The chief executive may direct that a detainee be transferred to a health facility at a correctional centre, or outside a correctional centre, if the chief executive believes, on reasonable grounds, that is necessary or desirable for the detainee to receive health services at the facility.

(2) The chief executive must have regard to the advice of a doctor appointed under section 21 (Doctors—health service appointments) when considering whether to make a direction under subsection (1).

6 THE BILL PROVIDES FOR UNETHICAL COERCIVE MEDICAL INTERVENTIONS

The Bill should not, as it does, empower the correctional authorities to order a doctor to carry out procedures without the consent of the detainee concerned and for reasons other than the treatment of a serious medical condition. This arises in the conduct of drug and alcohol testing ordered by the correctional authorities (cl. 133) and applying restraint or administering drugs to prevent escape (cl. 139(4)). The issue also arises in the doctor's conduct of a body search with a nurse present, not only in the event that a detainee has ingested or inserted something in his or her body "that may jeopardise the detainee's health or wellbeing" (cls. 115 & 116) but also in the event that the detainee has:

- "a prohibited thing concealed in or on the detainee's body that may be used in a way that may pose a risk to the security or good order at a correctional centre; or
- "has evidence of the commission of an offence or disciplinary breach concealed in or on the detainee" (cl. 115).

The AMA position statement is clear that such compulsory searches are unethical:

> "5.2 Medical practitioners should not perform body cavity searches to obtain evidence or to retrieve substances for evidentiary purposes.
>
> "5.3 Medical practitioners may perform body cavity searches on non-consenting prisoners or detainees only when, in the opinion of the attending medical practitioner, the life of the prisoner or detainee is likely to be endangered" (AMA 1998).

Position statement of the International Council of Nursing on the role of nurses in the care of detainees and prisoners is to similar effect. It states that:

> "Nurses employed in prison health services do not assume functions of prison security personnel, such as body searches for the purpose of prison security" (ICN 2006).

Consistently with the position of the AMA and the International Council of Nursing, New South Wales legislation permits compulsory medical treatment to save life or prevent serious damage to health but not otherwise:

> "A medical practitioner (whether that practitioner is a medical officer or not) may carry out medical treatment on an inmate without the inmate's consent if the Chief Executive Officer, Justice Health is of the opinion, having taken into account the cultural background and religious views of the inmate, that it is necessary to do so in order to save the inmate's life or to prevent serious damage to the inmate's health" (s. 73 *Crimes (Administration of Sentences) Act* 1999).

The only appropriate conclusion is that compulsory medical interventions that do not have a therapeutic purpose should be prohibited.

7 THE BILL PERMITS SOLITARY CONFINEMENT AS A DISCIPLINARY MEASURE WHICH IS BOTH INHUMANE AND MEDICALLY HARMFUL

The Bill allows solitary confinement as a disciplinary measure even though this is likely to have serious impacts on the health of detainees. This should not be allowed.

Under cl. 186, the correctional authorities can order separate confinement "as an administrative penalty for a disciplinary breach" (cl. 186(1)). "Separate confinement" is defined in cl. 150 as "confinement of the detainee in a cell, away from other detainees." Separate confinement as an "administrative penalty" may be for 3 days, 7 days or 28 days (cl. 183(d).

Solitary confinement can have serious impacts on the physical and mental health of detainees. In the words of the AMA position statement on health care of prisoners and detainees:

> "Solitary confinement, defined as a correctional facility regime in which a prisoner or detainee is confined separately from other prisoners or detainees as a means of punishment, is inhumane. Solitary confinement is medically harmful as it may lead to a number of physical and/or mental disorders" (AMA 1998 §6.1).

According to Dr Paul Mullen of Forensicare in Victoria:

> "The correctional culture and the physical realities of prisons are rarely conducive to therapy. . . . Separation and seclusion are all too often the response of correctional systems to troublesome prisoners, irrespective of whether those difficulties stem from bloody mindedness, distress, mental disorder or even suicidal and self damaging behaviours."

The Bill seeks to involve the therapeutic doctor in the process. He or she is to examine the detainee at the beginning and end of the confinement (cl. 186(2)(a)) but the clause does not oblige the correctional authorities to heed the doctor's advice. Moreover, there is no obligation to provide continuing medical assessments during the period of separate confinement. Monitoring during confinement is to be undertaken "at least daily" by a corrections officer and there is no provision for monitoring by a health professional (cl. 186(2)(b)).

8 OTHER SEGREGATIONS ARE PERMITTED WITHOUT CONSISTENT REGARD TO THE HEALTH AND WELL-BEING OF DETAINEES

Health and well-being should be a mandatory consideration for all the many grounds for segregation provided for in the Bill. Correctional authorities should be obliged to avoid separate confinement wherever possible and to take into account the advice of the doctor in all cases, not just in the case of segregation on the grounds of safety and health.

The AMA position paper on health care of prisoners and detainees acknowledges that separation of detainees may be required for the safeguard of detainees from self-harm, harm by other prisoners or detainees or because of infection but adds:

> "Where this results in the prisoner or detainee being isolated from all other prisoners or detainees, the isolated person should be provided with the opportunity to have regular contact with people outside the correctional facility environment, either face-to-face or by telephone" (AMA 1998, §7.3).

Decisions by the correctional authorities to order segregation may occur:

1) for "the safety of anyone else at a correctional centre; or security or good order at a correctional centre". (cl. 89(1));
2) for the protection or safety of the detainee (cl. 90(1));
3) on grounds of health (cl. 91(1));
4) by a correctional officer who believes that the detainee has committed a breach of discipline (cl. 155(2)(d));
5) by an investigator who is given a report about an alleged disciplinary breach by the detainee (cl. 156(2)(f));
6) by an administrator who is given a report about an alleged disciplinary breach by the detainee (cl. 157(2)(g));
7) by the chief executive for the purpose of investigation if, among other things, he believes that there is a danger that the association of a detainee with others would "undermin[e] security or good order at a correctional centre" (cls. 159 & 160).

"Health and wellbeing of the detainee" is a consideration in ordering segregation under cls. 89 & 91 (safety and health) but is not mentioned as a consideration for the making of the order or for the type of segregation ordered under cls. 90, 155, 156, 157 and 159-60.

8.1 Need for segregation should be avoidable

Recourse to punitive and damaging segregation can and should be avoided with community building strategies. The concept of the Inmate Development Committee that is provided for in NSW should be incorporated in legislation. Segregation involves isolating people from the prison community just as they have been isolated from the broader community. Rather than the punitive approach of segregation, the ACT should take the opportunity that prison provides to deal with behavioural problems. Further punishment only makes things worse.

9 THERE IS AN OBLIGATION TO LIMIT EXPOSURE OF DETAINEES TO RISK OF INFECTION BUT NOT TO RISK OF INJURY

Cl. 52(1)(d) obliges the correctional authorities to "ensure that as far as practicable, detainees are not exposed to risks of infection." There should also be an obligation not to expose detainees to injury.

Cl. 52(1) contains a set of admirable obligations on the chief executive regarding protection of the health of detainees but it does not specifically cover exposure to injury. Whole of body X-ray scans used in searching can have severe cumulative effects on those exposed to them and on their unborn children. It is understood such scanning is currently on trial at the Belconnen Remand Centre.

10 THE BILL IMPOSES AN OVERRIDING COERCIVE REGIME THAT DOES NOT REFLECT ACT AND NATIONAL DRUG POLICY

As it stands, the Bill would permit the exercise of discretions in ways contrary to the ACT and national drug strategies. The Bill should reflect ACT and national drug strategies by including among its objectives the minimisation of harm associated with drug (including alcohol) use in prison. The terms "harm minimisation" and "harm reduction" are not used in either the Bill or its explanatory statement.

Much of the Bill establishes an elaborate coercive structure of searching, drug testing, segregation, discipline and banning visitors to provide correctional authorities with the tools thought necessary to keep drugs out of the prison. Embedded in this is an equally vast set of discretions. The success of the prison will stand or fall on how the correctional authorities exercise those discretions. Granting discretions is, of course, unavoidable but the standard practice is for legislation to lay down parameters for their exercise and these are given effect to by courts in, for example, determining whether a decision maker has taken an improper matter into consideration.

The Bill itself and its aid to interpretation, the explanatory statement, are replete with guidance for decisions by the correctional authorities such as:

- the statement in the preamble about corrections being "as punishment, not for punishment";
- the statement in the object section (cl. 7) that detainees should be "treated in a decent, humane and just way"; and
- the disturbing statement in cl. 8 that "ensuring that public safety" is not just an important consideration but is "the paramount" consideration that can trump all others.

Taken in isolation, as the correctional authorities would be entitled to do in exercising their discretions, the scheme of the Bill and its explanatory statement focuses only on supply reduction. This would seem to be based on three false assumptions:

- that it will be possible for the ACT prison to do what no other prison has, to exclude substantial amounts of drugs from being available in it; and
- that continuing drug use is the paramount harm necessarily leading to disease and dysfunctionality; and
- that the coercive prison regime can put an end to the chronic relapsing condition that addiction is.

These assumptions are most clearly reflected in the explanatory statement. It refers in three places to the "serious problems in prisons" that "illicit drugs" pose:

> "Drug use can cause death or serious illness (through overdosing), spread blood borne viruses and diseases such as AIDS/HIV and Hepatitis B and C (through shared use of dirty needles), react badly with prescribed drugs, cause violent behaviour, jeopardise rehabilitation, and impact negatively on families" (explanatory statement 34, 55 & 85 quoting *Alexander Maconochie Centre Functional Brief 2005* p. 49).

The assumption that the use of illicit drugs necessarily entails many of these consequences is plain wrong. Harm reduction recognises that the response to illicit drug use can minimise if not eliminate nearly all of those serious consequences. Addiction itself, whether to a licit or an illicit substance, falls within the definition of "disability" in s. 4 of the Commonwealth *Disability Discrimination Act* 1992 (*Marsden v. Human Rights and Equal Opportunity Commission and Coffs Harbour and District Ex-Servicemen and Women Memorial Club Ltd* [2000] FCA 1619 (15 November 2000)). Injecting drug use does not necessarily lead to AIDS/HIV and hepatitis. There are steps that can eliminate death and acquired brain injury from overdosing. People who remain addicted can live responsible, stable lives. There are less harmful licit drugs that psychotic users of potent stimulants may continue using while stabilising themselves.

These assumptions are reflected in the ACT and National Drug Strategies which speak of harm reduction and non-coercive demand reduction as well as supply reduction. It is vital that the balanced interplay of the three pillars of Australian drug policy be included among the objectives in the Bill and the explanatory statement. As it stands, the Bill would appear to permit the exercise of discretions in ways contrary to the ACT and national drug strategies.

Without a reference to harm minimisation within the Bill and its explanatory statement as an aid to the Bill's interpretation, discretions are likely to be interpreted in a way that gives primacy to abstinence over the general health and well-being of detainees. Such a restrictive interpretation would make it difficult if not impossible, without legislative amendment, to give effect to recommendations of the Australian Medical Association and the United Nations Office on Drugs and Crime to combat blood borne diseases as well as harm minimisation drug policies generally.

Statements of the Australian Medical Association

The AMA has made the following statements on health care in prisons:

> "The AMA acknowledges that mandatory testing of prison inmates will not, on its own, prevent the transmission of these infections in prisons. Effective prevention among prison populations requires the establishment of preventive education programs, needle exchange for intravenous drug users and safe sex programs for those who engage in high-risk sexual behaviour. Prisoners and detainees have the same right to access, equity and quality of health care as the general population. The AMA considers that appropriate arrangements for proper care for prisoners found to have these infections should be made and that prior to release, effective community follow-up should be organised" (AMA 2004, §4.13).
>
> "8.5 Mandatory testing of prisoners or detainees will not, on its own, prevent the transmission of blood-borne and sexually transmitted infections. Effective prevention among correctional facility populations includes the establishment of preventative education programs, needle-exchange programs, methadone programs, and safe-sex programs as found in the general population.
>
> "8.6 Pre-test counselling and testing for blood-borne and sexually transmitted infections should be available to all prisoners and detainees.

> "8.7 All prisoners and detainees should be offered immunisation for Hepatitis B and other similarly preventable infectious diseases" (AMA 1998).

United Nations Office on Drugs and Crime (UNODC)

The United Nations Office on Drugs and Crime has called on governments to:

> "Ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are also available in prisons. This should include providing access to the full range of prevention commodities to prevent HIV transmission through unsafe sex, needle sharing, unsafe tattooing, and joint use of razors in those countries where these measures are available in the outside community, e.g., condoms, sterile needles and syringes, razor blades and sterile tattooing equipment. HIV prevention measures should be accessible in a confidential and non-discriminatory fashion" (UNODC 2006, rec. 60, p. 24).

The extent to which correctional authorities may have recourse to the following powers and mechanisms in the Bill will depend on the drug policy that they intend to implement. A coercive, supply reduction focus provided for in the Bill and explanatory statement as they stand will have frequent recourse to:

- compulsory drug testing with the goal of policing drug use,
- the searching of detainees and visitors including strip searching and exposure to harmful radiation,
- the banning of visitors.

A harm reduction approach with a focus on the health and well-being of the detainee would aim to provide:

- the carrot of first class drug abstinence based and substitution treatments;
- the constrained recourse to coercive measure;
- the applications of coercive measures in a differential way that serves to shepherd detainees who still use illicit drugs from more harmful to less harmful ones and from more harmful to less harmful means of consumption (e.g. from injecting to swallowing).

Discretion regarding exercise of the following coercive measures would be greatly affected by the governing drug policy.

10.1 Drug testing

10.1.1 Drug testing on admission

The chief executive may direct the detainee, orally or in writing, to provide a test sample (cl. 68(1))

The power is linked to initial assessments in cl. 66 "to identify any immediate physical or mental health, or safety or security, risks and needs"(cl. 66(1)(a)). The assessment is thus envisaged as going beyond the health needs of the detainee. If health of the detainee was the overriding consideration, the decision to test should be in the hands of the therapeutic doctor and be subject to the consent of the detainee.

What purpose is drug testing expected to achieve?

10.1.2 Targetted drug testing

(1) The chief executive may direct a detainee to provide a stated kind of test sample.

(2) The chief executive, or a doctor, or nurse, appointed under section 22 (Health professionals—non-therapeutic functions), may give a detainee a direction about the way a detainee must provide the test sample (cls. 133(1) & (2)).

10.1.3 Random drug testing

There is a power in the chief executive to order random testing "for detecting alcohol or drug abuse" (cl. 220(1)) with names not recorded. The Bill states this is "only for statistical purposes". In contrast, the explanatory statement makes clear that the information could be used for management of prison security:

> "This power enables corrections centres to check for the presence of illicit drugs in the centre" (explanatory statement p. 85)

10.1.4 Method of testing

The method of testing is not specified in any of the foregoing provisions, leaving it open to justify taking blood samples.

10.2 Non-therapeutic focus of drug testing

Drug testing is divorced from decisions by health professionals about what is in the best interests of the detainees' well-being. It is unethical for doctors to participate in this testing.

- Decisions to submit detainees to drug testing are made by the chief executive (cl. 133(1));
- They are to be carried out by health professionals that carry out non-therapeutic functions (cls. 133(3)(b), 220(1)).

Prison authorities can take a positive drug test (including a failure to provide) into account in decisions about the management of detainees:

> "The chief executive may have regard to the positive test sample in making any decision in relation to the management of the detainee under this Act (cl. 134(2)).

Failure to submit to a drug test is a disciplinary breach when a detainee is directed to do so (cl. 151(a) & example)

> "Examples of contravening chief executive directions— (a) failing to comply with a direction by the chief executive to provide a test sample or submit to a search under this Act".

It is "the Executive" - not the health authorities - that is empowered to make regulations relating to "alcohol or drug testing". Regulations on this subject fall within the category of regulations on the "management and security of correctional centres" (cl. 228(2)(g)(x)).

10.3 Strip Searching & Body searches

10.3.1 Strip searching

Cl. 69 provides for strip searching on admission: "the chief executive may direct the detainee, orally or in writing, to submit to a strip search." (cl. 69(1)).

Procedures for carrying out strip searches are laid down in cls. 112-15.

10.3.2 Body searching

Body searching provided in cl. 115 that is carried out without the consent of the person being searched is unethical. See heading 6 above.

The AMA Health's position statement on care of prisoners and detainees mentioned under heading 6 adds that "Body cavity searches should be performed by medical practitioners only" (§5.1).

Clause 115 reads:

> The chief executive may direct a doctor appointed under section 22 (Health professionals—non-therapeutic functions) to conduct a body search of a detainee if the chief executive suspects, on reasonable grounds, that the detainee—
>
> > (a) has ingested or inserted something in the detainee's body that may jeopardise the detainee's health or well-being; or
> >
> > (b) has a prohibited thing concealed in or on the detainee's body that may be used in a way that may pose a risk to the security or good order at a correctional centre; or
> >
> > (c) has evidence of the commission of an offence or disciplinary breach concealed in or on the detainee.

10.4 Searching of and banning visitors

Attempted enforcement of a coercive abstinence based regime would lead to the thorough search of visitors and, in many cases, the banning of visitors under cls. 146 and 147. Taken to its logical extreme, the demands of minimising the risk of contraband entering the prison would lead to widespread bans on family visits which would undermine a policy of fostering family links and nullify the work of the Standing Committee on Community Services and Social Equity in its report on *The forgotten victims of crime: families of offenders and their silent sentence* (June 2004).

11 NO PROVISION IS MADE FOR SYSTEMATIC INDEPENDENT INSPECTION AND MONITORING OF PRISON CONDITIONS AND PRISON HEALTH SERVICES

The Bill makes no provision for the systematic monitoring and review of prison conditions including review of health services in the prison. The Bill creates an authoritarian structure with only limited and *ad hoc* provision for outside independent inspection. Provision should be made for a standing community Prison Advisory Board with a mandate to call for information and make inspections and for an independent expert monitoring of the well-being of detainees and the health service within the prison.

As it stands, the Bill provides for inspection by people such as a judge, the human rights commissioner and the ombudsman (cls. 55 & 61). Their inspections may be carried out

only in accordance with directions made by the correctional authorities (cl. 61(4)) or regulations made by "the Executive" (cl. 228(2)) or only when it would be "reasonable" to do so (cl. 55(2)). An effective independent system of inspection is vital. Judging by the levels of violence inside and recidivism, NSW experience shows that inspection by the ombudsman and official visitors (who are not independent) are ineffective.

The isolation and degree of authoritarian autonomy of the prison regime are in stark contrast to limited authority of the generality of other branches of government which interact with each other and with non-governmental organisations in the provision of services to overlapping clienteles. Because prisons involve holding people in custody against their wishes, a reasonably authoritarian structure is probably necessary. That is all the more reason that a standing system of monitoring and review of the prison should be provided for by statute. Isolation should be minimised and transparency maximised.

To combat abuse in prisons, the international community has recognised the need for "non-judicial means of a preventive nature, based on regular visits to places of detention" of the sort that is now provided for in the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the UN General Assembly on 18 December 2002. This treaty calls for national preventive mechanisms which should ". . . be granted at a minimum the power:

> "(a) To regularly examine the treatment of the persons deprived of their liberty in places of detention as defined in article 4, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment;
>
> "(b) To make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture and other cruel, inhuman or degrading treatment or punishment, taking into consideration the relevant norms of the United Nations;
>
> "(c) To submit proposals and observations concerning existing or draft legislation" (art. 19).

Provision should be made for independent systematic monitoring and review of the new ACT prison by providing for:

- A standing community Prison Advisory Board with a mandate to call for information and make inspections;
- An independent expert monitoring of the well-being of detainees and the health service within the prison.

11.1 Prison Advisory Board

As had once been contemplated, there should be a Prison Advisory Board. It should have competence to carry out inspections and inquiries. It should have community representation from those interested in and knowledgeable about corrections. It should seek to ensure that there is a high level of prisoner and public consultation on all aspects of the prison. This should provide comment on corrections policies and procedures.

The value of this sort of representative body for prisons is stressed by the United Nations Office on Drugs and Crime in the context of HIV/AIDs prevention:

> "The development and implementation of policies and initiatives to address HIV/AIDS in prisons should . . . involve input and support from relevant international bodies and organizations; all levels of national government (including those with responsibility for public health issues and medical services; prisons and places of detention; legislative frameworks; law enforcement and the courts; and the cultural, social and economic environments that affect those individuals and communities most vulnerable to HIV/AIDS and incarceration), civil society organizations (including non-governmental and community-based organizations, and those providing services for prisoners and former prisoners); prison staff and their representative organizations; researchers, and relevant professional organizations. It must also recognize the important role and expertise of prisoners and former prisoners, the families and friends of prisoners, and people living with HIV/AIDS, and provide mechanisms for their meaningful participation throughout the process of developing and implementing legislation, policy, and programmes" (UNODC 2006, p. 13).

11.2 Expert health monitoring and advisory system

The very poor health status of prison populations calls for a standing system of independent expert monitoring of the well-being of detainees and the health service within the prison. The need for this for the ACT is accentuated by the absence of a health service independent of the correctional authorities and of a statutory mandate such as that of NSW Justice Health "to monitor the provision of health services in managed correctional centres" (s. 236A(b) *Crimes (Administration of Sentences) Act* 1999 (NSW)).

The need for a system of surveillance of well-being of the prison population is recognised by United Nations Office on Drugs and Crime in a 2006 publication, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response,* co-published with the World Health Organization and the Joint United Nations Programme on HIV/AIDS. It makes the point that:

> "Reform of prison legislation and policy, while essential, is therefore not sufficient on its own. Governments and prison systems must take the steps necessary to implement legislation and policy 'on the ground', and to ensure that these reforms are successful in achieving the objectives of improving the living conditions of prisoners, the quality of prison health services, and the working conditions of prison staff.
>
> "Therefore, regular reviews and quality control assessments – including independent monitoring – of prison conditions and prison health services should be encouraged by both national and international bodies as an integral component of efforts to prevent the transmission of HIV in prisons and to provide care for prisoners living with HIV/AIDS. This should include the development of public health surveillance systems and/or health care record management systems. Monitoring and evaluation is not only useful for assessing progress in improving the quality of prison health and HIV/AIDS services, it is also useful in securing financial support for prison programmes from national and international donors" (UNODC 2006, p. 14).

12 THE BILL PERMITS OBJECTIVES OF WELL-BEING AND REHABILITATION TO BE OVERRIDDEN UNJUSTIFIABLY BY OVERARCHING ILL-DEFINED CONCERNS FOR SECURITY

In cl. 8(a), the Bill gives wide and unjustified scope for correctional authorities to override the objective of "reformation and social rehabilitation" which should be the "essential aim" of the prison. The Bill does so on the ground of ill-defined and minimal concerns for security.

Australia and the ACT is bound by the International Covenant of Civil and Political Rights to have "reformation and social rehabilitation" as the "essential aim" of its prison system. The Covenant states that:

> "The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation" (art. 10(3)).

The Chief Minister repeatedly emphasised rehabilitation in his speech to the Assembly on the prison in August 2004. Rehabilitation with its associated elimination of recidivism also maximises the economic return for the huge capital cost of the prison and its $70,000 a year running cost per detainee.

Promoting the well-being of detainees is essential to achieve rehabilitation, particularly given the high level of mental health problems including addiction that exist among prison populations.

12.1 Public safety is made the "paramount" consideration

Public safety is made not just one of the key considerations of the correctional services under cl. 8(a) in decision-making about the management of detainees but "the paramount consideration". Moreover, the attainment of "public safety" is described in unqualified terms: not just "adequate public safety". Thus, by cl. 8(a), any element of security risk, no matter how small, could be used to justify a management decision contrary to the rehabilitative or other needs of a detainee.

The term "the paramount consideration" and related ones like "paramount interest" are strong ones confined particularly to legislation dealing with the protection of children and apprehended violence orders. In this Bill the abstract term "public safety" rather than an identified person is made the beneficiary and the interests of the identified person, the detainee, infringed on. Subjecting management of detainees to public safety as a "the paramount consideration" constitutes a ground for overriding much else in the Bill. This interpretation is supported by the explanatory statement. This explains of cl. 8(a) that it :

> ". . . clarifies that public safety is the most important consideration in the management of detainees. The reason for the Act's existence, and the agency's responsibilities under the Act, is to secure relevant people in custody.
>
> "While the Bill is a comprehensive expression of the powers the Territory's correction agency may exercise, it is not possible to foretell every possible crisis a corrections facility may face. The intent of this clause is to ensure that if a decision has to be made regarding the security of the corrections facility — and the law for that decision is not set out in the Act — the corrections agency is obliged to regard public safety as its first task and its ultimate task." (ES, pp. 6-7).

This appears to confirm that the intent of cl. 8(a) is to accord correctional authorities with a near limitless reserve power to do all manner of things in the name of "public safety" in the exercise of discretions under the Bill, except where "the law for that decision is not set out in the Act" whatever that means. It is a fearful provision. Being itself a specific legislative provision, it could, for example, justify management decisions of detainees that are contrary to the *Human Rights Act* 2004.

The concept of paramountcy, combined with "public safety" in unqualified terms, ignores principles of risk management. Virtually no decision to promote health, well-being or rehabilitation generally would be without risk. Paramountcy in cl. 8(a) thus provides correctional authorities with a trump card that they can play whenever they choose to veto implications in favour of those objectives that otherwise would arise under the Bill.

13 DENIAL OF OUTSIDE CONTACT ON THE GROUND OF COMMUNITY DISTRESS

Community distress is set down as a ground for denying telephone contact (cl. 47(6)(d)), mail (cl. 48(5)(d)) and visits from family members and others (cl. 49(4)(d)). The ground could be used to deny particular prisoners in the public eye with outside contact and to frustrate legitimate media investigation into conditions in the prison. Reference to community distress should be deleted.

While the examples given in the Bill, such as advocacy of domestic violence, of what would cause community distress seem justifiable, the term "causing community distress" is far broader and could be used to suppress contact that might reveal that conditions in the prison are distressful. Reference to community distress should be deleted. More limited grounds for denial of outside contact such as advocacy of violence and harassment would seem to be sufficient. Should prisoners be permitted to air grievances to the media? Should a code of conduct for media access to prison and prisoners be developed? Transparency, not hiding the realities of prison from the community should be the guiding principle.

13.1 Denial of telephone contact

By cl. 47(6)(d) correctional authorities have power to deny a detainee telephone contact if they consider the call "may have the purpose of causing community distress".

> *"Example—par (d)*
> "Mr F was imprisoned for intentionally inflicting grievous bodily harm against his former wife. He had been convicted previously of domestic violence offences. He believes he has a right to assault his former wife and advocates the matter is private. Mr F believes that organisations that support victims of domestic violence are a social evil. He begins to use telephone calls to his brother to organise him into inciting violence against organisations advocating women's rights. Following complaints from the organisations, the chief executive denies phone calls between Mr F and his brother."

13.2 Denial of mail

By cl. 48(5)(d) correctional authorities have power to deny a detainee receiving or sending mail if they consider the correspondence "may have the purpose of causing community distress".

"An example of (d) is mail to a journalist, or other individuals, to goad or provoke community feeling by glorifying offending behaviour such as rape, violence, paedophilia etc." (Explanatory statement, p.24)

13.3 Denial of visits from family members and others

By cl. 49(4)(d) correctional authorities have power to deny a visit from family members and others if they believe the visit may "have the purpose of causing community distress". The following example illustrates this provision:

"Example—par (d)
Mr J is convicted of numerous serious sexual offences against young girls. He begins to write letters to various public figures, including journalists, stating that his crimes were motivated by a love for the children and that he intends to change his name to that of one of his victims. He makes arrangements for a visit by a journalist for a story about why he wants to change his name. The chief executive may deny the visit on the ground that it may cause community distress."

"An example of (d) is a visit by a journalist, or other individual, with the intent of goading or provoking community feeling by glorifying offending behaviour such as rape, violence, paedophilia etc." (Explanatory statement p. 25)

14 THERE ARE AN UNACCEPTABLE NUMBER AND BREADTH OF GROUNDS FOR NOT MEETING RELIGIOUS, SPIRITUAL OR CULTURAL NEEDS OF DETAINEES

The Bill allows correctional authorities to derogate excessively from the obligation under cl. 54 to make provision for religious, spiritual and cultural needs of detainees including access to ministers of religion and religious services.

Cl. 54 permits derogations on the following grounds:

1. The core obligations in cls. 54(1) and (2) are qualified by the term "as far as practical".

2. Correctional authorities under cl. 54(3) can deny access if they come to the assessment on reasonable grounds that access may:

(a) undermine security or good order at a correctional centre; or

(b) revictimise a victim; or

(c) circumvent any process for investigating complaints or reviewing decisions under this Act; or

(d) cause community distress.

The issue of meeting religious and spiritual needs must be taken very seriously indeed. Experience in Australia has shown that failure to meet them can lead to serious security issues at detention centres. Denial of the right of religious observance has caused problems with refugees leading to hundreds of thousands of dollars of damage. The imperative to meet cultural needs is less strong.

The explanatory statement notes that "The practicality of providing for religious worship or exercise of spirituality will depend upon the logistics required to meet the needs of the detainee, or detainees" (p. 28). Logistics can depend on the number of staff on sick leave

that day or whether or not a particular room is available because it is being painted perhaps. These are not adequate reasons for stopping a Muslim observing his daily prayer obligations.

By cl. 54(3)(d) the correctional authorities may on grounds of causing community distress deny or limit detainees access to ministers of religion and religious services in the prison. This does not seem justified. Any legitimate interest that the correctional authorities would have in restricting accommodation of religious, spiritual or cultural needs would seem to be more than adequately safeguarded by a further ground of restriction, namely on the ground that access would "undermine security or good order at a correctional centre."

The derogation in cl. 54(3) on the ground of undermining "security or good order at a correctional centre" should be trimmed to the scope described in the explanatory statement. This refers to particular action by detainees to engage in religious or spiritual practices for ulterior reasons; it is cast in the form of an apprehension that "he or she may" engage in that conduct rather than the much broader impersonal "it may" of the Bill. The explanatory statement reads:

> "Clause 54(3) empowers the chief executive to deny or limit a detainee's practice, or request to practice, if the chief executive suspects the detainee will engage in any of the behaviour listed in (a) to (d).
>
> "An example of (a) is the use of religious services to communicate a threat to other detainee. Or the use of religious books or artefacts to hide contraband. An example of (b) is behaviour at a religious service to taunt or harass a victim. An example of (c) is behaviour or communication at a religious service that would pre-empt, prejudice or impair the investigation of a complaint or the conduct of a disciplinary process. An example of (d) is attendance at a religious service with the intent of goading or provoking community feeling, for example making anti-semitic comments at a jewish service" (Explanatory statement, p. 28).

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