Community Coalition on Corrections

Submission to AMC reviews

October 2010

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ABOUT THE ACT COMMUNITY COALITION ON CORRECTIONS

The ACT Community Coalition on Corrective Services is a network of community organisations and interested individuals that has operated since 2000 and taken a close interest in the development of the new ACT prison. The range of its work and steps that is has taken to influence government in the development of a humane and effective corrections system are in a large part documented in submissions and correspondence with the Minister that are available on its website at http://correctionscoalitionact.org.au. Its terms of reference are:

Objectives
The primary objective of the ACT Community Coalition on Corrections is to advocate for the development of a humane and effective corrections system which:

- Seeks to address the systemic social and economic causes of crime;
- Minimises the harm to prisoners' health and wellbeing caused by the prison environment; and
- Rehabilitates and re-integrates offenders into the community; and
- Is transparent and accountable to the community.

Members
The ACT Community Coalition on Corrections is a network of community organisations and interested individuals which engages in systemic advocacy for corrections reform and the rights of prisoners and their families in the ACT. The group includes members from a diverse range of organisations and interests.

Functions
To this end, the Coalition has a number of functions, which include:

- To monitor developments in ACT corrections, including ongoing adherence to the principles on which the Alexander Maconochie Centre was founded;
- To highlight issues faced by detainees and their families;
- To inform Government policy making processes relating to corrections;
- To conduct advocacy on corrections issues through submissions to Government, correspondence with Government Ministers, community forums and media advocacy;

- To enable the exchange of information between members of the Coalition, build relationships between organisations and thereby improve coordinated service delivery to prisoners;
- To provide a forum for relevant community organisations to engage in collaborative projects to secure better outcomes for offenders and the community; and
- To encourage open and positive relationships between all stakeholders in the corrections system.

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OBJECTIVE OF SUBMISSION

1. This submission has the same focus and rationale as the Correction Coalition's study published in April 2008 on mental health and the operational regime of the new ACT prison (its "*Healthy or Harmful?"* Study available at at http://correctionscoalitionact.org.au) the key recommendations of which the Government has dismissed. The submission and study before it argue that the operation of the prison regime must promote improvement in the poor mental health of those detained. To achieve this, the damaging operational regime of the traditional prison must not be replicated in the ACT. This can be achieved only if the regime is designed, operated and monitored with the close oversight of those with a deep understanding of how to promote mental well being. This approach goes beyond what is presently planned for forensic detainees or the treatment of mental illness in the prison population in its Crisis Support Unit or otherwise under the *Adult Corrections Health Service Plan*. Without an environment that promotes mental well being, rehabilitation will remain a pious dream and the new prison a costly institution that further entrenches disadvantage and does little to reduce crime.

2. Imprisonment is a response to crime in the community. It is an expensive response. According to the Productivity Commission it costs $170,236.00 for each detainee per year. If it is to be money well spent it must lead to a substantial reduction in re-offending by those sent to prison. Imprisonment should lead to less crime and fewer victims.

3. This submission is based on the assumption that how damaging or therapeutic a prison is to the mental health of those detained depends principally on how the prison is run. This submission focuses particular attention on the governance issues.

GOVERNMENT'S OBJECTIVES FOR THE PRISON

4. The ACT Government has set high standards against which the performance of the ACT Prison must be judged. The Coalition believes that these should be used as the basis of review of the prison. The Chief Minister articulated the standards in his speech to the Assembly in August 2004 of which the following are quotations:

- The Alexander Maconochie Centre would provide "more secure, humane and safer accommodation". ACT detainees would not be "accommodated with a significantly larger population where violence, assault and power are features of the dominant culture".
- "The prospects for the rehabilitation of ACT sentenced prisoners will be improved"
- "Possibilities for reducing rates of recidivism will be improved" and there would be "reductions in offending behaviour"
- "The health and well being of the ACT prisoner population will be improved"
- Programs would target "reducing drug and alcohol addictions"
- Programs would aim at "making improvements in mental health"

- There would be "minimising [of] self-harm"
- "Improvements in prisoner educational attainments will be targeted" and there would be "improved training and work skills that are appropriate and transferable to the workforce in the Canberra region"
- There would be "smooth re-integration of prisoners back into the ACT community on release"
- "Prisoners will have greater accessibility to, and interaction with, family and other supports to assist in their rehabilitation and to maintain family unity."
- The "risk factors confronting families with children coming into contact with the criminal justice system will be reduced."

5. Thus, compliance with human rights standards is not alone sufficient. Human rights standards are a means to an end and not an end in themselves. The question is whether the prison as it has been constituted and run will promote the objectives identified by the Chief Minister and, more broadly, the well-being of those exposed to the ACT corrections system, their families and the ACT community.

6. This submission reviews in some detail the history of planning for the prison – not the planning of the bricks and mortar but how the prison was to be run and how adequate the arrangements were for the prison to be in a position to deliver the government's social goals. It does this by focusing on how the needs of the largest and most testing prison demography were to be met, those suffering from at least two mental health problems: substance dependency and a second one. The history invites the conclusions that:

- Corrections planners charged with devising programs did not seek to engage the resources and expertise of either the government as a whole or of the community sector but, rather, relied on its own in-house resources;
- Corrections appeared to keep the Corrections Coalition at arms length by brushing aside correspondence and requests to engage in discussion about key issues on basic, non-controversial issues such as throughcare and performance indicators, not to mention the controversial one of a prison needle and syringe program.
- Corrections tended to use the application of the ACT Human Rights Act to the prison project as a public relations exercise to promote the prison rather than as imposing a set of standards that intimately affected every aspect of how the prison was to be run.
- The human and financial resources available to Corrections to plan for the operation of the prison were inadequate;
- The one exception to the tendency of Corrections to keep the community sector at arms length was planning for the development of the Solaris therapeutic program run by ADFACT. This has been financed by the Commonwealth, not the ACT (ADFACT (2008/09)).

- Neither Corrections nor any other ACT Government agency took on responsibility for planning or leadership in co-ordinating the provision of services. Corrections largely rested content with calling for community agencies to volunteer services.
- The community sector rather than Corrections has taken the initiative to put in place operational elements essential for the achievement of the Government's goals: programs such as the Inside/Out Program run by Directions and others listed in §3.5 of the Community Integration Governance Group;
- The ACT has not resourced the community sector to provide rehabilitation services;
- Because of staffing and other difficulties, the prison has not been able to deliver on its commitment to "to ensure each day is a 'busy, active day' based on therapeutic programs, education and training, employment within the AMC and recreation activities" (letter from the Chief Minister dated 22 June 2010).
- There are welcome new signs that Corrections is taking a pro-active role to engage the community sectors.
- The Coalition believes that a core focus of the prison review should be on improving the Corrections governance structure so as to endow it with the competence and confidence to deliver the Government's social dividends as well as the traditional prison objectives of containment and security. Virtually every aspect of the operation of the prison has an impact on the well-being of those detained. The government's mandate was simply too ambitious for the ACT Corrections to deliver.

GOVERNMENT'S RESPONSE TO THE COALITION RECOMMENDATIONS

7. The particular aspects of the prison that the Corrections Coalition wishes to bring to the attention of the review are those concerning the impact of the operation of the prison on the mental health of those detained. These were raised by the Chief Minister in his letter to the Coalition dated 22 June 2010. With one exception, this letter rejected or otherwise dismissed the seven key recommendations of its April 2008 study, *Healthy or harmful? Mental health and the operational regime of the new ACT prison.* The Chief Minister's letter and the Coalition letter dated 29 December 2008 to which the Chief Minister responded are available on the "correspondence" page of the Coalition's website at http://correctionscoalitionact.org.au. The seven key recommendations related to:

1. Adapting the management of the ACT Corrections system to introduce expertise and managerial competence in the delivery of programs essential for the realisation of the ambitious social outcomes that the ACT Government has set for the system;
2. The introduction of a system of dynamic security;

3. Managing addiction as a mental health rather than a disciplinary or criminal issue.

4. According priority to endowing those emerging from the system with the physical and mental capacity to take their place as functional and responsible members of the community;

5. Establishing standing arrangements to monitor and evaluate the effectiveness of the prison by reference to what occurs to people after and not just on their release; and

6. Establishing a seamless set of through care and after care arrangements.

SECURING A MANAGEMENT STRUCTURE CAPABLE OF DELIVERING DESIRED OUTCOMES OF THE ACT PRISON

8. The Corrections Coalition argued the case for: "A corrections board . . . to be responsible for the prison's operational regime." The Chief Minister rejected this for reasons he ascribed to Corrections rather than to himself. He wrote that: "ACTCS is satisfied with the extent to which mental health considerations have been incorporated into the operational regime of the AMC and does not believe that a board with mental health expertise such as the one proposed will be necessary."

9. The grounds cited in the letter confirm rather than allay the concerns that motivated the recommendation, namely:

- Assessment of all detainees within 24 hours of assessment;
- Making available to custodial staff who manage identified risks an assessment instrument giving an "indication of 'at risk' status".
- A case management system for each prisoner incorporating a rehabilitation plan which provides support and addresses criminogenic needs;
- two mental health positions in place within ACTCS – the Crisis Support Unit (CSU) Manager and the Principal Psychologist. The Chief Minister's letter went on to explain that "the Principal Psychologist position is currently vacant, the CSU manager is acting in the position and recruitment action has commenced."

10. In the opinion of the Corrections Coalitions", these measures fall a long way short of what is required to deliver the rehabilitative outcomes to which the Government is committed. They are indeed no more than what Australian Correctional Administrators have laid down for their own guidance and widely applied with indifferent success in corrections services across the country (Ogloff *et al* (2007); CORRECTIONAL ADMINISTRATORS (2004) §§1.3, 2.18-2.20 & 3.1-3.5). While in themselves worthwhile, they fall far short of what is necessary to deliver the rehabilitative outcomes that the ACT Government has identified for the prison and which the community expects (§4).

Mental illness as a core concern for the ACT prison.

11. The *Healthy or harmful study* made the point that prisons have become substitute accommodation for people with mental health problems. It summarised the findings as follows:

- An overwhelming majority of detainees have pre-existing mental health disorders even without taking into account substance use disorders. *Page 8.*
- A somewhat smaller majority has a substance use disorder. *Page 8.*
- Detainees with both a substance use and some other form of mental disorder are the expectation in prison rather than the exception. *Page 9.*
- Dependence and substance abuse are forms of mental disorder. *Page 8.*
- Prisons are populated by those with an accumulation of known risk factors for mental ill-health. *Pages 12-14.*

12. In particular, a large majority of the Australian prison population is made up of those with or who have recently experienced at least two mental health problems (in NSW it is 78.2% of men and 90.1% of women): substance dependence, a mental disorder or condition recognised by standard international diagnostic criteria, and other mental disorders. The Senate Select Committee on Mental Health described co-morbidity as "the expectation not the exception". It is vital that the needs of this large majority of detainees be effectively addressed if the promise of the ACT prison is to be realised.

13. A traditional and generally accepted rationale of the criminal justice system consisting of police, court and corrections is the security of the community in terms of prevention or minimisation of crime. Successful treatment of co-morbidity is a key to the achievement of this goal for as the *Healthy or harmful study* shows (pp. 8-11), co-morbidity is a particularly potent risk factor for crime. The Senate Selection Committee described the link in these terms:

> ". . . substance abuse and dependence and mental illness are independent risks for re-offending, and that when these disorders occur together, there is an exponential risk of re-offending. The South Australian Department of Health cited a study that showed that the presence of co-morbid mental health problems and substance abuse increases the rate of offending by people with mental health disorders discharged from hospital by up to five times." (Senate (2006) §13.135).

14. A Victorian study of the criminal conviction of people with schizophrenia over a period of 25 years showed that "subjects with schizophrenia were far more likely to offend if they also had a substance abuse problem. As the rate of substance abuse increased over time, a greater proportion of the total amount of convictions in each succeeding cohort was accounted for by patients with both schizophrenia and substance abuse. Patients with substance abuse problems accounted for 37% of all lifetime-to-date offending in the 1975 cohort and 69% in the 1995 cohort. As a result, by 1995, the rate of overall offending, and of violent offending in particular , among schizophrenia patients without a known substance abuse problem had ceased

to be significantly greater than that among the comparison subjects" (Wallace *et al.* (2004) p. 725). In short, increasing abuse of substances by those with non-substance mental health disorders (see Health or Harmful report, p. 10) is going hand in hand with greater rates of offending than are associated with a non-substance mental health disorder alone.

15. A NSW study published this year affirmed the potency of the link between comorbidity and offending in a study of re-offending. The study looked at "1,208 NSW prisoners who participated in the 2001 Mental Health Survey (conducted by NSW Justice Health)". "Within 24 months of their release from prison, 65 per cent of the total sample had re-offended, and their rate of re-offending was related to their mental health disorder/s. The weighted rate of re-offending was greater in prisoners who had comorbid substance and non-substance mental health disorders (67%) compared with prisoners who had: only a substance disorder (55%), a non-substance mental health disorder (49%), and no mental health disorders (51%). (Smith & Trimboli (2010)).

16. In summary the prison is set up for failing in terms of two linked key goals: substantial reduction in re-offending and returning to the community human beings capable of functioning as autonomous, responsible members of the community. There is a high prevalence of complex mental health problems in the prison population. High prevalence of comorbidity renders those problems particularly complex and hard to deal with yet they must be successfully tackled if the high expectations of the community and high investment in the prison are to be justified. This is a huge challenge which, overall, prisons have singularly failed to deliver. It stretches credibility to breaking point to expect that the ACT will meet expectations unless it is prepared to innovate by adopting the world's best practice or better.

The traditional prison causes or aggravates mental illness.

17. In a working paper commissioned by the Commonwealth on preventing mental illness, Professor Debra Rickwood states bluntly that legal proceedings and imprisonment are environmental stressors, exposure to which constitute risk factors for mental ill health (Rickwood (2005), p. 7). The most recent Mental Health Survey conducted in 2007 by the Australian Bureau of Statistics "showed that a number of social factors were highly associated with having a mental disorder in the past 12 months – unemployment, prior homelessness and previous time in prison" (*Breaking the silence* (2010),p. 63).

18. The Coalition's own study of the intimate relationship between how the prison is run and mental health bears this out. Its key findings included the following:

- Common risk factors for mental ill-health include physical, sexual and emotional abuse and poverty and economic insecurity. *Pages 12-14.*
- Many risk and protective factors influencing mental health problems are also acknowledged risk and protective factors for crime. Pages *12-14.*
- The usual prison environment further damages mental health because it is replete with many known risk factors for mental ill-health and crime. *Pages 12-14.*

- Improvement in mental health and reduction of recidivism requires the cultivation of protective factors like a sense of connectedness and minimisation of existing and additional risk factors. *Page 14-16.*
- There are barriers in the typical prison environment against detainees accessing mental health services. *Page 14-16.*
- Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigours of prison and by fellow prisoners as weak and unacceptably alien. *Page 14-16.*
- Treatment is typically concentrated on the relatively small proportion of detainees whose condition is obvious and whose behaviour causes management problems. Others tend not to receive the treatment they need. *Page 14-16.*
- The typical stresses of imprisonment are harmful to the mental health of those detained. The stresses include:
  + The sudden disruption in people's life;
  + The separation from family support; and
  + The coercive and highly regimented daily routine. *Page 16.*
- The regimented routine of the usual prison directed at conformity and compliance within which some who are mentally disordered thrive reduces their capacity to cope with the contradictions and complexities of the world outside. *Page 16.*
- To counter these effects, the new ACT prison must do much more than aim for conformity and compliance. *Page 17.*
- Strip searching is common in prisons including ACT remand centres and would continue at a significant level even with the permanent introduction of body scanning. *Page 18.*
- Frequent use of scanners gives rise to radiation concerns. *Page 19.*
- Strip searching is psychologically damaging. It is degrading and destructive of self worth for anyone, male or female, and particularly for a vulnerable prison population in poor mental health. *Page 18.*
- It is a practice of the gravest concern for women. An overwhelming number of women in prison have been traumatised by sexual abuse. Strip searches serve to perpetuate and intensify that. *Page 19.*
- The damaging regime of strip searching flows from a perception of security and community expectations to keep drugs out rather than promotion of the well-being of detainees. *Page 19-20.*
- Seclusion is widely used in prisons including ACT remand centres to confine people separately or otherwise drastically limit the extent that they can interact with others. *Page 21-21.*
- It occurs in the name of security, discipline, the welfare of the person secluded and to meet administrative needs including lengthy unscheduled lockdowns. *Page 21*

- Seclusion injures mental health and in the mental health system is viewed as a failure to respond in an adequate and timely manner to the needs of people who are mentally ill. *Page 22*
- Solitary confinement, which ACT legislation permits for up to 28 days, is particularly harmful. *Page 22.*
- Use of seclusion in padded cells under surveillance to prevent suicide or other self harm promotes later suicide attempts. *Pages 23-24.*
- The prison's operational regime should be designed to reflect the therapeutic principle that positive human interaction and support are fundamental for suicide prevention. *Page* 24.
- Corrections and other prison staff should receive lay training in understanding and working with detainees who have mental disorders. *Page* 24.
- Lack of meaningful activities is common in prisons including ACT remand centres. *Page 25.*
- Boredom makes for an unhealthy environment that stimulates anger and frustration impeding those detained from accepting responsibility for their actions. *Pages 25-26.*
- The new ACT prison should have a well designed and resourced program of activities. *Pages 25-26.*
- Many of the prison practices that are most injurious to mental health are taken out of concern to keep drugs from prisoners. *Pages 19-20.*
- It is unrealistic to expect that prison will be able to "cure" many prisoners of addiction, which is a chronic relapsing condition, but realistic that with good treatment their condition can be stabilised. *Pages 29-30.*
- Within the interlinked domains of self harm, overdosing and mental illness, the failings of the traditional prison regime in rendering people fit to resume their place in the community are obvious. *Page 33.*
- There is a sharp rise in the suicide deaths of men in the first weeks after release from prison. *Pages 34-34.*
- There is a high rate of overdose, including overdoses leading to death, among addicted people released from prison. *Pages 35-36.*
- Without good support within the community released prisoners with a mental health disorder are at high risk of reoffending and suffering a deterioration in their mental health. *Page 36-38.*
- Victims stand to benefit from a healthy operational regime through:

  \+ less crime and thus fewer victims if the poor mental health of those sent to prison is improved and not further damaged by the prison experience;

  \+ less revictimisation of people who have offended and who have themselves

suffered as victims of crime. A high proportion of people in prison have been victims of crime themselves;

+ the healthy prison regime establishing the conditions for implementation of the government's commitment to restorative justice. *Page 39.*

❖ The conditions required for restorative justice to work in a prison setting are respect, the assumption of responsibility and the freedom to solve the problems by those involved in conflict. These conditions will not exist in the new prison if it replicates those of the typical prison. *Pages 39-41.*

19. As an Institute of Criminology Study has put it, the severe economic and social disadvantages that typically characterise the prison population "are further compounded by experience of prison itself. In addition to the above, following release prisoners may experience stigmatisation and discrimination, lessened employment prospects, reduced access to housing, loss of family and social ties, negative mental health effects such as institutionalisation, increased risk of suicide and early death, and difficulties in accessing needed supports, such as drug treatment" (Borzycki (2005) p. xvi).

20. Such authorities simply reinforce the weighty evidence discussed in the *Healthy or harmful study* pp. 14-17 to the effect that the stresses that are part and parcel of the traditional prison aggravate existing or even cause mental illness. Professor Paul Mullen of *Forensicare* in Victoria was quoted in that report as writing:

> "Mental disorders and intellectual limitations are frequently constructed by staff and prisoners alike as a sign of vulnerability and vulnerable is not a safe label to wear in prison. Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigours of prison, and by fellow prisoners as weak and unacceptably alien. Prisons and jails are intended to be punishing and they provide hard and unforgiving environments which often amplify distress and disorder" (Mullen (2001) p. 36).

21. The Senate Select Committee endorsed the view that the "correctional ethos" "is fertile ground for conflicting priorities between clinical needs (the health priority) and security (the custodial priority). The correctional approach to the management of difficult behaviour can be the antithesis of the mental health approach" (Senate (2006) §13.95)

22. The Senate committee also noted that: "Incarceration results in the loss of many personal freedoms taken for granted in the community, including social supports, inter-personal relationships, employment, social status, and social role. These losses are commonly correlated with depressive disorder" (Senate (2006) §13.40).

23. What is more, corrections administrators themselves recognise the potential harm that imprisonment causes to mental health. Their standard guidelines recognise that:

- imprisonment may "injuriously affect" the "physical or mental health" of prisoners (CORRECTIONAL ADMINISTRATORS (2004) §2.32);
- In particular, "Prolonged solitary confinement, corporal punishment, punishment by placement in a dark cell, reduction of diet, sensory deprivation" are all cruel, inhumane or degrading" and can have deleterious effects on "the physical or mental health" of those detained" (*ibid*., §§1.75-1.76 & 1.80).

24. The administration of Corrections is thus faced with the formidable task of developing and implementing programs that:

- Firstly, address the many and complex issues facing people before, once again, they come into contact with the criminal justice system, and
- Secondly, also neutralise the damaging impact of the exposure to the system.

25. This is no ordinary task and no ordinary approach will suffice. It is unreasonable to expect that there will be any outcome from the ACT prison superior to the outcomes of Australian prisons generally unless something different is done. In a critique that it forwarded to Ministers on 22 December 2006 the Corrections Coalition expressed concern that planning was inadequate to produce the outcomes expected by the government:

26. The Corrections authorities seek to do this within a regime that is an unco-ordinated mixture of coercive or authoritarian measures on the one hand and health based and educational ones on the other.

  - Coercive or authoritarian measures include familiar supply reduction and demand reduction strategies such as searching of inmates and visitors, banning visitors who attempt to introduce drugs, drug testing, targeted monitoring of prisoner telephone conversations.
  - Health based and educational ones include "Opioid [sic] substitution maintenance program (eg Methadone)", "detoxification" and "peer education".

27. This mix, which is implemented in other Australian prison regimes, is unlikely to lead to substantially better outcomes than in those regimes as, indeed, the ACT Prison Strategy in the passage quoted above acknowledges.

28. There is no credible ground, on the basis of the documents released, for confidence that the new ACT prison will be substantially more effective in addressing the national scandal of prisons being warehouses for people with mental health problems, including ones of addiction.

29. These issues were addressed in an editorial of the *Medical Journal of Australia* and an associated media release of the Australian Medical Association (White & Whiteford (2006) & AMA (2006)).

  - The Australian Medical Association made the point that prisons have "become the mental health institutions of the 21st century. Governments must act immediately to reverse this situation."

- It called on "all jurisdictions to make imprisonment the action of last resort for those with mental health or substance abuse problems. Governments should also set specific annual targets for reducing the number of people incarcerated with these problems."
- Up to 80% of remandees and prisoners in NSW are dependent on alcohol, cannabis or amphetamines before entering prison.
- Recently released prisoners are at high risk of dying from an overdose. Deaths from all causes in some groups were found to be 17 times higher than in the general population in the 2 weeks following release.
- Despite these high morbidity and mortality rates, treatment services for prisoners and ex-prisoners are very limited and often ineffectual.
- The editorial observed that this poor treatment "makes little sense, even from a criminal justice perspective, as comprehensive services can delay or prevent recidivism in mentally ill offenders."
- Furthermore, "access to stable housing and to appropriate vocational rehabilitation services is essential for functional recovery".
- In one way or another illicit drugs are the reason why so many people with a mental disorder end up in prison.

30. Whether anything better is done crucially depends on management being adequately resourced by Government. The Coalition sees little in the way of superior performance in these domains.

Prison as a risk factor for offending

One of saddest illusion is that the ACT prison will reduce recidivism in the ACT. There is a well recognised concentration and interplay of risk factors which the *Healthy or harmful study* went into (see pp. 12ff). The risk factors for mental illness are similar to the risk factors for substance dependence are similar to the risk factor for crime and imprisonment is a risk factor for further crime and the other interlinked risk factors. In other words, add a risk factor to another – and the risk factor for the other social problems increases. A study on recidivism released earlier this year by the Bureau of Statistics identifies imprisonment as an extraordinarily potent risk factor for returning to prison:

> "Younger prisoners were more likely than older prisoners to be reimprisoned following release. Within 10 years of being released, the reimprisonment rate for the teenager group (those aged 17–19 years when released) was 61%, compared with 23% for those aged 35 years and over" (ABS (2010) p. 2).

The NSW Bureau of Crime Statistics and Research has gone further and shown that far from in some circumstances imprisonment actually increases the likelihood of reoffending compared to non-custodial penalties. A study published this year of two offences: non-aggravated assault or burglary compared the "time to re-conviction among 96 matched pairs of convicted burglars and 406 matched pairs of offenders convicted of non-aggravated assault. One member of each pair received a prison sentence, while the other received some form of non-custodial sanction. It was found

that" offenders who received a prison sentence were slightly more likely to re-offend than those who received a noncustodial penalty. The difference was just significant for non-aggravated assault but not significant for burglary.

The director of the Bureau, Dr Don Weatherburn, concluded that: "prison exerts no significant effect on the risk of recidivism for burglary. The effect of prison on those who were convicted of non-aggravated assault seems to have been to increase the risk of further offending. These findings are consistent with the results of overseas studies . . most of which either find no specific deterrent effect or a criminogenic effect." The study contains a useful summary of that earlier research. It is striking, to say the least, that the ACT Government should invest the millions of dollars ($43,304,000) a year in operating costs (Productivity Commission (2010) table 8A.9) that it does on an intervention the efficacy of which in terms of making the community safer is, at least, unproven. It may even increase the risk of crime. One would like to be assured that the ACT Corrections is thoroughly competent and committed to the Government's objectives.

Tackling comorbidity - a "wicked" task

31. In the best of circumstances, meeting the needs of the large majority of detainees who suffer from comorbid mental health conditions can be very difficult:

> "There are significant problems with the management of people with comorbidity. There is a dearth of evidence about best practice. Specialist mental health or alcohol and other drugs (AOD) services, where they are available, are usually separated physically, administratively and philosophically" (Gordon (2009) p. ix).

32. A prison environment makes solutions even more difficult to the extent that tackling just one element alone, substance dependence, has been described by Professor Anne Roche, Director of the National Centre for Education and Training on Addiction (NCETA) of Flinders University as "wicked" by which she means:

> a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. Moreover, because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems (Roche (2009), p. 6).

33. Corrections are preoccupied with the narrow issues of containment and security. Comorbidity is a "wicked" problem beyond the competence of the Corrections to solve and overcome. The obstacles that management has to contend with in implementing new policies are formidable:

- integrating new services with existing practices without creating confusion regarding the agency's operational philosophy (what has been called 'mission distortion'; after Corbett 1998, cited in Gavazzo, Yarchek, Rhine and Partridge 2003)
- insufficient capital and administrative resources to support new ways of working

- changed caseloads for case managers (or 'mission creep', where new tasks arising from innovation are simply added to existing duties; after Corbett 1998, cited in Gavazzo et al. 2003.
- staff resistance to new approaches and perceived increases in workload
- staff turnover, and
- recruiting qualified case management staff from correctional systems that may previously have focused on only surveillance/supervisory functions (Borzycki M (2005) pp 68-69.)

34. What is required is a Corrections management structure that brings to bear all relevant expertise to the task. In Professor Roche's view, a "collaborative" approach holds out the greatest likelihood of success:

> "Collaborative strategies aim to engage all stakeholders in order to find the best possible solution for all stakeholders. Typically these approaches involve meetings in which issues and ideas are discussed and a common, agreed approach is formulated" (Roche (2009), p. 8).

Shared risk factors: a pathway to shared problems

35. The foregoing discussion of the "wickedness" of comorbidity stresses the complexity of the combined conditions and the need for joined up approaches. The same can be said of the other social problems that characterise the prison population. The reviews will do well to base their recommendations on the known commonality of risk factors, and recommend that the ACT Corrections system focus on building up the known common protective factors. A strategy that successfully addresses one social problem is likely also to be successful in addressing others. The reviews would do well to heed the conclusions of a paper on structural determinants of drug use published by the Australian National Council on Drugs that government should "Take a broader view of drug prevention: "a. Acknowledge that drug use is one of a range of problem behaviours and should not be seen in isolation. Work collaboratively with others concerned with problem behaviours, including crime, suicide and educational problems, to address the shared pathways to these outcomes.

> "b. Understand how drug use is shaped by human developmental processes from birth. This requires consideration of:
>
> i. critical and sensitive periods in child development (hence the importance of early interventions);
>
> ii. developmental transitions (hence the importance of timing interventions to coincide with natural transitions);
>
> iii. the importance of family, community and other social networks in shaping human development.
>
> "c. Acknowledge that drug use is not simply an individual behaviour, but is shaped by a range of macro-environmental factors, including the economic, social and physical environment.

"d. Consider the impact of all government policies and programs on the macro environmental influences on developmental health. This needs to be done at the national, State/Territory and local government levels, and in all areas (including taxation, employment, education, urban planning, transport, justice and so on), not just the health portfolio.

"e. Shift the focus from the negative to the positive. Work towards supporting young people to be happy, socially connected, and engaged in life, rather than focusing on negative outcomes such as drug use (Spooner, Hall & Lynskey (2001),p. xi).

The challenge of co-ordinating post release services

36. A corrections service capable of delivering the benefits expected of it has a responsibility of ensuring the integration of effective services within the prison with complementary post release ones in the community. Active steps must be taken to ensure that collaborative efforts are effectively coordinated. One organisation should be assigned the role of lead agency that takes ultimate responsibility for ex-prisoners in the community. (Borzycki (2005)p. 119). This must be done "to avoid costly service duplication, to facilitate ease of prisoner access, and to ensure that prisoners do not fall through gaps in service provision" (*ibid*).

37. Ideally, partnerships are formalised arrangements, with all levels of operation from high-level policy initiatives to day-to-day agency interactions documented and appropriately publicised amongst relevant staff. Partnerships can be maximally effective when one partner is assigned to role of lead agency, and so ensures that collaborative efforts are effectively coordinated and one organisation will take ultimate responsibility for ex-prisoners in the community. (Borzycki M (2005)p. 119).

Support for an innovative management structure for the ACT prison

38. It is, to say the least, a tough call to manage a prison with objectives as ambitious as those that the Government has set for the ACT prison. What must be done is a skilled and careful, "balancing [of] surveillance and support functions" (Borzycki M (2005)).

39. In an article on identifying and accommodating the needs of mentally ill people in prisons, Professor James Ogloff of Monash University and the Victorian Institute of Forensic Mental Health (Forensicare) stressed that "strong links must be forged between mental health services, drug and alcohol services, and correctional services to ensure that the needs of people with this complex array of problems is met" (Ogloff 2002).

40. An Institute of Criminology paper commissioned by the Commonwealth Government identifies the importance of establishing while, detainees are in custody, strong bonds with a wide variety of support services to ensure post release support. Rehabilitative goals will not be achieved without this support:

"the provision of post-release services should be the concern of government agencies responsible for housing, health, and education; faith-based and

> voluntary organisations which provide social services; local businesses and industry; and the communities to which offenders return. The participation of these various sectors is also relevant because post-release adjustment is best addressed well before a prisoner is released, in what is more correctly called throughcare. Effective throughcare requires coordinated actions by government agencies, non-government service providers, and the community to ensure that returning prisoners do not fall through the service gaps between the agencies" (Borzycki M (2005)).

41. Collaboration between agencies is thus essential. It has been pointed out that to bring this about there should be a "lead agency to collaborative service partnerships" and "active support for these collaborations—for this 'joined-up' working—at all levels of an organisation" (Borzycki M (2005)). The same analysis goes on to specify the required elements of the collaborative partnerships. They would "benefit from:

- the selection of suitable staff from each agency to form partnerships: that is, those with suitable authority to take decisions and implement policy
- explicit recognition of shared goals, and the education of partners who may not have previously worked with correctional clients
- raising awareness of participating agencies' histories, including any obvious conflicts, and ensuring all intentions are made explicit to all partners
- establishing a lead agency to coordinate services and accept final responsibility for clients
- producing formal interagency agreements that outline aims, specific roles for each agency, protocols for addressing issues such as confidentiality, and program evaluation needs
- support for partnerships by leaders within all agencies
- partnership at all organisational levels, from senior management (seen in coherent policy), to [p.69] operational staff (evident in clear and formalised procedures)." (Borzycki M (2005) pp. 68-69).

42. Partnerships, or the coordinated working of relevant organisations, are necessary to ensure that the agencies that will provide post-release services act in concert to avoid costly service duplication, to facilitate ease of prisoner access, and to ensure that prisoners do not fall through gaps in service provision. Ideally, partnerships are formalised arrangements, with all levels of operation from high-level policy initiatives to day-to-day agency interactions documented and appropriately publicised amongst relevant staff.

43. Ogloff calls for "Mentally Disordered Offender Committees".

> "Beyond the need for minimum standards of care, it is beneficial to have a 'Mentally Disordered Offender Committee' at the jurisdiction-wide level to ensure some approval of the standards of care. This Committee should be small, with high-level representation from corrections (clinical and

> administrative representation), forensic mental health services, mental health services, and police. Such a committee is necessary for overseeing both the development of the interagency agreements and the implementation and ongoing monitoring of the mental health services for corrections. In addition, by having actual input into the planning and implementation of mental health services by high-level personnel in the various agencies, the likelihood that the agencies will become firmly committed to the directions established will be increased." (Ogloff (2002) p. 10).

Demonstrated inadequacies of corrections in effectively coping with comorbidity

44. A corrections board should be established with mental health expertise to be responsible for the prison's operational regime. At the very least this board should include the persons holding the positions of Director of Mental Health, ACT, Chief Psychiatrist, ACT and the Corrections Medical Officer and those with expertise in addressing determinants of social dysfunction and ill health such as education, housing, relationships, and employment which, unless addressed, will ensure those in the prison will be recycled through its doors time and time again.

Importance of staffing skills and culture in achieving satisfactory outcomes for people suffering from co-morbidity

45. Of pre-eminent importance in running a prison are skills in handling people:

- People skills in those having contact with people detained, who will often exhibit challenging behaviour;
- Leadership and personnel management skills of a high order to recruit, inspire, develop and manage a large workforce working in a challenging environment;
- Co-ordinating the services of a diverse range of organisations, official and community, and of expertise required to achieve goals set for the prison;
- Nurturing a culture among all those working within the prison that is conducive to the high aims set by Government and in particular which promotes goals of rehabilitation as well as containment and security.

STAFFING

Recognition of its importance

46. In the words of the Danish Department of Prisons and Probation, one of the most successful penal systems in the world: "The most valuable resource of the Prison and Probation Service is its staff." In its public comments, the ACT Government also acknowledges the central importance of staffing. The capacity to deliver a busy and active is primarily a factor of staffing and good staffing management.

47. The Chief Minister told the Assembly that staff would be selected and trained on the following basis:

> "A healthy, positive operational culture will be established through the size and design of the prison, its Operating Philosophy, coupled with the

> introduction of rigorous staff selection and training, clear competency standards, performance-based management and the imposition of sanctions for poor performance.
>
> "The recruitment and training of staff in custodial services and programs, industrial, education, training and health services will target and develop officers who are qualified, focused, skilled, sensitive and communicative" (Speech of August 2004).
>
> "The staff of the prison will be the key to its success; they will be screened, recruited, trained and supported to meet the diverse demands required of them. Rehabilitative efforts have a greater chance of changing an offender's behaviour and improving opportunities following release, when custodial and other professional staff work together in delivering effective treatment programs, are responsive to the needs of prisoners and model pro-social behaviour. A positive prison culture will lower the institutional 'temperature', reduce prisoner stress, frustration, boredom, violence and minimise the risks of harm to prisoners and staff" (Speech of August 2004).

The reviews need to consider the extent that these aims have been achieved.

48. Such views are also reflected in documents prepared in the planning of the prison and, in particular, the paper of Corrective Services on *Vocational Educational and Training and Rehabilitative Programs in The Alexander Maconochie Centre* dated May 2007. This states:

> "Programs should hire and retain staff with the necessary attributes to be able to deliver the program as intended and provide a role model for offenders. Effective staff will relate in a warm, enthusiastic, flexible and caring manner. They will be directive, solution focussed, and use approval selectively to reward appropriate behaviour. Staff should believe in the ability of offenders to change, believe that core correctional practice works, believe that they have the skills to implement such practice, believe that reducing recidivism is a worthwhile pursuit and that core correctional practice is supported by their managers.
>
> "Effective managers who also possess the staff qualities noted above should support programs. Management is responsible for creating and maintaining program integrity" (ACS (2007b) p. 25).

49. Similarly, the *ACT Corrective Services workforce plan July 2004 to July 2007* prepared for ACT Corrections by Cyrene Group Pty Ltd states that:

> "With the establishment of the new correctional system in the ACT an opportunity exists to implement and sustain a healthy, positive organisational culture by ensuring that all staff are screened, recruited, trained and supported in order to achieve the diverse demands required of them. Rehabilitative efforts will have a greater chance of changing an offender's behaviour and improving opportunities following release, if custodial and other professional staff work together in delivering effective treatment programs and are responsive to the needs of prisoners during correctional residency. In

addition, a healthy corrections culture will lower the institutional 'temperature', reduce prisoner stress, frustration, boredom and violence and minimise the risk of harm to prisoners and staff" (Cyrene Group (2007) p. 8).

Staffing issues of particular relevance to co-morbidity

50. Given the pervasive characteristics of the prison population, the skill, training and understanding of prison staff is what makes the difference between the usual prison for those in its care and one that adds to the harms of those who are already severely harmed. In short, the staffing is vital to give effect to the principle that the prison should not cause harm and to achieve the Government's ambitious rehabilitative goals for the prison. The object is not to turn the prison into a mental health hospital but to recognise that prisons have, in terms of the populations, been transformed into receptacles of the mentally ill. The object should be to do no harm. This can only be achieved by good management and staffing. Providing good expert drug and alcohol and mental health care is not alone enough. At the very least, the Coalition believes that that there should be integration of services; training of staff; awareness by staff of the implications of decisions and particular attention to minimise the risk of suicide and self harm both within the prison and on release:

> *Integration:* Mental health and other health services should be thoroughly integrated. Under present arrangements drug and alcohol services are engaged by and answerable to Corrections whereas mental health services are engaged and answerable to the Department of Health.
>
> *Training*: All staff with management authority or having contact with prisoners should be trained in the handling and treatment of people suffering from mental health conditions and substance dependency; and
>
> *Awareness of implications of decisions:* Prison management should be fully aware of the implications of its decisions including disciplinary ones on the mental well being of detainees. This requires appropriate consultative and managerial arrangements;
>
> *Particular attention to minimise the risk of suicide and self harm both within the prison and on release:* As the freshly published *Breaking the silence* report on suicide put it: "prisoners and other people who are involved with the criminal justice system have . . . been found to have higher rates of completed and attempted suicide" (p. 88). Thus, there should be clarification of the mental health services provided by Corrections Health with regard to the prevention of suicide and self harm and with regard to those under surveillance in the High Needs Unit or Crisis Support Area? (*Breaking the silence* (2010) p. 88).

Staffing concerns identified in the audit of the ACT Human Rights Commission

51. The 2007 ACT Human Rights Commission's Audit of existing correctional facilities identified some unsatisfactory staffing cultural aspects which can form a benchmark for the review to assess the extent to which the current culture is conducive to the realisation of the rehabilitative and other objectives of the new prison.

52. The Commission pointed out that developing the right staffing culture is necessary in order to move to a system of "direct supervision" or "dynamic security" that ACT Corrections is on record as favouring (ACS (2007d), pp. 16). This is a type of prison management that involves security based on good professional relationships between staff and detainees rather than physical barriers and the use of force and restraints. It was devised in the United States and regarded as best practice there and in the United Kingdom. It has been shown to have advantages for both detainees, staff and management.

53. The following are some comments made by the Human Rights Commission on prison culture including bullying and harassment:

> "Performance review procedures should include increased emphasis on assessing officers' ability to maintain effective relationships with detainees. More leadership, training and further procedures on anti-bullying and inter-detainee violence are also necessary" (Audit, p. 4).
>
> "In interviews, many officers spoke of the importance of maintaining a working relationship with detainees so that uses of force would be unnecessary. In other words, it was recognised that 'dynamic security' – that is security that is not dependent on physical restraints or barriers – was important. However, it was clear that some officers had a lower threshold than others when it came to seeing that their authority had been undermined" (p. 85).
>
> "Although ACT Corrective Services delivers training on anti-bullying that gives good practical examples of bullying in the workplace and which warns against accepting the culture and clientele as justification, there is a need for more leadership on this issue. Anti-bullying and harassment training should be offered yearly to all Corrective Services officers, and support mechanisms, such as a contact officer for a staff member who wishes to make a complaint against another officer, should be regularly reviewed to ensure they are working appropriately. A procedure should also be developed on inter-detainee violence and bullying which formalises the good practices adopted by many officers of actively watching for signs of bullying, letting suspected bullies amongst detainees know that they are being watched, and that there are consequences for bullying." (p. 94).

Lock-downs

54. The Human Rights Commission recommended in its audit that:

> Staffing Levels must be sufficient to ensure that lock-downs of the frequency and duration of those occurring at the remand centres in the last quarter of 2006 will be avoided. (Recommendation 1.3.3)

55. In its response to the audit, the government agreed and added:

> The Government resources ACTCS for staffing levels that will generally not require long or frequent lockdowns. Although ACTCS undertakes regular recruitment intakes designed to maintain sufficient staffing levels, staff

shortages such as occurred in the last quarter of 2006 cannot always be avoided.

56. The Coalition understands that lock downs are still occurring at the prison as a result of staffing shortages. The Coalition understands that the new 12 hour shift system has improved staff morale but that morale issues remain which manifest themselves in unscheduled absences which impede the running of programs.

Organised Activities

57. In its audit of remand facilities, the Human Rights Commission highlighted lack of activities as well as unscheduled seclusion from lock downs as contributing to frustration making for an unhealthy environment damaging to mental health. The Commission made three recommendations about the need for activities:

Recommendation 1.4.1

A program of organised activities must be offered to detainees at the remand centres..

In its response given in February 2008 the Government agreed to this:

"The Government agrees with this recommendation, however, this will continue to prove difficult to implement given the design constraints at the Remand Centres. The Activities yard is also the exercise yard for D yard; therefore access by other detainees is limited.

"The Activities Officer position was filled in December 2007 and organised activities are now being offered at both remand centres.

"There will be two designated positions for this purpose at the AMC."

Recommendation 1.4.2

Officers should be required to take detainees at both remand centres to the library and activities room on a regular basis

Government response: Agreed

"The Activities Officer is now implementing this recommendation."

Recommendation 1.4.3:

Detainees at BRC, particularly younger men, should be given more frequent opportunities to play sport in the large activities yard.

Government response: Agreed

"The Activities Officer is now implementing this recommendation" (ACT AG (2008)):

58. Corrections has continually stressed that detainees at the ACT prison will have a day brimming with gainful activities. Correction's paper on vocational eduction and rehabilitative programs acknowledged the detrimental consequences of boredom:

> "Boredom and inactivity in the correctional setting encourages drug use, undermines rehabilitation objectives and threatens security and safety. It is therefore important that the prisoner's day be marked by the prisoner's continuous engagement in purposeful activity. Over time, the prisoner will, through incentive-based regimes, exercise increasing levels of decision-making, assume greater levels of responsibility and will be placed in accommodation which reflects this. The means to achieve the integration of the prisoner's Rehabilitation Plans will be a Structured Day of meaningful work, programs (including visits) and recreation" (ACS (2007b) p. 42).

59. Corrections continued to reaffirm the meaningful structured day as an essential element of the new prison. For example, at his presentation on Throughcare and case management in the AMC at a Community Inclusion Board seminar on 22 April 2008, Mr Brian Dunn, Manager Offender Services, AMC told the gathering that:

> The case management approach for each prisoner is reflected in a Rehabilitation Plan and the objective of the Plan is to ensure each day is a 'busy, active day' based on therapeutic programs, education and training, employment with AMC and recreation activities. (ACIB (2008) p. 4).

60. The approach is even recited as an accomplished fact in the Chief Minister's letter dated 22 June this year to the Coalition:

> "Case management is set in place to assist prisoners. The case management approach for each prisoner is reflected in a rehabilitation plan which provides support and addresses criminogenic needs. The objective of the plan is to ensure each day is a 'busy, active day' based on therapeutic programs, education and training, employment within the AMC and recreation activities."

61. This is misleading. As the CIGG submission points out, until recently the case management system has not been working (CIGG (2010) p. 7). The Coalition understands that the days of many of those detained have been anything but planned and full. Indeed, prisoners complain of boredom including some who have returned from NSW and complained about the poor program in the ACT prison compared to what they experienced in NSW.

Inadequate training of staff to work with people suffering from comorbidity

62. Given the ubiquity of mental health issues among detainees, enhanced training is required for all staff working with detainees. Corrections do not require any pre-existing training for correctional officers in handling people suffering from substance dependence or with other mental health problems. Its brochure on recruitment and selection specifies that: "All the training you will require to begin work as a Custodial Officer will be provided during the first ten weeks of your employment. All you need to bring to the job is enthusiasm and dedication" (ACS (ND)). In contrast, Professor Ogloff stresses the importance of training in this way:

> "All persons who work with [Mentally Disordered Offenders] must play an active role in the identification and management of them (this includes

> correctional officers, chaplains, and other staff); thus, it is important to provide training to staff to enable them to identify and manage [Mentally Disordered Offenders]" (Ogloff JRP (2002) p. 12).

63. ACT Corrections attempts to make up for the want of training by its in-house efforts and also by sponsoring staff to undertake certain courses: Its recruitment brochure states that:

> "We will even fund further study and training, including:
>
> Certificate 3 in Correctional Practice (Custodial) from the Canberra Institute of Technology (CIT);
>
> Certificate 4 in Correctional Practice (Custodial) from CIT;
>
> Diploma of Community Welfare Work from CIT;
>
> Advanced Diploma of Community Services Management from CIT:
>
> Degree with a Bachelor of Justice Studies from the Australian National University" (ACS (ND)).

64. The Coalition has doubts whether such training of staff is adequate. The website for the Canberra Institute of Technology does not provide information on its certificate or diploma courses on corrections. The Correctional service training packet offered by the University of Canberra includes 20 units on "Offender management". This includes units on:

- Protect the safety and welfare of vulnerable offenders
- Response to offenders influenced by drugs or alcohol and
- Promoting cooperative behaviour.

The course includes no unit specifically dealing with mental ill health.

Ready access to mental health professionals

65. The prison needs to be serviced by an adequate number of mental health professionals (see §9. It appears to the Coalition that at the moment this is far from the case.

Support for disciplinary measures that are known to cause or aggravate mental disorders

66. Aspects of the *Corrections Management Act* 2007, the legislation that constitutes the legal framework for the operation of the ACT prison, authorise measures that are likely to harm the mental health of those detained. The Coalition identified these aspects at the time that Corrections urged the draft of the legislation on the Government and the Assembly:

> No provision for a timely review of decisions of correctional authorities having adverse impacts on the health of detainees
>
> Access by health professionals not guaranteed
>
> Patient confidentiality not secured

Correctional authorities can override medical advice concerning transfer to external health facilities

The Bill provides for unethical coercive medical interventions

The Bill permits solitary confinement as a disciplinary measure which is both inhumane and medically harmful. Other segregations are permitted without consistent regard to the health and well-being of detainees

No clear ethos consistent with the Government's goals for the prison and lack of clear commitment of staffing and management at all levels to that ethos.

67. No social system can obtain all the resources it might wish to use in the fulfilment of its goals. The way in which allocated resources are used is, therefore, of great significance. The most valuable resource of the Prison and Probation Service is its staff. Hence it is of decisive importance that the conditions of entry into and work within the Prison and Probation Service are such as enable the recruitment and retention of genuinely proficient personnel at all levels and for all functions. The communication plan of the prison project acknowledged the central role of staffing and managerial competence: A "healthy, positive operational culture" was to be achieved through "Operating Philosophy, coupled with the introduction of rigorous staff selection and training, clear competency standards, performance-based management and the imposition of sanctions for poor performance. The recruitment and training of staff in custodial services and programs, industrial, education, training and health services will target and develop officers who are qualified, focused, skilled, sensitive and communicative" (ACS (2007d) p. 46).

No provision for a timely review of decisions of correctional authorities having adverse impacts on the health of detainees

68. 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 s. 92) or of the impact of a prison practice on the health of detainees generally.

69. 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" (s. 21(5)).

70. Theoretically, administrative review of a decision of the correctional authorities may be sought by the person affected by the decision or a complaint made to the Human Rights Commission or Ombudsman but these are unlikely to be a timely or effective means of resolving health concerns.

71. Provision should be made for standing consultative arrangements to resolve differences of professional opinion relating to health matters.

Access by health professionals not guaranteed

72. The Act includes no general right of access of the medical staff to the prison and detainees. In other words, 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.

Patient confidentiality not secured

73. There seems to be no legal basis for health records on prisoners to be 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 corrections authority health care within the prison is at risk of being compromised through prisoner reluctance to communicate with prison medical staff.

74. The obligation to maintain confidentiality should be recognised as applying to all providing health services and not just medical practitioners.

75. There is explicit provision in clause 77 for the correctional authority to access to health records from outside the prison and no provision for the confidentiality of medical records made by the doctor appointed under s. 21.

> Clause 77:
>
> (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 (ACT, *Corrections Management Bill 2006: explanatory statement* (2006) p. 36).

76. 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 crisis, or to respond to one. (ACT, *Corrections Management Bill 2006: explanatory statement* (2006) p. 36)

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

78. The only confidentiality requirements in the Bill of medical records relate to:

(i) the power in the correctional authority to limit access within the correctional setting: i.e. to limit "the people who may access the health schedule and the circumstances for access policy or operating procedure" (s. 76(6)(b)).

(ii) the general obligation in s. 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. (s. 221(5)).

The health schedule

79. 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 s. 77 of the Bill. Likelihood of self harm is another example. These conditions should be included in the health schedule. What is to be included in the schedule is too broad. S. 77(5) states that it 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.

Amendments the Corrections Coalitions proposed:

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

(b) contents of "health schedule" 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 s. 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);

(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.

Background

80. 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".

81. 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 particular 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).

82. 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.

Correctional authorities can override medical advice on transfer to external health facilities

83. By clause 53 the corrections authorities have power to override the advice of the prison doctor in 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 it 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).

The Corrections Management Act provides for unethical coercive medical interventions

84. The Bill would empower the correctional authority to order a doctor to carry out procedures without the consent of the detainee concerned and for reasons other than his or her medical condition. This arises in the conduct of drug and alcohol testing ordered by the correctional authorities (s. 133) and applying restraint or administering drugs to prevent escape (s. 139(4)). The issues 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" (ss. 116 & 117) 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" (s. 116).

85. The AMA position statement declares 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).

The Act permits solitary confinement as a disciplinary measure which is both inhumane and medically harmful

86. The Bill allows solitary confinement as a disciplinary measure even though this is likely to have serious impacts on the health of detainees.

87. Under s. 187, the correctional authorities can order separate confinement "as an administrative penalty for a disciplinary breach" (s. 186(1)). "Separate confinement" is defined in s. 151 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 (s. 184(d)).

88. 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).

89. According to Dr Paul Mullens 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" (Mullen (2001)).

90. Dr Ogloff, also from Forensicare, told his audience at a Coalition forum in December 2008 at the Legislative Assembly that co-ercive interventions like imposing restrictive environments may:

> " . . . work in the short term but not in the long term. It's like a child again. If you want to stop the child over time from fighting and engaging in difficulty, you don't beat them and lock them in a closet. We know that that has long term problems. But that's what we still do in prisons. We don't beat people but we lock them in what is effectively a closet. And sometimes although we don't beat them physically, we still beat them emotionally" (Ogloff (2008)).

91. The Coalition understands that seclusion remains common in the prison: that unscheduled lock downs are frequent and that the Crisis Support Unit with prisoners segregated is full for much of the time.

92. 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 (s. 187(2)(a)) but there is no obligation on the correctional authorities to pay any heed to the doctor's advice. Moreover, there is no obligation to provide continuing medical assessments during the dangerous separate confinement. Monitoring during confinement is to be undertaken "at least daily" by a corrections officer (s. 187(2)(b)).

Other segregations are permitted without consistent regard to the health and wellbeing of detainees

93. Health and well-being should be a mandatory consideration for all the many grounds for segregation provided for in the Bill and the corrections authorities should be obliged to avoid wherever possible separate confinement and to take medical considerations into account in all decisions and not just in the case of those ostensibly on safety and health.

94. 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).

95. 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". (s. 90(1));
2) for the protection or safety of the detainee (s. 91(1));
3) on grounds of health (s. 92(1));
4) by a correctional officer who believes that the detainee has committed a breach of discipline (s. 156(2)(d));
5) by an investigator who is given a report about an alleged disciplinary breach by the detainee (s. 157(2)(f));
6) by an administrator who is given a report about an alleged disciplinary breach by the detainee (s. 158(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" (ss. 160 & 161).

96. "Health and wellbeing of the detainee" is a consideration in ordering segregation under ss. 90 & 92 (safety and health) but is not mentioned as a consideration for the making of the order or for the type of segregation ordered under ss. 91, 156, 157, 158 and 160-61.

INADEQUATE PLANNING FOR CASE MANAGEMENT AND THROUGH AND AFTER CARE

97. The Chief Minister included a strong statement in favour of throughcare in his media release of 9 January 2004:

> "The prison would be a safe and secure environment and aim to maximise rehabilitative and re-integrative opportunities for ACT prisoners – links with community agencies will also be encouraged to facilitate a 'throughcare' model of case management."

98. The Coalition wholeheartedly endorses the importance of through care but regrets the inadequate preparation and hence delay in devising and implementing an effective system.

99. The submission of the Community Integration Governance Group to the to the prison review also rightly stresses the central importance of an effectively managed case management system to support reintegration back into the community of those leaving the prison. It rightly observes that "a well-functioning transition and post-release system is a key aspect of meeting some of the basic objectives of the criminal justice system, ie reducing the rate of reoffending and reimprisonment".

100. There is no needs assessment, coordination of contracted outputs, or cross-agency monitoring of who delivers what to whom. The result is high risk of duplication and gaps in service provision to offenders and ex-offenders. The Coalitions endorses the elements of an effective through and after-care system identified in that submission including the need for:

1. **Provision of transitional services** which should be a core function of the corrective services system. Responsibilities and roles across other human services agencies (both government and community) must be planned rather than the current ad hoc approach, so that duplication and gaps are avoided, and there is a realistic assessment of service capacity to meet needs.
2. **Clear governance arrangements** to be developed to ensure responsibilities are clearly allocated, well understood by all parties, and subject to review.

101. This submission will not therefore, go into the case made by that submission for the provision of core, wrap-around services generally but would stress the absolute necessity for the involvement of well resourced and targeted, linked up mental health and drug and alcohol services addressing the core needs of the demography affected by co-morbidity.

102. The Coalition is pleased, in the words of the CIGG submission, that "After a shaky start and stretched resources, the community sector reports increasingly effective AMC case management processes."

103. The Coalition does believes that the shaky start does reflect upon the governance of the prison and that lessons can and should be learnt from a review the history of planning for management. It was the declared ambition of the government that the ACT prison should be ground breaking in its rehabilitative outcome yet, it

did not replicate even best practice in this area exemplified in Norway, Denmark and Finland or even Australian best practice found in Victoria and, more recently, in Queensland. Victoria in 2008-09 reported "a fall in the recidivism rate (the rate of return to prison within two years of release) for the seventh consecutive year [and] the achievement of the largest proportion of prisoners in employment" (p. 8.33).

104. Corrections recognized the central importance of case management to support through and after care if the prison was to meet its rehabilitative objectives. Indeed, the functional brief described case management as "the core of prisoner management and development" (p. 11). While it also recognised the need for involvement of the skills of external organisations both within and outside government, the plan for its implementation was developed by an in-house working group (ACS (2007b) p. 6). Case management is also mandated in the *Corrections Management Act* 2007 ss. 73 & 78. The Corrections Coalition understands that there has been a long delay in bringing the envisaged case management system into operation for the main reason that there were no trained case managers. Whether for financial reasons or otherwise, it was envisaged that the crucial role of case managers could be fulfilled by custodial officers. The prison's workforce plan explained the rationale as follows: "the modern day custodial officer is more like a case manager and less like a security officer. Positive engagement with clients will be critical to the success of the new strategic direction" (Cyrene Group (2007) p. 63). In the words of the Functional brief:

> "Each prisoner will be assigned an individual custodial Case Officer who will be supported by other professional staff. Case Management reviews will take place every three months" (ACS (2007a), p. 11)

105. Given the ingrained lack of trust by prisoners towards custodial officers that would require a paradigm shift to overcome, this expectation doomed the ACT Corrections case management scheme from the start. Dr Borzycki points out the difficulty of "recruiting qualified case management staff from correctional systems that may previously have focused on only surveillance/supervisory functions" (Borzycki (2005)). The Coalition notes the comments in the CIGG submission that "there has been a small increase in the number of case managers, and a recent commitment by management to minimise rotations." All too easily the role of case manager can conflict with the same person's correctional responsibilities and trying to do the best for the prisoner. For example if the prisoner breaches conditions and should be disciplined by solitary confinement but such confinement may exacerbate a pre-existing mental condition.

106. For the better part of 4 years the Corrections Coalition has been expressing concern about lack of adequate provision for through and after care. These concerns have been expressed in a string of correspondence from the Coalition (see: http://correctionscoalitionact.org.au/Correspondence/index.htm). The first was in a letter to the Chief Minister and Minister of Corrections and Health on 22 December, 2006. In the letter to the Chief Minister, the Coalition wrote:

- You also spoke of throughcare in prisoner management which "is aimed at ensuring an integrated and seamless approach to the delivery of services for offenders as they move between prison, community corrections and back to the

community." The released operational documents include no overall strategy nor do they contemplate planning for services after release into the community;

107. The Coalition went on to complain about lack of integretion of handling of people with mental health problems in the Corrections Drug and Alcohol strategy of management of detainees with mental health:

- "The overwhelming proportion of the prison population suffers from mental ill health or suffers from the mental disorder of substance dependence. Generally such prisoners will suffer from both. It is, therefore, vital that the prison mental health and drug strategies be thoroughly integrated. On the basis of the ACT Corrective Services Drug, Alcohol and Tobacco Strategy it appears that integration will not occur. It gives primacy to security which is reflected in a wide range of punitive measures that will undermine health and other rehabilitative objectives.
- In the critique dated 21 December 2006 attached to those letters, the Coalition called for Corrections to:
    - "Develop a plan providing for clear pathways to a co-ordinated range of services for released prisoners.
    - This will need to be drawn up by an authority other than Corrections though co-ordinated with Correction's "Throughcare" programme."

108. In his reply dated 16 March 2007, the Attorney-General wrote that: "ACTCS recognises that further work is required on planning for through care to the community and in determining which community agencies might provide the appropriate services. Further work will be undertaken on this matter in the coming months." Ominously, he bade the community be more realistic about what might be expected in terms of rehabilitation:

> "There has to be a realistic understanding by the community of what it can expect ACTCS in general, and the Alexander Maconochie Centre in particular, to achieve with respect to the many problems presented by prisoners. This should not be interpreted as any weakening of the commitment to rehabilitation in the AMC. However, we understand that there will always be community debate about `what works best' in rehabilitating prisoners and, as such, input such as your own is extremely welcome."

109. The "further work" that the ACS took in planning of through care appears principally to have involved calling for expressions of interest to provide services from community organisations. John Paget, Director, Prison Project, told a Corrections Coalition meeting on 16 August 2007 that Corrections had written 130 or so letters to community organisations "selected from the ACT Contact List". Corrections had informed a member of the Coalition that these included many sports and arts and craft ones. Mr Paget reported that Corrections had "received only 5 responses". Corrections planned to assess "how services offered would fit in to those provided by, for example, drug and alcohol workers or doctors, nurses or psychologists". Points that came out of the discussion included:

- Surprise was express that Corrections had not approached all organisations that provided services to the then existing Belconnen Remand Centre rather than picking out a sundry collection of organisations like sports and arts and craft ones from the Contact List as Corrections had told a Coalition member that it had. A number of corrections Coalition service providers were surprised that they had not received a letter.
- The process of calling interested organisations did not seem to involve a systematic consideration of the needs of prisoners.
  There was an impression that Corrections and relevant service providers were working in silos;
- Corrections itself did not have the resources necessary to give adequate attention to planning for service. It was preoccupied with commissioning the prison. The Minutes of the meeting record that:

  > The pre-occupation at the moment is not these services but getting the place built for commissioning next year. John Paget emphasised that the Prison Project is a small outfit with only 6 people. They have been visiting New South Wales, Tasmania and Victoria to see how these jurisdictions go about commissioning new facilities. Victoria alone deployed on their two new facilities 42 people to attend to just operational commissioning.

- It seemed that little if any funds would be available from the ACT Government to pay community organisations for services that they may take on. In August 2007. The prison's operating budget remained the same as it had been in 2003. Corrections hoped, that the operational budget would be indexed to preserve the dollar value that it had in 2003. It seemed that Corrections was proceeding on the basis that extra funds would not be available.

110. On 6 February 2009 the Coalition wrote to the Chief Minister proposing the establishment of "a cross-agency coordination body whose primary role would be to ensure that "throughcare" and "aftercare" services are well-planned, effectively and efficiently delivered, and subject to rigorous performance monitoring". The Coalition fowarded a copy of this letter to the Ministers responsible for health and corrections. The covering letter to the Minister for Health noted that: "the particular importance of a coordinated policy response to cope with the very high level of mental health and substance abuse needs among detainees".

111. Not having had a reply and remaining concerned at the lack of adequate planning and leadership for after care, the Coalition raised the issue once more in a letter to the Chief Minister dated 25 May 2009 which read:

> "The ACT Community Coalition on Corrections (the Coalition) seeks your Government's commitment to a whole of government planning and monitoring process to ensure effective aftercare for prisoners released from the Alexander Maconochie Centre (AMC). The Coalition remains concerned that insufficient attention is being given to coordination and communication about support for prisoners as they leave the AMC and re-enter the general

community, putting at risk the human rights and rehabilitation objectives of the AMC.

A forum was held on 14 May 2009, co-hosted by the ACT Community Inclusion Board and ACT Corrective Services, to discuss possible governance arrangements for the coordination of aftercare. An agreed outcome of this session was the establishment of a joint Government and Community Sector body to oversee aftercare coordination.

The Coalition strongly supports the establishment of such a group and urges you to act on this issue. The Coalition proposes that you establish a cross-agency coordination body whose primary role would be to ensure that throughcare and aftercare services are well-planned, effectively and efficiently delivered, and subject to rigorous performance monitoring.

A systematic approach is required, that brings in agencies beyond Corrective Services, who would be integral to the establishment of post release community support networks. Agencies that must be involved include Corrective Services, Housing ACT, ACT Health and Mental Health, key community organisations and other relevant agencies.

Specific issues such a body could cover include:

- Considering gaps in service provision, with recommendations on priorities;
- Continuing case management as needed, to ensure that aftercare is effectively linked to throughcare;
- Provision of timely, accessible and appropriate mental health and addiction support services;
- Enhancement of the capacity of family support networks of prisoners to provide support;
- Ensuring that specific offender groups, such as female and Indigenous, have their ongoing needs met;
- Determining lead agency responsibilities for key outcomes; and
- Establishing performance information.

Given the size and geographically contained nature of Canberra, we have a unique opportunity to get this right, and become a national and international model of excellent practice. To achieve this, we need not only a model prison, but also a model well-integrated system of throughcare and aftercare, including adequately resourced community services, to ensure that the substantial investment in the prison achieves the desired outcomes.

112. The Coalition ended with the assurance that it "would be happy to discuss these issues at your convenience and look forward to working with you in future" has not received a reply to that letter but the Chief Minister has since responded to the

Coalition's letter dated 6 February in a letter dated 22 June 2010. The Chief Minister sought to assure the Coalition that all was well:

> "The ACT Government is aware of the importance of supporting prisoners in their transition from prison to the community. As such, a throughcare approach is implemented at the AMC. Throughcare seeks to maximise rehabilitative and reintegrative opportunities for ACT prisoners by maintaining an integrated relationship between life in custody and life in the community. It seeks to enable a stable and managed transition from custody back into the community. ACTCS works in consultation with community organisations to ensure that this process is as seamless as possible.
>
> "Four throughcare seminars have been delivered since 2008. These seminars focused on the involvement of community agencies in the provision of services to prisoners and their families during incarceration and post-release. A throughcare expo was also held in February 2010. Local organisations and agencies possess extensive expertise in a variety of subjects and play an important role in helping to meet offenders' needs. In many cases they are able to provide advice and help to offenders while they are still in custody and, if necessary, to continue to provide it to the offender when he/she is released. In other cases they are only able to assist when the offender is released from custody. The help and advice offered to offenders by these agencies and organisations, forms an essential component of good throughcare work and their active involvement in the criminal justice system is encourage by ACTCS. A Community Reference Group has also been established as a medium to inform the community about the prison's operation and to receive community input, particularly in the areas of prisoner rehabilitation and reintegration.
>
> "To assist in the throughcare approach there are also multiple authorised and accredited visitors who regularly visit the AMC, talk to prisoners and/or staff and observe the day to day activities within the prison. Authorised visitors are generally members of community organisations.
>
> "In addition, every prisoner has a case manager assigned to them who is responsible for preparing post-release plans for the prisoners that will incorporate mental health support if required.

PEER SUPPORT

113. A sensitive challenge of managing a prison is the provision of peer support. Peer group support is a matter of particular importance for the comorbid population both from the point of view of those suffering a drug or alcohol dependency and of those having another mental health condition.

114. Dr Brown Director, ACT Mental Health, has told the Coalition "that in the mental health sector there is recognition of the importance of a strong role for peer support and that should carry over into prison. She added that she could not speak about what Corrections was planning around that more generally" (minutes of Coalition meeting of 20 September 2007).

115. Professor Ogloff of Forensicare in Victoria has backed this up. The then president of the Mental Health Consumer Network mentioned to the Coalition forum on suicide and self harm that the network was interested in consumer support because of the high percentage of people with mental health problems coming to prison. "The Consumer Network," he said, "was making efforts to develop a peer network and services to support others to engage consumers to work directly with them. He asked how that can be done. Professor Ogloff described such support as "critical":

> We have consumer consultants who are actually consumers who now have a formal paid role – in serving a constancy role in the organization. So they advise us. They work really as a link between patients and community.
>
> The other thing is that services like ours: we have staff, not many, two staff from our service in Victoria work with prisons. They follow up everyone who has been identified and involuntarily treated under the Mental Health Act. So when they are getting ready to leave, these people are notified. They make contact and they make sure there is going to be a link back to Mental Health.
>
> But the consumer bit is critical. In our service it's worked extraordinarily well having consumer advocates. You know consumers – someone who is essentially stabilised but who knows what it is like and can be much better than any of us at being a bridge between individuals in terms of helping them make the transition. (Ogloff (2008)).

116. Peer support has long been recognised to have health benefits in the area of substance dependency. In some jurisdictions, funding is provided for peer support programs within the prison, in light of the success of such programs in the community (Loxley *et al.* (2004) p. 220).

117. Justice Action runs a mentoring program involving people who have been in jail which has been very useful. At a Coalition meeting John Paget was asked about encouraging such a program in the ACT. He replied that the suitability of someone with a criminal record to provide services in the prison depends entirely on the nature of the criminal record. He added that it was his experience in South Australia, that if an embargo was placed on employing people with a criminal record, no Aborigines would be employed. He was used to employing people with criminal records. One has to be a little careful about risk management. Each case would be reviewed on its merits. There would certainly be no in-principle objection to people with a criminal record providing services (Minutes of Coalition meeting of 16 August 2007). The proposed legislation on employment of those dealing with vulnerable people may have an unfortunate constraining bearing on this.

118. Corrections is to be congratulated for facilitating the peer support program by the Women and Prison Group.

COLLECTION OF PERFORMANCE MEASURES AND THEIR INTEGRATION INTO THE MANAGEMENT OF THE PRISON

119. Early in the piece, the Coalition raised its concerns about the absence in planning of identification of adequate performance measures. Over nearly four years, the Coalition tried with indifferent success to engage Corrections in detailed discussion of this issue. In its critique of "the extent that the operational regime of the proposed ACT prison promotes rehabilitation" attached to its letter to ministers on 22 December 2006 it wrote:

> "Documentation issued so far is defective in that it contains no clear statement of what is involved in rehabilitation. Without that understanding there is no way of knowing whether the new ACT prison will be promoting the objective of rehabilitation.
>
> "At the very least the ACT Government needs to commit itself to measurable indicators of change. Given the potential importance of the family support network for the wellbeing of people, it should measure the "health" of such a network as well as matters specific to the person imprisoned. Indicators should thus include:
>
> - change in physical health on admission and release; including whether suffering from hepatitis C or B or HIV and other blood borne diseases;
> - change in mental health on admission and release;
> - changes in substance dependency on admission and release;
> - changes in social functionality of prisoners who are dependent on a substance;
> - attempts at self harm in prison including attempts at suicide;
> - assaults suffered by prisoners;
> - changes in health status of those released from prison in the first six months after release;
> - changes in the health and employment status and extent of family and social integration within six months of release compared to pre-arrest status;
> - recidivism;
> - changes in the capacity of those in the family support network of prisoners to provide support.
>
> "Documentation on the prison had very few of such measures. For example, of the 25 performance measures in the ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008 (pp. 29-30) only about six could be said to be a direct measure of improvement in the health and general welfare of the people concerned. The rest, like the "number of people banned and/or charged by the AFP" and "peer support sessions conducted" relate to administrative activities which are ambiguous or, at best, only remotely related to rehabilitation of the individual."

120. In his reply dated 16 March 2007 the Attorney-General refused to accept the criticism of performance measures in the Corrections drug strategy:

> A further concern raised in your letter was the perceived lack of . . . indicators such as recidivism or changes in health status by which rehabilitation can be judged'. With respect, I believe that the Performance Indicators proposed for the AMC, as detailed in the ACTCS AOD Strategy, sufficiently address this concern.

121. The Coalition took up the matter again in its letter to Simon Corbell of 30 April 2007, asserting that "Of the 25 so called Performance Indicators in the AOD Strategy only 6 will measure outcomes, the rest are simply measures of 'busyness'":

> The Coalition's letter made the point that performance measurements for rehabilitation should be in place to give effect to these objectives. On the advice of your Department you wrote that "the Performance Indicators proposed for the AMC, as detailed in the ACTS AOD Strategy, sufficiently address this concern." They patently do not as the attached table shows. An evaluation strategy needs to be established which is based on adequate performance indicators and which clearly and transparently measure the performance of the AMC against the objectives that have been established. The Coalition has concerns that the proposed performance indicators will not be adequate to the task. Of the 25 so called Performance Indicators in the AOD Strategy only 6 will measure outcomes, the rest are simply measures of "busyness". The Coalition therefore asks that a great deal more attention be paid to the identification of performance indicators in the AOD Strategy and other documents.

122. The Coalition attached to its letter a table comparing outcomes from the prison to which the Chief Minister had committed the Government with those identified in the corrections drug strategy and what the Coalition suggested.

PEFORMANCE MEASURES FOR THE ALEXANDER MACONOCHIE CENTRE

Outcomes to which the Chief Minister has committed the Government	*Performance measures under Drug, Alcohol and Tobacco Strategy*	*Proposed performance measures*
Humane and safe detention "More secure, humane and safer accommodation" - Not "accommodated with a significantly larger population where violence, assault and power are features of the dominant culture".	------	• Assaults and other victimisation of prisoners including bullying • Extent of self harm • Changes in mental health status during detention
Rehabilitation "The prospects for the rehabilitation of ACT sentenced	------	Changes before and in six months after detention in: • Welfare dependency

Outcomes to which the Chief Minister has committed the Government	*Performance measures under Drug, Alcohol and Tobacco Strategy*	*Proposed performance measures*
prisoners will be improved"		• Employment status • Accommodation status • Debt • Family integration • Social contacts e.g. with others in the dru scene
Recidivism "possibilities for reducing rates of recidivism will be improved" and "Reductions in offending behaviour"	------	Changes over time in the percentage of released prisoners who re-offend.
Physical Health "The health and well being of the ACT prisoner population will be improved"	------	Change in physical health on admission and release; including whether suffering from hepatitis C or B or HIV and other blood born diseases
Addictions "reducing drug and alcohol addictions"	"Decreased demand for drugs in the AMC, PDC and community corrections" (p. 29)	Extent of drug and alcohol use in six months before detention, on release and six months after release
Mental Health "making improvements in mental health"	------	Change in mental health on admission and release
Self harm "minimising self-harm"	"Deaths and self-harm in custody" (p. 30)	Deaths and self-harm in the six months following release as well as during custody
Education and skills "Improvements in prisoner educational attainments will be	------	• Skills and educational qualifications attained in detention • Usefulness of those skills in the Canberra

Outcomes to which the Chief Minister has committed the Government	*Performance measures under Drug, Alcohol and Tobacco Strategy*	*Proposed performance measures*
targeted" "improved training and work skills that are appropriate and transferable to the workforce in the Canberra region"		workforce • Employment status before and after detention
Reintegration "smooth reintegration of prisoners back into the ACT community on release"	------	See under *Rehabilitation* above
Family interaction "Prisoners will have greater accessibility to, and interaction with, family and other supports to assist in their rehabilitation and to maintain family unity."	------	Performance measures need to be developed directed at: • Changes in positive family and other relationships during detention; • Changes in family unity associated with detention; • Extent of contact between detainees and family; • changes in the capacity of those in the family support network of prisoners to provide support
Children of detainees "risk factors confronting families with children coming into contact with the criminal justice system will be reduced."	------	Performance measures need to be developed directed at: • maintenance of healthy relationship of prisoners with their children (§5.14) • whether relationship of prisoners with their children has fractured (§5.17) • extent to which children of prisoners get into difficulties such as school drop out, develop mental health problems, self harm, become drug dependent or offend (§2.33)

123. The Coalition replied to the Attorney-General on 1 June 2007 with a further letter requesting confirmation that the Government remains committed to listed outcomes from the prison identified in the Chief Minister's speech to the Assembly in August 2004.

124. The Attorney-General replied to this letter by one dated 15 August 2007. This letter suggested that the Coalition discuss performance indicators with Mr Paget at a meeting scheduled with Mr Paget the following day, 16 August 2007. The Coalition

did not receive this letter until well after that meeting to which, in any case, had been arranged to discuss engagement of non-government organisations in the operation of the new prison (letter of Coalition to Mr Paget dated 24 July 2007) and did not discuss performance indicators beyond a revealing incidental reference to reports that community organisations would need to provide on their visits. As recorded in the Minutes of the meeting, Corrections was preoccupied with the audit requirements measuring inputs and not with measuring outputs:

> "John Paget said that Corrections would want to be sure, in order to comply with the Audit Act, that a contracted service was in fact being delivered. There will thus be a reporting regime that will give comfort to the Auditor-General. The Government would also wish to know that what it was paying for is contributing to outcomes that the Government wishes. John Paget does not quite know what they will be. In some therapeutic programs, it is possible to measure the inputs but measuring the outcomes is very difficult" (Minutes of Coalition meeting dated 16 August 2007).

125. In a further effort to engage Corrections in detailed discussions on performance measures, the Coalition wrote to the Chief Minister in October 2007, inviting the participation of Corrections in the development of a report card. On 10 December 2007 the Chief Minister replied declining to participate on the ground that:

> "the Prison Project has been subject to close government scrutiny since its inception. There will be mechanisms established within government to monitor and review the AMC's operations against policy and operational objectives, as part of normal audit and review processes. Therefore, the ACT Government has chosen to decline your invitation to participate in the Community Coalition's 'report card'".

126. This appeared to contradict what the minutes of the Coalition meeting of 16 August recorded: that the head of the prison project did "not quite know what outcome indicators will be. In some therapeutic programs, it is possible to measure the inputs but measuring the outcomes is very difficult."

127. The refusal of Corrections and Government to plan for outcome measures of core relevance to detainees suffering comorbidity conditions was confirmed in the Chief Minister's letter dated 22 June 2010 giving the Government's reply to the key recommendations of the Coalition's *Healthy or harmful* study. One of the recommendations was that:

> There must be put in place standing arrangements to monitor and evaluate the effectiveness of the prison by reference to what occurs to people after and not just on their release.

128. The reasons for this were explained on p. 33 of the report:

> "Evaluation of the effectiveness of the prison regime must involve evaluation of the capacity of those who graduate from it to function in society. Prison must not be evaluated as a closed system – on how well people function within it – but on whether it enhances people's capacity in the real world.

> Prison will not be rehabilitative unless it serves to enhance that capacity. Standing arrangements to monitor and evaluate the effectiveness of the prison must therefore assess what occurs to people after and not just on their release. If people return to the community with no measurable improvement in social and economic outcomes, the new prison will have failed its own objectives. Even worse, if it turns out that people released are at greater risk of committing suicide, of overdosing because of an addiction or are in worse mental health, the Government and the community must both acknowledge and address this. The Government and community must also know whether the prison will reduce recidivism which will, of course, track success in rehabilitation."

129. The Chief Minister's letter dismissed the need for Corrections to assume responsibility for post corrections data.

> "As mentioned above, it is the intention of ACTCS to collect data on recidivism which will be used to evaluate rates of recidivism and rehabilitation. In addition, there are mechanisms established within government to monitor and review the AMC's operations against policy and operational objectives, as a part of normal audit and review processes. With respect to your suggestions concerning post-release surveys, I draw your attention to the proper limitations placed on ACTCS once a prisoner is no longer in its legal custody.

130. It is, of course, quite right that privacy of graduates of the prison are respected but, patently, it is possible to gain the information of post release health status and the like by means that satisfy the requirements of ethical committees overseeing research. The level of suicide can, for example, be gauged by a review of coroners' records. The Chief Minister's response invites the conclusion that the Government wishes to remain in wilful ignorance of how effectively the prison is tracking in delivering the social dividends that the Government has promised.

Lack of reporting on recidivism

131. That the prison will reduce recidivism has featured in the Government's rhetoric as justification for the prison and in the creation of a safer community. Less crime that flows from reduced offending is the earnest hope of the ACT community and the main if not only justification in the eyes of many of its residents to justify that very high outlay to build and run the prison. The Chief Minister's words to the Assembly in August 2004 have already been quoted: "Possibilities for reducing rates of recidivism will be improved" and there would be "reductions in offending behaviours".

132. It is all the more surprising then that the Corrections has not and still is not reporting on any possible measure of recidivism. In particular, unlike all other jurisdictions in the country it does not report on either of the two measures of recidivism used by the Productivity Commission in the production of the commission's annual report on government services. The two measures are:

- the percentage of prisoners returning to prison within two years of release

• the percentage of prisoners returning to corrective services (either prisons or community corrections) within two years of release.

133. A footnote to the Commission's report explains that: "The ACT did not report on either indicator, because for most of the reporting period the majority of full-time prisoners sentenced in the ACT were held in NSW prisons." This may be some justification for not providing information on return to prison but the Corrections should still be able to provide data on return to community corrections which it administers.

134. There is much academic debate on what the best measure of recidivism should be. This is reflected in a lengthy discussion in a Corrections planning paper for the prison (ACS (2007b), pp. 55-56). Achieving perfection in that or in knowing what recidivism is in absolute terms is less important than knowing the trend over time in accordance with a consistently collected (if imperfect) set of statistics. To assess the impact of the new prison one needs to know a recidivism rate for ACT sentenced prisoners for several years before the establishment of the new prison and the continued collection of statistics on a similar basis from the time that the new prison opens. It is for this reason that the Coalition wrote to the Government in April 2007 that "Base line measures of recidivism should be established before the AMC is opened" (see §122). This does not appear to have been done.

135. Unlike the Department of Disability, Housing and Community Services which has responsibility for youth detention, the Department of Justice and Community Safety does not have a target for recidivism but instead purports to apply the following amorphous and subjective accountability measure:

> "Reduced risk of offender re-offending for clients of ACT Corrective Services - % and number of offenders whose assessed risk reduces over time"(ACT Treasury (2010), output 2.1, p. 260).

136. The Attorney-General in an answer in the Assembly on 7 December 2007 to a question from Mr Seselja stated:

> (1) The ACT does not report on recidivism as an indicator.
>
> > (a) This data is not presently disaggregated from NSW data; however, ACT Corrective Services is working towards collating the data for input into its database system when the Alexander Maconochie Centre is in operation.
>
> (b) Refer to (a).
>
> (2) The projected recidivism rate for the Alexander Maconochie Centre will initially be benchmarked against the national recidivism rate.

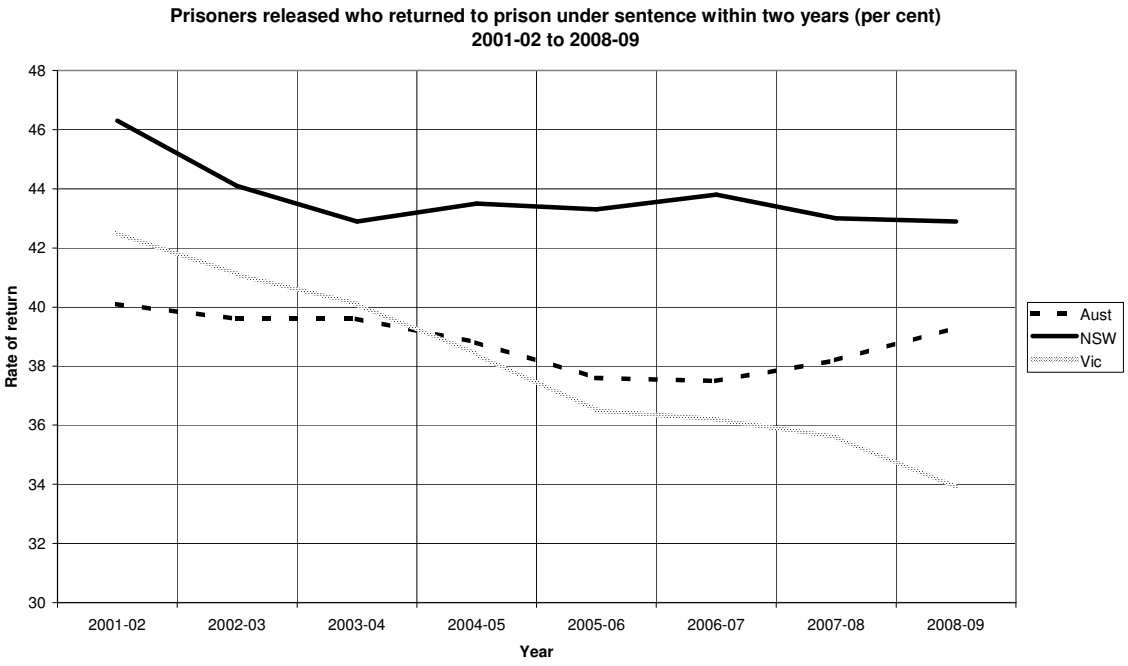
137. In summary, the present situation appears to be that:

(a) Corrections has yet to identify the recidivism rate over a run of years for ACT prisoners who served their sentences in NSW. In other words, Corrections has not established a benchmark against which the performance

of the new prison can be compared to performance of ACT prisoners under the NSW system.

(b) It is intended that the performance of the new prison will be compared not against the best Australian practice (Victoria) but against the national return to prison rate.

138. A great deals hangs on what an ACT recidivism rate is compared to as the following chart of return to prison rates drawn from the Report on Government Services shows:



Source: Productivity Commission, *Report On Government Services 2010,* vol 1, part C, Justice, table C3, p. C11. & *Report On Government Services 2007* table C4:

Utilisation of performance indicators in management of the prison

139. From the above history, the Coalition infers that:

- in planning for its opening, Corrections did not take effective measures to identify performance measures for the new prison or
- the performance measures that it did focus upon related to inputs of "busyness" rather than outputs;
- Corrections did not see it as its responsibility to collect data on whether graduates from the prison were effectively rehabilitated and reintegrated into the community;

- There was no plan to capture key performance indicators into a management system to guide day to day management of the prison.

140. It is this last point about capturing key performance indicators into a management system to guide day to day management of the prison that the Coalition wishes to make brief reference. The Coalition suggests that close attention be paid to prisons where this is done. In particular, the Coalition urges consideration of the adoption of a management system such as has been successfully applied in the Oslo prison in Norway since September 2001.

141. The Oslo prison itself identified 25 “measurement parameters." These included

- the number of service days done,
- police access to custody cells
- the degree of prisoners' dissatisfaction or satisfaction with their situations.
- visits,
- the use of narcotics,
- escape attempts, violence and threats of violence,
- leaves of absence,
- degree of cooperation with external bodies,
- absences due to illness among the employees,
- changes in employees' competence profiles,
- worker contentment,
- budget deviations; and
- the number of positive notices in the nationwide media.

142. These 25 parameters cover all significant aspects of both the condition of inmates and the work of prison employees. The Governor of the prison, Are Høidal, explained that the management system that has operated since September 2001 was to meet government requirements. He explained that:

> “we must be more goal oriented. Amongst other things, there are now faster penal reactions, requiring tighter individual follow-up of the prisoners. In order to achieve this, Oslo Prison must be more effective than it previously has been. To make this possible, we must have better control tools and better decision-making tools than before.”

143. Information on this system, referred to as "a Balanced Scorecard" is available at http://www.sas.com/success/pdf/osloprison.pdf.

144. A lot of other information in English about the system applied in this Norwegian prison (only slightly larger than that of the ACT) is available on the web.

145. The Coalition urges that inquiries be carried out into the feasibility of providing management with a similar resource.

INADEQUATE APPRECIATION OF WHAT A HUMAN RIGHTS COMPLIANT PRISON ENTAILS

146. From the start, Corrections embraced the concept of a human rights compliant prison that met the requirements of the ACT's Human Rights Act 2004. It hosted a forum on 2 July 2004, the day after the Human Rights Act commenced. "To guide us through this process in the ACT, we have a human rights working group which includes representatives of the Human Rights Commissioner, the Ombudsman and Dept of Justice. the working group is developing the operating procedures for the new prison so that we can deal with potential areas of contention, now, not after commissioning" (Paget (2005).

147. Indeed, John Paget, the Director of the Prison Project was very well versed in both international and national aspects of human rights and prisons (see Paget (2005)). Mr Paget and others representative of Corrections stressed human rights compliance in addresses to a wide variety of community groups. For example, Mr Paget informed the Coalition on 16 August 2007 somewhat dismissively that he had been dealing with some 60 or 80 groups and not just the 15 represented at that Coalition meeting. He mentioned that in the previous week "he spent time with the National Women's Council [and that in the] next week he [was] to meet with a collection of Aboriginal community groups. There are thus 60 odd groups having an interest in the project and have been engaged in it in some shape or form." The Coalition had the impression that:

- Stress was placed on the physical structure and layout and that Corrections was far less willing to engage in discussion about its operation.
  A feature of presentations to community groups was the human rights compliance of the physical structure and layout of the prison with its views, "cottages", absence of bars on windows and the like. According to Professor Ogloff such matters are of second order importance compared to staffing culture:

  > "You cannot have a new building without a new culture. So the hospital I work in opened in 2000 and replaced Victorian institutions that you can now tour. So people come to Victoria and they look at these old institutions which are now tourist sites. They were housing mental health patients 10 years ago and when the Thomas Embling Hospital opened it was expected that things like aggression would be reduced, self harm would be reduced, damage to furniture. We actually reviewed it within the first year or two of opening and all

those things were actually up. There were higher rates of all these things because the culture itself didn't change. So it's the culture first, the building second. The only way I know to instil it that I know is clear policies and very strong leadership from professional correctional managers." (Ogloff (2008)).

- When there was discussion of operational aspects, Corrections tended to stress legal remedies rather than engage in discussion of how the operation of the prison would be tailored to comply with human rights standards and achieve the government's rehabilitative objectives – an impression evidenced by the reluctance of Corrections to have meaningful discussions on matters like performance indicators and through and aftercare. The Coalition would have welcomed free ranging discussion with Corrections on how best to achieve the objectives for the prison enunciated by the Chief Minister in his speech to the Assembly in August 2004. Audiences were assured that the Corrections Management Act and operating procedures were drawn up in close consultation with a Human rights working group.

  For example, in discussion on 15 March 2007 with the Director of the Prison Project, a lawyer from the Department of Justice and Community Safety (together taken as reflecting the views of Corrections) and a representative of the Human Rights Commission on the Corrections Management Bill, Corrections concentrated on the legal question of how the Human Right Act will require courts to apply a purposive interpretation of the Bill when enacted:

  > "The ACT has a purposive approach to interpretation. This includes interpretation of human rights in a manner that maximises them. Unless it is absolutely clear that the legislation in question qualifies the right, the legislation has to be read as consistent with a human right."
  >
  > The point was also made that the bill had been drafted in close consultation with the Human Rights Commission. A Human rights working group consisting of Human Rights Commissioner, the Ombudsman and the Dept of Justice but no community representation had provided the human rights oversight in planning for the prison. In a lecture that the Director of the ACT Prison Project gave in 2005 he noted that:
  >
  > > "The working group is developing the operating procedures for the new prison so that we can deal with potential areas of contention, now, not after commissioning" (Paget (2005)).
  >
  > This information was reassuring, but it left open how, in practical terms, those in the prison would be able to embark on the cumbersome legal process to secure prompt redress for any infringements of their human rights. Some at least, had the impression

at the meeting that redress under the Human Rights Act was a bit like the Ritz Hotel in being open to all.

- There was undercurrent in much discussion by corrections of human rights and the prison that human rights were all very good but that it was necessary to be realistic and recognise that the ACT was establishing a prison. For example, the Corrections human rights forum on 2 July 2004 was divided into three sessions, the first two of which were both about "the operation of safe and secure prisons." Mr Paget's lecture on "*Human rights, prisons and women prisoners*" included the following parting warning:

  "We are not doing this through rose-coloured glasses. Correctional history is littered with well-meaning 'liberal' correctional regimes that went wrong. Also, we are acutely aware that if the public perception is that the Human Rights Act is simply a "prisoners' charter" then the Act will be damaged, and that will be in no-one's interests." (Paget (2005)).

  And there was the invocation in the letter of 16 March 2007 from the Attorney-General that: "There has to be a realistic understanding by the community of what it can expect ACTCS in general, and the Alexander Maconochie Centre in particular to achieve."

- For the Coalition the greatest practical benefit of the Human Rights legislation has been the audits and other investigations of correctional facilities undertaken. When these have been made public (and not all have), they have provided an accurate and detailed picture of conditions and thus constitute a reliable basis upon which the Coalition and Community at large can forms views about the prison. The Coalition notes with concern comments by the Human Rights Commissioner that shortage of funds are impeding the Commission undertaking further audits and other investigations.

148. The observance of human rights is not brought into effect by proclamation of the concepts but at the level of implementation which involves human beings aligning their behaviour to human rights norms. The experience of the Coalition in the years leading up to the establishment of the prison has brought to mind the sober warning of Professor Tony Vinson: "that the best [of the many] prison systems that he had seen [were] in the countries [like The Netherlands and Sweden] . . . .where there is least optimism about any gains that will come from prison . . . . If you manage to put people out the back door no worse than they were when they came in the front door, that would be a big achievement" (Vinson (2008)).

MANAGING ADDICTION AS A MENTAL HEALTH RATHER THAN A DISCIPLINARY OR CRIMINAL ISSUE

149. 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)) yet in many respects Corrections responds with disciplinary measures to the addiction of prisoners. The *Healthy or harmful study* argued that rather than giving top priority to making detainees drug free, priority should be given to people emerging from prison with the physical and mental capacity to take their place in society as responsible members who are capable of fulfilling their obligations both to those dependent on them and the community at large. Promoting a drug free prison should be subsidiary to promoting the overall well being of prisoners which may well require that priority should be given to other problems before "solving" their drug problem. This is particularly the case in the area of comorbidity of substance abuse and mental disorders – which in prison is "the expectation rather than the exception". The focus should be on stabilisation of an addiction problem rather than unrealistically in all cases requiring prisoners to overcome their addiction. Such an approach accords with the reality that many people get into serious trouble with drugs because of other problems (e.g. self-medication for a mental illness) and that the primary focus should be on addressing those problems rather than the drug one:

> "the strength of the causative relationship from our experience has been from pre-existing mental illness towards substance misuse, not from substance misuse towards mental illness" (Father Peter Norden SJ).

150. The Chief Minister rejected the need for such a priority. "ACTCS," he wrote, "gives equal priority to making prisoners drug free and ensuring they have the physical and mental capacity to take their place as responsible members of society." However desirable it is that both goals are met and that treatment and other help be directed to that end, the reality is that many who have become abstinent in prison will relapse to drug use when faced with the difficulties of reintegrating themselves into the community. As the *Healthy or harmful study* pp. 34-36 examined, the danger of aiming for two goals is that both will be missed with a resulting high risk of death from suicide and overdose upon release. The success of the prison in achieving long term abstinence will be impacted by the proportion of prisoners who have the benefit of the Therapeutic Community and of the effectiveness of the through care programmes in easing their return to the community and supporting their mental health and other needs. At present only a small number of prisoners have a place in the TC program, none of whom are women. The attitude of other prisoners is said to deter many from undertaking the program.

151. The Drug, Alcohol and Tobacco Strategy 2006–2008 (ACS (2007c)) that Corrections formulated served as the basis for the establishment of the new prison and shaped the operational regime of the prison. In recognition that not all drugs and all means of consumption are equally dangerous, the strategy acknowledged the desirability of differential sanctions for drugs entailing different levels of harm. It envisaged voluntary drug free cottages and thus for the operation within the prison of a Therapeutic Community. It contains one reference to the reduction and not just elimination of drug use being a worthy aim. On the other hand the Corrections drug strategy can be criticised on a number of grounds:

- Both the Corrections Drug Strategy and the *Corrections Management Act* (which makes no reference at all in its body or in the Act's associated explanatory statement to "harm minimisation") accord priority to prisoners becoming drug free and are informed by the belief that the prison environment can force prisoners to overcome their addiction.
    - ♦ This outlook and belief is reflected in the many references to enforcement to prevent drugs coming into the prison and to penalising those who breach the drug rules.
- The Corrections Drug Strategy pays only lip service to the integration of service delivery for mental health and substance abuse problems that the report of the Senate Select Committee on Mental Health emphasised:

    "Governments appear to have difficulty engaging with the realities of dual diagnosis. This is reflected in the declaration in the National Mental Health Plan that 'drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'. The evidence before the committee clearly indicates that it is counterproductive to separate out mental health and drug and alcohol services in such a definite way" (Senate (2006) §14.166).

    In the prison, treatment of drugs is divided between a) Health, responsible for mental health and prescribing and dispensing pharmacotherapies, and other drug treatment services for which they are answerable to and b) controlled by Corrections.
- The focus on enforcement with references to searches and penalisation of visitors will impede the aim of integration of prisoners with their families which the document itself accepts is crucial to achieve successful reintegration into the community after release.
- The document as a whole is littered with platitudinous general statements. As such it appears a public relations production rather than as a meaningful guide for managing the large and very real difficulty of substance abuse in a prison environment – a reality that has come to pass. rather than insisting that it can be overcome.
- It lacks a robust statement that first class drug treatment (incorporating integrated drug substitution and integrated abstinence programs) and a public health focus regarding substance abuse is a key to the achievement of good order and other beneficial outcomes from the prison.
- There is no recognition that, as in the community, drug workers in the prison should be the responsibility of the authority responsible for health in the prison.
- The strategy makes no provision for sterile syringes.

152. Professor James Ogloff who has had vast experience in prisons in British Columbia and now with Forensicare and Thomas Embling Hospital in Victoria, has written in support of the integration of drug and alcohol workers with the mental health team:

> "Depending upon the nature of the correctional system, the alcohol and drug counsellor (or equivalent) should also be affiliated with the mental health team, given the extensive overlap between offenders with mental illness and substance abuse problems" (p. 20).

153. In a letter dated 22 December 2006 to the Chief Minister, the Coalition observed that under the Corrections drug strategy, the approach to mental health was not integrated with the drug strategy:

> "The overwhelming proportion of the prison population suffers from mental ill health or is dependent on substances. Generally such prisoners will suffer from both. It is, therefore, vital that the prison mental health and drug strategies be thoroughly integrated. On the basis of the ACT Corrective Services Drug, Alcohol and Tobacco Strategy it appears that integration will not occur. It gives primacy to security which is reflected in a wide range of punitive measures that will undermine health and other rehabilitative objectives" (Ogloff (2002) p. 20).

154. The Attorney-General on behalf of the Government replied on 16 March 2007, apparently taking the point about the Corrections drug strategy but asserting that it needed to be read with other documents:

> "In your letter it was stated that the ACT Corrective Services (ACTCS) Drug, Alcohol and Tobacco Strategy (AOD Strategy) emphasised security at the expense of prisoner health and rehabilitative objectives. While the Coalition's concerns are noted, the ACTCS AOD Strategy should not be viewed in isolation but should be read in conjunction with the following documents:
>
> - The AMC Functional Brief (Available on the AMC website)
> - Vocational Educational and Training and Rehabilitative Programs in the AMC 2006 (Available on the AMC website)
> - The ACT Health, *Corrections Health Services Plan* -- to be published later this year."

155. When this was written, Corrections planned that health services would be under the control of corrections which, in their mind, would facilitate the integration of mental health. Corrections saw itself as outsourcing drug and alcohol services. As it turned out, of course, the Corrections Management Bill was amended so that the 2007 Act provides for the therapeutic doctor to be appointed by the Health Department. The resulting adult corrections health plan does not purport to integrate drug and alcohol and mental health services. Corrections Health carry out a "drug and alcohol assessment" on prisoners when they enter (ACT HEALTH (2008) p. 16). They provide methadone replacement therapy (ibid., p. 14). The core medical staff is "supported by an extensive team" but the list that follows includes no reference to drug and alcohol services nor to the prison's therapeutic community. In other words the prison lacks the integration of mental health and drug and alcohol services which best practice says should exist:

"The core medical and nursing staff will be supported by an extensive team comprising of, but not limited to, general practitioners, forensic mental health staff, psychiatrists, other health professionals including allied health staff, dental staff, health promotion experts and an administration officer. This team will undertake:

- mental health assessments upon remand;
- specialist mental health services including psychiatric services (note a secure mental health inpatient unit is planned to operate from a separate campus and is not included in the Corrections Health Plan);
- general practice services;
- dental health clinics;
- specialist medical services;
- allied health services including access to the full range of secondary and tertiary services as required;
- health promotion;
- palliative care; and
- specific services for Aboriginal and Torres Strait Islander prisoners" (ACT HEALTH (2008) p.14)

156. At the Coalition meeting of `4 Nov. 2007, Barry Petrovski outlined concerns of the Mental Health Community Coalition around the absence of a forensic mental health facility, the absence of community sector capacity to complement mental health services provided by the government and for pathways to be established for those emerging from the prison to community services. He said that several sites for the forensic mental health facility were being considered. A well qualified person from Forensicare in Victoria was advising on the facility. He said that consumer-carer participation is a key policy platform within ACT Health at the moment. Health is developing an over-arching consumer-carer participation framework for all health services.

157. Issues that came up in discussion of the paper:

- The need for professional mental health input independent of Corrections in the development and operation of the prison's operational regime.
- The suitability of ACT Mental Health, the ACT Chief Medical Officer, the AMA (as suggested in the paper) or Forensicare to fulfil such a role.
- The need for whole of Government planning to make "throughcare" a reality including supported accommodation tied to packages of care for people recovering from a mental illness.
- The need for community organisations to be actively involved in this process.
- Provision of resources to fund this.

- The importance of having mental health input from consumer-carers and the community sector into the operational regime through an oversight body.
- Similar involvement of drug and alcohol consumers and the community sector.
- The scope for the Community Consultative Committee with a strong consumer-carer and community sector representation to have a mandate to provide advice on the operation of the prison.
- Whether a special consultative forum to look at the operational regime should be recommended, this forum to have government and consumer-carer and community sector representation.
- Whether such a group should be attached to the Human Rights Commission.
- Whether there exists in other jurisdictions like Canada examples of innovative prison governance such as the Coalition is considering.
- Need for the Coalition, ACTCOSS, the Mental Health Coalition and Consumer Network to work closely together.

STRATEGIES TO DEAL WITH COMORBIDITY

158. The logic is unanswerable that if the ACT wishes to reduce recidivism and otherwise reap the benefit expected by the Government of the prison, the ACT must implement programs that research tells us are effective in addressing the needs of those with a comorbidity and desist from practices that research tells us aggravate mental disorders including substance dependency. We know that this comorbidity, shared by a large proportion of the detainee population, is likely to be the most potent factor behind incarceration. The high proportion of drug consumer arrests illustrates that a high proportion of drug users are exposed to the stresses of the criminal justice system:

159. The problem is complex but far from insoluble. The reviews should identify programs that work and the changes to the management structure that are capable of giving effect to those programs. The recent study by the NSW Bureau of Crime Statistics and Research usefully summarises interventions that are known to work with this population which so often falls between the cracks of existing services:

> " . . . rates of re-offending are substantially elevated among those with a mental health disorder only where it involves comorbid substance and non-substance mental health disorders. Unlike some re-offending risk factors which are static and thus cannot be changed (such as the offender's age, gender and criminal history), an offender's mental health status and substance misuse are 'dynamic risk factors' and therefore more amenable to change with effective treatment.
>
> There is considerable evidence that various programs or strategies can reduce the re-offending rates of mentally ill offenders, drug misusing offenders and offenders with comorbid substance and non-substance mental health disorders" (Smith & Trimboli (2010) p. 9).

160. Information in the following table is drawn from pp. 9-10 of the same study:

Table: Programs that effectively address comorbidity

Program	*Whether implemented in the ACT*	*Comments*
Opioid maintenance treatment such as methadone	Provided by Correction Health	
Specialised mental health court to divert mentally ill offenders from the traditional court system	Not available in ACT	18 months after enrolling in a mental health court, the likelihood of participants being charged with any new crime and with new violent crimes was, respectively, 26 per cent and 55 per cent lower than that of comparable individuals who received treatment-as-usual. (9)
Drug court	Not available in the ACT	Drug courts have been found to achieve, on average, a statistically significant 10.7 per cent reduction in recidivism rates of participants relative to treatment-as-usual comparison groups. NSW drug court participants were 17 per cent less likely to be reconvicted for any offence, 30 per cent less likely to be reconvicted for a violent offence and 38 per cent less likely to be reconvicted for a drug offence at any point during the follow-up period (which averaged 35 months)
Diverting individuals from prison to community-based treatment and support services	Police and court diversion programs theoretically available.	
In-prison 'therapeutic community' programs, that is, programs for drug-involved offenders in a prison setting which contains separate residential units	Solaris program run by ADFACT. Available in the prison. Funded by the Commonwealth (ADFACT (2008/09)).	Only a small proportion of detainee population on program. Gains in terms of reduced recidivism are only modest: "the average therapeutic Community can reduce recidivism by 5.3 per cent, and a community aftercare component slightly increases the program's effectiveness to 6.9 per cent"
work-release therapeutic	Not implemented?	A study of recidivism and drug

Program	*Whether implemented in the ACT*	*Comments*
community program		relapse experiences of substance-abusing female prisoners as they re-enter the community ". . . found that, compared with women who did not receive treatment, women who completed a six-month work-release therapeutic community program were significantly more likely to remain arrest-free and to engage in less extensive drug use.
Multi focused co-ordinated Treatment programs involving pre-release planning and intensive case management	Inadequately implemented. Recommended in CIGG submission	Treatment programs which are well-planned, co-ordinated, intensive and provide integrated attention to both substance and non-substance mental health disorders are particularly relevant to reducing re-offending (and psychiatric hospitalisations) among offenders with comorbid substance and non-substance mental health disorders when they are released from prison. Recidivism rates can be significantly reduced for mentally ill offenders by combining pre-release planning and intensive case management services that deal with both their mental health and substance abuse problems and by providing offenders with a treatment program based on interagency collaboration (across criminal justice and health settings). The researchers compared the reconviction rates of two groups of mentally ill offenders released from prison. A group of 64 offenders, 18 of whom participated in an intensive case management program were compared with a group of offenders matched on a number of variables that predict recidivism, including number of prior convictions, age at release and gender. Two years following their release from prison, the felony reconviction rate for program

Program	*Whether implemented in the ACT*	*Comments*
		participants was half the rate of the matched controls (23% vs 42%).

COSTS

161. Delivering the social benefit identified by the Government for the ACT prison does not come cheaply. The total costs of Corrective Services in the 2010-11 budget for:

> "Provision of safe and secure custody for prisoners with a strong focus on the delivery of rehabilitative, educational and vocational programs, effectively managing unsentenced offenders and community based corrections programs, and providing advice and services to the ACT justice system"

was $45,392,000 (ACT Treasury (2010) p. 255). This is in spite of the fact that in many cases, community organisation supply services do so within their general budget without supplementation by Corrections. That may lead to under estimation of the real cost of supplying services. On the other hand, the small size of the detainee population for the ACT compared to other jurisdictions, involves higher per capita costs to provide programs tailored to meet the diverse needs of individual detainees.

162. The high cost of Corrections in the first full year of operation of the ACT prison, is reflected in the Productivity Commission report on Government 2010 (Productivity Commission (2010b) table 8A.9), which reveals the "Real net operating expenditure per prisoner per day" for the ACT to be $466.40. This is 122% higher than the Australian average, 126% higher than NSW and even 92% higher than Victoria with its praised after and through care programme. The cost per head may even be higher. On 6 May this year, in answer to a question the Attorney-General reported on that "The daily cost per prisoner as at end December 2009 was $510". Moreover the reported 29% increase in detainee population in the past 12 months Bucci (2010)) means that the prison population will quickly outstrip the capacity of the prison and will impose huge additional burdens on the budget. The disproportionately high ACT Corrections budget is a reason in itself to pay close attention to the efficiency and effectiveness of ACT Corrections. And the issues go beyond Corrections.

> (a) is the ACT community receiving value for money by investing so much money in incarcerating its citizens when it is known that incarceration is likely to harm mental health, do little to reduce substance dependence for the prisoners as a whole, many of whom are not getting the benefit of the Solaris programme?
>
> (b) is money better spent on community programs targeting those at high risk of offending?
>
> (c) is the complex condition of comorbidity beyond the capacity of Corrections and prison management as presently constituted?

CONCLUSION

163. Time and again in this review of certain aspects relating to operation of the prison, the need for appropriate managerial structures has come up, whether it be for a lead agency to co-ordinate throughcare, mechanisms to engage the whole of government in providing services within the prison or the need for close co-operation between drug and alcohol and other mental health services. The submission has also made the point that giving effect to human rights principles must intimately affect every aspect of how the prison is to be run from discipline to activities to maintaining links of prisoners with the family and community. One possible response will be to make *ad hoc* managerial changes to cope with each individual matter.

164. The Coalition argues, though, that all the aspects of running the prison are so various yet interrelated in their capacity to impact on the prison's capacity to achieve the objectives that the Government has set for it that only by governance changes at the highest level of Corrections as put forward by the Coalition in its *Healthy or Harmful* study will be effective to initiate and drive change at all the different levels and aspects.

165. ACT residents provided heart-rending evidence to the joint inquiry of the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission into mental health services leading to the *Not For Service* report (e.g. MHCA (2005) pp. 201, 215, 279, 308). The report catalogued the scandalous failings of the mental health system in this country which often leaves police to handle mental health needs and utilises prisons as *de facto* mental health facilities. The cost in human suffering has been enormous. Moreover, as the example of countries like Norway show, the community stands to gain enormously by a corrections system that seeks to arm those detained with the capacity to function effectively in the outside community. Reintegration of those detained into the community should be core business of Corrections which is not the case with ACT Corrections which sees its responsibility ending once someone detained leaves their control. It needs to have the capacity, expertise and resources to ensure the co-ordination of services to its graduates to ensure that they do not reoffend. Those with comorbity are the most likely to reoffend which is why services should be focussed on addressing the needs of this demography.

REFERENCES

ABS (2010): Australian Bureau of Statistics (ABS), *Repeat imprisonment*, (2010) at over.http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/LookupAttach/4102.0Publication16.03.102/$File/41020_RepeatImprisonment.pdf visited 20/04/2010

ACCC (2008): ACT Community Coalition on Corrections, *Healthy or harmful? Mental health and the operational regime of the new ACT prison* (ACT Community Coalition on Corrections, Canberra, April 2008) at http://correctionscoalitionact.org.au

ACS (2007a): *ACT Correctional Centre, Alexander Maconochie Centre, Functional Brief,* March 2005, (Amendment No 2)

ACS (2007b): ACT Corrective Services, *Vocational Educational and Training and Rehabilitative Programs in the Alexander Maconochie Centre* (Canberra, May 2007) at http://www.cs.act.gov.au/__data/assets/pdf_file/0020/57152/ProgramsPlanUpdated07.pdf;

ACS (2007c): ACT Corrective Services, *Drug, Alcohol and Tobacco Strategy 2006–2008* (Canberra, 6 September 2007)

ACS (2007d): ACT Corrective Services, *Communication plan: Alexander Maconochie Centre Project* (Canberra, April 2007) http://www.cs.act.gov.au/amc/publications

ACS (ND): ACT Corrective Services, *Becoming a Custodial Officer, A career with ACT Corrective Services,* (Canberra, ND) at http://www.cs.act.gov.au/__data/assets/pdf_file/0020/64064/14098_JCS_Recruit_Brochure.pdf visited 23/09/2010

ACT AG (2008): ACT Attorney-General, "Government response to the recommendations of the report of the human rights audit on the operation of ACT correctional facilities under corrections legislation" (February 2008) at HRaudit_GovtResp.doc

ACIB (2008): ACT Community Inclusion Board, Inclusive practices: ACT prisoners and their families, seminar, 22 April 2008, summary report (ACT Community Inclusion Board, May 2008)

ACT HEALTH (2008), AUSTRALIAN CAPITAL TERRITORY, ACT Health, *Adult Corrections Health Services Plan 2008-2012* (Canberra, March 2008)

ACTHRC (2007): ACT Human Rights Commission, *Human Rights Audit on the Operation of ACT Correctional Facilities under Corrections Legislation* (ACT Human Rights Commission, Canberra, July 2007) at http://www.hrc.act.gov.au/assets/docs/Corrections%20Audit%202007.pdf visited 22/08/2007

ACT Treasury (2010), *2010-11 Budget Paper No. 4, Department of Justice and Community Safety* (Canberra, 2010).

ADFACT (2008/09): Alcohol and Drug Foundation, Australian Capital Territory, ADFACT Annual Repoort 2008/09 (Canberra) at http://www.adfact.org/PDF/Adfact_annual_report_20082009.pdf visited 9/24/2010.

Legislative Assembly, Standing Committee on Health, *Reference: Access to syringes by intravenous drug users* (2003*)*:Australian Capital Territory, Legislative Assembly, Standing Committee on Health, *Reference: Access to syringes by intravenous drug users*, *Transcript of evidence*, 1 May 2003 pp. 47-50 at http://www.hansard.act.gov.au/hansard/2003/comms/health12.pdf visited 14/08/03.

AUSTRALIAN CAPITAL TERRITORY, *Corrections Management Bill 2006: explanatory statement, circulated by authority of Simon Corbell MLA, Attorney General* (2006) at http://www.legislation.act.gov.au/b/db_27985/current/pdf/db_27985.pdf at http://www.legislation.act.gov.au/es/db_27988/current/pdf/db_27988.pdf

AMA 1998: Australian Medical Association, *Health care of prisoners and detainees*, 1998, AMA Position Statement, at http://www.ama.com.au/web.nsf/doc/SHED-5G4V8L/$file/healths_gd_ps_health%20care%20prisoners%20&%20detainees.pdf visited 15/05/2007

AMA (2006): Australian Medical Association, "Treatment, not prison, for mentally ill", media release, 17 Sept. 2006 at http://www.ama.com.au/web.nsf/doc/WEEN-6TN6MH.

CIGG (2010): Community Integration Governance Group, *Submission to AMC review* (September 2010)

CORRECTIONAL ADMINISTRATORS (2004): Australia, Correctional Administrators, *Standard Guidelines for Corrections in Australia Revised 2004* at HTTP://WWW.CS.ACT.GOV.AU/__DATA/ASSETS/PDF_FILE/3750/GUIDELINES.PDF VISITED 03/05/06

Borzycki M (2005): Borzycki M., *Interventions for Prisoners Returning to the Community.* Attorney-General General's Department, Australian Government at http://www.crimeprevention.gov.au/agd/WWW/ncphome.nsf/AllDocs/DAD69C1C8D3D5F28CA256FDB001DD4B4?OpenDocument

Breaking the silence: suicide and suicide prevention in Australia: a seminal report (Lifeline Australia, The Inspire Foundation, Ozhelp Foundation, Centre for Mental Health Research, ANU, Suicide Prevention Australia, The Salvation Army, Brian and Mind Research Institute, 2010)

Bucci (2010): Nino Bucci, "Corbell baffled by jump in imprisonments" in *The Canberrra Times*, Friday 17 September 2010, p. 2.

Butler & Allnut (2003): Tony Butler & Stephen Allnutt, *Mental illness among New South Wales prisoners* (NSW Corrections Health Service, Matraville, August

2003) at http://www.justicehealth.nsw.gov.au/pubs/Mental_Illness_Among_NSW_Prisoners_2003.pdf at visited 18/11/05

Cyrene Group (2007): Cyrene Group Pty Ltd, *ACT Corrective Services Workforce Plan July 2004 to July 2007* (Tuggeranong, 20 October 2004) at http://www.cs.act.gov.au/__data/assets/pdf_file/27353/ACTCS_WFP.pdf.

Denmark (1994): Denmark, *A Programme of Principles for Prison and Probation Work in Denmark* (Ministry of Justice, Department of Prisons and Probation, Copenhagen 1994) at http://www.kriminalforsorgen.dk/Admin/Public/DWSDownload.aspx?File=%2fFiles%2fFiler%2fOm+kriminalforsorgen%2fPrincipprogram_UK_-_09-2008.pdf visited 23/09/2010

FFDLR (2003):Families and Friends for Drug Law Reform, *Submission of Families and Friends for Drug Law Reform to the Inquiry into support services for families of people in custody by the Standing Committee on Community Services and Social Equity of the Legislative Assembly for the Australian Capital Territory* (September 2003) at www.ffdlr.org.au and http://www.aph.gov.au/senate/committee/mentalhealth_ctte/submissions/sub319a_attach1.pdf

Fazel S, Danesh J (2002) Serious mental disorder in 23,000 prisoners: A systematic review. Lancet, 359, 545-550.,

Gordon (2009): Andrea Gordon, *Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician,* National Drug Strategy, monograph series no. 71 (Department of Health and Ageing, Australian Government, Canberra, 2009)

Herrman H, McGorry P, Mills J, Singh B (1991) Hidden severe psychiatric morbidity in sentences prisoners: an Australian Study. American Journal of Psychiatry, 25, 461-470

Brinded P, Simpson AIF, Laidlaw TM, Fairley N, Malcolm F (2001) Prevalence of psychiatric disorders in New Zealand prisons: A national study. Australian and New Zealand Journal of Psychiatry, 35, 166-173.

Loxley *et al.* (2004): Wendy Loxley, John W. Toumbourou,Tim Stockwell, Ben Haines, Katie Scott, Celia Godfrey, Elizabeth Waters, George Patton, Richard Fordham, Dennis Gray, Jann Marshall, David Ryder, Sherry Saggers, Lena Sand & Jo Williams, *The prevention, of substance use, risk and harm in Australia: a review of the evidence, Monograph* (The National Drug Research Institute and the Centre for Adolescent Health, January 2004) at mono_prevention.pdf

MHCA (2005): MENTAL Health Council of Australia, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia. A report of the consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal*

Opportunity Commission (Mental Health Council of Australia, Canberra, 2005) at http://www.mhca.org.au/notforservice/documents/NFS_Finaldoc.pdf visited 20/10/05

Ministerial Council on Drug Strategy, *National corrections drug strategy 2006–2009* (2008) at http://www.ancd.org.au/publications/pdf/national_corrections_drug_strategy.pdf visited 22/8/08

Mullen (2001): Paul E Mullen, *Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services* (2001) at http://www.aic.gov.au/crc/reports/mullen.pdf

Ogloff (2002): "Identifying and accommodating the needs of mentally ill people in gaols and prisons", *Psychiatry, Psychology and Law*, 9(1), 1-33.

Ogloff (2008): James R P Ogloff, "Suicide and self harm and the new ACT prison" forum of the ACT Community Coalition on Corrections, Reception Room ACT Legislative Assembly, 2 December 2008. Audio at http://correctionscoalitionact.org.au/Forums/Recent/Recent.htm visited 9/26/2010

Ogloff *et al.* (2006): James R P Ogloff, Michael R Davis, George Rivers and Stuart Ross, *The Identification of Mental Disorders in the Criminal Justice System*, Criminology Research Council Consultancy (2000) at 2006-ogloff.pdf

Ogloff *et al* (2007): James RP Ogloff, Michael R Davis, George Rivers and Stuart Ross,"The identification of mental disorders in the criminal justice system", Trends and Issues in crime and criminal justice no. 334, Australian Institute oaf Criminology (March 2007) at http://www.aic.gov.au/documents/E/B/4/%7BEB4E29C4-4390-41C6-8EEF-93AB042C6BFC%7Dtandi334.pdf

Paget (2005): John Paget, Director, ACT Prison Project, *Human rights, prisons and women prisoners – 20 April 2005* at 2005 CSAC Women's Forum

Productivity Commission (2010b), *Report on Government Services 2010; Chapt 8: Corrective Services: Errata — Report on Government Services 2010* (January 2010).

Senate (2006): Senate, Select Committee on Mental Health, *A national approach to mental health: from crisis to community, First report* (March 2006) at http://www.aph.gov.au/Senate/committee/mentalhealth_ctte/report/report.pdf

Rickwood D (2006a), *Pathways of Recovery: Preventing Further Episodes of Mental Illness* (Monograph). Prepared for the National Mental Health Promotion and Prevention Working Party, November 2005 (Commonwealth of Australia, Canberra)

Rickwood (2006b), Debra Rickwood, *Pathways of Recovery: 4As Framework for Preventing Further Episodes of Mental Illness. prepared for the National Mental Health Promotion and Prevention Working Party,* November 2005

(Department of Health, Commonwealth of Australia, Canberra, 2006) at Framework_April 2006.pdf

Roche (2009): Anne Roche, "Drug and alcohol addiction in the criminal justice system:the Australian perspective" (Director of the National Centre for Education and Training on Addiction (NCETA), Flinders University) presentation at a conference on Drugs, Crime and Their Impact on the Community, Adelaide, 10-11 September 2009) at http://www.aic.gov.au/en/events/aic%20upcoming%20events/2009/~/media/conferences/2009-duma/ann_roche.ashx at 11/09/2010

Smith & Trimboli (2010): Nadine Smith and Lily Trimboli, "Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners" in *Crime and Justice Bulletin, contemporary issues in crime and Justice,* (NSW Bureau of Crime Statistics and Research) no. 140, May 2010

Spooner, Hall & Lynskey (2001): Spooner, Catherine, Wayne Hall, Michael Lynskey (2001), *Structural determinants of drug use: a report prepared by the national Drug and Alcohol Research Centre UNSW* (ANCD, Canberra), at http://www.ancd.org.au/images/PDF/Researchpapers/rp2_youth_drug_use.pdf visited 17/04/2010

Vinson (2008): Tony Vinson, Prisons – Can they be Human – Can they even Rehabilitate?
Forum on 26 February 2008 organised by Christians for an Ethical Society at www.ces.org.au

Wallace *et al.* (2004): Cameron WALLACE, Paul E. Mullen & Philip Burgess, "Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders" in *American Journal of Psychiatry*, vol. 161, pp. 716-727 (2004)

Weatherburn (2010): Weatherburn, Don, "The effect of prison on adult re-offending" in *Crime and Justice Bulletin, contemporary issues in crime and Justice,* (NSW Bureau of Crime Statistics and Research) no. 143, August 2010

White & Whiteford (2006): Paul White and Harvey Whiteford, "Prisons: mental health institutions of the 21st century?" at *Medical Journal of Australia,* vol. 185, no. 6, pp. 302-03 (18 September 2006) http://www.mja.com.au/public-/issues-/185_06_180906/whi10502_fm.pdf.