Families and Friends for Drug Law Reform (ACT) Inc.

committed to preventing tragedy that arises from illicit drug use

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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

RECOMMENDATIONS

Recommendation 1:

Programmes for the support of families of those in detention should be consistent with the following principles:

(a) the hardship of family members dependent on the member detained should be minimised;

(b) the family's support for the detained person during the detention should be maximised;

(c) the capacity of the family to assist in the reintegration of the released member into the community should be reinforced;

(d) the capacity of the family to bring up children should be strengthened; and

(e) the health of the detained family member should be protected. *[Page 20.]*

Recommendation 2:

Support should be provided:

(a) to meet the crisis and longer term material needs of families whose life is disrupted by the detention of a members; and

(b) to assist the family to cope with the non-material stresses associated with detention, notably where these are compounded by substance abuse and mental disorder of the member in custody. *[Page 22.]*

Recommendation 3:

Procedures should be in place to make a prompt assessment of the needs of the family of everyone who is detained. *[Page 29.]*

Recommendation 4:

Strategies should be developed for relevant government and non-government agencies to provide a co-ordinated range of support to the families of those detained. *[Page 29.]*

Recommendation 5:

Obstacles arising from the regime of remand centres and prison that serve to limit reasonable access of families to members detained should be removed. *[Page 32.]*

Recommendation 6:

Where necessary, assistance with transport should be provided to families to enable them to visit detained members. *[Page 32.]*

Recommendation 7:

A dignified and congenial human and physical environment should be provided for families to visit detained members. *[Page 32.]*

Recommendation 8:

Leadership, support and training is required to bring about recognition among custodial staff of the need to enhance family support for prisoners and on how this can best be brought about. *[Page 32.]*

Recommendation 9:

In order to maximise the support from families for the transition of detainees to the community:

- (a) the needs should be assessed of the family as a whole as well as the released member; and
- (b) community programmes providing the support required should be co-ordinated. *[Page 34.]*

Recommendation 10:

Where a family is able to provide useful support falling short of accommodation for a member released from detention, help should be provided to enable the member to secure accommodation convenient to the family. *[Page 34.]*

Recommendation 11:

People with serious mental disorders should not be detained in remand centres or sent to prison. *[Page 36.]*

Recommendation 12:

Concern for some interests of those with mental disorders should not undermine the capacity of those willing to provide support. *[Page 39.]*

Recommendation 13:

Interventions should not focus on blame and separation of someone with a mental disorder from his or her family but should focus on enhancing the capacity of the family to provide support. *[Page 40.]*

Recommendation 14:

Support should be provided for families seeking to support a member who has a mental disorder. In particular a scheme of treatment plans should be established. These plans should involve the person with a mental disorder and all those closely involved in the life of that person including the family and professional helpers. *[Page 42.]*

Recommendation 15:

Policies for admission to psychiatric service units and attendance by the Mental Health Crisis Assessment and Treatment Team should be adjusted or co-ordinated with other services to permit early intervention in the case of each new relapse rather than when the relapse has reached crisis proportions. *[Page 42.]*

Recommendation 16:

One or more facilities with necessary separations should be established to provide a caring environment for those with a mental illness including those under 18:

(a) to head off a crisis before it occurs and to provide relief for family and other carers; and

(b) as an alternative to remand or prison for those who may have become caught up in the criminal law. *[Page 44.]*

Recommendation 17:

Mental health services should be integrated with other support for those with a mental disorder and their family. *[Page 46.]*

Recommendation 18:

All measures available in the community at large should be taken to maintain and improve the physical health of those detained. In particular:

(a) every effort should be taken to ensure that people do not emerge from detention with infectious blood borne diseases contracted in detention;

(b) effective interventions should be implemented that are known to reduce or eliminate the dangerous public health risk of blood borne disease within remand centres and prisons. *[Page 48.]*

Recommendation 19:

Recognising the reality of availability of illicit substances in corrective institutions, detention regimes should be framed around effective drug strategies that maximise the health and welfare of those detained. *[Page 50.]*

Recommendation 20:

Sterile syringes should be provided in corrective institutions where ACT prisoners are sent. *[Page 60.]*

Recommendation 21:

The guiding principle of corrections should be to strengthen the community links of those subject to corrections and should not be their isolation. This principle should apply even for those deprived of their liberty. *[Page 65.]*

Recommendation 22:

Corrections must own a broader social responsibility that extends beyond the containment of detainees to the integration of support services for families and detainees consistently with the best practices in the community at large. *[Page 67.]*

Recommendation 23:

Measures of harm minimisation available in the community for illicit drug use should also be available in prisons and remand centres in conjunction with best practice drug treatments. *[Page 70.]*

Recommendation 24:

As part of a broader social responsibility, authorities should not allow efforts to prevent drugs entering corrective institutions to undermine the maintenance and development of family bonds and capacity of the family to support the detained member's reintegration into the community after release. *[Page 73.]*

Recommendation 25:

Consistent with the findings of early intervention research, the Legislative Assembly and Government should take leadership roles in support of the introduction of a consistent set of social policies to address the serious social problems including mental illness and drug abuse presently associated with detention. *[Page 75.]*

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I. INTRODUCTION

To paraphrase John Donne, no one is an island unto him or herself. To follow through his insight, when the prison door clangs shut, it closes on us all.

Something has gone radically wrong when a member of our society is held in custody – for the victim of a crime, for the community at large, for the person detained and for those who stand closest to that person, notably the family.

The family may lose a breadwinner or carer, a child may lose a father or a mother, a brother or sister may lose their mate, a man or woman may have lost someone they love. In the broad sense these are the family of the detained person. When someone is detained it is not enough to focus on only the victim of the crime and the prisoner.

The tribulation that detention can bring to the life of the person locked away is but one aspect. Those who are detained will emerge. The injury to the community will be compounded if a released prisoner re-offends. This is far less likely to happen if there is a family to turn to for support. This does not just happen. The capacity of the family to provide that support is likely to be inadequate. The family will require nurture in order to provide useful support to the prisoner.

The family has a role not only on release but also during the entire detention. The family is likely to be crucial in the rehabilitation of the imprisoned while he or she is detained. The family itself is unlikely to be in a strong position after release to support the reintegration of the prisoner into the community if regular links are not maintained during the imprisonment. Without this, the family may, for example, be worried that the person released that they loved will be so changed that they neither know nor love him or her. A set of strategies therefore needs to be in place to maintain and strengthen links between family and the imprisoned during detention.

Where children are involved, the utmost care needs to be taken to ensure that the loss to imprisonment of a parent or sibling does not serve to damage the life chances of that child. For example, loss to imprisonment of a mother or father and poverty through loss of a breadwinner are risk factors associated with antisocial behaviour, crime, mental health and homelessness. Imprisonment must not be allowed to perpetuate and amplify risk factors from one generation to another as it does now.

In short, it is important to have strategies in place to support the family of those in prison because:

(a) those who are dependent on the imprisoned should not themselves be punished for the misdeeds of the imprisoned member;

(b) the opportunities for rehabilitation of the imprisoned are likely to be greatly enhanced if family links are maintained and the family strengthened; and

(c) imprisonment can endanger the life chances of children in the family of the imprisoned.

The mind set is totally inadequate that views imprisonment as a two dimensional issue between the State and the imprisoned. Involving the victim is an advance but it too is still inadequate. Imprisonment must not be a costly warehousing of community problems or an instrument of community vengeance. It should not, as it often does now, make social problems worse. Rather it should be taken as an opportunity to assist the resolution of social problems. The close involvement of the family is essential to the achievement of this objective.

Society as a whole stands to benefit by an approach that enhances the capacity of the family of those in detention to support its member; the benefit is not confined to the person detained and his or her family. Society has to pick up the pieces when family support fails. It does so through, for example, higher crime levels from repeat offending, wasteful diversion of resources; breakdown of families and the amplification of problems through generations. As a community we must invest in ourselves – not let stresses rip our community apart.

II. THE CONTEXT OF ILLICIT DRUG USE, IMPRISONMENT AND FAMILIES

The Committee is charged with examining support services for families of people in custody. Broader issues such as why so many people are imprisoned and whether there are better correctional options are thus not within the Committee's terms of reference. Nevertheless, in order to prescribe any meaningful improvements in this area, it is essential that the Committee is clear why people are in prison and the common factors that affect relationships between those people and their families leading up to their imprisonment. Therefore, this submission now discusses one of the most potent factors associated with crime – use of illicit drugs – and the impact of use of illicit drugs on families.

A. Links between illicit drugs and imprisonment

It is widely believed that there are strong links between illicit drugs and crime. This is evidenced by the high level of substance abuse among those imprisoned. Substance abuse is also associated with another big correlate of criminal behaviour, mental illness. It is known that substance abuse aggravates the risk of criminal behaviour among those who have a mental disorder. The high cost of maintaining a drug habit leads many to finance their addiction by crime, notably property crime and drug dealing. Australia has a particularly high level of property crime. Illicit drug use also intensifies the risk factors that crime will occur whether that use be by the perpetrator or by others in the perpetrator's family. It is clear that

there is a potential for big reductions in crime in the absence of abuse of illicit substances as studies of effective drug treatments have shown.

1. High level of substance abuse and mental disorder among those imprisoned

An overwhelming proportion of people in prison have either mental health problems or problems of substance abuse –often both. In evidence before a House Representative Committee last year Dr Richard Matthews, Chief Executive Officer of the NSW Corrective Health Service, stated that 90.1% of women on reception in NSW have some form of mental disorder as do 78.2% of men. On substance abuse he reported that compared to 2.8% in the general community, 74.5% of women on reception in NSW corrective institutions are dependent on or abuse alcohol or another drug. For men the figures are 7.1% and 63.3%.[1]

The drug use monitoring program (DUMA) conducted over a number of years by the Institute of Criminology shows that the level of illicit drug use is far higher among those arrested than in the general population. Compared to the Household survey figure of 16.9% of the population at large who have used any illicit drug including cannabis in the last 12 months[2] the 2002 DUMA study found that on arrest for a property offence 60% of adult males tested positive to a drug other than cannabis. The equivalent proportion arrested for a violent offence was 40% .[3] The DUMA figures are fairly much consistent with the findings of Dr Matthews when account is taken of factors such as the relatively small window of opportunity for detection of some illicit drugs like heroin and the fact that alcohol use is not included in these DUMA figures (although prescription drugs indistinguishable from illicit drugs are). Australian illicit drug reports show that there are many arrests of people as consumers. In 2001-02 there were 58,768 consumer arrests across Australia compared to 14,457 provider arrests. Of this the figures for the ACT were 221 and 52.[4]

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1. Evidence to the House of Representatives Standing Committee on Family and Community Affairs on 16 August 2002.

2. Australian Institute of Health and Welfare, *2001 National drug strategy household survey: first results* (Drug statistics series no. 9) (Canberra, May 2002) table 2.1, p. 3 at http://www.aihw.gov.au/publications/phe/ndshs01-/full.pdf visited 23/05/02. This publication does not give the proportion of those who have used an illicit drug other than cannabis in the last 12 months but this is probably about a quarter of the 16.9%. Many users of one illicit drug would have used another. Even so, amphetamine usage at 3.4% of the population was the most consumed illicit drug after cannabis at 12.9%.

3. Australian Institute of Criminology, *Media Release: The link between drugs and crime,* 16 March 2003 at http://www.aic.gov.au/media/2003-/20030316.html visited 30/05/03.

4. Australian Crime Commission, *Australian illicit drug report 2001-02* (Australian Crime Commission, Canberra, 2003) table 8.1, p. 127.

2. Substance abuse aggravates the risk of criminal behaviour among the mentally disordered

Substance abuse is also known to be intimately linked to the other big correlate of criminal behaviour: mental disorders. Drug misuse often occurs in company with a mental disorder. Indeed, as a National Mental Health publication points out, substance abuse disorders such as addiction are classified as mental disorders.[5] It is clear that the coexistence of substance abuse, including abuse of alcohol, with other mental disorders dramatically increases the risk of offending behaviour. This is shown in a survey of the literature by Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University. For example:

- A large and sophisticated American study that followed up people discharged from public psychiatric in-patient facilities (the MacArthur collaboration) found that: "Those with coexisting substance abuse were significantly more prone to violence than those not similarly burdened. . . . Substance abuse was . . . significantly more common among patients (31% vs 17%) [than a non-patient control group] and amongst patients with substance abuse the prevalence of violence was significantly higher than others in their neighborhood."[6]
- Whatever the myth, schizophrenia is not particularly associated with violence or other offending behaviour. It is substance abuse that makes a difference. In an Australian study that traced the criminal histories of just over 1,000 people with a diagnosis of schizophrenia: "Over 20% of males with schizophrenia had been convicted of a criminal offence with over 10% having a conviction for violence compared to 8% of controls who had a recorded offence with 2% violent convictions. A co-existing diagnosis of substance abuse was significantly associated with the chance of acquiring a conviction (49% vs 8.6%) including convictions for violence (17% vs 2%)."[7] "In those with schizophrenia who did not have a problem with substance abuse, there was only a modest increase in offending."[8]

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5. Commonwealth Department of Health and Aged Care, *Promotion, prevention and early intervention for mental health-a monograph* (Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, 2000) pp. 3 &105.

6. Summary of study in 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) pp. 7-8 at http://www.aic.gov.au/crc/reports-/mullen.pdf visited 3/08/02.

7. Summary of study in Mullen (2001) fn 6, p. 8

8. Victorian Institute of Forensic Mental Health, *Submission to House of Representatives Standing Committee on Family and Community Affairs:*

- In another Australian study carried out in Victoria: "A recorded comorbid substance diagnosis was strongly associated with offending. Those males who had been diagnosed with schizophrenia and had also received a diagnosis of co-existing substance abuse were over 12 times more likely to be convicted than a member of the general population compared to less than 2 for those without a substance abuse diagnosis. This disparity between those with and without substance abuse was similarly marked for violence and homicide offences."[9]
- From a United States Community study: "In the previous year violent acts were reported by 2.4% of the non disordered population. This rose to 12% in schizophrenia and in major depression to 11%. Substance abuse as a primary diagnosis was associated with a rate of acknowledged assault of 25%. Those with major mental disorders who were also substance abusers accounted for much of the violence in the mentally disordered."[10]
- A New Zealand birth cohort study of 961 twenty-one year olds: "This study concluded that engaging in greater violence was associated with schizophrenia as well as with marijuana and alcohol dependence both independently, and in association with schizophrenia. Arseneault and colleagues (2000) note "persons with at least one of these 3 disorders constituted only one fifth of the sample but they accounted for more than half the sample's violent convictions and violent acts".[11]

The results of the Swiss heroin trial provide strong evidence of confirmation that the association between crime and the combination of mental disorders and abuse of illicit substances is one of cause and effect. After treatment for varying periods with medically prescribed heroin a survey of three groups of the severely dependent users on the trial showed that between 46% and 65% fewer had bad or very bad psychological health. At the same time the number of patients having committed crimes registered by the police reduced by about 40%. Even more striking, during treatment there was a reduction of close to 70% in the average number of crimes per patient as recorded by the police and by the end of the survey periods the number who reported not having any illegal income more than doubled to between 83% and 89% of those in treatment.[12]

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substance abuse in Australian communities (submission no. 52, 2000) in submissions authorised for publication, vol. 2, pp. 404-15 p. 407.

9. Amplifications and explanations in parentheses have been omitted. Summary of study in Mullen (2001) fn 6, p. 11. Similarly see Victorian Institute of Forensic Mental Health (2000) fn 8, pp. 406-07.

10. Summary of study in Mullen (2001) fn 6, p. 14.

11. Summary of study in Mullen (2001) fn 6, p. 15.

12. Switzerland, Federal Office of Public Health, *Treatment with prescription heroin: Arguments concerning the popular vote on the Urgent Federal Ordinance on the medical prescription of heroin (treatment with medically*

The association of the combination of mental disorders and substance abuse with crime is a growing problem. As Dr Paul Mullen has written:

> "The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995."[13]

Substance abuse contributes significantly in at least the following ways to mental disorders associated with high criminality:

(a) Substance misuse very often gives rise to mental disorders like addiction;

(b) In an effort to self medicate, those who have other mental disorders are particularly likely to have resort to the abuse of illicit drugs and alcohol and thus are exposed to the same risks of involvement in criminal conduct (e.g. stealing to raise money for drugs) as those who have no other mental disorder;

(c) Treatment of those who are both drug dependent and suffer from a mental disorder distinct from addiction is more difficult and treatment services are scarcer than for those suffering from drug dependence alone;

(d) Substance abuse by parents is a risk factor for adverse mental health outcomes during the infancy and childhood of children of these parents.[14]

(e) Substance abuse by children is a risk factor for other negative outcomes like school failure which amplify the risk of the children developing a mental disorder.[15]

(f) Substantial substance abuse in a neighbourhood is a risk factor for violence and other crime in that neighbourhood which also amplifies the risk of those in the neighbourhood developing a mental disorder.[16]

3. Australia has a particularly high level of property crimes

Australia is not the low crime country that we would like to believe. By world standards Australia has a high level of property crime. According to the Institute of Criminology:

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prescribed heroin) on 13 June 1999 (GEWA, Zollikafen, April 1999) part VII, paras. 2.2 & 3. Translation at www.ffdlr.org.au of a French version at http://www.admin.ch/bag/sucht/drog-pol/abstimmg/f/index.htm

13. Mullen (2001) fn 6, p. 17. References included in the source text have been omitted from the quotation.

14. Commonwealth Department of Health and Aged Care (2000) fn. 5, pp. 49, 74

15. *Ibid.*, p. 16.

16. *Ibid*.

> "In terms of property crime, the evidence is . . . one of significant increases over the past 20 years, particularly for break and enter and motor vehicle theft. In comparative terms the recent International Crime Victim Survey estimates that Australia ranked highest in terms of burglary, second highest in terms of motor vehicle theft, and third highest in terms of theft of or from cars and person theft. In addition, public rankings of crime and public-order problems place break and enter above all the other problems listed. These data suggest that crime in Australia is a significant problem and has been increasing."[17]

4. Illicit drug use as a cause of crime

The large increase in acquisitive crime affecting the general community seems to have co-incided with big increases in drug use. Noted criminologists have observed this in relation to Europe and the same almost certainly applies to Australia:

> "Drug use and the emergence of open scenes were followed by rapidly rising crime rates in Western Europe throughout the 1970s and 1980s. In Switzerland, e.g., burglaries and robberies increased by several hundred percent during that period. International comparisons suggest that the extent of involvement in property crime among addicts on any kind of hard drugs is about 10 times higher than among non-users. Thus, the increasing crime trends over the last 30 years may reasonably be seen as a side-effect of increasing drug use."[18]

Drug use is clearly a causal factor of crime when a user is moved to commit a crime when under the influence of the drug or in order to raise the funds required to purchase further supplies of drugs. A survey of the Institute of Criminology has shown that 26% were "'sick' for illicit drugs" at the time of the offence.[19] The Prime Minister, himself, has suggested an even higher proportion. According to him "Between 45% and 60% of convicted offenders committed property crimes to support drug habits. Some 64% of offenders admitted using drugs (to give them a lift, or courage) to commit an offence."[20]

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17. Toni Makkai, "Illicit drugs and crime", p. 111 in Adam Graycar & Peter Grabosky (eds), *The Cambridge handbook of Australian criminology* (Cambridge University Press, 2002) chapt. 6, pp. 110-25.

18. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Summary of Research Findings concerning the Effects of Heroin Prescription on Crime" (paper delivered at international symposium on heroin-assisted treatment for dependent drug users, 11 March 1999).

19. Toni Makkai, "Drugs and property crime" in Australian Bureau of Criminal Intelligence, *Australian illicit drug report 1997-98* (Australian Bureau of Criminal Intelligence, Canberra, March 1999) pp. 105-13 at p. 109.

20. Prime Minister, "Launch of the Australian National Council on Drugs" 16 March 1998.

Different drugs have different effects which can manifest themselves in criminal behaviour. It is frequently said that amphetamine like stimulants lead some users to violence.

5. Illicit drug use intensifies the risk factors that crime will occur

These immediate causal links between illicit drug use and crime, though obviously potent, are probably only the superficial links between illicit drug use and crime. The main contribution of illicit drugs to crime seems to lie in the introduction and intensification of risk factors in the life of offenders. This is where families come in.

It is now widely recognised that why someone commits a crime cannot be adequately explained by the circumstances at the time it was committed. Whether a risk factor like illicit drug use leads to crime is likely to depend on an accumulation of other risks factors and countervailing protective factors throughout the life of a person rather than the existence of one risk factor in isolation. Risk and protective factors feed back into each other.

Substance abuse is one of many potent risk factors for crime yet it is particularly influential because of the extent that it heightens other risk factors.

Thus use of an illicit substance by a young person may contribute to poor school performance. Poor school performance may lead to the intensification of substance abuse which could increase the likelihood of drop out from school, the onset of depression and other physical and mental health disorders.

Substance abuse by people other than the child can increase the risk factors for that child by degrading the child's influential family and wider social environment. Family violence and disharmony, long term parental unemployment, abuse and neglect of children, low birth weight and school failure are among the risk factors that are often associated with parents whose life is out of control because of their illicit drug use. In other words, use of illegal drugs has a big indirect as well as a big direct influence on criminal behaviour. Much of the crime today is the fruit of a crop sown thirteen or more years ago by substance abuse affecting the family and other social environment of children who are now adults in trouble with the criminal law.

In summary, the close association of illicit drugs with crime is explained in many ways:

- Users moved to commit a crime when under the influence of illicit drugs;
- Users moved to commit crime to raise the funds required to purchase further supplies of drugs;
- Those attracted to the distribution of illicit drugs by the money to be made;
- Those engaged in crime because of the intensification of risk factors brought about by illicit drug use within their family and social environment;

- As explained in part II.A.1, those engaged in crime because of a mental illness precipitated or aggravated by use of illicit drugs or the chaotic and stressful lifestyle that often accompanies an illicit drug habit.

6. Potential for big reductions in crime in the absence of abuse of illicit substances

This close correlation between illicit substance abuse and crime points to the potential that exists of securing, by appropriate drug policies, very large reductions in crime. The potential exists in reducing both the number of people engaged in delinquent activities and the number of offences committed by those who continue to commit crime.

The very large crime reductions by those on the large scale Swiss trial of the medical prescription of heroin show this is possible. Those selected for the trial were addicted opiate users who had been resistant to other treatments and whose life was in disarray – the very sort of people who have been targeted in the ACT by intensive policing campaigns like Operation Anchorage. 83% of those detained in the ACT during that operation were "heroin addicts" and this coincided with a 23.2% reduction in burglary.[21] A survey of 319 people on the Swiss programme after a year's treatment showed that there was a 94% reduction in the number engaged in serious property crime defined as burglary, muggings, robbery and pick-pocketing. 55% fewer engaged in other property offences that included thefts, shoplifting and receiving or selling stolen property. This smaller reduction in the prevalence of other property crime was accompanied by an 88% reduction in the incidence rate which meant that those who continued to commit those offences committed far fewer crimes.[22]

B. Impact of illicit drug use on families

Families are known to have a big influence on the likelihood that a child will engage in antisocial and criminal behaviour. Supportive and caring parents, family harmony, security and stability, a supportive relationship between the child and another adult and strong family norms and morality are among the factors that are considered to provide protection against this outcome.[23] "The evidence is now quite

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21. Monika Boogs, "Sex crime up, but most offences down" in *Canberra Times*, 16 August 2002, p. 3.

22. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Summary of Research Findings concerning the Effects of Heroin Prescription on Crime" (paper delivered at international symposium on heroin-assisted treatment for dependent drug users, 11 March 1999).

23. National Crime Prevention, *Pathways to prevention: developmental and early intervention approaches to crime in Australia* (National Crime Prevention, Attorney-General's Department, Canberra, 1999) p. 138.

overwhelming that juveniles with strong attachments to their family are less likely to engage in delinquency."[24]

The Commonwealth report, *Pathways to prevention,* lists the following family protective and family risk factors for antisocial and criminal behaviour:

FAMILY PROTECTIVE FACTORS	FAMILY RISK FACTORS
supportive caring parents family harmony more than two years between siblings responsibility for chores or required helpfulness secure and stable family supportive relationship with other adult small family size strong family norms and morality	*Parental characteristics:* teenage mothers single parents psychiatric disorder, especially depression substance abuse criminality antisocial models *Family environment:* family violence and disharmony marital discord disorganised negative interaction/social isolation large family size father absence long term parental unemployment *Parenting style:* poor supervision and monitoring of child discipline style (harsh or inconsistent) rejection of child abuse lack of warmth and affection low involvement in child's activities neglect

SOURCE: National Crime Prevention, *Pathways to prevention: developmental and early intervention approaches to crime in Australia* (National Crime Prevention, Attorney-General's Department, Canberra, 1999) pp. 136 & 138.

The previous section discussed why illicit drug use is a potent risk factor for crime. At the same time, illicit drug use can degrade the wellbeing of a family and its capacity to be a protective influence against a child becoming a delinquent or enmeshed in other problems like depression, homelessness and attempted suicide.

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24. John Braithwaite, *Crime, shame and reintegration* (Cambridge University Press, Cambridge, New York and Oakleigh, 1998 first published 1989) pp. 27-28.

The same factor can operate to degrade the capacity of the family to serve as a support for the rehabilitation of an imprisoned member.

A family can be affected by illicit drug use in various ways and degrees of severity. At one extreme the impact can be so severe as to render the family dysfunctional. At the lower end of the continuum, the family may remain robust with capacity to provide support for a child who has developed a drug habit. For the purpose of discussion the families in which there is drug use are grouped into low, medium and high risk families.

1. The "low" risk family

Young people who commit crime can come from families that display a low set of family risk factors for crime. The Commonwealth's publication, *Pathways to prevention* lists factors personal to the child, school factors and community and cultural factors that are associated with antisocial and criminal behaviour. These are in addition to the family risk factors listed above at page 10. Thus there is a higher risk of children ending up in crime if they are of low intelligence, lacking in empathy and low esteem (listed child risk factors), have failed at school and been rejected by their peers (schooling risk factors) and have suffered intense loss from the death of a family member (a life event risk factor). The risk will be intensified if the child starts abusing illicit drugs.

There are many cases where the family of a child that becomes drug dependent and caught up in the criminal law is a family with a low set of family risk factors for crime. Put around the other way, dependent drug use leading to crime occurs with troubling frequency in families where the protective factors are high.

This is explained by the attitude of young people to drugs. Research carried out for the Commonwealth Government revealed that illicit drugs were potentially attractive to a wide range of young people of normal personality types.[25] There were those who tended to be outward looking and those who tended to be inward looking. Outward looking ones tended to be more extrovert, positive and confident in their approach to life and were typically more independent and emotionally stable. Those who tended to look inwards were "generally more introvert and pessimistic in attitude. While many are serious and deep thinking they often appear to be less stable emotionally and more likely to follow the lead of others." In both groups there were those who would be most unlikely ever to touch drugs. Among the outward lookers these were the "considered rejectors" who "believe that drugs are bad, and are a major problem in all circumstances. They are self-motivated people, with little or no need to add excitement to their lives. They are happy with their lives and feel in control of things." They accounted for 16% of 15 to 24 year olds. Among the inward

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25. Blue Moon Research & Planning Pty Ltd, *Illicit drugs: research to aid in the development of strategies to target youth and young people* prepared for the Commonwealth Department of Health & Aged Care, Population Health Social Marketing Unit (June 2000) at http://www.health.gov.au/pubhlth-/publicat/document/reports/nidc_bluemoon1.htm. The following account is drawn from pp. 1-30 of this report and in particular pp. 27-29.

lookers 13% of 15 to 24 year olds "have little or no need to add excitement to their lives. They differ from the Considered Rejectors in that they are not particularly happy or secure in their lives, and they do not feel in control of things."

At the other end of the scale among the outward lookers were "thrill seekers" who were prepared to take risks. Comprising 20% of 15-24 year olds, they ". . . enjoyed the excitement of drugs, the 'buzz', the sense of risk, the excitement and the belief that drugs were 'cool'. Their curiosity and pursuit of excitement could tempt them to trial 'hard' drugs, despite their awareness of the potential dangers." Among the less confident inward lookers were "reality swappers" comprising 16% of 15-24 year olds. They "believed that the reality they experience while on drugs was better than the 'straight' world. They believed they lacked the self-respect, love and interests that their peers enjoyed. Moreover while they often acknowledged that their problems were increased because of the drugs they took, the only relief they knew was through drug-taking." The heaviest drug users were likely to come from these two groups.

The 37% between the extremes of both the inward looking and outward looking personality types "showed a moderate level of use or potential use of illegal drugs".

In short, among the young population there is a large proportion with personality types with a moderate or high potential risk of using illicit drugs. Some of the personality qualities such as preparedness to experiment and take risks that predispose young people to use are qualities that are generally admired. The point that drug use can be a problem in any family is also expressed in the Commonwealth Tough on Drugs booklet for parents: *Our strongest defence against the drug problem . . .* [26] under the heading "Why do young people take drugs?"

> "Some parents think that young people use drugs only if they are having problems at home or at school. But there are many other reasons:
>
> - Availability and acceptability of the drug.
> - Curiosity and experimentation.
> - Wanting to be accepted by peer groups.
> - Rebellion.
> - Depression.
> - As a way to relax to cope with stress, boredom or pain.
> - To experience a high or a rush."[27]

Another indication that usage of illicit drugs in the community extends well beyond a narrow group of people with a high accumulation of risk factors is revealed in household surveys. The most recent survey, that of 2001, reported that a very high proportion of the Australian population in younger age groups had used an illicit

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26. Australia, *Our strongest defence against the drug problem* written by E. Abetz, Special Minister of States ([2001], Commonwealth of Australia, Canberra)

27. *Ibid.*, p. 10.

drug “recently”. “Recently” was defined as at least once during the previous 12 months.

	Age groups			
	14-19	*20-29*	*30-39*	*40-49*
Males	28.8%	40.4%	25.2%	14.4%
Females	26.6%	30.5%	15.6%	9.5%

SOURCE: From Australian Institute of Health and Welfare, *2001 National drug strategy household survey: first results* (Drug statistics series no. 9) (Canberra, May 2002) table 3.11, p. 21 at http://www.aihw.gov.au-/publications/phe/ndshs01/full.pdf visited 23/05/02

What this means from the point of view of the present inquiry is that illicit drug usage will lead to the entanglement within the criminal law system of a significant number of young people from families displaying few if any of the risk factors commonly associated with crime. Illicit drug usage serves as a potent recruiter of young people to crime. This is particularly so where the young person has a serious mental disorder like schizophrenia, major affective disorders, bipolar disorders and other psychotic conditions.[28]

The “low risk” family of such a child will, like any other, be subject to high stress by the crime, drug use and, possibly, mental disorders of the child. Even so, it is likely still to retain the capacity to provide considerable support to help the reintegration of even adult children. In the event that someone from such a family is imprisoned it is in the interests of everyone that the family’s capacity is supported and enhanced.

2. The “medium” risk family

Research shows that the greater the accumulation of risk factors bearing on a young person and the fewer the protective factors, the greater the likelihood of the child becoming caught up in delinquent behaviour. Substance abuse, a mental disorder or the combination of these magnifies the risks considerably.

An otherwise low risk family may be put under a lot of stress if one or both parents loses a job or if the father is absent for long periods. Circumstances may lead to low involvement in a child’s activities. There may be marital discord. Such factors are also risk factors for drug use.[29] Crime could result from the combination of these

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28. Mullen (2001) fn 6, pp. 14 & 44.

29. Penny Mitchell, Catherine Spooner, Jan Copeland, Graham Vimpani, John Toumbourou, John Howard and Ann Sanson, *The role of families in the development, identification, prevention and treatment of illicit drug problems: commissioned by the NHMRC for the Strategic Research Development Committee’s National Illicit Drug Strategy Research Progr*am (National Health and Medical research Council, 2001) p. 6.

sort of family factors with others referred to earlier (page 11) that are personal to the child, school factors and community and cultural factors.

Such a family with a member imprisoned will have a highly stressful event added to other severe stresses that by themselves call for support of that family. It will be so much the more in need of support as a result of the arrest and imprisonment.

3. The "high" risk family

Very often the family structure of the imprisoned is in tatters. The family of these young people, as the imprisoned typically are, may have disintegrated. They may have a partner and a child themselves. As likely as not drugs were a big destructive influence in their family of upbringing. Their partner as well as themselves could have a drug problem too. The worst imaginable does happen. Sue Mickleburgh, the director or Marymead, has painted some such scenarios at a forum arranged by Families and Friends for Drug Law Reform:

> "We see children who are 8 years old or even younger who really I can only describe as feral. They often have been exposed to multiple adults and the behaviours of those adults. Often they have been exposed to direct or indirect sexual experiences. They're often very grossly inappropriate in the way they seek attention and affection and they often cause grave offence to people in the community. I can remember a child who came to live with us in one of the residential cottages and who was very unhappy about his separation from his mother, giving a very graphic account of what he would do to my mother if he ever bumped into her. And all of this places them at extraordinary risk in the community at large.
>
> "We see toddlers who are often looking after themselves for significant periods of time when their parents are either physically or mentally unavailable to them. They have inadequate food and sleep. Terrible accidents sometimes happen to them. They suffer burns, have falls from quite high places. And the chaos of the household often means that health needs are not met. We had a little girl who had had hearing difficulties diagnosed. Hearing aids had been provided to her but the hearing aids could never be found in the morning before going to school so she would go to school. She wouldn't hear anything. She wasn't learning anything."[30]

These nightmare visions of an underworld can be recognised in the following list of family factors associated with drug abuse assembled by researchers in the United States.

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30. Families and Friends for Drug Law Reform, Drug Action Week forum - "Drugs affect all sectors of our community" (2001) convened by Families and Friends for Drug Law Reform. Transcript at www.ffdlr.org.au.

Family factors associated with drug abuse[31]

Family history of behaviour problem, including:

- parental or sibling role modelling of antisocial values and drug-taking behaviours
- favourable attitudes about drug taking
- parental criminality, psychopathology, antisocial personality disorder & substance abuse

Poor socialisation practices, including:

- failure to promote positive moral development
- neglect in teaching life, social, and academic skills to the child or in providing opportunities to learn these competencies
- failure to transmit prosocial values and disapprove of youth's use of drugs

Ineffective supervision of the child, including:

- failure to monitor the child's activities
- neglect
- latchkey conditions
- sibling supervision
- too few adults to care for the number of children

Ineffective discipline skills, including:

- lax, inconsistent, or excessively harsh discipline
- parental behavioural undercontrol or psychological overcontrol of the child
- expectations that are unrealistic for the developmental level of the child creating a failure syndrome
- excessive, unrealistic demands or harsh physical punishment

Poor parent-child relationships, including:

- lack of parental bonding and early insecure attachment
- repeated loss of caregivers
- negativity and rejection of the child by the parents, including:
  - cold and unsupportive maternal behaviour
  - lack of involvement and time together, resulting in rejection of the parents by the child
- maladaptive parent-child interactions

Excessive family conflict and marital discord with verbal, physical, or sexual abuse

Family disorganisation, chaos, and stress

- often because of poor family management skills, life skills, or poverty

Poor parental mental health, including depression and irritability

- which cause negative views of the child's behaviours, parental hostility to child, and harsh discipline

Family isolation:

- lack of supportive extended family networks
- family social insularity
- lack of community support resources

Differential family acculturation:

- role reversal
- loss of parental control over adolescents by parents who are less acculturated than their children

31. From Source: Kumpfer, KL, Olds DL & Alexander JF, *Family aetiology of youth problems* in R.S. Ashery, E.B. Robertson, and K.L. Kumpfer (eds), *Drug abuse prevention through family interventions* (NIDA Research Monograph 177). Rockville, MID: National Institute on Drug Abuse: 1998:42-77 as reproduced in Mitchell et al (2001) fn 29, p. 15.

Use of illicit drugs is widely spread in the community. It is far from being the case that every user fits the "junkie" stereotype but drug abuse whether alone or in association with mental disorders is generally present to make the worst situations as bad and as intractable as they are.

C. Importance of support being provided in the context of the family

The snapshot of low, medium and high risk families illustrates, if crudely, the wide range of human situations that the Committee will need to take into account in its recommendations on support services for families. One set of measures is most unlikely to be helpful for all. The immediate situation of those in custody and their family should not be considered in isolation from their life up to that point and from the future. The reasons for this largely self evident proposition include the following:

(1) We are dealing not just with individual human beings but with human beings dependent on each other. The family is likely to be the grouping where the interdependence is most concentrated or which, if strengthened, holds out the greatest promise of benefit to all.

(2) The insights of early intervention highlight the importance of the family in its influence on the upbringing of young people. Most of the potent risk and protective factors associated with mental health, substance abuse and other social problems as well as crime are closely associated with families. The influence of the family is of most significance at transitions between life phases[32] of which the exercise of the coercive powers of the State through arrest and detention is clearly one. The capacities of the family of upbringing and additional family relationships established in early adulthood by the person in custody have a strong bearing on the outcomes for the detained person.

(3) Insights into what makes for a low crime society point to the importance of community links as described in the context of restorative justice and reintegrative shaming. This point calls for amplification.

Restorative justice and reintegrative shaming are criminological concepts built around the interdependence of we humans in a community. Restorative justice "emphasises the repair of harms and of ruptured social bonds resulting from crime; it focuses on the relationships between crime victims, offenders, and society".[33] Professor Braithwaite of the ANU, who has done much to develop the concepts,

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32. National Crime Prevention (1999), fn 23, pp. 131-32.

33. Kathleen Daly and Hennessey Hayes, "Restorative justice and conferencing" in *Cambridge handbook of Australian criminology* (2002) fn 17, pp. 294-312 at p. 294 quoting K. Daly and R. Immarigeon, "The past, present, and future of restorative justice: some critical reflections", *Contemporary justice review*, 1(1) pp. 31-45 at p. 22 (1998).

writes that "communitarianism and interdependency" are the societal conditions for low crime.[34]

> "Interdependencies must be attachments which invoke personal obligation to others within a community of concern. They are not perceived as isolated exchange relationships of convenience but as matters of profound group obligation. Thus, a communitarian society combines a dense network of individual interdependencies with strong cultural commitments to mutuality of obligation. Individual interdependencies are interpreted within the framework of group loyalities – father-son interdependencies are symbolically part of family obligation, employer-employee interdependencies part of company loyalty."[35]

For all these reasons the Committee should conduct its inquiry in the light of the broader context of the family and the person in custody and the implications of the support and other interventions that they may recommend. There is potential to do much good. Thus, while the Committee's terms of reference require it to focus on support services for families of those in custody, the Committee should look beyond these short term temporal circumstances. What should be done for families in those circumstances should be framed in the context of the life of all closely concerned, including the person in custody and that person's family. Unless this is done any recommended assistance and other interventions of the Committee will not be grounded in reality with a result that those interventions are likely to be ineffective and wasteful.

It should be more and more obvious that justifications for imprisonment and the practices that are associated with it are overwhelmingly the reverse of those that inform interventions to address social problems in other contexts. Assistance to overcome poverty addresses such things as enhancing the capacity of members to work, helping with the education of children and addressing the family's health needs. All are seen to be related. In the case of child protection, best practice involves first and foremost seeking to build up the capacities of the family to care for the child. Removal of the child generally causes more problems than it solves. It is recognised that to be successful, interventions to address such problems should not be confined to the particular out of work bread winner (in the case of poverty) or child (in the case of protection) but must also take into account the needs of all those closest to those people.

Such an obvious approach nevertheless represents an alien mindset when it comes to traditional custodial interventions in response to crime. This has to be changed for we know that imprisonment makes many problems worse. To give just a few examples:

- it creates poverty through people losing work and finding it very difficult to get work after release;

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34. Braithwaite (1989), fn 24, p. 84.

35. *Ibid.*, pp. 85-86.

- it brutalises and makes better criminals of many inmates;
- the health of people who leave prison is often worse than when they enter through violence, rape, contracting blood borne diseases and developing worse drug problems; and
- drug dependent people leaving prison who in prison have been abstinent run a high risk of relapsing under the stresses of readapting to life outside and of suffering fatal overdoses.[36]

1. Families are at the centre of transmission of risk or protective factors between generations

Insights from the study of early intervention challenge us not just to focus on the whole of people's lives but to do so in terms of one generation succeeding another. This is recognised in criminology. "[K]nowledge is passed from one generation to the next on how to organize particular types of offending, how to neutralize the moral bind of the criminal law."[37] The degraded capacity of one generation forms the risk factors for the next. Risk factors are not just transmitted down generations but, without interventions, tend to be magnified in the process.

Troubles of the indigenous community will necessarily call for the close attention of the Committee given the grossly disproportionate number of indigenous young people caught up in the corrections system. In this community the accumulation of risk factors down generations is plain. This was documented in the *Bringing them home* report:

> "The impacts of the removal policies continue to resound through the generations of Indigenous families. The overwhelming evidence is that the impact does not stop with the children removed. It is inherited by their own children in complex and sometimes heightened ways."[38]

The influence on the indigenous population of the relatively new risk of the abuse of illicit drugs is catastrophic.[39]

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36. Sheila M. Bird & Sharon J. Hutchinson, "Male drugs-related deaths in the fortnight after release from prison: Scotland, 1996-99" in *Addiction*, vol. 95, pp. 185-90 (2003).

37. Braithwaite (1989), fn 24, p. 26

38. Human Rights and Equal Opportunity Commission, *Bringing them home: report of the National Inquiry into the separation of Aboriginal and Torres Strait Islander Children from their families* (April 1997) p. 222. See also Roderic Broadhurst, "Crime and indigenous people" in *Cambridge handbook of Australian criminology* (2002) fn 17, chapt. 12, pp. 256-80 at pp. 268-69.

39. Address of Isabel Norvell, Chairperson of the Aboriginal Drug and Alcohol Council (SA) at Brian McConnell & Tony Trimingham (eds), *National Families & Community Conference on Drugs: "Voices to be heard": Conference proceedings, 10-11 November 2000* (Families and Friends for

Drug abuse is a particularly potent element in the transmission and magnification of risk factors from one generation to another because of its close association with many other potent risk factors. It is easy to see how a downward spiral through several generations can occur. Imagine generation one being brought up in a low risk family. While the risks of drug abuse among the children may be low, section B.1 showed how drugs are potentially attractive to a wide range of perfectly normal young people – from among those who have a normal risk taking personality or who have low self esteem. Some from this low risk environment have their life chances and those of their own children badly degraded. There may be capable grandparents to help out. A further generation on and there will no longer be this intergenerational support. To quote again the Director of Marymead, Sue Mickleburgh:

> "[W]e're now certainly seeing second generation families. Of course, there are children who are resilient, who will break out of the lifestyle of drug abuse but there are others who have not been able to escape that and it's really quite difficult to imagine how they're going to find their way out of that."[40]

In ways such as this drug abuse is bringing about a growing community of suffering embracing both indigenous and non-indigenous Australians.

2. "Family" should embrace the "extended family"

It will be clear by this point that Families and Friends for Drug Law Reform urges the Committee to take a wide view of the "family". It should include everyone in a close personal relationship to the person in custody. It should, therefore, embrace

- the traditional nuclear family of married parents and children;
- those in a de facto relationship;
- the children;
- grandparents, aunts and uncles where these care for children or otherwise provide support;
- the extended families according to different cultural traditions
- those within the broader kinship relationships of Indigenous communities
- those in a close mentoring relationship such as a sports coach or a former teacher or the person fostering a child of the person in custody.

No one who is in a close personal relationship with the person should be excluded from the circle of potential support or dependence that is the hallmark of "family".

Drug Law Reform, Canberra, July 2001) pp. 33-36. Available on www.ffdlr.org.au.

40. Drug Action Week forum (2001) fn 30.

III. STRATEGIC OBJECTIVES

To state the obvious, holding someone in custody for a time deprives that person of liberty to be in the community and it deprives the community, and particularly their family, of his or her presence. Deprivation of liberty is the essential element – a harm justified by the suspected or proven criminal conduct of the person in custody. Almost invariably the family of that person will also suffer hardship. Harm to the family should be minimised. Maintaining family links and support during the detention is a key to the rehabilitation of the offender. Efforts should be directed to maximising that support. Flowing on from this, the successful re-integration into the community of a released prisoner will in a large measure depend on assistance for that person from his or her family. The family is likely to be there for the freed prisoner 24 hours a day 7 days a week, something that external support services can never hope to match. It makes sense to strengthen the capacity of the family to provide that assistance. Children are often the ones on whom imprisonment – generally of a parent – has the most serious and enduring consequences. Strengthening of the capacity of the family to bring up children is therefore vital. The physical health of the ex-prisoner is an element of that capacity. People in custody have substantially greater health problems than the community at large.[41] When they emerge they should be in better health. They should certainly not, as so often happens at the moment, re-enter the community in worse health. Blood borne diseases, notably hepatitis C and HIV, can blight the life not only of the ex-prisoner but his or her sexual partners and echo down generations through their children.

For these reasons Families and Friends for Drug Law Reform believes that the Committee should adopt the following four strategic objectives in recommending support for the families of people in custody.

Recommendation 1:

Programmes for the support of families of those in detention should be consistent with the following principles:

(a) the hardship of family members dependent on the member detained should be minimised;

(b) the family's support for the detained person during the detention should be maximised;

(c) the capacity of the family to assist in the reintegration of the released member into the community should be reinforced;

(d) the capacity of the family to bring up children should be strengthened; and

(e) the health of the detained family member should be protected.

Each of these will be considered in more detail.

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41. ACT Community Care, *Improving health services to people in custody in the ACT: a model for delivery* (February 1999) p. 4.

A. Minimising hardship of family members dependent on the member detained

Even arrest and remand can be devastating for families. If it is the breadwinner who is detained, the family will be without an income which the State and other agencies may eventually go some way to make up. Arrest and subsequent imprisonment can grievously disrupt the life of those outside. The arrested person may lose a job. The family may lose their accommodation. In the meantime children have to be fed and their education and health attended to. It is said that the family outside does it tougher than the member put away and there is often much truth in that. The family should not be made to suffer for the wrongs of an imprisoned member yet that is what happens.

The harm to the family upon incarceration is not just the loss of material support and absence of the member. Debilitating shame often also accompanies the arrest and continuing detention. The shame can splinter families. A father and a sibling may deal with that shame by seeking to cut off all links with an incarcerated child. A mother and other siblings may want to maintain links but be overcome with depression. Unbearable tensions often develop between different family members.

Where addiction and other mental disorders are involved the disempowering effects of shame may already have poisoned relationships. "Parents [when they initially recognise substance abuse] often experience considerable distress, which can undermine effective responding."[42] According to a recently published study of the Vietnamese community ". . . the drug use of a child [has] often led to family break up or disintegration."[43] "Shame" and related words like "guilt" and "stigma" formed a recurrent theme at the national families and community conference on drugs that Families and Friends for Drug Law Reform and Family Drug Support organised in 2000. "The stigma associated with drug use, especially illegal drug use, leads to parents becoming enveloped in shame and guilt and this causes them great anxiety."[44] A mother who is a registered nurse described in the following terms her experience following the addiction of her son:

> "None of the agencies we had contact with could offer much help or advice for us as parents, and even close friends and family could not understand what we were going through. Their criticisms, advice and suggestions, and the rejection we felt, added to our shame and isolation. We continued to flounder in a black sea of despair, never knowing what crisis we would have to deal with next or whether our children would even manage to stay alive."[45]

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42. Mitchell et al (2001) fn 29, p. 39.

43. Ruth Webber, "The impact of illicit drug use on non-using siblings in the Vietnamese community" in *Australian journal of social issues,* vol. 38, no. 2, pp. 229-45 (May 2003) at p. 238.

44. *National Families & Community Conference on Drugs* (2001) fn 39, p. 118.

45. Story of "Phoenix" in *National Families & Community Conference on Drugs* (2001) fn 39, p. 73.

A poem presented to the same conference reads in part:

> "Somebody's daughter, son, grandson, mother, father or brother.
> Is it real? Can it be? It is. It's not just a nightmare.
> It is real. It is happening to us and to him, our son.
> Pain, shame, heartache and grief. Hopelessness.
> Drugs, crime, depression, psychosis, suicide thoughts,
> Spiralling dysfunction.
>
> "Police, court, jail, probation, the street.
> How can it be? What can we do? Where can we go?
> A merry-go-round of try this, go here, go there.
> No room. Go home. How can we stand this another moment?"[46]

The National Families & Community Conference on Drugs concluded that:

> "The stigma of drug use is compounded by the stigma that surrounds imprisonment. This stigma is debilitating and makes it very hard to reintegrate prisoners into the community."[47]

It noted that:

> "Stigma needs to be addressed:
>
> - within the family; and
> - in the community attitudes towards the prisoner and his family."

Recommendation 2:

Support should be provided:

(a) to meet the crisis and longer term material needs of families whose life is disrupted by the detention of a members; and

(b) to assist the family to cope with the non-material stresses associated with detention, notably where these are compounded by substance abuse and mental disorder of the member in custody.

B. Maximising the family's support for the detained person during the detention

Family support is often of the first importance for the well being of a detained family member. As one former prisoner described the support that his family:

> "Their support in gaol has made a big difference and gives a feeling of worth. My mother told me once that I'm not the black sheep of the family, just at times the lost sheep!"[48]

The usefulness of that support is likely to vary during the course of the detention:

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46. "Julie's Poem" in *National Families & Community Conference on Drugs* (2001) fn 39, p. 72.

47. *National Families & Community Conference on Drugs* (2001) fn 39, p. 7

48. *National Families & Community Conference on Drugs* (2001) fn 39, p. 91.

- On arrest and remand when people are particularly vulnerable to depression and self harm;
- Coping with longer term incarceration; and
- Preparing the detained person for reintegration into the community on release.

Arrest and remand constitute a time of crisis accentuated by the removal of ". . . an individual from the social supports he or she normally utilises at a time of crisis — be these the support of family, friends or others in the community."[49] People are placed ". . . in institutional custody at a time of high vulnerability. This increases pressures upon the individual and the potential risk of self-harm of a physical or psychological nature."[50] In the United States "a number of important studies [have] identified the much higher death rates in police and remand custody compared with prison custody."[51] Those who harm themselves tend to be ". . . younger prisoners, often under 21, who were experiencing considerable psychological distress. They appeared unable to cope with the prison environment and had few social contacts within the prison system, as well as little outside support and contact from family and friends."[52] This knowledge points to the importance during the early days of detention of minimising the rupture that arrest normally represents by maximising the contact between the detained person and his or her family when the family is able to provide support.

Suicide and other forms of self harm prompted by factors such as the harshness of life in detention with its episodes of brutality continue to be serious problems in prison. "It has been estimated that the suicide rates for prisons are at least four times higher than for the general community. . . . It has been estimated that

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49. Rick Sarre, Sue King and David Bamford "Factors affecting remand in custody in three Australian jurisdictions" (1999) being a paper presented at the 3rd National Outlook Symposium on Crime in Australia, Mapping the Boundaries of Australia's Criminal Justice System convened by the Australian Institute of Criminology and held in Canberra, 22-23 March 1999 at http://www.aic.gov.au/conferences/outlook99/sarre.pdf visited 9/06/02.

50. *Ibid*.

51. John Dawes, "Deaths in custody: moving beyond a statistical analysis" (1999) being a paper presented at the 3rd National Outlook Symposium on Crime in Australia, Mapping the Boundaries of Australia's Criminal Justice System convened by the Australian Institute of Criminology and held in Canberra, 22-23 March 1999 p. 2 in http://www.csc-scc.gc.ca/text/rsrch-/reports/r75/r75e.shtml visited 16/07/02. See also Peter Camilleri, Morag McArthur & Honey Webb, *Suicidal behaviour in prisons: a literature review* (School of Social Work, Australian Catholic University, Signadou Campus, Canberra, March 1999).

52. Camilleri, McArthur & Webb, (1999) fn 51.

for every suicide there is anywhere from 30 to 100 attempts."[53] Family contact and support can also reduce this propensity for self harm.

The same contact and support can minimise the danger of the further social marginalisation of the person detained. The social cost of imprisonment to the community exceeds the high economic cost of running the prisons. The increasing use of imprisonment in recent years:

> ". . . widens the gate and leads to more people being imprisoned, with the consequent loss of opportunities within the community through loss of social skills, employment, relationships, increasing stigmatisation, exposure to more serious offenders, and possible contagion."[54]

Maintaining and strengthening family links during the imprisonment can mitigate these serious harms. Without such links there is a higher likelihood of imprisonment turning out a more willing and effective criminal. The "contagion" that happens in prison is explained by labelling theory.

> "Once a person is stigmatized with a deviant label, a self-fulfilling prophecy unfolds as others respond to the offender as deviant. She experiences marginality, she is attracted to subcultures which provide social support for deviance, she internalizes a deviant identity, she experiences a sense of injustice at the way she is victimized by agents of social control, her loss of respectability may push her further into an underworld by causing difficulty in earning a living legitimately."[55]

In short, maintaining and strengthening family links during imprisonment reduces the likelihood of imprisonment leading to further marginalisation of the prisoner and his or her greater identification with a criminal sub-culture.

Being detained is an enormous life change. So is release into the community. The routines of imprisonment can deskill inmates. Picking up the threads of life outside and fending for oneself can be enormously difficult and demoralising. Release is a time of great danger for released prisoners who have been abstinent. The pressures upon them often lead them to relapse. Their tolerance to drugs following from their abstinence puts them at high risk. The death rate of recently released prisoners from opiate overdose is frighteningly high. A recent Scottish study of some 20,000 recently released prisoners revealed that drug related mortality was seven times higher in the two weeks after release than at other times at liberty. It was even 2.8 times higher than the rate of prison suicide.[56] As discussed in the next section, it is families who can provide the best bridge into the community. This support cannot be turned on upon release without the relationship being nurtured during detention.

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53. Camilleri, McArthur & Webb, (1999) fn 51.

54. John Dawes and Anna Grant, "Corrections" in *Cambridge handbook of Australian criminology* (2002) fn 17, chapt. 5, pp. 93-109 at p. 99.

55. Braithwaite (1989), fn 24, p. 19.

56. Bird & Hutchinson (2003), fn 36.

C. Reinforcing the capacity of the family to assist in the reintegration of the released member into the community

Gone are the days when attempts at rehabilitation of offenders were regarded as fruitless and thus a waste of money. A paper of the Australian Institute of Criminology speaks of "an emerging international consensus of expert opinion as to the effectiveness of rehabilitation programs." It refers to studies which ". . . when taken together, offer consistent evidence that offender rehabilitation programs can have a positive effect in reducing recidivism."[57] Punitive measures probably cause more harm than good. A review of "evidence on the effectiveness of various sentencing options in preventing recidivism, conclud[ed] that sentencing options based on punitive approaches (such as prison sentences or community orders) have a limited capacity to influence the future behaviour of persistent offenders."[58]

In the case of drug dependence the best outcomes most often occur when the links are retained between the user and his or her family. This is consistent with the known potency of family risk and protective factors already referred to in connection with crime, substance abuse, mental disorders and other problems. Interventions that strengthen family links are, therefore, worthwhile.

A 2001 literature survey by the National Health and Medical Research Council of the role of families in, among other things, the treatment of illicit drug problems states that:

> "Moderate to large effect sizes have been observed in evaluations of Functional Family Therapy (FFT) in reducing acting-out and delinquent behaviours in indicated populations, when compared with alternative or no treatments controls. . . . [One study] found that with less serious offenders, reductions in recidivism ranged from 50 to 75 per cent and with very severe cases a 35 per cent reduction was found."[59]

Very often assistance in straight forward practical matters is all that is necessary to enable a family to maintain support on a sustainable basis for a family member. This may, for example, be the provision of accommodation for an adult child who has a mental illness and vulnerable to substance abuse. Although a family may have difficulty coping with the adult child resident in their home, they may be able to provide on a long term basis a lot of necessary support for that child if he or she has separate accommodation. Building up the capacity of families to support a member released from detention will take many forms and should take reflect the situation of both the person detained and the family.

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57. Kevin Howells & Andrew Day, "The rehabilitation of offenders: international perspectives applied to Australian correctional systems" in *Trends and issues in crime and criminal justice*, no. 112, (May 1999) p. 2 at http:-//www.aic.gov.au/publications/tandi/ti112.pdf visited 31/03/03.

58. *Ibid*., p. 5.

59. Mitchell et al (2001) fn 29, p. 38.

D. Strengthening the capacity of the family to bring up children

"While prisoners are frequently demonised in the press and in the public imagination, it should be remembered that they also retain other identities as sons and daughters, fathers and mothers, husbands, wives and partners, which it is crucially important to acknowledge."[60] This overlooked truism has particular bearing on children. For example, it is known that factors such as absence of father, poverty, criminality of parents and lack of involvement of a parent in a child's activities can have negative consequences for a child at school and increase the risk of antisocial and criminal behaviour.[61] If we are to ensure that the risk factors of crime and other social problems are not perpetuated and magnified in coming generations we must see to it that there is the best possible support for children of families who have an incarcerated parent or sibling.

E. Protecting the health of the detained family member

All too often a family is presented with a member released from prison in poor physical health. Hepatitis C and HIV are contagious diseases. They can be transmitted to sexual partners and children and can thus blight the life of them as well as that of the ex-prisoner. The community at large has a major interest in effective health strategies for prisons to prevent the spread of blood borne diseases. Because of the congregation in prison of people with substantially greater health problems than the community at large there is a need for a particularly high quality and concentrated level of health care to apply in prisons.

Custodial institutions in Australia are high risk environments for the transmission of HIV and hepatitis C. Practices involving known pathways of infection of these diseases occur frequently: contact with blood from assaults, widespread intravenous drug use without sterile syringes and unprotected homosexual sex. The rate of HIV and AIDS infection among prisoners is likely to be much greater than the general community because of the high proportion of intravenous drug users in the prison population.[62]

Hepatitis C is rampant in prisons. "Over 50 percent of Australian IDUs test positive for hepatitis C infection. With similar proportions of IDUs reporting a

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60. Dawes & Grant (2002) fn 54, p. 103.

61. National Crime Prevention (1999), fn 23, pp. 135-39.

62. "Information on AIDS and HIV prevalence and incidence in Australian prisons is not systematically collected, counted or analysed" (Sandra Eggar & Hans Heilpern, "HIV/AIDS and Australian prisons" in *HIV/AIDS and prisons: proceedings of a Conference held 19-21 November 1990* edited by Jennifer Norberry, Matt Gaughwin & Sally-Anne Gerull (Australian Institute of Criminology, Canberra, 1991) pp. 65-83 at p. 66).

    "Approximately 5,700 Australians have died, and a further 11,000 currently live with chronic HIV infection" (Fourth National HIV/AIDS Strategy (draft) 27 July 1999, chapt. 1).

history of imprisonment, it is not surprising that hepatitis C infection is one of the most prevalent blood borne viral infections in prison populations."[63] Dr Paul Haber, Staff Specialist, Drug and Alcohol Services, at the Royal Prince Alfred Hospital in Sydney has reported that "80% of prisoners [in NSW] have chronic hepatitis C. Of those who have it 20% will develop cirrhosis over 20 years. Within this group only some will go on to develop serious conditions but because of the large pool of people with the disease it is the leading reason for seeking liver transplants. It's treatment is therefore a major health cost. Some 200,000 people are estimated to have cirrhosis."[64] "Imprisonment has been found to be associated with hepatitis C infection in a number of studies."[65]

IV. PROGRAMS

This part of the submission recommends specific programs that should be taken to promote the five strategic objectives just described. The programs put forward are not meant to constitute a comprehensive list. Some good programs consistent with those objectives are already being implemented such as those run by Prisoners' Aid and Kairos Inside and Outside. So they can expand, programs like these should receive more support than they presently do. ACT corrective institutions, including those that the ACT uses, should make a point of keeping themselves aware of and be prepared to implement promising programs overseas and elsewhere in Australia that are consistent with the strategic objectives.

The recommended programs are listed below under four broad headings: supporting the family of those in detention, facilitating family contact with the detained member, supporting the family on release of the detained member and maintaining and improving the health of that member– mental and physical. In reality all programs recommended have as their objective the support of the family. As explained in the objectives, those that focus on the health of those detained do so indirectly by seeking to ensure that they re-emerge into the community free of disabling conditions that would incapacitate their life and those of their family.

A. Support for family of those in detention

Arrest and subsequent detention are serious life events for those who may depend on the person remanded as well as for the person detained. "Remand in custody interrupts the capacity of the individual to assume family and social responsibilities and assumes that others will provide for any dependants, whether these are children, parents or other intimates."[66] The coercive intervention in the life

63. K. Dolan, "Surveillance and prevention of Hepatitis C infection in Australian prisons: A discussion paper" NDARC Technical Report no. 95 (2000) p. 4.

64. Paul Haber, "Hepatitis C in prisoners: incidence, prevalence and management in NSW" (presentation to APSAD Conference, Canberra, 10 November 1999).

65. Dolan (2000) fn 63, p. 6.

66. Sarre, King & Bamford (1999) fn 49, p. 4

of a person can lead to loss of a job and housing and other disruptions with serious consequences for all immediately involved and for the community at large. In other words, the tribulation involved in arrest and custody can have serious implications in the following ways for the family and other support circle of the person in custody. In particular the crisis of detention can:

(a) increase the risk of mental illness, school failure, substance abuse and other negative outcomes for dependent children;

(b) lead to a breakdown of the family or related support unit that depended on the person in custody; and

(c) reduce the capacity of the family or related support unit to be a key agent of support and rehabilitation of the person in custody.

In the final resort the community will probably have to bear the financial and other costs of those harmed by the custody including the cost of re-establishing their lives or of their dysfunction promoted by the harm of custody. It is foolish if the community intervention (custody) undertaken in response to an anti-social behaviour increases rather than reduces the likelihood of further anti-social behaviour.

1. Prompt assessment of the needs of the family of those arrested

Detention is likely to be a time of crisis for the family of the person detained as much as for that person. The needs of the family associated with the vulnerabilities inevitable in a crisis require prompt attention. The family is likely to be bewildered and traumatised not least by a lengthy period of stress that preceded detention if the detained person has been on drugs, has a mental disorder or both. Families can be filled with shame, grief and alienation that in some cases can result in a great difficulty even meeting with other people. Their self esteem so low that they lack the confidence of accessing any support agencies they know about. The family of a detained or imprisoned person may even be shunned by those it would ordinarily looked to for friendship and support.

Procedures should be in place to make a prompt assessment of the needs of the family. Its requirements may be in the form of:

- counselling of parent and children;
- guidance about where it may obtain legal advice;
- advice on how the health and other needs of the detained member may be met;
- financial assistance;
- liaison with schools to minimise harm to children against the likelihood that the arrest or conviction of the family member becomes public; and
- liaison with the employer of the detained person.

To link with the family at such a stressful time as a detention, it is essential that the assessment have regard to cultural sensitivities of the family concerned. This applies particularly in the case of indigenous families and those of different cultural backgrounds.

The assessment should lead to the family being plugged in to all services that may be relevant to their situation. It is just as important to do this where the relations between the family and the person detained are ruptured. In the great majority of cases those relations will be strained. The capacity of the family to provide necessary longer term support for the detained member will be reduced unless relations with the family are repaired.

2. Co-ordination of family services

Attending to the family of a perpetrator or suspected perpetrator is beyond the normal scope of intervention by police and correctional authorities. It therefore requires the development of co-ordinated strategies involving a range of government and non-government agencies including Prisoner's Aid. A holistic approach is required and should not be discounted simply because it involves responses that cross traditional lines of responsibility.

Recommendation 3:

Procedures should be in place to make a prompt assessment of the needs of the family of everyone who is detained.

Recommendation 4:

Strategies should be developed for relevant government and non-government agencies to provide a co-ordinated range of support to the families of those detained.

B. Facilitating family contact

At present there are formidable barriers to families maintaining a continuing relationship with members on remand or in prison. The obstacles further alienate those detained from their support network to the detriment of themselves, their family and of the wider community. A preoccupation with trying to keep drugs out is principally responsible for the lack of openness of correctional institutions to contact between detainees and their families. This is discussed below in section V.D.

1. Convenience of access by family

There are a range of practices that serve to limit the access of families to members detained on remand or in prison. These include:

(a) The limited number of visitors permitted for overly restricted times. Where this is for want of adequate visiting facilities those facilities should be expanded.

(b) Putting family members to the inconvenience of having to present themselves for a visit without any assurance that they will be permitted to see their detained member. (See the boxed account below of a visit to Belconnen Remand Centre.) This can happen where a corrective institution does not permit visits to be booked and allows a limited number of visits on a first come first served basis.

(c) Not advising family of when prisoners are moved to another facility. Families and Friends for Drug Law Reform, for example, is aware of a family

booking a visit to Goulburn Gaol for the following weekend only to find that the family member had been moved to another prison before their arrival.

(d) To the greatest extent possible prisoners should be held in prisons that are reasonably accessible from Canberra.

(e) Where necessary, assistance with transport should be provided to families to enable them to visit detained members. This is an important factor in the absence of a prison in the A.C.T.

2. Dignity for family visits to be secured

As the following account of a visit to the Belconnen Remand Centre illustrates, correctional institution can be intimidating. Mostly they are physically uncongenial. The ethos is at best one of toleration of visits. Suspicion is often evident that the family may be seeking to smuggle in contraband – particularly drugs (see section V.D below). The surroundings for visits are under constant surveillance. Little or no provision is made for visits by children. In this strained environment the scope for supportive interaction between family members is extremely limited.

The attitude expected by corrections authorities of custodial staff is important. There is no way that family bonds can be enhanced in a prison environment if the ethos of the institution is that those detained are scum who should have thought what they were doing to their families before they committed the crime and that their family should blame the prisoner and not expect society to molly coddle him or her. Engendering a sense of worth of the detained person is an essential part of the process. As a prisoner has put it to us:

> "In gaol inmates mostly get messages from many directions that they are bad and will continue to use drugs and do crime. When I've been flat, down, depressed, anxious or stressed and thought I may end up using on release (or before) and end up full of guilt and regrets and go into manic overdrive I contemplate escape to get it out of the way (not caring about the high chance of getting caught and returning as either way I'll be back) or suiciding and save myself the anguish."[67]

Leadership, support and training is required to bring about recognition of the need to enhance family support for prisoners and on how this can best be brought about.

A visit to Belconnen Remand Centre

by a member of Families and Friends for Drug Law Reform

I present myself at the reception area of the Belconnen Remand Centre. I am lucky.

On the wall is a barred pigeon hole. There's a voice behind it and part of a human figure. I say who I have come to visit – a young woman, I'll call her Christine, for whom from time to time I have provided foster care. I am early enough and lucky enough – early enough because I'm within the quota of about 5 visitors allowed this visiting session – there are two sessions a day - and I'm the only one

67. *National Families & Community Conference on Drugs* (2001) fn 39, p. 90.

who has wanted to see Christine that day. Inmates are allowed only one a day. Will the young mother, baby in pram, who comes in after me be so lucky? At least I've got a car. Goodness knows how many buses she has had to wait for to get here with that child.

I am given a key to a locker because you are not allowed to take anything in with you – not some lollies, not a magazine, not even postage stamps and certainly not your handbag. You must empty all your pockets. What's going to happen if the baby needs a bottle or its nappy needs changing?

I must then fill out a form about who I am and why I want to visit so and so. I must produce identity to prove that I am who I say that I am. I see an elderly woman (Italian I guess) who's obviously nervous and not finding this form filling easy. You've got to present yourself at least 15 minutes before the designated visiting time to allow for all these procedures.

By now there's about seven of us for the five visits. That doesn't count the baby and a couple of other young mothers with small kids in tow. We're told we now have to go to a waiting room. We walk down a long corridor and are scanned by a metal detector. It's very small room, about 2 x 3 metres. We're all standing crammed together – the young mums, me (I'm alone), the elderly Italian woman, and some pretty rough looking types – male. We're strangers to each other. There's no window. Everyone's tense. I'm glad I'm not claustrophobic. I understand that the room is used as an interview room for inmates to see their lawyer. None of the staff have been welcoming. No one is glad that we have come.

They locked us in the room while they collect the inmates. We wait and wait. Eventually someone unlocks the door and tells us to follow. We enter a room that seems much larger – about 5 x 7 metre – and there they are. They're all in green from neck to knee - overalls zipped down the back. All the feet are wearing thongs. I forget that these figures are not convicted prisoners. Christine is one of them.

The welcoming is as tense as everyone feels. Everyone is self conscious. We spread around the room. It's bare except for some chairs and a desk. The floor is vinyl. Christine and I find a space and a couple of the chairs. A warder at the desk is watching us all. The side of the room beside the corridor is glass.

What do we say to each other in this goldfish bowl? She's not really interested in the outside world. I know she feels like shit. She's detoxing. I can sense the same is true for most of the others dressed in green. We, the visitors, don't feel much better. I see that some of the young women are hanging out for a smoke but, of course, it's no smoking.

We've been told that no physical contact is allowed but I'm glad that they do not seem to enforce that strictly. A couple are canoodling in a corner. There are some embraces but the atmosphere doesn't relax. The baby starts crying. There's no tea, no coffee, just a 5 x 7 metre bare room for 45 minutes. We had to arrive together and we've got to leave together. It's hard filling up time with words in that atmosphere. Other kids are howling by now.

I've been told that I can't give Christine lollies or the magazine that I brought. Back out the front I ask about money? Yes, that would be possible but, it is evident that that's not easy either. I have to hand it in at the barred pigeon hole at the front. They've got to open an account for Christine. All this takes time. I learnt that it was three days before she got access to it.

Recommendation 5:

Obstacles arising from the regime of remand centres and prison that serve to limit reasonable access of families to members detained should be removed.

Recommendation 6:

Where necessary, assistance with transport should be provided to families to enable them to visit detained members.

Recommendation 7:

A dignified and congenial human and physical environment should be provided for families to visit detained members.

Recommendation 8:

Leadership, support and training is required to bring about recognition among custodial staff of the need to enhance family support for prisoners and on how this can best be brought about.

C. Support for the family on release of the detained member

In its discussion of the transition from prison to the community, the ACT Prison Community Panel made two points of particular relevance to the committee's inquiry. These are that:

- The stage of transition of a detainee before and after release "is critical to successful reintegration into society;" and
- "Where possible, this [transition] should involve family members and others who have been identified as being able to support the prisoner on release."[68]

Just as detention in the first place was an important point of transition in between life phases so is release from prison. The released prisoner is faced with many daunting challenges in re-establishing his or her life. These include finding accommodation, seeking a job and grappling with financial problems. As discussed in part II.C, the insights of early intervention have underscored the importance of managing well these transitions. Assistance provided by the social context has a big influence on reintegration into the community. In this case ". . . forms of assistance or intervention may need to be tailored to the individual's particular needs, to the particular demands being faced."[69]

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68. ACT Prison Community Panel, *An ACT prison – "Getting it Right"* (Canberra, December 2000) §7.4, p. 61.

69. National Crime Prevention (1999), fn 23, p. 133.

The stresses on any released prisoner in re-establishing him or herself in the community are magnified if that person has had a drug problem. Even with the best of intentions those stresses can be the very sort of ones for which drug use provided relief. Relapse is thus on the cards and with it goes a high risk of a fatal or damaging overdose because abstinence has reduced the person's tolerance. There is also the real challenge for the user in remission who seeks to establish outside prison a circle of support alienated from his or her drug using friends of many years standing. Getting and staying off drugs can be a very lonely and alienating experience.

It is in this context that family support will most likely be crucial. The best support will depend on the circumstances and personalities of the family unit concerned. There thus should be:

- an assessment of needs of the family as a whole as well as the released member; and
- the co-ordination of community programmes to provide the support required.

As the ACT Prison Community Panel put it with just the prisoner in mind:

> "There should be a strong focus on ensuring the income support and other services that a prisoner may require upon release are put in place early. Other services may include housing (apart from the use of a half-way house), assistance in finding employment, medical, mental and coping counselling and various community support programs."[70]

It is likely that a focus on support for the prisoner in the context of the needs of his or family will be more effective than focussing on the released prisoner as an individual. It is also likely to result in a need for less overall external support in that the support provided to the family should enhance the capacity of the family to support its released member.

Families and Friends for Drug Law Reform would particularly emphasise the frequent need for accommodation for family members. Many families can provide a lot of support if the member they care for is not resident in their home but that support falls away if the person cared for is resident in the family home. In the light of a tight rental market it is very easy to discriminate against people with a mental illness, a drug habit or both. The problem is further compounded for ex-prisoners. Long term supported accommodation for those with a mental illness is in extremely short supply. Because of this, people who are doing well in supported accommodation are often asked to leave and live independently. As a result they end up in crisis and the whole cycle starts again.

Recommendation 9:

> In order to maximise the support from families for the transition of detainees to the community:

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70. ACT Prison Community Panel (2000) fn 68, §7.4.4, p. 63.

(a) the needs should be assessed of the family as a whole as well as the released member; and

(b) community programmes providing the support required should be co-ordinated.

Recommendation 10:

Where a family is able to provide useful support falling short of accommodation for a member released from detention, help should be provided to enable the member to secure accommodation convenient to the family.

D. Maintaining and improving the mental health of those detained

How best to provide for those with a mental disorder has been long and hotly debated. Families and Friends for Drug Law Reform does not pretend to be abreast of all the issues in that debate or even to have an accurate overview of the range of mental health needs and existing services. Even so, from the account given in sections II.A.1 and II.A.2 it is evident that policy regarding drugs and mental health policy are inextricably linked. The coexistence of substance abuse with other mental disorders greatly increases the risk of offending and "[t]he evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing."[71]

Families and Friends for Drug Law Reform is aware of the situation of families that are striving to care for a mentally ill member who is also dependent on illicit substances. Their efforts to do so while attempting to maintain some normalcy in the rest of their life are heroic. This is all the more so in the light of the patchiness of assistance available and of policies, some well meaning, that tend to undermine their efforts. The predicament of many families can only be described as desperate. Some give up and leave it to community services to attempt to pick up at least part of the support that the family was providing. Stigmatising community attitudes or want of skills or financial capacity paralyse the response of other families who would have been willing to support their drug dependent and mentally ill member.

It is from these perspectives that Families and Friends for Drug Law Reform puts forward the following propositions. They are grouped under two headings: firstly a set of things that should not be and, secondly, a set of things that should be. The negative propositions are the following:

(a) Remand centres and prison are no place for people with serious mental disorders.

(b) The existence or otherwise of a serious mental illness warranting urgent psychiatric treatment should not be the determinant of whether support is provided.

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71. Mullen (2001) fn 6, p. 17.

(c) The needs of those with a mental disorder and their families should not be defined or limited by reference to the professional competences of those involved in providing some support.

(d) Concern for some interests of those with mental disorders should not undermine the capacity of those willing to provide support.

(e) Concern to provide requisite professional support for those with a mental disorder should not be done in a way that diminishes the capacity of the family to provide appropriate longer term support.

(f) Interventions should not focus on blame and separation of someone with a mental disorder from his or her family but should focus on enhancing the capacity of the family to provide support.

The positive propositions are the following:

(a) Provision of adequate treatment and services for those with a mental disorder and substance dependence.

(b) Support for families seeking to support a member who has a mental disorder.

(c) Support should be available to head off a crisis rather than be available only when a crisis arises.

(d) Provision of facilities where the mentally ill can be cared for when a crisis is looming or to provide relief for family and other carers.

(e) Provision of a facility outside remand centres and prison where those with a mental disorder who become caught up in the criminal law may be cared for.

(f) Integrate mental health services with other support for those with a mental disorder and their family.

1. Remand centres and prison are no place for people with serious mental disorders.

We can do no better than quote the words of Professor Paul Mullen, Professor of Forensic Psychiatry at Monash University and Clinical Director of the Victorian Institute of Forensic Mental Health:

> "The correctional culture and the physical realities of prisons are rarely conducive to therapy. Rigid routines, the pedantic enforcement of a plethora of minor rules, the denial of most of that which affirms our identity, add to the difficulties of managing vulnerable and disordered people. 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. Hierarchy and coercion which tends to rule in the official structure is often mirrored in the subculture of the prisoners. 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. Equally however they provide remarkably predictable environments with clear rules and limited but well delineated roles. Some mentally disordered individuals thrive in this world stripped of the contradictions and complexities of the outside world. Sadly thriving in total institutions is rarely conducive to coping in the community."[72]

It is a measure of the desperation of families and the lack of support in the community, that some have greeted with relief or even sought the arrest of a family member, as a means of securing care for them. The notion that remand centres and prisons are safe and caring drug free places for mentally disturbed people or indeed any young person addicted to drugs amounts to a cruel hoax. Nothing is further from the case.

> "Contact with the criminal justice field . . . exposes the vulnerability of mentally disordered people. A large majority of forensic mental health patients and clients have had substantial contact with the criminal justice system, which generally, as a matter of course, brings them into contact with other substance abusers. These contacts are often retained when they are released into the community. There is also the ever-present danger that the mentally disordered in the criminal justice system, and to a lesser extent in the community, will fall victim to the stand-over tactics of drug dealers."[73]

Recommendation 11:

> People with serious mental disorders should not be detained in remand centres or sent to prison.

2. The existence or otherwise of a serious mental illness warranting urgent psychiatric treatment should not be the determinant of whether support is provided

The medical decision of whether someone suffering from a mental disorder warrants admission to a psychiatric ward is distinct from whether that person may need support and whether their family on whom the person primarily relies for support itself needs support. Families and Friends for Drug Law Reform has heard of people seeking treatment for themselves being turned away from psychiatric wards because their condition was not serious enough. Applications by parents are refused on medical grounds for compulsory treatment of an abusive and grossly disruptive child with a severe mental disorder.

The medical decision may well be a correct one though the decision is sometimes taken because of lack of treatment facilities and other resources. Whatever the case, a decision about treatment should not be the determinant of

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72. Mullen (2001) fn 6, p. 36.

73. Victorian Institute of Forensic Mental Health (2000) fn 8, at pp. 412-13.

whether the person or family should receive support. The behaviour of disturbed people can be distressing even if it falls short of warranting psychiatric treatment or intervention by the police. It can consist of protracted verbal abuse, the family member putting himself in dangerous situations and engaging debt particularly when substance abuse is involved. As the Victorian Institute of Forensic Mental Health has put it:

> "Substance abuse creates disruptive and threatening behaviours which can alienate family and social supports, so essential to the stability of an offender's mental condition. These family and social supports are generally already subject to high levels of stress as a result of the pattern of substance abuse, offending and mental disorder."[74]

This is not to argue that compulsory treatment for those with medical disorders should be more readily available. What it is arguing for is that more support for the person and their carer is at times necessary to prevent a need for compulsory intervention. The support called for may have little to do with health expertise. What may be required is respite care to allow a family to recharge its batteries or financial assistance because a carer has taken time off work without pay.

3. The needs of those with a mental disorder and their families should not be defined or limited by reference to the professional competences of those involved in providing some support.

This point is similar to the previous one. The needs of the family supporting someone with a mental disorder and the broader life needs of that person may lie partly or wholly beyond the professional competence of mental health professionals. A professional decision that a particular treatment is or is not warranted is one thing. Quite another thing is whether support may be needed because of the behaviour of someone with a mental disorder.

4. Concern for some interests of those with mental disorders should not undermine the capacity of those willing to provide support

There is a justified concern to avoid infringing the interests of those with a mental illness in, for example, having a treatment that they do not want, in securing the confidentiality of their medical condition or in passing on information bearing on their well being received by someone like a teacher in a position of trust. The caution around compulsory or unsanctioned medical treatment is thoroughly justified in the light of the history of abusive practices. On the other hand, there must be some proportionality between the benefits of, for example, taking regular medication and the consequences that flow from not doing so. Families and Friends for Drug Law Reform has been told of a detainee with schizophrenia whose refusal to take his medication led to a month in isolation because of disruptive behaviour where he was being administered Valium that was not a treatment for his condition.

Concern to avoid infringing the individual rights of a person with a mental disorder has to be seen in the context of the life and the framework of social support

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74. Victorian Institute of Forensic Mental Health (2000) fn 8, p. 414.

around that person. No human, much less someone with a mental disorder, lives divorced from their fellows. A balancing of interests of that person is unavoidable. Restrictive criteria surrounding legally sanctioned compulsory psychiatric treatment attempt that balancing. A less restrictive criterion will be justified in the case of rights to privacy in the case of information of acute relevance to the welfare of the person concerned. Carers have found a narrow interpretation of confidentiality in the ACT to be a serious block in the responsible delivery of services to the cared for person. A school counsellor may be in possession of information about a young man who is showing signs of developing schizophrenia that if shared with that student's parents could head off a crisis leading to the imprisonment or even suicide of that young man. In these circumstances, only in hollowest of terms can it be said that a refusal to pass on information has protected the interest of that young man. The sharing of information among those who have at heart the interests of a mentally disordered person has obvious benefits:

> "In order for services to be integrated, and consumers, young people, carers and professionals to work effectively together, there must be a shared vision, and more information sharing, and willingness to give and receive feedback."[75]

A member of Families and Friends for Drug Law Reform has put it this way:

> ". . . parents may well have taken their child, then [a] teenager, to the doctor concerned that there is a problem. However, even before the age of 18 carers are often excluded from the caring loop. When dealing with mental illness this could be seen as negligence on behalf of the 'caring professions'. Carers know the cared for person well and know the triggers, the pattern of an episode. However, until that person goes into full blown psychosis and lives are at risk – only then are they listened to. We underestimate the family's natural authority in these circumstances. Carers consider the privacy issue and narrow interpretation of confidentiality in the ACT to be a serious block in the responsible delivery of services for the cared for person."

However engaged with a young person with a mental disorder, some like a doctor or youth worker are unlikely to have the daily duration of contact that a family can be expected to have. The teacher of a young person may, in fact, have more contact hours than a family. Whatever the case, none of these professionals are likely to have the depth of concern that a family has. At the very least those professionals should turn their mind to whether, for the benefit of the young person, the family as carer should have certain information that comes to their attention. The professional may believe that the family should have the information but fears that with it the family may react inappropriately and against the interests of the young person. That is reason to consider whether support and professional guidance should not be offered to the family. It is not a reason to do nothing.

It is as well to bear in mind in considering the value of confidentiality that whether it applies to restrict the passing of information is in many circumstances

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75. *National Families & Community Conference on Drugs* (2001) fn 39, p. 112.

close to being a matter of procedure rather than substance. In the ACT the Australian Federal Police attending an incident use a Referral Management System operated by SupportLink Systems to place people in contact with any number of agencies in the ACT providing support. The basis of this wide dissemination of information is the consent given by the person to the police officer attending the incident. Another example of the flexibility possible with an advance consent is found in the widely used standard form of enduring power of attorney that authorises the attorney to consent to medical treatment of the donor and even to withhold or withdraw medical treatment.

Recommendation 12:

Concern for some interests of those with mental disorders should not undermine the capacity of those willing to provide support.

5. Concern to provide requisite professional support for those with a mental disorder should not be done in a way that diminishes the capacity of the family to provide appropriate longer term support

Even where no question of confidentiality of information arises, there is a tendency to exclude families as largely irrelevant to the main object of treating someone with a mental disorder. This was described in the 2000 National Family and Community Conference in the following terms:

> "There is a real need for parents and other carers to work in partnership with professional service providers to treat, educate and support the client. Often a therapeutic treatment or support regime is worked out by professionals independently of parents or carers, yet they can provide much insight into effective care and treatment for the person, and can be important as part of the treatment and care team. The wisdom and experience of the client, carers, parents and the professional need to be pooled to achieve the best outcome. It was agreed it was important for care givers not to give up - to ensure that their views were heard."[76]

Whereas the processes of the criminal law and corrections have started to pay some attention to the voices of victims of crime they give scant attention to the voices of families of those caught up in the system. Indeed those processes tend to gag the voices of those who are in the best position to ensure that there is not a cycle of reoffending.

6. Interventions should not focus on blame and separation of someone with a mental disorder from his or her family but should focus on enhancing the capacity of the family to provide support

There is nothing more destructive than blame and stigma of the capacity of a family to support a member with a mental disorder. Linked substance abuse with its additional baggage of blame and stigma only intensifies the destructiveness. Many mental illnesses including addictions are chronic and relapsing conditions. No family

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76. *National Families & Community Conference on Drugs* (2001) fn 39, p. 112.

is unscathed by such experiences and few manage to combine maintenance of their own integrity with support for their troubled member.

Mental disorders, substance abuse and delinquent behaviour can strike in any family. The capacity of families displaying few of the risk factors commonly associated with such conditions (see part II.B above) can be damaged by blame and stigma. Even so, these families are generally so much better able to cope and provide continuing support than the more typical affected family that displays more risk factors. For example, an American account of aiding youth with mental health needs mentions that:

> "Fifty percent of parents have significant abuse issues, 33 percent of parents have a history of domestic abuse, 24 percent of parents have been incarcerated, and 22 percent of families have documented mental illness."[77]

Blame and stigma ensures that the more in need the family is of support itself, the less capable the family is rendered to look after itself and contribute effectively to help its troubled member.

It is in no one's interest for the processes of the criminal law and corrections system further to disempower the capacity of the family to provide support. Guilt will exist for the wrongs done to other members in the community. That should be a springboard to re-integrate the wrongdoer into the community not be destructive of the capacity for support of the wrongdoers' family on which the success of the re-integration is likely to depend.

The widespread ignorance and stigma around mental illness and associated illicit drug use needs to be addressed. It is particularly debilitating for families when they meet it in the person of those involved in the criminal justice system. As a member of Families and Friends for Drug Law Reform has put it, ". . . apart from education to reduce stigma and increase public knowledge, direct education of the police, prison warders, magistrates is all essential."

Recommendation 13:

> Interventions should not focus on blame and separation of someone with a mental disorder from his or her family but should focus on enhancing the capacity of the family to provide support.

7. Provide adequate treatment and services for those with a mental disorder and substance dependence.

The care and treatment of those who have a dual diagnosis of a mental disorder and substance dependence is notoriously inadequate. This is for a number of reasons including shortage of funding, the demanding nature of the work, prejudice and dividing lines of professional competence that reflect training and limits of professional responsibility but not the real world. Parents have told Families and

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77. Bruce Kamradt, "Wraparound Milwaukee: aiding youth with mental health needs" in *Juvenile Justice Journal,* vol. VII, no. 1 (April 2000) at http://www/ncjrs.org/html/ojjdp/jjnl_2000_4/wrap.html & wrap2.html.

Friends for Drug Law Reform that a psychiatrist or other doctor visits Goulburn prison only once a week.

Many families who have had a member with such a dual diagnosis have met the reaction that Anne Deveson describes towards her son:

> "There was even a punitive response from members of the medical profession. One of my most vivid recollections was after Jonathan had attempted to kill himself. It was his second or third attempt and I went to see the doctor at St Vincent's who said in a cold voice: 'I really can't help you much with your son's schizophrenia because he is a drug addict.'"[78]

The difficulties spring not only from punitive attitudes. Plain thoughtlessness and poor organisation contributes to the burden of the family and its mentally ill member. For example, Families and Friends for Drug Law Reform is aware of mentally ill detainees being

- moved between prisons without their medication;
- being confused with other prisoners and being sent or not being sent to other detention centres; and
- being discharged from the Salvation Army Camp in Morisset for disruptive behaviour and being left to make his own way back to Canberra. He was too scared to do so. He slept in a park and was finally put on a Canberra bus by NSW Police. Back in Canberra in an exhausted state he was roused out of bed, arrested and charged with breach of bail. The detainee concerned had been sent to Morisset at the instance of the Magistrates Court.

8. Support for families seeking to support a member who has a mental disorder

There needs to be much more support available for families seeking to care for mentally disordered family members. In the words of one tired, desperate mother: "I always have to find the solution." Families and Friends for Drug Law Reform believes that it is manifestly absurd and inhumane to deny adequate support in the community for those suffering from serious mental health problems. In particular, it is unjust and inefficient that so little is available to support families who are prepared to devote so much of their life and resources to the care of such a member. In desperation they give up. Crimes occur that better care could have avoided. Suffering is brought on the victims of those crimes as well as on the family and the Government ends up paying a huge price for a service that probably intensifies the mental health problems of the person imprisoned.

Families and Friends for Drug Law Reform believes that treatment plans should be drawn up for those in the community with serious mental health problems. These plans should be drawn up with the involvement and consent of those with the mental health disorder. The family, professional helpers and others closely involved

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78. *National Families & Community Conference on Drugs* (2001) fn 39, p. 42.

in the life of that person should also be involved. Following through such plans should make it far less likely that those with serious mental health problems get caught up in the criminal law system. If, in spite of that, they do, the plan should ensure that there is a ready network that can work with police and corrections authorities and services. Support for the family should be in place to undertake the main burden of support for the detained family member after release.

Recommendation 14:

> Support should be provided for families seeking to support a member who has a mental disorder. In particular a scheme of treatment plans should be established. These plans should involve the person with a mental disorder and all those closely involved in the life of that person including the family and professional helpers.

9. Support should be available to head off a crisis rather than be available only when a crisis arises

Of course, resources need to be available to cope with crises but it is a far better use of resources to provide support that prevents a crisis occurring. Families and Friends for Drug Law Reform has heard of people presenting themselves to psychiatric wards and being turned away and of families being denied help for a member because a condition was not serious enough. There are families who for want of support have welcomed and even approached police to arrest a family member in the belief that as a prisoner that member will obtain the treatment that they have not been able to obtain in the community. Families and Friends for Drug Law Reform is even aware of a case where the Mental Health Tribunal assured the parents of someone suffering from schizophrenia that conviction of their son would mean that he would be treated at Long Bay. As it turned out, he ended up in Goulburn. The parents were told that it is up to detainees to advise families and friends of their whereabouts.

Policies for admission to psychiatric service units and attendance by the Mental Health Crisis Assessment and Treatment Team should be adjusted or co-ordinated with other services to permit early intervention in the case of each new relapse rather than when the relapse has reached crisis proportions. Limiting resources to respond only in an emergency is tantamount to a policy of encouragement of crises. Withholding support or intervention until a crisis is a crazy situation. The more serious the episode the more resources, including those of the criminal law, are likely to be drawn in and the greater the human suffering.

Recommendation 15:

> Policies for admission to psychiatric service units and attendance by the Mental Health Crisis Assessment and Treatment Team should be adjusted or co-ordinated with other services to permit early intervention in the case of each new relapse rather than when the relapse has reached crisis proportions.

10. Provide facilities where the mentally ill can be cared for when a crisis is looming or to provide relief for family and other carers

Facilities are in short supply where someone who is mentally ill can be cared for in times of particular stress for the person concerned and their family. To quote two well regarded American practitioners involved in child protection:

> "We have found that people with schizophrenia can function reasonably well when they live in a structured setting, take their medication and have family support. Generally, a combination of medication and psychotherapy is effective and may be helpful in controlling the symptoms. At other times, life's stressors add to the severity of the symptoms."[79]

Without diminishing the safeguards surrounding compulsory treatment there is much that can be done to provide attractive and emotionally secure places for the mentally ill at times of particular stress. A place should be set up where people can go to be kept safe for short periods. There is nowhere in the ACT. There was a sobering up facility. Press coverage of a need for a time-out facility has highlighted this issue. Most recently the Leader of the Opposition renewed a call for such a facility following revelation that 18 ACT mental health clients had died from suicide in the previous 18 months.[80] It is crucial that the criteria for admission to the facility be broad enough to permit people to be accommodated before a serious crisis develops. The need for such a facility is thus distinct from the need discussed below for a similar one for those who do become caught up in the criminal law and where enforced detention may be required.

The benefits of such a facility have been demonstrated overseas. For example, a report of a "Wraparound" in Milwaukee for youth with mental health needs, describes the use made of homes to provide for short term crisis stabilisation rather than admission to psychiatric hospital:

> "Youth participating in Wraparound are automatically enrolled in [a] crisis service, and their care plans include a crisis safety plan that the team can immediately access. The Mobile Urgent Treatment Team reviews all requests for inpatient psychiatric hospital admissions and operates two 8-bed group homes that provide short-term (up to 14 days) crisis stabilization. The crisis team and care coordinator work with the family to return the child to the community. Because of the crisis team's availability, Wraparound Milwaukee has nearly eliminated the use of inpatient psychiatric care for most youth in the project."[81]

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79. Insoo Kim Berg & Susan Kelly, *Building solutions in child protective services* (W.W. Norton & Co., New York & London, 2000) p. 182.

80. *Canberra Times*, Tuesday 2 September 2003, p. 2.

81. *Ibid*.

11. Provide a facility outside remand centres and prison where those with a mental disorder who become caught up in the criminal law may be cared for

Where a crisis has developed and a suspected crime committed there is a lack of secure facilities where those concerned may be detained and where they can receive the care they need. There is also no secure accommodation such as a psychiatric service unit for young people under 18. Magistrates Cahill and John Burn are among those who have criticised the lack of secure facilities for such people. The *Canberra Times* has recently reported that:

> "The Canberra Schizophrenia Fellowship, Australian Federal Police, Mental Health Crisis Assessment and Treatment Team and Chief Magistrate Ron Cahill have endorsed the idea. A time-out facility could be an option for people with mental illness who were in Belconnen Remand Centre or could not be treated in the community or placed in Canberra Hospital's psychiatric unit."[82]

A specialist facility such as this would permit more rapid identification of what are real threats to community safety and what are not. The experience in Sydney of Anne Deveson's son illustrates this point:

> "Jonathan once spent nine months in Long Bay Gaol on remand. He was picked up by a taxi when he was psychotic, and because there had been a recent bout of taxi cab murders, the driver became nervous, drove Jonathan to the metropolitan police station where he obediently walked up the steps and told the police he was about to hold up the cab driver for his heroin habit. The words were put in his mouth; he did not ever have a heroin habit – he never used the harder drugs – and he had no weapon to use for a hold-up. Nevertheless, he was charged with attempted armed robbery and it took nine months to get the charges dropped - twenty four hours before the case was due to come to court."[83]

There is a need for a facility for those in a pre-crisis situation. This is discussed in the previous section. The object of that facility would be to head off a serious crisis occurring. As the present section argues, there is also a need for a facility where, in spite of other strategies, a crisis has occurred involving someone with a mental illness becoming caught up in the criminal law system. The following recommendation covers both these categories.

Recommendation 16:

> One or more facilities with necessary separations should be established to provide a caring environment for those with a mental illness including those under 18:
>
> (a) to head off a crisis before it occurs and to provide relief for family and other carers; and

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82. *Canberra Times*, Tuesday 2 September 2003, p. 2.

83. *National Families & Community Conference on Drugs* (2001) fn 39, p. 42.

(b) as an alternative to remand or prison for those who may have become caught up in the criminal law.

12. Integrate mental health services with other support for those with a mental disorder and their family

People should not be defined by their problems. Much less should they be defined by the particular focus of an organisation or a particular "problem" seen to loom largest. In spite of attempts to make adjustments at the edges, these criticism apply with force to the social intervention of the criminal law and corrections. A detainee has committed or is suspected of having committed a crime. The failure that this represents is likely to be repeated unless the factors that led to the person committing the crime are addressed. This includes any mental disorder of the detainee that may have contributed to the crime. The insights of early intervention tell us to expect a range of other factors like substance abuse, low school achievement and unemployment. We can also expect a range of family factors. This points to the need of integrating mental health services with other support for the detainee and their family and the corrections intervention working towards the same end. The range of support should be dictated by the complexity of reality and not by an arbitrary label.

The successful Wraparound program in Milwaukee for youth with mental health needs illustrates the value of "an array of services and resources to respond to the multiple needs identified by families."[84] The array consisted of:

- Care Coordination
- In-Home Therapy
- Medication Management
- Outpatient-Individual Family Therapy
- Alcohol/Substance Abuse
- Counseling
- Psychiatric Assessment
- Psychological Evaluation
- Housing Assistance
- Mental Health Assessment/Evaluation
- Mentoring
- Parent Aide
- Group Home Care
- Respite Care
- Child Care for Parent
- Tutor
- Specialized Camps
- Residential Treatment
- Foster Care
- Day Treatment/Alternative School
- Nursing Assessment/Management
- Job Development/Placement
- Kinship Care
- Transportation Services
- Supervision/Observation in Home
- Afterschool Programming
- Recreation/Child-Oriented Activities
- Discretionary Funds/Flexible Funds
- Housekeeping/Chore Services
- Independent Living Support
- Psychiatric Inpatient
- Hospital

84. *Ibid*.

- Emergency Food Pantry
- Crisis Home Care
- Treatment Foster Care

Effective intervention requires the co-ordination of the range of services determined by the strengths and range of needs of the families concerned. It should not be a response exclusively focussing on mental health needs.

Recommendation 17:

Mental health services should be integrated with other support for those with a mental disorder and their family.

E. Maintaining and improving the physical health of those detained

Someone who emerges from detention in poor physical health is a burden on his or her family. If injury or disease is serious enough it will be disabling for life and, in the case of transmissible blood borne diseases, a blight on the establishment of future family relationships and children. Chronic illness is a recognised risk factor of crime and, as can be expected, those in detention have substantially greater health problems than the community at large. Lest their present and future families are to suffer more and to prevent hardship and dysfunction echoing down generations, the object should be for the health of those detained to be improved by the time they are released. Above all their health should not deteriorate. To do so is, after all, consistent with the legal duty on the state to care for those it detains.

Illicit drug use is associated with much of the poor health of those in detention. Use of illicit drugs is also behind a lot of the notorious violence of prisons. No remand centre or prison has managed to keep drugs out, yet the high level of supervision in them means that use occurs in them more covertly than in the community. Consequently in remand and prisons there is a far higher risk than in the community of the spread of hepatitis C and HIV, a risk that is amplified by unsafe sexual practices.

The seriousness of the situation world wide is well expressed as follows by the authors of a report on Swiss prisons:

> "[I]nfectious diseases such as HIV and hepatitis spread very easily. It comes as no surprise therefore to learn that today, penal institutions play a major part in the transmission of such infectious diseases. Among inmates, the proportion of infected individuals is several times higher than in the population at large. And since prisons constitute a social melting pot of sorts, these health risks are not limited to injection drug using inmates and their co-detainees, but in the long term constitute a hazard for large parts of the population, principally through unprotected sexual contact. This makes the effective prevention of infections in a prison environment a major health policy issue that reaches well beyond prison walls."[85]

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85. J. Nelles, A. Fuhrer et I. Vincenz, *Drug-, HIV- and hepatitis prevention in the Cantonal Men's Prison of [Realta]: Summary of the Evalu*ation (Swiss

Interventions are readily available that can slash if not eliminate the dangerous public health risk of diseases such as the spread of blood borne viruses within remand centres and prison. They include:

- adoption of detention centre regimes that do not encourage inmates to consume drugs by means such as unsterile injection that entail a high risk of spreading disease;
- provision of sterile syringes;
- provision of sterile tattooing facilities;
- provision of a range of the most effective substance abuse treatments, both pharmaceutical and therapeutic;
- heroin on prescription; and
- provision of condoms;
- conjugal visits.

The introduction or many of these interventions are mired in controversy. Indeed all of them were. Some interventions such as the provision of condoms and methadone have been introduced in spite of controversy and to varying extents in different jurisdictions are now accepted practice.[86] At least one, namely the provision of sterile tattooing facilities, is looked on favourably. The Director of ACT Corrective Services gave his personal endorsement to it earlier this year:

> "I would be in favour of arranging for tattooing to be done on a controlled basis in such a way that you minimise any possibility of spreading disease as a result of tattooing. We know that the culture of these organisations is such that they're going to do it anyway."[87]

Some interventions such as allowing conjugal visits are permitted on a limited scale in some Australian jurisdictions.[88] Other interventions remain highly controversial in

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Federal Office of Public Health, 1999) at http://www.admin.ch/bag/sucht-/forschev/e/eval/realta2.htm.

86. *Australian illicit drug report 1997-98,* fn 19, pp. 123-24.

87. Australian Capital Territory, Legislative Assembly, Standing Committee on Health, *Reference: Access to syringes by intravenous drug users, Transcript of evidence*, 1 May 2003 p. 51 at http://www.hansard.act.gov.au/hansard-/2003/comms/health12.pdf visited 14/08/03.

88. In Victoria (*Australian illicit drug report 1997-98,* fn 19, p. 123). Regarding Canada and The Netherlands see Gino Vumbaca, *"Finding a better way": a review on the policies, programs and practices currently being implemented in overseas jurisdictions to deal with HIV/AIDS, hepatitis and drug use issues both within the prison system and the wider community* (1998 Winston Churchill Memorial Trust of Australia Report, NSW Department of Corrective Services, Sydney, [1998]) pp. 11, 23.

a prison environment. These can be divided into two classes of intervention: those like the provision of sterile syringes that operate in the ACT community and medically supervised injection facilities and prescription of heroin that so far are not.

Given the disabling and life threatening nature of the diseases in question, both for the detainees and their present or future families, it is necessary to understand fully and scrutinise closely the objections to the introduction of known effective preventative measures. It is important that concerns be taken seriously and provided for but refusal to even countenance the introduction of these interventions should not be an option.

Four important approaches or interventions are now examined to illustrate these issues. These are:

- Provision of a range of the most effective substance abuse treatments, both pharmaceutical and therapeutic;
- Framing of detention regimes around the realities of substance abuse to produce the best health outcomes;
- Sterile syringes and medically supervised injecting facilities; and
- Heroin on prescription.

Recommendation 18:

All measures available in the community at large should be taken to maintain and improve the physical health of those detained. In particular:

(a) every effort should be taken to ensure that people do not emerge from detention with infectious blood borne diseases contracted in detention;

(b) effective interventions should be implemented that are known to reduce or eliminate the dangerous public health risk of blood borne disease within remand centres and prisons.

1. Provision of a range of the most effective substance abuse treatments, both pharmaceutical and therapeutic

The very high prevalence of substance abuse and dependence among prisoners and the strong correlation between drug abuse and offending behaviour means that the provision of effective substance abuse treatments should have the highest priority. Unless effective treatment and other effective drug strategies are in place, detention will be counterproductive, heaping severe additional burdens on families of the detained as well as on the community at large.

A range of approaches are required to treat the many in detention who are addicted to substances. Treatment strategies need to have regard to the realities of drug use such as the following:

- people take drugs for different reasons including self medication of a mental disorder, to cope with effects of physical pain or abuse or plain boredom;

- addiction is a chronic relapsing condition that can take years if ever to get over; and
- drug users can be at different stages in their use varying from those who see their use as fitting their needs well to those who would like nothing better than to be free of their dependence.

An approach that one size fits all is doomed to fail many. The following principles should be observed in regarding drug treatment for those in detention:

- Drug treatment should be guided by the best medical advice.
- It should avoid treatments that peer reviewed evidence shows are ineffective such as the arbitrary time limits and prescribed reduction programs for those on methadone.
- Promising new treatments such as the prescription of buprenorphine should be promptly introduced.
- Drug free sections should be set apart in remand centres and prisons for those who wish to be in a drug free environment.

Naltrexone should be available for those addicted to heroin who are highly motivated to overcome their addiction and have good family and other support. It has been successful for the brother of a member who lobbied long and hard for him to have access to it in prison in Queensland. The brother has written:

> "I know that if I relapse or believe I am going to continue to relapse I have access to medication that will help me to avoid that. . . .
>
> "I don't recommend Naltrexone for everyone, as it can be very dangerous if you take it for a while, stop taking it and use heroin again. I believe a person must be truly sick and tired of being an addict and must possess a true desire to want to stop using heroin. You usually only find this desire with people who have used for a long time, 10 to 15 years or longer."[89]

2. Framing of detention regimes around the realities of substance abuse to produce the best health outcomes

Having the best drug treatments in remand centres and prisons is necessary but not sufficient. The institutional regime must complement the same goal. Because substance abuse affects so many detainees and its effects are so stressful, detention regimes should be framed around effective drug strategies. At present it is the other way around. Drug strategies in remand centres and prison are severely compromised by the institutional demands as traditionally conceived of those places. The result is that

- the drug dependence of the inmates is often made worse rather than better;

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89. *National Families & Community Conference on Drugs* (2001) fn 39, pp. 92-93.

- they are at high risk of contracting serious diseases or of complications to diseases they already have;
- they are at heightened risk of violence involving drugs;
- attempts at establishing an environment directed at reintegrating inmates into the community are compromised;
- the instability of a large population hanging out for drugs or affected by stimulants like methamphetamines, linked to violence, produces a dangerous occupational health and safety environment for staff.

There are many illustrations of these points. Drug testing and searching is a strong incentive to use drugs that are less detectable. The drugs will generally be of higher potency and more dangerous. Searching is also likely to mean that drugs are consumed in ways that add to harms. Vumbaca illustrates the approach that should be followed by reference to testing for cannabis:

> "Urine testing for cannabis in prison presents real problems by increasing incentives for cannabis users to switch to harder drugs. Cannabis is obviously much easier for prison authorities and staff to detect (due to its bulk and smell) and for laboratory technicians (given it can be detected for weeks longer in the urine than many other drugs) yet presents a much less public health risk than injectible drug use.
>
> "Accordingly, prison urine testing needs to either be restricted in its use for detecting cannabis (for example it would be appropriate in drug free units) or at the very least incentives as well as punishments for negative and positive tests are required. For instance, a positive test may result in referral to drug service rather than immediate punishment and a series of negative results, particularly by those prisoners with a history of drug use, may result in an increase in privileges rather than just a lack of penalties being imposed. The cost effectiveness of a program, that when widely applied (as is the case with current random mandatory programs), seems to only confirm that a group, with a high proportion of drug users, are involved in drug use, obliges further evaluation."[90]

Recommendation 19:

> Recognising the reality of availability of illicit substances in corrective institutions, detention regimes should be framed around effective drug strategies that maximise the health and welfare of those detained.

3. Sterile syringes and medically supervised injecting facilities

"About 25 percent of Australian prisoners inject drugs with shared syringes while incarcerated."[91] A prisoner in New South Wales wrote the following to us:

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90. Vumbaca (1998) fn 88, p. 32.

91. Dolan (2000) fn 63, p. 6.

> "I've known people who have had pretty large habits prior to gaol but had easy access to heroin while inside which dwarfed any previous habit. . . . I heard today from one of the medical staff here that in one section of the gaol (maximum security) one needle is being used between 20 odd people."[92]

This poses an enormous danger to their health, that of their fellow prisoners, the present and future families of the prisoners and the community at large. A recently published study of a random sample of prisoners in New South Wales, where ACT prisoners are held, states:

> "Our findings . . . confirm that a proportion of IDUs (approximately 50% in this study) continue to inject drugs in prison, with approximately two-thirds of this group sharing needles and other injecting paraphernalia (e.g., spoons and water) at their last prison injection.
>
> "The high level of sharing injecting equipment in prison is a likely consequence of their limited supply within the correctional system. Supplying a syringe to a prisoner carries a one year sentence under the Correctional Centres Act and the possession of a syringe by a prisoner can lead to the imposition of a range of punitive measures. The scarce supply of needles combined with the high levels of exposure to blood borne infections in the prisoner population enhances the possibility of the transmission of viral hepatitis and HIV when sharing occurs."[93]

The authors of this study included two members of the NSW Corrections Health Service.

In contrast, objections to providing clean syringes in detention centres have been expressed in strong terms. The then Opposition Spokesperson on Corrections, Mr Hargreaves, issued a press release in 2000 in which he "slammed" a decision of the then government to task "the Corrections Health Board of the ACT to examine the feasibility of a needle exchange in prisons". The Shadow Minister gave the following reasons:

> "'This is a blatant admission that the fight against the use of drugs in our corrective services institutions has failed. It assumes that the issue of condoms to prevent the spread of Hepatitis C and HIV isn't working either.
>
> 'The very thought of this is abhorrent. There are so many questions, which spring to mind that I doubt any literature search will satisfy them.
>
> 'Who is going to supply the drug? Is the Government going to supply the heroin to prisoners? Is the Government going to stand idly by while the prisoners buy their own?
>
> 'Will we have another social laboratory using a captive audience?

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92. *National Families & Community Conference on Drugs* (2001) fn 39, p. 89.

93. Tony Butler, Michael Levy, Kate Dolan and John Kaldor, "Drug use and its correlates in an Australian prisoner population" in *Addiction research and theory*, vol. II, no. 2, pp. 89-101 (2003) at p. 99.

‘Will we have an ongoing supervised injecting place before a trial to prove they work?

‘Will the custodial officers be at risk from the prisoners using syringes as weapons?

‘What sort of message are we sending here?

‘I agree that prisoners should have access to the same drug treatment regimes that are available to those on the outside, but not to the extent of having the wherewithal provided for prisoners to continue their habits.

‘We have to break the cycle of drug dependence and crime - not encourage it or make light of it.’ Mr Hargreaves said.”[94]

The present Chief Minister, Mr Stanhope, is on record as stating last December that a proposal of the Opposition to ensure that sharing of needles in ACT detention and remand centres will cease by June 2003 was “ill-founded, unworkable and irresponsible" because the result could be achieved only by providing sterile syringes.[95] Illustrating the inconsistencies that so often surrounds discussion of this issue, Mr Stanhope’s statement contradicted that of Mr Hargreaves in admitting the inefficacy of any means other than the provision of sterile syringes to prevent the sharing of syringes. According to Mr Stanhope, “No prison or remand centre in the world has been able to achieve this goal [of preventing needles entering remand and detention centres].”[96]

In evidence on 1 May this year before the Standing Committee on Health, Mr James Ryan, the Director of ACT Corrective Services, canvassed a large number of objections to a syringe program in ACT corrective institutions.[97] These and one or two additional objections are listed below:

- Unsupported by correctional administrators of countries whose correctional philosophies are most akin to Australia’s;
- Where implemented, provision of syringes is for only a small minority of detainees;
- Provision of syringes to detainees in the ACT would be of benefit for only a short time and probably only a small part of their detention;
- Provision of syringes would reduce the incentive and opportunity for detainees to get on top of their substance abuse;

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94. Media Statement “Needle Exchange In Prisons?” of 13 July 2000 by John Hargreaves, Opposition Spokesperson on Corrections.

95. Chief Minister, media release no. 345/02 dated 10 December 2002.

96. Chief Minister, media release no. 351/02 dated 11 December 2002.

97. ACT, Legislative Assembly, Standing Committee on Health, *Transcript of evidence*, 1 May 2003, fn 87 pp. 47-50.

- Grounds for the provision of syringes in terms of public health are not sustainable;
- Legislation would need to be changed to permit the provision of syringes in correctional institutions;
- If a prison authority supplies syringes it may lead to liability of those running detention centres for ill health resulting from injection of illicit substances;
- It is impracticable to separate those who would use syringes from those being treated for drug dependency;
- Provision of syringes would involve the supply of things that could be used as weapons to endanger other detainees and custodial staff; and
- The provision of syringes would create an occupational health and safety danger from inadvertent needle stick injury for custodial staff.

To most of these objections a short answer can be given.

a) Unsupported by correctional administrators of countries whose correctional philosophies are most akin to Australia's

Sterile syringes are provided in prisons in a growing number European countries. "As of December 2000, a total of 19 prison-based syringe exchange (PSE) programmes were identified in Switzerland, Germany and Spain."[98] Six of these have been evaluated with "very positive" results.[99] Sterile syringes are also distributed in Moldova and Kyrgyzstan.[100] Within the last two years or so prison-based syringe exchange programs were at the planning stage in Italy, Portugal, and Greece.[101] The

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98. Kate Dolan, Scott Rutter & Alex D. Wodak, "Prison-based syringe exchange programmes: a review of international research and development" in Addiction, vol. 98, pp. 153-58 (2003) at p. 154. For Switzerland see also ABC, Radio National, The Health Report, "Heroin Prescription and Needle Exchange in Prison," transcripts 10 August 1998. For Spain see also Paper delivered at 13th International AIDS Conference, Durban, South Africa - 9-14 July 2000 "Needle exchange programme (NEP) in the prison of Bilbao 2 experience years: 1997-1999" at http://www.aegis.com/conferences/13WAC-/TuOrD322.html.

99. Dolan (2003) fn 98, p. 157.

100. Ralf Jürgens, *HIV/AIDS prevention from drug dependent persons within the criminal justice system* presented at the Commission on Narcotic Drugs Ministerial Segment: Ancillary Meetings; Ancillary Meeting on HIV/AIDS and Drug Abuse, Vienna, 16 April 2003 (2003, Canadian HIV/AIDS Legal Network) p. 7 at http://www.aidslaw.ca/Maincontent/issues/prisons-/prison_presentation160403.pdf visited 27/08/03.

101. Dolan (2003) fn 98, p. 157.

current state of implementation is described in the following account prepared earlier this year:

Mr Ryan stated that "there doesn't appear to be any wide-based official support for these programs by the correctional administrators in Canada, New Zealand and the UK, countries whose correctional philosophies are more akin to ours" (p. 48). It is clear that the proposal should be examined with particular care but that we should not depart from what Anglo Saxon English speaking countries do is a poor reason, particularly given the composition of Australian society. It is certainly not a reason to reject a proposal supported by sound reasons. It is relevant that Canada is actively looking into the provision of syringes in prisons.[102] The ACT should do no less. In June this year the Health Committee of the Canadian House of Commons recommended that:

> "Correctional Service Canada provide harm reduction strategies for prevention of HIV/AIDS amongst intravenous drug users in correctional facilities based on eligibility criteria similar to those used in the outside community (as per the recommendation of the December 2002 report of the Special Committee on the Non-Medical Use of Drugs)."

This is specifically intended to refer to "needle-exchange programs for drug users within federal prisons so as to curb high rates of HIV infection among prisoners."[103]

b) Where implemented, provision of syringes is for only a small minority of detainees

According to Mr Ryan access to existing syringe programmes in prison is limited to "especially identified and targeted prisoner groups who represent a small percentage of the total prison population" and he knows of no country where syringes are provided to remandees. He added that the one prison needle exchange that he had seen in operation had "worked".

In fact syringes are provided in at least one remand centre. In ". . . a remand prison in Geneva . . . a doctor handles syringes for drug addicts."[104] In any case the points that Mr Ryan make are no reason for doing nothing. The ACT should plan for the provision of syringes for at least an "especially identified and targetted" group in the new ACT prison. It should also examine extending it to all prisoners and remandees who may benefit. It is understood that the prison is being planned on the basis that it would house remandees.

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102. Vumbaca (1998) fn 88, p. 25.

103. *Toronto Star*, 5 June 2003.

104. ABC, Radio National, The Health Report, "Heroin Prescription and Needle Exchange in Prison," transcripts 10 August 1998; Vumbaca (1998) fn 88, pp. 5 & 8-9.

c) Provision of syringes to detainees in the ACT would be of benefit for only a short time and probably only a small part of their detention

Mr Ryan pointed out that "in the event of an NSP for offenders in custody in the ACT, when a remandee is sentenced into New South Wales [as is the case until the ACT gets its own prison] he would then go from a situation where there is a program into one where there isn't a program and in these circumstances we'd need to establish whether an NSP is appropriate merely for that remand period" (p. 48).

Even before an ACT prison is built, a syringe program for ACT remandees would have health benefits even for remandees who are ultimately sentenced to prison. Many remandees are found not guilty or of those that are many are not given a term of imprisonment. Illnesses that could threaten the life of prisoners and through them their family are contractible from just one unsterile injection.

d) Provision of syringes would reduce the incentive and opportunity for detainees to get on top of their substance abuse

According to Mr Ryan "[r]emand is an opportunity for detainees to improve their health and to reflect upon their situation. Arguably an NSP [needle, syringe programme] might reduce the opportunity for detainees to address their substance abuse programs and may even provide an excuse not to do so. It may also promote drug use with other detainees"(p. 48).

There are many answers to this objection including:

- the loss of freedom entailed in detention is itself a strong incentive for detainees to reflect on their situation including any drug problem that may have contributed to them being there;
- remandees who are yet to be found guilty should enjoy the presumption of innocence; it is inconsistent with that that they should be *expected as a matter of discipline* to reflect on their health problems (addictions);
- people should be detained for serious offences. They are not detained because they have a serious health problem in the form of a raging addiction (which is not an offence) and, under prosecutorial guidelines, should not be detained solely for a minor offence of use or possession of a small quantity of drugs for personal use;
- the questionable assumption that coerced drug treatment is effective in the long term and that it has overall health benefits for those who undergo it;
- as Mr Ryan has conceded, in the absence of counterproductive and intolerable regimes such as eliminating contact visits and isolation of prisoners, it is virtually impossible to keep drugs out of corrective institutions;
- the issue is not therefore a question of permitting the use of drugs in an environment where they did not exist but whether Corrections should lower the risk of detainees contracting serious diseases in the event that they do use;

- the question of whether the provision of syringes in detention centres may encourage drug use is no more relevant in those centres than it is in the community where clean syringes are widely provided;
- the consensus of expert opinion supported by many surveys is that the provision of clean syringes in the community has not promoted drug use. Detention centres should be no different.

e) Grounds for the provision of syringes in terms of public health are not sustainable

According to Mr Ryan: "Although we agree that sharing needles and syringes presents a health problem, we don't consider that the arguments on the grounds of public health equity for access are likely to be sustained. Nor do they outweigh, in our view, the disadvantages, at this point anyway, of introducing such a program" (p. 49). In different language Mr Hargreaves seems to have been making the same point when he criticised the commissioning of a study to examine the feasibility of a needle exchange in prisons: "This is a blatant admission," he said, "that the fight against the use of drugs in our corrective services institutions has failed. It assumes that the issue of condoms to prevent the spread of Hepatitis C and HIV isn't working either."[105]

The implications of this comment are far reaching:

- it seems to be asserting that the "health problem" of prisoners sharing syringes are overstated or even incorrect;
- it expresses the value judgement that there are disadvantages from the point of view of running a correctional institution of providing syringes that outweigh the public health benefits of doing so.

As Families and Friends for Drug Law Reform understands the situation, the overwhelming opinion among public health experts is that the use of sterile syringes is effective to reduce what is a high risk of intravenous drug users contracting blood borne diseases. Sexual intercourse, whether homosexual or otherwise, and injection are different infection pathways for the blood borne diseases of most concern. The provision of condoms helps with one but not the other. Indeed, there is a mountain of evidence in support of this conclusion. For example, research prepared for the Commonwealth Department of Health in May 2002 found from 778 calendar years of data from 103 cities around the world with HIV seroprevalence measurements that:

> ". . . cities that introduced NSPs had a mean annual 18.6% decrease in HIV seroprevalence, compared with a mean annual 8.1% increase in HIV seroprevalence in cities that had never introduced NSPs"[106]

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105. Media Statement "Needle Exchange In Prisons?" of 13 July 2000 by John Hargreaves, Opposition Spokesperson on Corrections.

106. Health Outcomes International Pty Ltd, National Centre for HIV Epidemiology and Clinical Research & Michael Drummond, *Return on investment in needle & Syringe programs in Australia, final report* (Commonwealth Department of Health and Ageing, St Peters, SA, May

The inexpert opinion of prison administrators should count for little on the risks of unsterile injecting when it contradicts sound scientific evidence and the opinions of experts.

The value judgement is highly questionable that disadvantages from the point of view of running a correctional institution of providing syringes outweigh the public health benefits of doing so. This reflects a mindset that sees correctional institutions as quarantined from the rest of society. They are not. Just as what happens in society at large affects the clientele of corrective institutions, so does what happens in corrective institutions have implications for society outside. Those in corrective institutions have come from the community and will move back into it. They have existing and future families including sexual partners and children who will be affected by what happens to them inside. Those outside the circle of their family also have an interest in ensuring that those released do not become agents for diseases and are reintegrated as law abiding members of the community.

Assessing the balance of convenience between running a correctional institution and broader public health benefits is a matter on which the views of correctional personnel is relevant. They should not be decisive.

f) Legislation would need to be changed to permit the provision of syringes in correctional institutions

Mr Ryan stated that legislation need to be changed because ". . . the present legislation, . . . clearly recognises the importance of excluding illicit drugs, needles and syringes from correctional facilities." If legislation stands in the way of meritorious reform it should be changed just as other legislation is continually being changed.

g) If a prison authority supplies syringes it may lead to liability of those running detention centres for ill health resulting from injection of illicit substances

According to Mr Ryan "the free access to an NSP in a custodial environment would raise . . . serious duty of care issues. The provision of syringes will not, of itself, reduce the dangers of overdoses or harm from injecting substances smuggled into the facility. The issues in the instance of an overdose resulting in death may include who is responsible for the substance taken and the dose, whether drugs for injection by detainees should be prescribed and distributed by health services perhaps to avoid harm caused by the injection of a substance the content of which is unknown, and the possibility of a person becoming an intravenous drug user while in detention. This already occurs, as we know, but at least not in an environment where needles and syringes are sanctioned" (p. 49).

These issues regarding duty of care have been faced in relation to the provision of syringes in the community. If legal advice has it that prison authorities require protection from litigation of the sort mentioned, then this should be provided for in legislation. Mr Ryan seems to make the excellent (the desirability of overcoming the dangers in using illicit substances themselves) the enemy of the good (the reduction in the high risks associated with a particular means of taking them).

The risks of litigation where sterile syringes are provided should be balanced against other credible risks of litigation from failure to provide those facilities. In particular the present unsatisfactory situation raises issues of breach of duty of care concerning:

2002) at http://www.drugpolicy.org/docUploads/ROIfinal.pdf visited 29/10/02 p. 1.

- failure to keep illicit substances out of prisons;
- failure to provide effective health care for a health condition of detainees in the form of an addiction;
- failure to provide conditions to minimise the known dangers of an activity known to take place in detention centres, namely injection of drugs using unsterile syringes.

These circumstances may even give rise to a right of action by a family member as well as by an ex-detainee.

h) It is impracticable to separate those who would use syringes from those being treated for drug dependency

Mr Ryan raised the practical difficulty of attempting to separate those using syringes from those being treated for their drug dependency. He described it in terms of: "exclud[ing] any group using a needle and syringe program from the mainstream of the population" (p. 49). Were such a programme introduced it would be necessary, as he sees it, "for the health services to identify those detainees who are not treatable in any other way than by giving them needles and drugs and to manage them accordingly" (p. 50). He questioned whether it would be "feasible [to do] this . . . for remandees in the ACT, given the small, mixed population that we have." "We're flat out," he continued, "separating the major separations that we have already by virtue of gender, protection and so on" (p. 50).

Undoubtedly practical issues of separation arise in relation to drug treatment within corrective institutions. Even so, Mr Ryan himself suggested an even more complex scheme of separation as a means of controlling the spread of blood borne virus. This is discussed below at page 60. From experience overseas the issue is not the separation of those using syringes from the rest of the inmates – an impossible exercise given the secrecy surrounding illicit drug use – but in the separate accommodation of those who elect for treatment or otherwise to be in a drug free area. Such a unit recognises the reality of the ubiquity of drugs within corrective institutions and the need to provide an environment verified by drug testing to assist those seriously intent on addressing their drug use problem. They have, for example, been established in many English prisons.[107] As Vumbaca puts it, drug free units should be established "with strong community alliances to allow inmates an environment to address their drug [use] whilst in prison and when released."[108]

In summary, the practical issue of providing for the separation of detainees in remand as well as prison arises from the need, irrespective of whether sterile syringes are provided, for an effective drug treatment strategy within those institutions. The case for the provision now of such a separation does not depend on whether sterile syringes are provided. It is up to the Government to provide the resources for this separation.

A related issue that Mr Ryan raised is also a red herring. He queried whether "the introduction of a [syringe] program. . . also raises issues in relation to the provision of similar policies and practices for the use of non-injecting drugs and even, say, alcohol." Most of those in prison are poly drug users. They will have their drug of choice but there, as in the community, will most likely use whatever it available, whether it be pills, alcohol or an injected drug (p. 49).

i) Provision of syringes would involve the supply of things that could be used as weapons to endanger other detainees and custodial staff

Fear about the use of syringes as weapons to threaten staff and other detainees is real. As Mr Ryan described the situation, ". . . offenders in custody are denied access to anything that could be used as a weapon—I'm talking about our offenders in custody on remand—such as a kitchen knife, until such time as they are classified worthy of trust. That's usually unlikely for our remandees and only happens after careful classification as sentenced prisoners, if they go that far. Prisoners habitually as a group seek out opportunities to obtain or manufacture

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107. Vumbaca (1998) fn 88, p. 18.

108. Vumbaca (1998) fn 88, p. 32.

objects that could be used as weapons. The use of a needle or syringe as a hold-up weapon is commonplace and very often effective, mainly because of the threat of contaminated blood being associated with them" (p. 49).

The concern of staff is high. Mr Ryan explained that: "As is the case in all other jurisdictions in Australia, custodial staff in the ACT are strongly opposed to the introduction of needle exchange services" (p. 49). "[I]t remains," he continued, "an important industrial issue in corrections. One of the reasons for this is the memory of the death from AIDS in 1999 of custodial officer Geoff Pierce, who contracted AIDS following an assault with a blood-filled syringe at Long Bay in July 1990" (p. 49).

The following considerations are relevant to these concerns:

- a programme for the provision of sterile syringes in corrective institutions would not involve the introduction of syringes where they do not already exist. As shown by a study on drugs in prisons in the *Australian illicit drug report 1997-98*, unsterile syringes are already circulating in prisons.[109] Mr Pierce was a victim of just such an instrument. Mr Ryan disclosed that "since January of this year we've found four at Belconnen and two at our new temporary remand centre" (p. 48);
- from the information available, syringes provided in corrective institutions overseas have not been associated with assaults. According to Dr Kate Dolan of the National Drug and Alcohol Research Centre who has closely studied Swiss research on the provision of syringes in Swiss prisons: "The results are promising; nobody was assaulted, and that's a main objection to syringe exchange."[110] In a survey published this year she and her co-authors reported that no instance of "the use of needles as weapons" was reported in six evaluations that had taken place of prisons in Germany and Spain as well as Switzerland;[111]
- methods of dispensing and the requirement of use of provided syringes within designated areas as part of a clinically controlled programme can minimise the risk of them being used as a weapon;
- a lot of violence in prisons is closely associated with the possession of drugs and actions associated with addicted detainees desperate for a fix. A strategy involving first class drug treatment would reduce the frequency and intensity of violence across the board including the risk of assaults with syringes; and
- six evaluations of prison programmes in Switzerland, Germany and Spain have shown a generally favourable reaction by prison staff to the programmes. For example, it has been reported of two evaluations in Germany, one in a women's prison and the other in a men's one, that:

  > "Initially there was a high level of acceptance among staff due to the prisons initiating demands for a [syringe exchange] and the

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109. *Australian illicit drug report 1997-98,* fn 19, pp. 114-28 at p. 125.

110. ABC Health Report, 10 August 1998 fn 104.

111. Dolan (2003) fn 98, p. 153.

collaborative nature of the planning. However, there was some variance between the two prisons. Staff at the men's prison were more reserved about their expectations for the success of the programmes."[112]

j) The provision of syringes would create an occupational health and safety danger from inadvertent needle stick injury for custodial staff

The occupational and safety concerns of custodial staff about syringes is based not only on the risk of assault but also on the prospect of accidental needle stick injury particularly when searching for contraband. The risk of this happening would be greatly reduced if syringes cease to be contraband. In the words of Vumbaca dispensation of syringes as part of a clinically controlled programme "increases the level of safety for staff as it reduces the current practice of inmates hiding or secreting needles in various locations that will eventually be searched by staff and therefore represent serious needlestick injury risks."[113]

Recommendation 20:

Sterile syringes should be provided in corrective institutions where ACT prisoners are sent.

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In summary none of the objections to the provision of sterile syringes in prison are particularly strong. None is an answer to the real and immediate danger from detention centres as they are presently run to the spread of life threatening and disabling blood borne disease. Fear of assault with an infected syringe is the most serious concern and this alone demands that the utmost care should be taken in the development of any syringe programme for detention centres. However, assault with an infected syringe is a risk that already exists. It is one that would be reduced by the provision of syringes in conjunction with a comprehensive and high quality drug strategy for detention centres.

Separation of detainees with blood-borne diseases

Before leaving the subject of syringes an alternative "approach" to limit the spread of blood borne disease should be mentioned. In recognition of "the importance of this issue" Mr Ryan suggested that "... we have mandatory screening on entry into custody and at a further time thereafter to cover any incubation period to enable us to make decisions about who really is likely to spread these diseases. I also think that such screening should be undertaken on exit so that we can measure what we're trying to do" (p. 50). He observed that "screening of that type may not be feasible for remandees because of their often too short period on remand," but added that, "I believe that perhaps it's something we should consider for ACT-sentenced prisoners if and when they are accommodated in the ACT in the future." Mr Ryan did not say whether syringes would be provided to either group but given the objection to the provision of syringes that be mentioned earlier, it would seem no provisions would be made.

Aside from ethical objections that Mr Ryan referred to, such a proposal would almost certainly be ineffective. This is because:

- it would, as Mr Ryan admits, not be feasible to protect uninfected short term remandees;
- there would need to be three basic separations of detainees: a pre-screened group of prisoners, a group that tested positive to a blood borne disease and a group that was tested uninfected. Those who have tested positive should also be separated further: at the very least on the basis of whether they have hepatitis C, HIV or both. In the light of the cost and difficulty of any separation of groups of detainees the practical difficulties

112. Dolan (2003) fn 98, p. 156.

113. Vumbaca (1998) fn 88, p. 32.

in providing for all these separations would be much more difficult than just a separation from the mainstream based on a volunteered commitment to be drug free;

- in a mixed pool of pre-screened detainees there would be a continuous risk of fresh infection given the notorious availability of illicit drugs and injecting equipment in detention centres. It would be physically impossible to isolate a newly arrived detainee until a new infection is detectable. Unless this is done, though, it would never be certain that a detainee moving from the unscreened to the uninfected group would in fact be uninfected.
- given the practical impossibility of excluding illicit drugs and contraband including syringes from any area of a detention centre where the inmates want them enough, there is no assurance that an infected syringe would not be smuggled into the uninfected group; and
- without the provision of uninfected syringes to the infected groups there would be nothing to prevent the cross infection of different strains of the same disease which can intensify the effect of the disease on the infected person. This problem would be compounded if there was no separation between those testing positive for HIV, hepatitis C or both.

His proposal would also augment operational health and safety risks for staff by giving a false sense of security that those who have been tested free of blood borne viruses are in fact free.

4. Heroin on prescription

Trials in the community have shown substantial benefits in prescribing heroin under medical supervision to severely addicted users who have not responded to other pharmaceutical treatments like methadone. The feasibility of doing this has been demonstrated in large trials in Switzerland and The Netherlands and years of clinical experience in the United Kingdom where it has always been permissible for doctors to prescribe it as a maintenance treatment. The trial in The Netherlands showed that heroin prescription was more effective than even methadone which has been regarded as the most effective pharmacotherapy for treatment of opiate addiction. The proportion of patients in the Dutch trial with a favourable response in the group that received heroin was 20-25% higher than in the group that received methadone alone.[114]

Like any other effective treatment, heroin prescription reduces the demand for illicit drugs. This is particularly significant in the environment of a corrective centre where demand for illicit drugs is associated with many of the most serious security concerns. In fact, the feasibility of heroin prescription in a corrective

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114. The Netherlands, Central Committee on the Treatment of Heroin Addicts, *Medical co-prescription of heroin two randomized controlled trials*, (Utrecht, February 2002) at www.ccbh.nl.

environment has been established as a small part of the large trial in Switzerland. The official assessment concluded:

> "The pilot study of heroin prescription in a prison environment showed that this procedure required changes (in its operation and in the attitude of staff), but that the positive findings increasingly took precedence. Furthermore, it was noted that good collaboration with outpatient treatment centres could be readily established for the follow-up treatment of discharged inmates."[115]

Vumbaca, formerly of the NSW Department of Corrective Services, wrote the following encouraging account of the pilot programme following a study visit he made to Switzerland:

> "In relation to the heroin prescription program, inmates received who are part of the community based program are eligible, as are inmates with a history of having failed on other drug treatments (although numbers are limited by funding arrangements to only 9 inmates with a fairly constant waiting list of 4-5 people). Inmates on this program are brought to the medical centre where they are given pre-filled heroin syringes for self-injection in the room (limited to 3 inmates at one time) three times a day. The program operates exactly as that in the community although an officer, as well as nurse, are always present whilst the inmates are injecting. Some of the results noted by staff are that inmates on the program have an improved prison based work performance and they are no longer involved in the violence or problems created (especially at visits) with trying to obtain illicit heroin to inject whilst in prison."[116]

V. STRUCTURAL ISSUES

There are precedents to guide implementation of all the programmes described in the previous part. If strategic objectives listed in part III are accepted, programmes such as those mentioned in part IV need to be implemented. It is clear enough what technically is required to implement any of those programmes. Even so, a number of large, non-technical obstacles block their implementation. The provision of syringes in corrective institutions is a prime example. This final part looks at such obstacles. They are matters of attitude and broad policy that, for want of a better term, are described as structural issues.

A. Corrections as a part of the community – not apart from it

A big obstacle to corrections providing better outcomes for the family of detainees, victims, the detainees themselves and the community at large is a mindset that sees isolation of the detainee from the community as an integral part of

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115. Ambros Uchtenhagen, *Programme for a medical prescription of narcotics: final report of the research representative: summary of the synthesis report* (University of Zurich, Zurich, 1997) p. 9 at http://www.liv.asn.au/news-/pro_issues/19990820.html.

116. Vumbaca (1998) fn 88, pp. 9-10

corrections practice. Deprivation of liberty may be a desirable intervention to secure correctional objectives but deprivation of liberty does not and should not necessarily entail isolation of the person deprived of liberty from the community.

Many difficulties that obstruct programmes to strengthen links between detainees and their families flow from a view that prison should be an institution apart from the rest of the community. This springs from a sense that someone who breaks the criminal law should be expelled from the community. From this perspective places of detention are places of exile. The notion that a malefactor should be kept apart underpins various approaches to the purpose of imprisonment such as the punitive, protective and rehabilitative models. Expulsion fits neatly with punitive and protective approaches. That an offender should be cut off from the community as a punishment is over and above the deprivation of liberty that prison also involves. This separation as well as deprivation of liberty is seen as part of legitimate retribution for the offender's wrongs. Moreover, isolation is thought to ensure the protection of the community from further predation by the offender and to deter other potential offenders. Isolation from the community is seen as valuable even by those who would see a rehabilitative role for imprisonment. Mr James Ryan, the Director of ACT Corrective Services, told the Standing Committee on Health that:

> "For many detainees, remand provides a period of calm in a life that's otherwise dictated by the demands of obtaining illicit drugs out in the streets. Remand is an opportunity for detainees to improve their health and to reflect upon their situation."[117]

However much expulsion and isolation as a strategy for corrections is seen as a legitimate response to an infringement of community interests, it is imperfect and even works against the promotion of other community interests.

- In the absence of life time isolation the imprisoned person is detained only temporarily. Unless imprisonment means that the person imprisoned is less likely to commit further crime against the community after release, imprisonment is imperfect even from the point of view of protection of the community.
- The economic costs to the community of imprisonment to achieve isolation are very high. The ACT Government pays some $70,000 a year per prisoner held in NSW; and
- Imprisonment is known to be of limited deterrence. The likelihood of being detected rather than the length of sentence is more significant. "The criminological literature on deterrence . . . shows reasonable support for an association between the certainty of criminal punishment and offending, but little support for the association between crime and the severity of punishment."[118]

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117. ACT, Legislative Assembly, Standing Committee on Health, *Transcript of evidence*, 1 May 2003, fn 87 p. 48.

118. Braithwaite (1989), fn 24, p. 69.

- Isolation does not fit a person well for resumption of life in the community to which he or she will return. This flows from:
    - the routines and other structures of prison life that diminish the capacities of inmates to survive in the community. In Mullen's words prisons ". . . provide remarkably predictable environments with clear rules and limited but well delineated roles. Some mentally disordered individuals thrive in this world stripped of the contradictions and complexities of the outside world. Sadly thriving in total institutions is rarely conducive to coping in the community";[119] and
    - The crowding together in prison of "the cast-offs of society, people with substance abuse problems, mental illness, intellectual impairment, and low levels of education and employment"[120] – all potent risk factors for crime – increases rather than decreases the likelihood of released prisoners re-offending. "Reality shows . . . that a high proportion of offenders who spend time in prison eventually commit further offences and many of them are returned to prison".[121]
- Of particular relevance to this inquiry, isolation cuts the imprisoned off from their family that may have depended on them. The community has an interest in the well being of these dependent family members which is likely to be harmed by the isolation.
- Similarly, the family isolated by imprisonment from the inmate is likely to be the most effective support for the inmate's successful reintegration into the community. Isolation serves to reduce the family's capacity to support the released prisoner.

Indeed the isolation that is seen as an inherent element of imprisonment is at odds with the overwhelming understanding of effective social interventions. The injunction in favour of a "holistic approach" may be more honoured in the breach than the observance but at least it is generally acknowledged to be necessary to underpin successful social policy. It is reflected in learning about early intervention, concepts of social capital, effective child protection policies and programmes like "Wraparound", referred to on page 43. In its insistence on isolation, corrections stands apart like a shag on a rock from this shared understanding. Examples in corrections where that assertion may seem too sweeping in fact reinforce the point. The most effective initiatives in prisons, whether education and development of work

119. Mullen (2001) fn 6, p. 36.

120. Adam Graycar & Peter Grabosky, "Trends in Australian crime and criminal justice" in *Cambridge handbook of Australian criminology* (2002) fn 17, pp. 7-26 at p. 19.

121. Satyanshu Mukherjee, Debbie Neuhaus & John Walker, *Crime and justice in Australia* (Australian Institute of Criminology, Canberra, 1990) p. 51.

skills and pre-release programmes, and the expansion of non-custodial penalties all acknowledge the importance of strong links to the community, not isolation. Unfortunately, when something goes wrong, such as an escape, there is a strong tendency to revert to the isolationist home ground of corrections.

In Braithwaite's words: "Prisons are warehouses for outcasts; they put problem people at a distance from those who might effectively shame them and from those who might help reintegrate them. Imprisonment is a policy both for breaking down legitimate interdependencies and for fostering participation in criminal subcultures."[122] Deprivation of liberty may be an effective correctional strategy. That is far less likely to be the case when deprivation of liberty is associated with isolation from the community. Indeed, it is hard to imagine a more counterproductive social intervention than imprisonment involving isolation.

Recommendation 21:

> The guiding principle of corrections should be to strengthen the community links of those subject to corrections and should not be their isolation. This principle should apply even for those deprived of their liberty.

B. Integration of service delivery

Flowing from the principle that the community links of those subject to corrections should be strengthened is a related one that the services inside and outside detention centres should be integrated to support detainees and their families.

The Report of the ACT Prison Community Panel is replete with recommendations that extend beyond merely the housing of inmates in secure conditions. Its recommendation that the prison's aims and philosophy should be rehabilitative is expressed in robust terms:

> "The aims and philosophy of an ACT prison should be the provision of appropriate programs for prisoners to assist rehabilitation, health and welfare, transitional programs and after-release support."[123]

To mention just some references aimed at rehabilitation, the report recommended that:[124]

- "[t]he prison officer should have a role in case management under the direction of, and with assistance from, external professional case managers";
- that health management should follow "a holistic approach centred largely on the concept of case management";

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122. Braithwaite (1989), fn 24, p. 179.

123. ACT Prison Community Panel (2000) fn 68, §3.2.1, p. 24.

124. See *ibid.*, §3.6, p. 28; §4.2.2, p. 31; rec. 12(ii), p. 36; §5.2, p. 45; §5.3.1, p. 46; §5.3.2, p. 46; §5.3.3, p. 46; §5.3.4, p. 48; §5.3.5, pp. 48-59.

- "carers and support volunteers should be identified in consultation with prisoners who have a mental illness. They should be provided with facilities for staying with the prisoner during times of extreme need";
- the appointment of "Prison Program Officers with appropriate adult education and training and/or psychological qualifications and experience";
- "programs . . . focus on general and specific health needs of prisoners";
- there be cognitive therapeutic programmes dealing with matters such as the management of stress, anger and abusive behaviour;
- the integration of prisoners "into prison employment and training programs where possible to foster skills for productive, crime-free lives";
- sporting and recreational programmes involving community organisations and custodial officers to "provide links to similar community activities upon release";
- transition to release programmes that to be effective must involve "links to community services and facilities".

These and others in the report all involve the provision in the prison of services available in the community to fit inmates for life beyond prison. For the effectiveness of the services, the committee explicitly called in many cases for the co-ordination of services in prison with community service providers.

It is as clear as can be that services within prisons should be closely co-ordinated with services in the community. The logic is that what is available in the community should be available in prison and indeed at a higher standard than in the community because of the congregation in prison of so many with greater needs.

This has implications for the traditional pattern of prison management that sees itself apart from other service providers. This is of the utmost relevance to the terms of reference of the Committee. As shown in this submission it is essential that there be co-ordinated support for families and detainees for the good of both and for the community at large. This means that corrections must own broader social responsibility than merely the containment of detainees. Health is an important but only one area where the broader needs of detainees and their families is in tension with narrower institutional needs of corrections:

> "The health-corrections interface encompasses the curious mix of inmates' health and welfare in contrast with the security, safety and good order of the institutions concerned. Typically, it is described as the distinction between the therapeutic and the punitive establishment, or medical as opposed to custodial staff. It is perhaps best exemplified by the debate surrounding the implementation of needle and syringe exchange programs."[125]

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125. *Australian illicit drug report 1997-98,* fn 19, p. 126.

The bar for corrections is high here just as it is high for service providers in the community. The importance of co-ordinated service provision across different ranges of real life needs is beyond question. Silos that prevent co-ordination must be broken down if the needs of individuals in the context of their social environment – particularly their families – are to be effectively and efficiently met. As expressed by one successful agency:

> ". . . the needs of different family members cannot be dealt with in isolation. The parent's alcohol and drug problem, or intellectual disability, or psychiatric disorder are closely intertwined with their parenting capacity and the welfare of the children. If each organisation is focussed on a different individual within the family, or one aspect of each individual, frequently problems arise in collaboration between these organisations."[126]

Programs such as those drawing on the Wraparound philosophy should be instituted involving a model of managed care that is tailored to each detainee that engages families and others in the intervention process.

Recommendation 22:

> Corrections must own a broader social responsibility that extends beyond the containment of detainees to the integration of support services for families and detainees consistently with the best practices in the community at large.

C. Drug policy

Controversy about drug policy is at the heart of many of the thorniest problems concerning corrections. This submission has described:

- how a high proportion of clientele of corrective institutions are there because they have a severe drug problem;
- how illicit drug use associated with mental disorders is a particularly potent risk factor for crime;
- how addiction can affect the capacity of families to provide support to reintegrate detained members when they are released into the community;
- how drug addiction serves to amplify risk factors for crime down generations.

The submission has also made the point that a large measure of the criminality and other harms associated with illicit drug use are avoidable by treatment and other strategies that focus on illicit drug use as a health issue rather than a law enforcement one. These strategies under the umbrella of harm minimisation do not directly strike at the dynamics of the illicit drug trade but aim to reduce to the maximum extent the individual and community harms associated with illicit drug use. Indirectly they also serve to undermine the illicit drug distribution network by reducing the demand for

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126. Dorothy Scott & Di O'Neil, *Beyond child rescue: developing family-centred practice at St Luke's* (Solutions Press, Bendigo, 2003, first published 1996) p. 114.

those illicit substances. In a highly regarded American study on cocaine prepared for the Office of National Drug Control Policy of the United States Army the point is made that:

> "Treatment programs decrease cocaine consumption in two ways: First, most people reduce consumption while in treatment and, second, some people do not return to their original levels of consumption after they leave treatment."[127]

The study adds that:

> "Even though the debate on the effectiveness of treatment focuses on treatment's ability to get people to stay off drugs after they leave a treatment program, one-fifth of treatment programs' overall effectiveness is due to the suppression of cocaine use while people are in treatment."[128]

These observations can be confidently applied to illicit drug markets other than cocaine.

There is obviously a tension between the focus of harm minimisation and the illicit status of the drugs involved. A user necessarily commits a crime by possessing if not also consuming the drug. Over the years boundaries, largely determined informally, have been recognised in the community between where policing should end and health care and other minimisation strategies take over. Thus, police no longer routinely attend drug overdoses as they used to. Police do not normally harass illicit drug users at syringe dispensing and treatment centres and so on.

In striking contrast, corrective institutions contest the introduction of equivalent harm minimisation measures in detention centres. For example, the supply of bleach to clean syringes and methadone treatment programmes are available in detention centres in only some Australian jurisdictions[129] even though corrective authorities acknowledge the availability of illicit drugs and syringes in those centres despite their efforts to keep them out. Police and correctional services representatives expressed the unresolved tension of their attitude to illicit drugs at a conference in 1998:

> "Respondents were unanimous in their support of total prohibition on drugs in prison. The majority of respondents were, however, quick to say that this was 'ideal but virtually unachievable'."[130]

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127. C. Peter Rydell and Susan S. Everingham, *Controlling cocaine: supply versus demand programs prepared for the Office of National Drug Control Policy, United States Army* (RAND, Drug Policy Research Center, Santa Monica, 1994) p. 7.

128. *Ibid.*, p. 23.

129. *Australian illicit drug report 1997-98,* fn 19, p. 122.

130. *Ibid.*, p. 123.

From a legal point of view such tensions could be resolved easily by legislation at the hand of governments and legislatures. While there may be scope to move to some extent in that direction, the explanation probably lies elsewhere for the much greater reluctance to implement harm minimisation measures in detention centres than in the community at large.

One factor may be the sense that prisons and remand centres are felt to be places where the law in its full rigour should be upheld and this is seen to be inconsistent with some of the most effective measures of harm minimisation that seem to involve colluding with an illegal activity. At least a partial answer to this objection is the proclaimed practice of police and prosecutorial authorities not to detain people for offences concerning personal use of illicit substances. (The extent this "practice" is actually given effect to is uncertain given the high level of "consumer" compared to "provider" arrests that police report.)[131] When people are detained it is most likely for more serious offences such as burglary and drug dealing. That these offences may relate to the drug dependence of those arrested – their health condition – does not alter the fact that this is not what in most cases they are being detained for. It is thus incongruous that their raging drug habit should become the focus of coercive action against them and denial to them of a modicum of safety for attempting to maintain that habit in prison. To do so, as so often happens, is tantamount to applying punishment under the criminal law to deal with a health problem.

In principle, people should not be punished because they have a health problem. At the same time, such a health problem should not be an excuse for crime. The practical answer to this conundrum is to provide the best possible drug treatment within places of detention because, to repeat the point already made, treatment greatly reduces demand for illicit drugs even when it does not lead to long term abstinence. The better the treatment the more attractive it is likely to be to people who want to get their out-of-control lives back together. Everything should be done to facilitate treatment including separation of those who opt for treatment from the rest of the prison population. For that remainder, standard harm minimisation measures recognising the reality of illicit drug use should be available in the prison and remand centre just as they are available in the community. Standard harm minimisation measures include encouragement to enter treatment. The experience of corrections is that forcing abstinence on people does not work.

Opposition to this approach is informed by a moral viewpoint that places an absolute value on becoming drug free regardless of the consequences and, as this submission has striven to show, those consequences are fearful. They include:

- a high risk of overdose leading to death or brain injury when relapsing after being released from detention. One in 200 adult male injector is

131. Australian Crime Commission, *Australian illicit drug report 2001-02* (Australian Crime Commission, Canberra, 2003) table 8.1, p. 127. See also text at fn 4 above.

likely to die in the fortnight after release from an imprisonment of fourteen days or more;[132]

- susceptibility to life threatening and life disabling diseases for the detainee;
- the loss of support to family members arising from those diseases;
- the high risk of the released detainee infecting members of their family and others in the community; and
- high health costs to the community of treatment of the disease and other poor health arising from clandestine drug use.

Recommendation 23:

Measures of harm minimisation available in the community for illicit drug use should also be available in prisons and remand centres in conjunction with best practice drug treatments.

D. Security as an impediment to family contact

Concern to keep out contraband, particularly in the form of drugs, constitute a large impediment to the maintenance and development of family links with detainees on which the detainee's and family welfare depends. The Director of ACT Corrective Services, Mr James Ryan, told the Standing Committee on Health, that:

> ". . . the entry of drugs could be reduced significantly if contact visits by visitors were disallowed. Indeed, this is a measure taken often in the event that a prisoner is caught receiving contraband from a visitor. In the extreme, prisoners could be separated in a way that prevents the traffic of drugs within a prison. No visitor contact and minimised prisoner to prisoner contact would largely solve the problem."[133]

In recognition of the importance of visits he added that ". . . these are measures that are obviously draconian and are reserved for the extreme cases of prisoner behaviour." The ACT Prison Community Panel was also conscious of the negative effects that security efforts to keep out drugs could have on rehabilitation. "[T]here needs to be," it reported, "a balance between rehabilitation, including family visits, and drug detection and penalties."[134]

The present balance is not a happy one. Intense effort is put in to keeping drugs out of correctional establishments and this is focussed largely on the visitor barrier. As a survey of drugs in prison states: "

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132. Bird & Hutchinson (2003), fn 36, p. 189.

133. ACT, Legislative Assembly, Standing Committee on Health, *Transcript of evidence*, 1 May 2003, fn 87, p. 47

134. ACT Prison Community Panel (2000) fn 68, §4.4.3.1, p. 39.

> "Most commonly, contraband is passed over or under a prison's perimeter or through visitor reception areas, particularly during contact visits."[135]

The myriad of ways in which drugs can be concealed makes for distrust and suspicion about visitors and very restrictive visiting protocols. Drugs are "most commonly concealed on the inmate's or visitor's person, internally or externally". Drugs are known to be passed "orally from visitor to inmate during a kiss". Drugs are sewn "into the seams of clothing" and concealed in "personal property, foodstuffs, prosthetic limbs and bandaged parts of the body." Detection methods include "random and targetted searches of visitors and inmates, using drug dogs, urinalysis, and intelligence work." Telephone monitoring is also common. It seems that "more women than men are caught smuggling contraband at the visitor barrier."[136]

Intrusive searches of visitors are permitted. As reported in 1998 the situation throughout Australia was as follows:

> "New South Wales, Queensland and Tasmanian legislation requires visitors to produce baggage and turn out their pockets, but only New South Wales and Queensland use metal detectors. South Australian legislation allows for pat searching and detention of visitor on suspicion of smuggling contraband; Group 4 and CORE can also do this. ACM can perform external searches only with the permission of the visitor. Northern Territory legislation allows prison authorities to search visitors, including strip searches, on suspicion of introducing prohibited materials. In Western Australia any person seeking to enter, or who is near, a prison can be searched to ensure security and good order."[137]

Authorities also use drug detector dogs. "Passive-alert dogs survey people at the correctional centre barrier and approach any suspect person or package, sit, and stare at them or it."[138]

The hostile environment for visits lacking any modicum of privacy is being intensified. "Northern Territory and Queensland have focused on strengthening the security surrounding visitor access areas in order to reduce supply. The Territory is planning to introduce ion scanning technology along with 'improved visitor access controls'. Queensland has introduced a computerised information system based on finger-scanning of visitors, the training of 'visit' staff in Customs techniques used to detect carriers and suppliers, and fixed seating and transparent tables to improve surveillance."[139]

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135. *Australian illicit drug report 1997-98,* fn 19, p. 116.

136. *Ibid.,* p. 117.

137. *Ibid.,* p. 118.

138. *Ibid.,* p. 119.

139. *Ibid.,* p. 121.

Visitors caught smuggling drugs can, of course, be prosecuted for an offence. They can be and are barred from visiting. "Visitors found smuggling in New South Wales can be prohibited from visiting for 12 months to two years for minor quantities, for five years for large quantities, and for 10 years for a second offence. They can also be imprisoned for two years to life, depending on the amount smuggled."[140]

Similarly inmates caught with drugs or paraphernalia may be and are deprived of contact with their family and other visitors. Victoria has "imposed the periodic loss of contact visits (three to 12 months), restricted access to the Residential Visit Program and Special Visit Days with Children, and a review of a prisoner's security rating." Similar penalties seem applicable in other jurisdictions. New South Wales has a "penalty unit" system under which an inmate who accumulated sufficient points faces a series of penalties.[141] Loss of contact with family also happens when an inmate returns a positive urinalysis. "New South Wales, CORE and Group 4 penalise positive results with a loss of contact visits. . . . Victorian prisons continue to use the identified drug user system, whereby inmates who return positive tests suffer periodic loss of contact visits or placement sanctions."[142]

It is clear that the effort put in to preventing entry of drugs into corrective institutions borders on the obsessive. It is an effort that at most reduces the availability of drugs in those institutions. It is unsuccessful in keeping drugs out of them. At the same time it virtually destroys the environment necessary for the maintenance and strengthening of the links between inmates and their family and others upon which the welfare of the inmate and family depend. Security measures and the obsessive concern about drugs make the visiting environment recommended by the ACT Prison Community Panel sound like wishful thinking:

> "The facilities [for visiting] should be user-friendly, promote a relaxed atmosphere, and where necessary provide privacy. Visits should be encouraged and regular times for visits identified and promulgated.
>
> "Facilities for families with children are essential, and child-minding facilities should be available. The Prisoner Support Program could operate a centre for visitors, which provide public telephone, lockers for valuable items, mothers' room, tea and coffee facilities, light snacks and cold drinks. Facilities for informal social activities such as barbecues could also be made available."[143]

Security measures may not deter some families from retaining links. These are less likely to be families that have a lot of problems themselves. It is the medium

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140. *Ibid.*, p. 119.

141. *Ibid.*

142. *Ibid.*, p. 120.

143. ACT Prison Community Panel (2000) fn 68, §8.2.1, pp. 64-65.

and high risk families mentioned in sections II.B and II.C who are most likely to be caught up in the campaign of corrective authorities about drugs. They are the ones that are likely to be most intimidated. Needing co-ordinated support to provide the best chances for themselves and their detained member, suspicion and punitive responses focussing only on drug use and the perceived good order of the corrective institution are guaranteed to make the situation for such families worse rather than better. Almost certainly those families will have a range of problems (and strengths) of which drug use is but one and probably not the most troubling. Obsession about drugs should no longer be the tail wagging the whole corrective dog.

Recommendation 24:

As part of a broader social responsibility, authorities should not allow efforts to prevent drugs entering corrective institutions to undermine the maintenance and development of family bonds and capacity of the family to support the detained member's reintegration into the community after release.

E. Community attitudes

This submission has recommended a number of changes that may seem to challenge popular attitudes. Such recommendations include:

- greater openness of prisons and remand centres to family and community links, a move that might be seen as going soft on criminals; and
- implementing in prisons and remand centres measures of harm minimisation that are available in the community including a governance regime less focussed on stopping drugs being smuggled in.

Such community concerns must be addressed by political leadership. The starting point has to be the sort of society we wish to live in and what must be done to achieve that objective.

Recognising the importance of human interdependency, Families and Friends for Drug Law Reform submits that Government policies should promote a caring and cohesive society sustainable through generations. Of particular relevance to the terms of reference of the Committee, governments should foster an environment that:

- reintegrates detainees into the community;
- recognises that support from those closest to detainees, namely their families, is essential to achieve this reintegration;
- ensures that those dependent on detainees and particularly children should not suffer because of the detention.

Current practices work against these ends by:

- driving a wedge between young people and families through drug policies that do nothing to reduce the supply of illicit substances but which serve as an extraordinarily potent risk factor for mental illness, suicide, crime and other serious social problems;

- through lack of capacity for early intervention to head off episodes of mental illness, encouraging crises to develop;
- going beyond depriving those who have committed crimes of their liberty by isolating them from their family and the community thus reducing rather than increasing their capacity for reintegration;
- providing little if any support to the families of those detained to build up the family's own capacity that will be crucial for the support of their detained member;
- increasing the risk factors for mental illness, crime and other social problems for those who are left without support by the detention of a family member;
- exposing those who are detained to a high risk of emerging with life threatening or disabling health conditions that are also likely to blight the lives of their family members and spread blood borne disease into the community at large;
- requiring the expenditure of an ever increasing level of resources on programmes that will never get on top of the problem and indeed which make things worse.

All these points are informed by and consistent with the insights provided by early intervention theory and research which are widely accepted by governments and which are being applied, if only partially, in the development of policy regarding early childhood, child abuse, mental health, suicide and crime. The insights of this research provide a solid basis for community education in support of the implementation of consistent policies that will reduce serious social harms.

Recommendation 25:

Consistent with the findings of early intervention research, the Legislative Assembly and Government should take leadership roles in support of the introduction of a consistent set of social policies to address the serious social problems including mental illness and drug abuse presently associated with detention.

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"No man is an island entire of itself; every man is a piece of the continent, a part of the main. If a clod be washed away by the sea, Europe is the less, as well as if promontory were, as well as if a manor of thy friend's or of thine own were. Any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."
(Meditation 17 (1623-1624) from *Devotions upon Emergent Occasions* by John Donne)

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ANNEX

RECOMMENDATIONS OF

Workshop 7 - Families, Drugs and the Law

National Families & Community Conference on Drugs: "Voices to be heard": Conference proceedings, 10-11 November 2000

Workshop themes:

Discussion followed three paths: firstly, improvement of the existing law enforcement system as it applies to people with substance abuse problems; secondly, reform of prison practices and, thirdly, overall reform involving recognition that the criminal law has been ineffective in controlling drug use.

Improving the existing law enforcement system

Families with a child caught up in drug abuse need legal advice to help their child. They should know where to turn to for this assistance. Families are disempowered without access to information about the legal system, their rights, and how to help their family members. A court supported system similar to the Family Drug Support phone-line was suggested. It would also help if criminal lawyers spoke to parent groups. There should also be adequate legal aid.

Those involved in administering the legal system must be conversant in the medical dimensions of mental health and substance abuse disorders. Police and magistrates in particular should receive thorough training on these conditions that affect a high proportion of those caught up in the criminal system.

It was acknowledged that diversion was preferable to prison. Diversion systems go some way to recognising the importance of addressing drug abuse as a health problems.

At the same time it was important that much greater funding be injected into health interventions to help those with drug problems before they become caught up in the criminal justice system. A shortcut from substance abuse to treatment would lead to large cost savings in the justice system.

The workshop recommended that as much should be spent on the health budget as the law and order budget.

Restorative justice and addiction treatment should be the focus, not punishment.

Prisons

Great concern was expressed about the utility of prison for people with drug abuse problems. The working groups felt that prisons fail in rehabilitating inmates. They are extremely expensive and a waste of money in that they tend to breed worse criminals, increase social dislocation and foster long term unemployment.

Prison visiting: Impediments to prison visiting should be reduced and visits fostered.

Regular visits are an important means of keeping prisoners connected to their family and the community. Fostering of such bonds is in most cases essential to promote rehabilitation.

- Visitors – including families are often treated in a demeaning way.
- Visiting rights are denied for trivial reasons.
- There is an obsession with drug security which impedes the development and maintenance of links between the prisoner, his family and the community.

Attitude of prison system and its officers: Changing the attitude of the prison system and its officers is one of the major challenges.

Stereotypical and contemptuous attitudes about drug users (who form the large majority of prisoners) are one of the main impediments in the way of securing change required for rehabilitation. These attitudes spill over to families of prisoners.

Families need to speak up but families often remain silent in the face of unsatisfactory treatment of prisoners and conditions out of fear that calls for change would jeopardise the prisoner. This allows unsatisfactory prison conditions to continue.

Family links should be encouraged: The many impediments to maintaining family links need to be overcome. These impediments include:

- overly inflexible, opaque and unfair restrictions on visiting,
- absence of or inadequate transport for families to visit remote prisons, and
- families treated in a demeaning way when they visit prison (see above).

Community life skills: Prison programs should maintain and develop skills necessary to live in the community.

In many ways prisons cocoon prisoners from the outside world, prison destroys independence and employers do not want to employ ex-prisoners.

As a result of these factors, prisoners are less able to cope with the outside world

Re-integration into the community: Greater attention must be given to the reintegration of prisoners into the community and to lower the high risk of fatal overdose which presently exists for prisoners released into the community:

- Half way houses or prison annexes should be established and required to assist reintegration of prisoners into the community. They are needed to provide links to accommodation and employment.
- Prison and community drug support services should be integrated.

Drug treatment and mental health: Treatment in prison is of great concern. There is a crying need for more and better drug treatment. Prisoners should have access to the best available treatments.

Prisons presently serve as society's receptacle for many with mental health problems. These same prisoners generally have substance abuse problems.

Prisoner with mental health problems include some who have acquired a brain injury from overdosing.

Prisons are unsuitable for psychiatric treatment. Prisoners who require such treatment should be in a facility other than a prison.

Stigma: The stigma of drug use is compounded by the stigma that surrounds imprisonment. This stigma is debilitating and makes it very hard to reintegrate prisoners into the community.

Stigma needs to be addressed:

- within the family; and
- in the community attitudes towards the prisoner and his family.

Publication of stories: To promote change of community attitudes and rehabilitation, the stories of prisoners and their families need to be told and publicised with compassion and dignity.

Overall reform

We need policies that address drug abuse as a medical and social issue. At present the criminal law, and particularly attitudes of zero tolerance, is part of the problem rather than the solution. The criminal law should play only a limited role in activities surrounding personal use. These should be decriminalized.

The workshops recommended substantial changes to the present system. Prescription heroin and supervised injecting rooms, should be promoted to reduce the impact on the community of illegal activity to obtain illicit substances. Such measures would undermine the illegal distribution system by reducing demand and taking the profit out of the market.

As things now stand the criminal law creates obstacles to assistance. It is also ineffective in that it does not protect children from access to drugs. If anything it promotes that access. It undermines the rights of those who need help and fosters a culture of suspicion and silence. Sometimes people are too scared to seek help. It stigmatises health problems, divides families and undermines hope and compassion.

SOURCE: Brian McConnell & Tony Trimingham (eds), *National Families & Community Conference on Drugs: "Voices to be heard": Conference proceedings, 10-11 November 2000* (Families and Friends for Drug Law Reform, Canberra, July 2001) pp. 116-18 at www.ffdlr.org.au.