



*Making prisoner health a priority*

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**POLICY PAPER PREPARED FOR THE  
ACT MINISTERS OF CORRECTIONS  
AND HEALTH**

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**JULY 2006**

## ABOUT ACTCOSS

ACTCOSS acknowledges Canberra as the traditional lands of the Ngunnawal people. We pay our respects to their elders and recognise the displacement and disadvantage traditional owners have suffered since European settlement. ACTCOSS celebrates the Ngunnawal's living culture, continuous care of this land and valuable contribution to the ACT community.

The ACT Council of Social Service Inc. (ACTCOSS) is the peak representative body for not-for-profit community organisations, people living with disadvantage and low-income citizens of the Territory. ACTCOSS is a member of the nationwide COSS network, made up of each of the state Councils and the national body, the Australian Council of Social Service (ACOSS).

ACTCOSS' objectives are representation of people living with disadvantage, the promotion of equitable social policy, and the development of a professional, cohesive and effective community sector.

The membership of the Council includes the majority of community based service providers in the social welfare area, a range of community associations and networks, self-help and consumer groups and interested individuals.

ACTCOSS receives funding from the Community Services Program (CSP) which is funded by the ACT Government.

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## INTRODUCTION

**Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity<sup>1</sup>**

**WORLD HEALTH ORGANIZATION, 1946.**

The World Health Organization (WHO) definition of health has remained unchanged since it came into force in 1948, the same year that one of Australia's delegates to the International Health Conference that developed the definition, Dr Herbert Vere Evatt, became President of the General Assembly of the United Nations. Doc Evatt led Australia's delegation to the 1946 health conference that developed this definition. ACTCOSS believes that this is a good starting point for discussion of the health needs of people who come into conflict with the law, given the robust nature of this definition and its links to human rights.

The development of policy necessitates some philosophical underpinnings. In ACTCOSS' case, it is the recognition of the human rights of all people to be treated with dignity and be accorded the benefits of living in a first world economy in one of the most affluent cities in one of the richest nations in the world. Not to mention the first jurisdiction in Australia to adopt a form of bill of rights.

ACTCOSS was a strong supporter of the ACT Government's introduction of the Human Rights Act 2004. The organisation was, however, disappointed that this Act included only some of the rights under the International Covenant on Civil and Political Rights (ICCPR) and has continued to press for an expansion of the rights under that Act to include the International Covenant on Economic, Social and Cultural Rights (ICESCR). This belief underpins ACTCOSS' development of its prison policy statement, which is appended to this paper.

That the rights and protections of these universal instruments extend to prisons has been explicitly recognised in the Basic Principles for the Treatment of Prisoners adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990 which states:

*Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and*

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<sup>1</sup> Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

*Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants (para. 5).*

The right of prisoners to receive the best standard of health care available<sup>2</sup> has been accepted for decades, if not delivered. In the 1978 Nagle report<sup>3</sup>, recommendation ten states that:

*"In all cases the appropriate test for the provision of medical and other health care should be whether it is necessary for the health of the prisoner. Prisoners should receive the same medical and health care as a private citizen. The cost of such a provision is no answer to necessity."*

Similarly, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)<sup>4</sup> outlined that:

*Correctional institutions should have health care standards that are equal to those provided to the general public. . . . In addition, such services 'should contribute directly and indirectly to the efforts of the inmates to rehabilitate themselves'.*

ACTCOSS believes that acceptance of the principle that those in detention should have necessary health care equal to that provided to the general public must take into account the markedly poor health status of those detained. The standard of physical and mental health of the custodial cohort is markedly below Australian average health. Indeed, their poor health status is a risk factor contributing to their incarceration. Intensive, high quality health care is therefore needed in custodial institutions to deliver similar outcomes to that expected in the general community. If access to health is demonstrated by equality of outcomes, prisons will need to provide above average care for inmates to ensure that they achieve the community standard of health prior to discharge.

These considerations apply in particular to the provision of intensive, high quality mental health care. This is because, as described below, a large number of prisoners have a mental disorder or illness. The care of these people is subject to "The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" adopted by General Assembly resolution 46/119 of 17 December 1991<sup>5</sup>. This provides that detained people "should receive the best available mental health care":

*"These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the*

<sup>2</sup> As outlined in ICESCR, Article 12 and the General Comments.

<sup>3</sup> J.F. Nagle, *Report of Royal Commission into NSW Prisons*, 1978. Recommendation 10.

<sup>4</sup> S. Kerr, *Health Services to Correctional Services in the Northern Territory*, Northern Territory, Department of Correctional Services, 1989, p. 6 quoted at RCIADIC §24.4.11.

<sup>5</sup> UNHCR: <http://www.unhcr.ch/html/menu3/b/68.htm>.

*[covenants and other general instruments]" (para. 20(2)).*

ACTCOSS sees it as equally important that the Government and Corrections officials join the discussions between community service providers and groups such as the Beyond Bars coalition to widen the debate over sentencing, with the aim of reducing the prison population and ensuring that relevant health interventions are added to the mix of community-based options facing people caught up in the criminal justice system.

ACTCOSS therefore takes as its starting point these international instruments including ICESCR Article 12 and particularly the general comments on that article<sup>6</sup>.

*"States parties are also obliged to fulfil (provide) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to fulfil (promote) the right to health requires States to undertake actions that create, maintain and restore the health of the population. Such obligations include: (i) fostering recognition of factors favouring positive health results, e.g. research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health."*

The overwhelming evidence is that people who come into contact with the corrections system are already experiencing poorer health and require higher levels of health services than the general population. They are also mistrustful of services provided within corrections facilities and take measures that may not be in their long term health interests as their way of protecting themselves from perceived threats. Development of trust takes time, however many people coming into custody are on remand and might be there for a very short period of time. One of the challenges facing the AMC is the development of programs that can make a start on addressing prisoner and remandee health deficits that can connect with community-based services and that inmates value enough to follow through with post-released.

The literature shows that restoration of good health and the development of personal skills in health management will better equip the inmate population for a return to the community, reduce a risk factor for re-offending and provide some protection for the community from the detrimental health outcomes that can occur in institutions. To quote the AMA's position statement on the health care of prisoners and detainees:

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<sup>6</sup> United Nations Committee on Economic, Social and Cultural Rights, General Comment 14, "The right to the highest attainable standard of health", 11/8/2000, UN Doc E/C.12/2000/4. The right to health is also found in UDHR Article 25.1; ICESCR Article 12; CERD Article 11.1(f); CEDAW Article 12; CROC Article 24.

*“Because prisoners will return to society after their imprisonment, their health is an issue of concern to the general population.”*

The length of time a person is in the AMC should not be the determining factor for the level of health support and treatment they receive. ACTCOSS is looking to the AMC to be best practice, and to develop a reputation for its health responses that will allow future inmates to relax their guard a little within the medical centre, to ensure the maximum benefit from the health services they require.

## **ACTCOSS' INTEREST IN CORRECTIONS' HEALTH POLICY**

To assist with the development of policy, ACTCOSS from time to time convenes a range of advisory committees. One such group, the Canberra Community Coalition on Corrective Services (the Corrections Coalition), was established in 2000 to examine corrective service issues in the ACT, including the establishment of an ACT prison and the functioning of the existing remand system. Its members have come from a wide cross-section of the community, including church groups, the health sector, alcohol and other drug services, prisoner's support groups and youth representatives.

The Corrections Coalition is currently working to develop a range of discussion papers and forums on issues that involve the community sector's interaction with the Alexander Maconochie Centre (AMC). The area of immediate concern to the Corrections Coalition was identified as the health of inmates. This comes from the recognition of the social determinants of health, the growth in understanding of the precursors to offending behaviour and the poor health of people in the corrections system when compared to the general population.

To inform itself of the current and potential health regimes in corrections, the Corrections Coalition held two special meetings in 2005 which were addressed by the current medical officer for the Belconnen Remand Centre, Dr Graeme Thomson, and Anthony Burton from the Health Services Planning Unit within the ACT Department of Health.

This policy paper is informed by the research and knowledge of the current members of the Corrections Coalition, which includes:

- Family and Friends for Drug Law Reform
- Prisoner's Aid
- Quakers Access to Justice program
- Youth Coalition of the ACT
- CAHMA
- Australian Community for Christian Meditation
- Softlaw Community Projects
- St Vincent de Paul – Samaritan House

The paper also draws on ACTCOSS' work on human rights and international research and precedent.

**MENTAL HEALTH**

As the following table shows, a very high proportion of prisoners present at intake with some form of mental health disorder.

<b>Table 4: NMHI – Mental Health</b>				
Receptions (n = 756m/165f) Community (n = 6,627m/6,837f)				
	<b>Male %</b>		<b>Female %</b>	
	Reception	Community	Reception	Community
Psychosis	10.7	0.43	15.2	0.41
Depression	16.0	3.4	23.6	6.8
Anxiety	33.9	7.1	55.8	12.1
Personality	39.9	6.83	56.4	6.13
Any Mental disorder	78.2		90.1	

Source: Evidence by Dr Richard Matthews<sup>7</sup> to the House of Representatives Standing Committee on Family and Community Affairs

The problems of mental health will become more prevalent in the future should the detention in prison of applicants for refugee status or overseas residents awaiting processing of other visa applications increase.

Recognition of mental health problems must not be seen as being confined to those inmates with a diagnosed mental illness much less to forensic mental health prisoners. Recognition and treatment of poor mental health must extend to all inmates experiencing symptoms.

A Victorian study on prisoner health in 2003 found that:

*The overwhelming impression conveyed by the data is that the prisoner population is far less mentally healthy than the wider Victorian population. The overall pattern of findings reflects a prevalence of all the major mental illnesses than is found in the general population. Moreover, a very high percentage of prisoners have attempted suicide or otherwise engaged in acts of self-harm. The prevalence of addictive behaviour is also extraordinarily high. This situation is serious enough to require that careful attention be paid to the provision of broad-based mental health services to prisoners (p.18).*

<sup>7</sup> Dr Richard Matthews MBBS, currently (2006) Deputy Director-General, Strategic Development, NSW Health and Chief Executive Officer of Justice Health. Overheads he presented to Family and Communities Affairs Committee. Transcript of evidence in Hansard, 16 August 2002, pp. FCA 1,230-1,238 accessed at: <http://www.aph.gov.au/hansard/rep/commtee/r5665.pdf>

....Prisoners were asked if they had ever thought about committing suicide. Just less than half (n=220, 46%) of the prisoners reported having had such thoughts. Of those who had suicidal thoughts, around 60% had actually attempted suicide (p.29)<sup>8</sup>.

It is therefore crucial that suicide prevention programs are uppermost in planning for the wellbeing of inmates and remandees. Addressing depression and suicidal thoughts with inmates, both on admission and throughout their time in the AMC, will be pivotal to overall health goals.

The observation of the Royal Commission into Aboriginal Deaths in Custody still apply to the general prison population:

*"Prisoner mental health care appears to be an area which has received little attention and few resources over the years, despite the fact that a high proportion of the prison population suffer from some form of mental or behavioural disorder" (RCIADIC §24.4.18).*

For all detainees with a mental disorder, the AMC should implement the principle of equivalence articulated in the National Statement of Principles for Forensic Mental Health, namely:

*Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population. Where health facilities are provided within a correctional facility, there should be appropriate equipment and trained staff, or arrangements made for such services to be available, at a standard comparable to regional and community standards.*

*Services should ensure equality in service delivery regardless of an individual's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous conditions, forensic status, and physical or other disability. This Principle of Equivalence applies to both primary and specialist mental health care (principle 1).*

There is growing evidence that prison stresses the mental health of all detainees. The AMC must, therefore, ensure an environment that minimises these environmental stresses and provide high quality and accessible mental health services to meet the needs of all the inmates, remandees and sentenced prisoners alike.

ACTCOSS would also like here to point out the absolute necessity of researching better primary mental health care services to be made available in community settings. The AMC should not become a de-facto mental health institution because we cannot provide adequate community care and support for people with mental health problems and anti-social behaviours.

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<sup>8</sup> Deloitte Consulting, *Victorian Prisoner Health Status Study, February 2003*. Accessed at: <http://www.justice.vic.gov.au/CA2569020010922A/page/Prisons+and+Community+Corrections-Reviews+and+research-Victorian+Prisoner+Health+Study?OpenDocument&1=0-Prisons+and+Community+Corrections-&2=0-Reviews+and+research-&3=0-Victorian+Prisoner+Health+Study~>

Similarly the AMC population will have a high proportion of inmates who have a substance dependence problem.

<b>Table 5: NMHI – Drug &amp; Alcohol 12 Month prevalence dependence/abuse (DSM-IV)</b>					
Receptions (n = 756m/165f) Community (n = 6,627m/6,837f)					
		<b>Male %</b>		<b>Female %</b>	
		Reception	Community	Reception	Community
Alcohol	Dependence	19.2	5.2	16.4	1.8
	Abuse	3.2	4.3	1.8	1.8
Cannabis	Dependence	18.1	2.4	22.4	0.7
	Abuse	2.4		2.5	
Opioid	Dependence	33.3	0.2	53.4	0.2
	Abuse	1.9		0.6	
Sedative	Dependence	11.6	0.4	28.6	0.3
	Abuse	0.3		0.0	
Stimulant	Dependence	27.9	0.3	47.8	0.1
	Abuse	2.9		2.5	
Any disorder		63.3	7.1	74.5	2.8

*Source:* Dr Richard Matthews evidence to House of Representatives Standing Committee on Family and Community Affairs<sup>9</sup>.

This high proportion of drug and alcohol misuse among inmate populations means that programs to address these as health issues will feature prominently in the AMC. At present the documentation looks at the role of social workers within the prison, who will be Corrections employees. ACTCOSS believes that there is a need for clarification on the role of this group of workers as we believe it is not possible for employees of ACT Corrections can be effective in delivering drug and alcohol programs. Counsellors in such programs must be independent of the custodial role, as the perception that the drug and alcohol workers are “screws” will prevent the development of the rapport needed for treatment programs to be effective. ACTCOSS also believes that counsellors need to be working with medical staff in devising programs for individuals, a

<sup>9</sup> Overheads presented to Family and Communities Affairs Committee. Transcript of evidence in Hansard, Friday, 16 August 2002, PP. FCA 1,230-1,238 accessed at: <http://www.aph.gov.au/hansard/reps/commtee/r5665.pdf>

process that will be impossible if medical records are to remain confidential.

## **Co-MORBIDITY**

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In most cases, those with a mental disorder will also have a co-morbid substance dependency. These problems reinforce each other. More and more people with mental disorders are using illicit substances for self medication or otherwise. Stresses associated with dependent drug use magnify the otherwise low risk factor of mental illness for crime. Mental health problems are further aggravated by the stressful processes of the criminal law. Thus, unless a special care is taken, people with a common dual diagnosis of substance dependence are likely to emerge from detention less able to cope in the community and very vulnerable to resuming a drug dependence that will very likely see them back in detention.

The National Comorbidity Initiative has found that<sup>10</sup>:

*people with co-occurring mental health and substance use disorders*

*(1) have worse psychiatric symptoms, treatment compliance and prognosis*

*(2) use more treatment and service resources*

*(3) have a greater propensity for suicidal and self-harming behaviours and poorer physical health habits*

*(4) have fewer social supports or financial resources with which to seek treatment other than on an outpatient basis from public sector community providers and*

*(5) exhibit the highest rates of expensive public psychiatric hospital admissions and criminal justice system involvement.*

*Rosenberg, Goodman, Osher et al (2001) reported higher rates of infection with HIV and hepatitis among those with dual diagnosis. Drake & Mueser (2000) stated that over 100 studies have demonstrated higher rates of adverse health and social outcomes associated with dual diagnosis.*

These are present problems and emerging areas for research and the trial of new therapies. ACTCOSS asks that the ACT Corrections Health Plan incorporate resources to address known needs in this area, as well as capacity to implement innovative programs to assist people whose mental health and drug/alcohol dependency bring them into conflict with the legal system.

## **ASPECTS OF PRISON HEALTH**

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<sup>10</sup>National Drug Strategy and National Mental Health Strategy, *Current practice in the management of clients with comorbid mental health and substance use disorders in tertiary care settings* 2003. Commonwealth of Australia. P.11 of 307. Accessed at: [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm/\\$FILE/comorbid\\_current.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm/$FILE/comorbid_current.pdf)

Responsibility for prison health needs to cover specific aspects, namely:

- Those social determinants that have contributed to poor health status [and offending] of inmates;
- Personal medical care of those in detention;
- Preventative health care involving the physical environment and the prison regime that may impinge on the health of inmates; and
- Specific needs, including Indigenous inmates, women (including women with accompanying children), sexual health programs, gay, lesbian, transgender, bisexual and intersex, and the varying time frames for health services provided to remand and sentenced inmates.

### **SOCIAL DETERMINANTS OF HEALTH**

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Recognising that poor health is itself a risk factor for offending, there are also social determinants of health that need to be addressed when implementing health programs in detention facilities. The adoption by the Government of the “healthy prison” model for the AMC recognises this important aspect of holistic treatment of people who are incarcerated, by adopting an operating philosophy that aims to ensure:

- everyone is and feels safe;
- everyone is treated with respect as a fellow human being;
- everyone is encouraged to improve himself or herself and is given the opportunity to do so through the provision of purposeful activity; and
- everyone is enabled to maintain contact with their families and is prepared for release<sup>11</sup>.

Such a regime is important when it is recognised that the lack of adequate education, poverty, exposure to violence as a child, abuse, intellectual disability, Foetal Alcohol Syndrome, hearing loss, acquired brain injury and a host of other problems can leave people with inadequate skills to negotiate adulthood, leading them into conflict with ACT law. Some of these issues have also been pointed out in the AMC’s research on rehabilitation<sup>12</sup>.

ACTCOSS has also found in its work on the corrections system over the past decade that people who become involved in the criminal justice system often have a long history of unmet need in terms of their experience of poverty, childhood abuse or mental health and/or substance

<sup>11</sup> AMC operating philosophy, accessed at: <http://www.cs.act.gov.au/amc/home/ACTCorrectionalCentre>

<sup>12</sup> University of South Australia Forensic and Applied Research Group, *Rehabilitative Strategies for Preventing ReOffending*, 2000(?) Accessed at: [http://www.cs.act.gov.au/\\_data/assets/pdf\\_file/27334/PublicationsLitRevRehab.pdf](http://www.cs.act.gov.au/_data/assets/pdf_file/27334/PublicationsLitRevRehab.pdf)

misuse issues. In 2004 ACTCOSS held a forum on the issues, "Who gets to go to jail", to explore these issues. Attendees explored how people with disorders such as Attention Deficit Disorder, certain intellectual disabilities and those with personality disorders can become caught up in the legal system because of the features of their illness or disorder. These can include poor impulse control, lack of awareness of the feelings of others, poor personal management skills and low anger thresholds.

The forum discussed the fact that women who are imprisoned are more likely to have been the victim of childhood abuse. Much of their offending behaviour stems from drug and substance dependence, which have developed as a response to trauma. Such offending behaviour and its underlying causes are best treated in a community setting.

Comments from health practitioners in the corrections system indicate that 90% or more of people who are detained have a degree of post-traumatic stress disorder from childhood abuse. It is accepted that most drug users in the community are canny enough not to get caught, so the people who do get caught tend to have had a chaotic life and a traumatic background.

The health implications of these "social determinants of offending" are that many of these people also lack the resources and skill sets needed to maintain good physical and mental health. An example was given by Dr Matthews in the aforementioned Parliamentary Committee appearance when he showed the Committee a slide of the mouth of a young woman who was a heroin addict. The woman required full extraction of all remaining teeth and replacement with dentures. Dr Matthews noted that asking that patient to give up her analgesic of choice, heroin, was nonsensical, given the condition of her dental health. Dental care is costly, both in monetary terms and in terms of the person's personal capacity to deal with pain and stress. A Canadian study<sup>13</sup> also found that a higher than expected number of inmates had significant hearing loss when compared to the general population. In a corrections context, any health plan will need to be able to begin to address a higher level of impairment, illness and neglect of health, while assisting the person to services and therapies that will help them to manage their health into the future.

Health practitioners must work to address long term health neglect, health impacts of chaotic lifestyles, as well as the impacts of incarceration. All of these must be addressed to achieve the goal of improved health outcomes and achievement of a community standard of good health.

#### **PERSONAL MEDICAL CARE OF THOSE IN DETENTION**

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One of the major threats to the continuance or development of good health is the lack of honest and open exchanges between patient and

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<sup>13</sup> Corrections Service of Canada, [http://www.csc-scc.gc.ca/text/pblct/forum/e062/e062e\\_e.shtml](http://www.csc-scc.gc.ca/text/pblct/forum/e062/e062e_e.shtml)

medical practitioner. Ex-prisoners and service providers report that inmates are reluctant to open up and be vulnerable in a system where they fear brutalisation. The AMC must engender a sense of security, privacy and trust between the medical practitioners and the inmates, supported by staff who are non-judgemental. Some of the aspects of personal medical care that ACTCOSS wishes to see given particular emphasis include (but not exclusively):

- ❖ Holistic services that aim for a *state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*, which is adequately funded to make up for the inequalities of health experienced by remandees and inmates;
- ❖ Gender balance in the medical team;
- ❖ Choice of doctors, particularly for women inmates;
- ❖ Specific health facilities recognising the privacy needs of remandees;
- ❖ Independent health practitioners;
- ❖ Removal of blockages to allow 24 hours per day, undelayed access to medical staff, including mental health workers and practitioners;
- ❖ Medical treatment as a right, with no "gatekeeper" role for custodial staff;
- ❖ Confidential records with restricted access;
- ❖ Voluntary HIV/AIDS testing and strict confidentiality on status;
- ❖ Health screening on day of admission;
- ❖ An accessible and confidential methadone program from intake, including additional health and dental screening to ameliorate the adverse health effects of methadone;
- ❖ Measures to keep remandees "comfortable" while awaiting methadone that do not compromise their ability to pursue their court case;
- ❖ An accessible and confidential amphetamine withdrawal program;
- ❖ Accessible and confidential programs for alcohol and benzodiazepine dependence;
- ❖ Exploration and adoption of a wide variety of available drug substitution programs;
- ❖ Adequate pain management programs and access to pain relief medication;
- ❖ Access to health complaints mechanisms;
- ❖ Drug and alcohol workers employed as part of the independent medical team;
- ❖ Specific Indigenous Health Services;
- ❖ Access to an on-site pharmacy;
- ❖ Accessible and confidential needle exchange program;
- ❖ Wide-ranging wellbeing and general health courses and skills building for both inmates and AMC staff;
- ❖ Training for AMC custodial staff on public health issues and developing trust;
- ❖ Access to community based health and wellbeing services; and

- ❖ Good support services that minimise uncertainty and fear, particularly in relation to pre-release issues such as securing accommodation, transitioning to community based therapies, gaining employment and income support.

## **PREVENTATIVE HEALTH CARE**

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ACTCOSS sees this as being the primary area for expression of the WHO definition of health:

*“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”*

The range of responsibility for the Corrections Health Service should extend beyond the acute medical care of inmates. Many elements of the physical structure and regime of the prison have the potential to impinge on their health. The AMA position statement on health care of prisoners and detainees notes the detrimental impact of prison environmental factors on the physical health:

*“The physical environment of correctional facilities influences the health of prisoners and detainees. . . . The provision of health care is potentially constrained due to the physical and social environment of correctional facilities. Prisoners and detainees may face particular health problems, both pre-existing and associated with incarceration, such as exposure to blood-borne and sexually transmitted infections, inadequate provision of a broad range of harm-minimisation measures, and lack of access to health education programs” (para. 1).*

In addition to the physical environment, the prison culture also affects the way that services are delivered. As several services pointed out at a recent ACTCOSS forum on the prison, there are many covert practices within prisons. Using needles, tattooing, body piercing, drug taking: custodial officers could detail many more activities that are expressions of inmates boredom, defiance, need or way of coping with incarceration. Covert activities, however, are risky activities within an institutional setting, as discovery often means increased punishment. Sometimes these behaviours and their resulting effects may be hidden for fear of retribution.

ACTCOSS believes that the AMC has the opportunity to remove many of these covert activities; however any analysis of behaviour will show that some people will continue to try and change their situation by covert means. The Health Plan must aim to eradicate as many of these behaviours through good, open, health-oriented programs (including new drug and alcohol programs), or by allowing such things as professional

tattoo artists to attend the prison for tattooing and body piercing. There is also a role for the Health Plan to mesh with any skills development, education and activity programs to ensure that inmates feel engaged and productive.

Such links also assist in addressing the mental health needs of inmates. The Royal Commission into Aboriginal Deaths in Custody noted evidence that:

*In addition, the environment of the prison can contribute to a high demand for health services. Boredom, frustration and powerlessness may lead to psychosomatic illness. The closed nature of imprisonment and the violent nature of many prisoners can also contribute to a high incidence of trauma. (RCIADIC §24.4.4)*

Dr Paul Mullen, Clinical Director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University describes in even more detail the generally non-therapeutic prison environment:

*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 [construed] 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. (Mullen 2001, 36)*

It will, therefore, be an enormous challenge for the AMC to break the standard prison mould. This will be possible only if prison health authorities are given a clear mandate to be involved in the framing and running of the prison regime and substantial resources to implement what is required.

The environmental factors for which the prison health authorities should have joint responsibility with the custodial authorities need to include, but also extend beyond those listed in the UN Standard Minimum Rules for the Treatment of Prisoners:

- (a) *The quantity, quality, preparation and service of food;*
- (b) *The hygiene and cleanliness of the institution and the prisoners;*
- (c) *The sanitation, heating, lighting and ventilation of the institution;*
- (d) *The suitability and cleanliness of the prisoners' clothing and bedding;*
- (e) *The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities (§26(1)).*

Of even more importance is the implementation of measures of harm minimisation identified in the AMA position statement on health care of prisoners and detainees:

*9.1 Many prisoners and detainees have used injectable drugs. Imprisonment can increase drug use and the risks of transmission of blood-borne and sexually transmitted infections. Harm-reduction programmes are important in the prevention of the spread of HIV and Hepatitis C among injecting drug users.*

*9.2 Imprisonment increases the risks of sexual and physical assault. Adequate resources should be provided for preventing sexual and physical assaults from occurring in prisons. Appropriate counselling should be provided for those who have been sexually and physically assaulted in prison.*

*9.3 In order to protect staff, prisoners, detainees and the public, appropriate arrangements for access to needle and syringe exchange programs, sterilising equipment for tattooing and skin piercing, provision of methadone maintenance therapy, specific education about HIV, Hepatitis C and other blood-borne and sexually transmitted infections, and access to condoms should be available.*

*9.4 Health care should be provided for all prisoners and detainees known to have a blood-borne or sexually transmitted infection. With the prisoner or detainee's consent, effective community follow-up should be organised prior to their release.*

*9.5 Critical incident monitoring and review is vital to any harm-minimisation program. In particular, rape, suicide, assault and illicit substance use should be monitored. The results of such monitoring should be regularly reviewed by an appropriately constituted group, drawn from both health and corrections authorities.*

*9.6 Non-smoking prisoners and detainees should not be exposed to environmental tobacco smoke.*

Services within the ACT and former inmates have also identified such measures as women inmates having access to adequate supplies of sanitary products. There should also be adequate provision of razor blades and toothbrushes to ensure these items are not being shared.

## **INDIGENOUS HEALTH**

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There is a need for specialist services to address Indigenous health in the corrections system. Nationally, Indigenous incarceration rates are 15

times those of non-indigenous Australians<sup>14</sup> and while the ACT rate is slightly lower than the national figure, this over-representation is of grave concern to the community. Given the widespread recognition of the comparatively poor health outcomes of Indigenous communities within the ACT<sup>15</sup>, Indigenous inmates will pose significant challenges to the Corrections Health Plan. As stated at the start of this paper, evidence of access will be taken as being the equality of outcomes, which must be achievable. ACT Health has a role in ensuring that adequate numbers of Indigenous health providers are accessible for the AMC, to ensure that culturally appropriate health services are delivered.

## **WOMEN AND PRISONS**

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ACTCOSS believes that the weight of evidence is against the incarceration of women. Our Prison policy states that:

ACTCOSS continues to point to best practice models which support a residential and separate facility to a men's facility, where women's ongoing roles as carers can be maintained, and women are able to access appropriate supports and services. We reiterate that, particularly for women, custodial sentences must be only used as the option of last resort and every effort must be made for placement in community-based programs before considering a custodial sentence.

ACTCOSS believes attention must be given to the causal factors behind women's offending behaviours. Whether a woman is in the AMC for remand or for a custodial sentence, there needs to be specific health programs that meet their needs, as are provided in the general community. ACTCOSS also believes that the specific needs of women for sexual health and family planning services must be met.

An associated practice that will raise issues for health professionals, particularly in the mental health field, is the continued use of strip and body cavity searches. Such procedures are seen by women as a form of sexual assault which can trigger a wide range of responses in a cohort that has such a high level of assault victims among its members. It appears that the reasons given for strip searches, to prevent the smuggling of contraband into the prison setting, are not supported by evidence that would support their continued use. There is some evidence that women will refuse visits by family members and friends if strip searches are conducted as part of the pre- or post-visit routine<sup>16</sup>. This has

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<sup>14</sup> Australian Bureau of Statistics Year Book 2004, accessed at: <http://www.abs.gov.au/Ausstats/abs%40.nsf/94713ad445ff1425ca25682000192af2/11d3d2aeb026b334ca256dea00053a79!OpenDocument>

<sup>15</sup> ACT Government Health Action Plan, Priority areas for action: <http://www.health.act.gov.au/c/health?a=da&did=10020918&pid=1054015570#628044165>

<sup>16</sup> Sisters Inside evidence to Parliamentary inquiry into the practice: reported at: <http://www.spr.org/en/news/2004/0127-1.html> Sisters Inside are also quoted as saying that of nearly 42,000 strip searches over a three year period, only two searches yielded "significant contraband".

an impact on the mental health of inmates, and adversely affects their long term relationships with their children.

There is provision within the AMC for women to keep their young children with them within the complex. This is not the ideal, as expressed in our policy, and we believe these women should be accommodated within the community. If women within AMC have children with them, it goes without saying that there needs to be specific paediatric services available and that the children also have immediate access to medical services, 24 hours per day.

## **SEXUAL HEALTH**

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ACTCOSS is pleased that the brief for the AMC includes the idea of personal private visits, which would provide opportunities for sexual contact between inmates and their partners. Sexual contact with a partner can assist in continuing relationships that assist offenders to integrate into the community post-release. It is anticipated that relationships will be widely defined to allow same-sex partners equal access.

Permitting personal private visits is also a vital primary and public health measure to combat blood borne diseases among male inmates who might otherwise participate in risky sexual practices with a variety of male partners.

ACTCOSS suggests the following be taken into account when considering protocols for personal private visits:

- ❖ That the visit is not a form of reward or control, and that the visits be confirmed as a normal part of prisoner activity;
- ❖ That guidelines for personal private visits be clearly written and circumstances defined so that inmates are aware of their rights;
- ❖ That partners and inmates are provided with counselling from an independent agency on the meaning of personal private visits, and their rights with regard to these visits;
- ❖ That adequate safety measures be put in place to protect visitors and inmates from coercion and personal injury;
- ❖ That AMC staff have adequate education and training to ensure that these visits are handled confidentially and with respect for the inmate and their partner;
- ❖ That inmates with no identifiable "partner" are provided with counselling and alternatives, including the opportunity to discuss engaging sex workers.

The general age cohort of prison inmates makes it imperative that the AMC address the widest interpretation of sexual practice through education and information for both remandees and sentenced prisoners. ACTCOSS believes that the Corrections Health Plan has a role in supporting safe sexual practices between consenting adults and masturbation.

There is an additional need for programs to deter sexual predators, given the adverse effects of their sexual offences on both perpetrator and victim. While sexual predation may be more about power than close personal contact, the AMC must be prepared to deal with both victims and perpetrators to deter and minimise such behaviour through appropriate and adequate counselling and therapy.

The AMC Health Plan must emphasise, again, that health interventions are confidential and that medical staff are empathetic and non-judgemental. It is important that inmates who have sexual health problems or issues feel that they can discuss these freely and without prejudice. While levels of trust need to be developed to achieve the goal of frank and honest exchange between medical practitioner and patient, neglect of this important aspect of health care risks leaving serious gaps in the information required for informed diagnosis and protection of public health.

#### **SEXUAL ORIENTATION**

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The Corrections Health Plan needs to address the fact that inmates may identify as lesbian, gay, transsexual, bisexual or intersex (GLTBI). In addition there is a cohort of men who have sex with men, but who don't identify as homosexual.

Optimally it would be good practice to provide community-based practitioners whose medical practice with specialist knowledge to be available both for patient consultation and staff skills development. However, regardless of the availability of community-based services, it is imperative that all AMC medical staff are discreet, non-judgemental and sympathetic when dealing with inmates. They must also understand the physical and mental health issues of incarceration for people who are lesbian, gay, transsexual, bisexual or intersex, as well as those men who have sex with men while in prison.

#### **REMAND VERSES SENTENCED PRISONERS**

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International standards require that those remanded in custody pending trial or sentencing should be accommodated separately from those who are sentenced.

People entering into the corrections system on remand are particularly vulnerable to stress-related illness and mental health breakdown. While these people may only be in the AMC facility for a matter of days, they have a higher propensity for self-harm in those few days than most sentenced prisoners. There is also the reality that many remandees are suffering withdrawal from poly-drug use.

Remandees may not reveal substance misuse, needle sharing or other health risk factors because of their concern for the progress of their court case, so getting clear, correct information on their health status can be difficult. It is also impossible to commence some forms of medical treatment as the remandee is focussed on other outcomes. In this context, assurance of confidentiality is vital. This requires an independent prison medical service with drug and alcohol workers responsible to it. Establishing contact with the remandees' community-based health services (where these exist) is one way to ensure that correct information is available to support good health decisions.

## CURRENT ACT PRACTICE

ACTCOSS believes that the current practices in Corrections Health that must be protected and amplified include:

- The independent status of current health practitioners;
- The philosophy that inmates are entitled to the same medical care as other members of the community;
- That health services are delivered as a right, not a privilege;
- That medical treatment is not manipulated as a punishment;
- That the records of current inmates in the Belconnen Remand Centre are confidential and access is restricted;
- That HIV/AIDS status is confidential and testing is voluntary;
- Health screening on day of admission;
- Specific health facilities recognising the privacy needs of remandees;
- Choice of doctors, particularly for women inmates;
- Relatively good relationships between custodial staff and remandees;
- The weekly review meetings to inform staff and keep them in touch with concerns/issues for inmates health;
- Methadone program;
- Some withdrawal programs for alcohol and benzodiazepines; and
- Access to health complaints mechanisms.

ACTCOSS does, however, have concerns that some practices do not reflect a human rights approach to incarceration, such as:

- The employment of drug and alcohol workers as Corrections staff, not as part of the independent medical team;
- The lack of Medicare rebates for prisoner health – ACTCOSS is aware this is not the choice of the ACT, but is an area for national lobbying;
- Lack of an Indigenous Health Service, although we understand Indigenous service providers are having input into the Government's plans for delivery of services to Indigenous inmates of the AMC;
- Potential for delays in screening remandees on intake due to the lack of a full-time, on-site GP;
- Lack of an on-site pharmacy;
- On call status of mental health professionals – given the recognised high prevalence of mental health problems and risks in the remand population, this area is under-resourced;
- Delay in providing methadone programs for remandees who are not on a program on intake;

- Measures to keep remandees “comfortable” while awaiting methadone must not compromise their ability to pursue their court case (denial of human rights);
- Lack of alternative drug substitution programs;
- No amphetamine withdrawal program;
- Lack of a medically supervised needle exchange program;
- The existence of an illegal, unhealthy needle exchange scheme that sets a premium on used needles and syringes;
- Limits on wellbeing and general health courses and skills building;
- Lack of connection between community based services and inmate population;
- Lack of policy-making role for the Correction’s Health Board;
- Wide variety of wellbeing courses to develop living skills and cognitive development.

## PRACTICES IN OTHER JURISDICTIONS

### NEW SOUTH WALES

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It is appropriate to look across the border, given that the New South Wales system currently houses ACT sentenced prisoners.

In Government owned and run prisons, health services are provided by a statutory health service, Justice Health, which covers both adult and juvenile institutions. In private prisons, such as Junee, the companies that run the prison provide the health services.<sup>17</sup>

Justice Health is subject to a Board which “comprises twelve members appointed by the NSW Minister for Health. Two Board members are nominated by the Department of Corrective Services, one by NSW Health and one by the Department of Juvenile Justice. One Board member is elected from the staff of CHS. The Board is responsible for the corporate governance practices of the Service” (Annual Report, 2003-04). The CEO of Justice Health, who is a doctor, has a statutory responsibility for maintaining statistical records of health services to inmates. A Centre for Health Research in Criminal Justice is one of the programs of the Justice Health which has published surveys on issues such as mental health and blood borne viruses.

### UNITED KINGDOM

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In the UK, Prison Health was created in 2002<sup>18</sup> as a partnership between the Prison Service and the Department of Health. Budgetary responsibility for health services for inmates was transferred from the Prison Service to Health, and the prisoner population was linked into the National Health Service through the use of Primary Care Trusts (PCTs) located near the individual prisons.

Responsibility for health services in prison falls jointly on the heads of the Prison Service and the Department of Health. The service includes regular monitoring of prisoner health (“traffic light” reports), participation in the collection of health care statistics, oversight by a Chief Inspector of Prisons, a standards audit unit and has a program of clinical governance.

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<sup>17</sup> See the GEO Group Australia website: <http://www.thegeogroupinc.com.au/health.htm>

<sup>18</sup> Web page for Prison Health:

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/fs/en>

Includes history.

*“An admirable feature of the [British] Prison Service, is that it now conducts a range of audits both internal and external) on the operations of prisons, including the health care. The health services in prison are sometimes internally audited by a health services team that on short notice is able to review a sample of medical records, interview staff and provide inmates with a questionnaire. Suggestions of improvements to the service are also sought by the review team. There is also the Inspectorate of Prisons that is able to conduct reviews at any time within a prison to ascertain the quality of service delivery and compliance with policy and procedure in all areas of prison operation, including health care. These audits are an important tool in maintaining minimum standards within the prison service” (Vumbaca, 17-18).*

## **NEEDLE AND SYRINGE EXCHANGES**

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ACTCOSS is very keen for the AMC to trial a needle and syringe program (NSP). Despite the opposition shown by custodial staff and Corrections Ministers across Australia, ACTCOSS believes international experience will provide a way to engage these groups in the debate about harm minimisation and corrections settings.

One major breakthrough came in January 2005, with police in Britain adopting an NSP as an occupational health and safety measure for their members. The Lothian and Borders Deputy Chief Constable, Malcolm Dickson put it this way<sup>19</sup>:

*'People coming into our custody are not permitted to take illegal drugs. This is a welfare-centered approach. As a service, we accept that drug users adopt a lifestyle that most members of the public would not necessarily choose. What we are trying to do here is raise the users's awareness of the dangers associated with that lifestyle, offer them help referral help and support and go some way towards protecting them and others from the very real threat posed by used needles.'*

Canada's HIV/AIDS Legal Network has also reviewed the issues involved, with a comprehensive review of the international evidence on NSP<sup>20</sup>. ACTCOSS will comment further on the need for an NSP in the AMC in the next section on a human rights framework for the ACT's corrections complex.

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<sup>19</sup> Needle Exchange Scheme, Lothian And Borders Police: New Initiative To Reduce Health Risks To Police Staff And Reduce Harm To Drug Users . Accessed At: [http://www.lbp.police.uk/press\\_release/articles/2005%5cjanuary%5c14%5c2.htm](http://www.lbp.police.uk/press_release/articles/2005%5cjanuary%5c14%5c2.htm)

<sup>20</sup> Canadian HIV/AIDS Legal Network, “Prison Needle Exchange: Lessons learnt from a Comprehensive Review of Evidence and Experience”, 2004. Accessed at: <http://www.aidslaw.ca/Maincontent/issues/prisons/pnep/PNEP-report.pdf>

ACTCOSS believes that there need to be a range of services and approaches in a human-rights focussed corrections systems. The overriding principle must be that people are not deprived of liberty where there can be alternatives, such as restorative justice options, community-based sentences and remedial programs that address offending behaviours. It is also paramount that incarceration is seen as unsuitable for people with mental health problems.

ACTCOSS will continue to lobby for increased community-based alternatives to a prison, but believes that where courts choose a custodial sentence, the following principles are fundamental for any prison that operates under the ACT's human rights regime.

In terms of governance, the prison health services must:

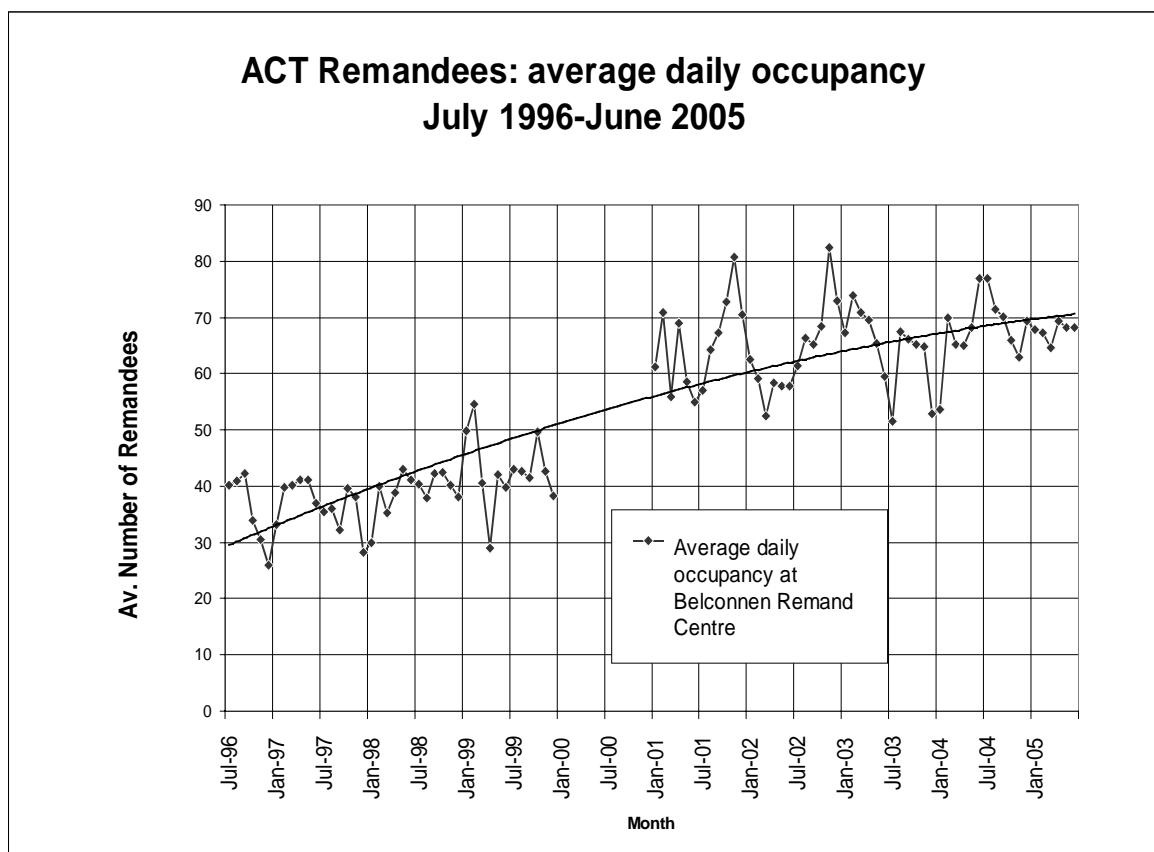
- Be independent, with a clear legislative mandate to support improved health of inmates;
- Have responsibility for:
  - (a) personal medical care of those in detention;
  - (b) advice on preventative health and, in conjunction with corrective services, for those aspects of the prison regime that impinge on the health of inmates;
  - (c) advice on programs addressing the social determinants of health.
- Demonstrate that Ministerial responsibility falls with the Minister of Health with all disputes over health programs going to Cabinet;
- Employ drug and alcohol workers answerable to the health and not the corrective service;
- Ensure the confidentiality of health treatments, including drug and alcohol, mental health and sexually-transmitted disease treatments;
- Have an independent audit and appraisal process;
- Provide high quality dental health care;
- Incorporate needle exchange programs;
- Provide for personal private visits and support safe sexual practices;
- Develop skills in both remand and sentenced prisoner populations on health issues, including exercise, nutrition, and stress management;
- Provide good ancillary services, such as physiotherapy, chiropractic and podiatry;

- Implement a holistic through care model that includes medical practitioners from the community, allowing inmates' medical practitioners to continue care for ongoing conditions;
- Provide a stable workforce and continuity of programs;
- Ensure custodial staff are well-trained to recognise mental health problems and who have a role in health promotion and exemplification;
- Work in support of social determinants of health – social connectedness, occupation, role in society;
- Connect to employment/skills development programs that connect the inmate to the community;
- Encourage the involvement of the community sector to provide support for programs in the prison and post-release;
- Connect to integrated post-release services, including accommodation options and support to find employment/training.

This check-list is not exhaustive, however ACTCOSS is encouraged by the research and publications that the AMC website contains on the importance of services within the new complex. We will be actively involved in the future debates on the need for a human rights focus within the AMC and any other corrections facilities run by the ACT Government.

## DEFENSIBLE SPENDING ON CORRECTIONS

The costs of implementing the current criminal justice system are growing steadily. The following chart shows that the number of people detained on remand in the ACT has grown by 133% over the past 10 years. It is vital for the wellbeing of the community that this trend be reversed.



	<b>TOTAL COST</b>		<b>GOVERNMENT PAYMENT FOR OUTPUTS</b>	
	<b>2004-05 EST. OUTCOME \$'000</b>	<b>2005-06 BUDGET \$'000</b>	<b>2004-05 EST. OUTCOME \$'000</b>	<b>2005-06 BUDGET \$'000</b>
OUTPUT CLASS 2				
CORRECTIVE SERVICES	30 505	30 778	29 546	29 904
OUTPUT 2.1 CORRECTIVE SERVICES	30 505	30 778	29 546	29 904

### *Output classes.*

*Provision of services and advice to the courts and releasing authorities about offenders and the management of community based sentences, custodial sentences, parole orders and parole applications and the construction of the new ACT prison.*

*Corrective Services will provide for:*

- *an average of 70 remandees at any one time;*
- *an average of 125 prisoners at any one time;*
- *an average of 25 periodic detainees at any one time; and*
- *16,000 community service work hours.*

*(Department of Justice and Community Safety  
2005-06 Budget Paper No. 4, p.340)*

JACS total budget for 2005-06 was \$104 million. The total ACT budget is \$2.7 billion (\$2,716 million). Currently the cost of imprisonment of ACT prisoners in New South Wales gaols is around \$9 million per year. ACTCOSS does not believe that there are many opportunities in the short term to reduce this expenditure, and that the rationale for the prison can never be any form of budgetary saving. Assisting people with high needs is expensive, and cheap solutions produce flawed outcomes.

ACTCOSS would like to see the ACT Government take a lead roll in the national debates on law and order issues by budgeting for, and delivering the promised programs and prison that is outlined in the plans and documents on the AMC website. While corrections appear a high cost budget item, insufficient is spent in terms of services delivered to individuals to assist them to integrate into the community and to prevent their re-offending. ACTCOSS therefore believes that a defence of corrections spending needs to be undertaken, with the Government pointing out the obvious deficiencies of the current transportation of prisoners across the Territory's borders.

The ACT community, like many others, appears to believe that the withdrawal of a person's freedom by the court is just the start of the punishments meted out by a custodial sentence. There is also a widespread belief that imprisoning people has beneficial effects in terms of public safety. ACTCOSS believes part of the Government's role is to ensure that the community understands the benefits to public safety of humane, human rights-based programs that support the prisoner and their dependents. This includes health services that significantly improve the health of inmates over the time of their sentence. We welcome the inclusion of the following measure in the 2005-06 budget for the Department of Justice and Community Safety:

***Adequate offender programs and services targeting offender behaviour*** – *the percentage and the number of sampled offender case plans where the case plan goals are achieved. This indicator measures whether the justice system is responding to the causes of individual offending and impacting upon those causal factors. This is a new measure for which it is not possible to establish a realistic target for 2005-06. The objective of establishing the measure is to monitor trends over time and to continuously improve the responsiveness of the system. (JACE, Vol4, p. 344)*

ACTCOSS looks forward to the first data compiled to report against this goal. That data will prove useful in broadening community understanding of what doesn't work: low cost programs that don't provide long term health benefits and programs that are run for a short time and then cease. The ACT community will be given interpretations of the prison environment as "motel" like or palatial by opponents: the Government needs to educate the community on what it sees as the value of prison sentences and their role in rehabilitation. Again, there is a need to promote the point of view that an angry, humiliated person in poor health is not the stated intent of sentencing, and that to spend more on programs is to provide the best outcomes in terms of community safety and public health. Both the Health Minister and the Attorney General have a role in being the defenders and champions of the prison and its programs.

There are emerging data on the outcomes from alternatives to custodial sentences that show recidivism can be cut down by some programs. The reductions are modest, but significant. ACTCOSS believes that the ACT Government and the courts are obliged to disseminate and debate these issues with the community, on whose behalf they act.

Finally, there also needs to be recognition that some people will fail and re-offend, despite a human rights framework, increased access to services and improved health programs. Change will happen slowly and lifetime habits and coping mechanisms cannot be overcome with improved health services and some education. The Government must resist future calls for a reduction in services, as this would be a denial of the human rights of those people incarcerated in the AMC. Instead, ACTCOSS believes that greater community-building, social welfare and support for people experiencing mental health or drug and alcohol problems is the only way to reduce the long-term costs of corrections in the ACT.

# ACTCOSS POLICY PLATFORM ON A PRISON FOR THE ACT

## PREAMBLE

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### A HUMAN RIGHTS FOCUS

ACTCOSS strongly advocates that the development of a prison for the ACT accepts as a principle that prisoners are entitled to recognition of their human rights under all international human rights instruments. We draw particular attention to the specific rights outlined by the Government in introducing the ACT Human Rights Act 2004 (the Act). Drawing on the preamble of the Act, ACTCOSS maintains:

“Human rights are necessary for individuals to live lives of dignity and value.”

Custodial sentencing imposes a restriction on the liberty and movement of offenders, it does not remove their other human rights. Prisoners have the right to dignity and recognition of their inherent value as people. Practices within the prison must have this as an underlining principle.

“Respecting, protecting and promoting the rights of individuals improves the welfare of the whole community.”

ACTCOSS believes this is a cornerstone of civil society. In a direct way, providing supports and services that address the issues which may have contributed to an individual's contact with the corrections system meets that obligation. The strong evidence regarding the high level of negative health outcomes, mental health issues, suicidal behaviour, substance abuse, violence and sexual abuse that has been experienced by those in custodial facilities must be responded to, to provide them an opportunity of rehabilitation and reintegration into the community at the conclusion of their custodial sentence.

“Setting out these human rights also makes it easier for them to be taken into consideration in the development and interpretation of legislation.”

Clear legislative frameworks and transparency around the implementation of these frameworks is essential to ensuring an appropriately managed prison that complies with the Human Rights Act. Accountability and transparency of policies and practices is vital, and objective scrutiny of these needs to be built into the process.

“This Act encourages individuals to see themselves, and each other, as the holders of rights, and as responsible for upholding the human rights of others.”

The administrators and service providers within the ACT prison have an obligation to ensure that the rights of prisoners are recognised and protected. There is also an obligation to ensure that inmates understand their rights and have access to the remedies that will be offered to other community members who feel their rights have been infringed.

“Few rights are absolute. Human rights may be subject only to the reasonable limits in law that can be demonstrably justified in a free and democratic society. One individual's rights may also need to be weighed against another individual's rights.”

The rights and needs of particular cohorts within the community must be recognised and responded to. In looking at the issues for women facing custodial sentences, there is the need to draw on best practice, and the use of residential and separate facilities that

appropriately respond to the needs of women, and ensure that they don't become even more marginalised even within the prison population.

“Although human rights belong to all individuals, they have special significance for Indigenous people—the first owners of this land, members of its most enduring cultures, and individuals for whom the issue of rights protection has great and continuing importance.”

The particular rights, as well as the challenges and barriers facing our Indigenous community must be recognised in the planning and establishment of a prison. The cultural issues and the additional risks need to be explicitly addressed in the design, establishment and operation of any correctional facility within the ACT.

ACTCOSS believes that early intervention, diversion and non-custodial sentencing should be the cornerstones of corrections policy. ACTCOSS strongly supports innovative models which utilise concepts such as restorative justice and the like as a way of providing options that do not include custodial sentences. ACTCOSS supports a policy where custodial sentences are seen as a last resort.

This is in recognition of the fact that custodial sentences have failed as a method of rehabilitation. ACTCOSS notes, however, that most often custodial sentences are imposed to meet a community demand for punishment of crime.

ACTCOSS recognises that the number of prisoners sentenced from ACT jails into NSW facilities has continued to increase over the past decade. Therefore, ACTCOSS believes that there is a strong case to support the need for a prison in the ACT to address:

- The primary concern, which is to ensure that prisoners are able to maintain links with family and community (particularly noting the needs of children with parents in custody);
- The desire for the ACT to control the outcomes for people in prison;
- The desirability of ACT community organisations to be able to provide services to prisoners and their families in a holistic and restorative way;
- To better integrate corrections services into the wide suite of rehabilitative and restorative practices; and
- The financial drain on the ACT economy of continuing to send prisoners across the border to New South Wales.

ACTCOSS believes that the following are vital in the development of a new prison in the ACT:

- That the whole suite of human rights instruments that are applied to the community are applied to the residents of any corrections facility;
- The prison is complemented by the development of best practice, community-based, restorative, holistic sentencing models;
- There is transparency of contractual arrangements involving public funds and rigour and efficacy in the regulatory regime of the corrections service;
- There is transparency and accountability around practices within the prison (eg introducing independent official visitors that are reflective of the population);
- That there is the provision of specific programs that address the needs of prisoners (including medical intervention, response to drug and alcohol issues, suicide prevention and response where there are issues of violence and abuse);
- That the specific needs of vulnerable groups of prisoners are responded to, including the needs of women prisoners, people with intellectual disabilities, Indigenous prisoners and prisoners from culturally and linguistically diverse groups;
- There is the development of new and emerging corrective services functions; and
- There is a focus on the advocacy of the rights, needs and interests of prisoners and their significant others, including the involvement of prisoners and ex-prisoners in management and oversight

In relation to a women's prison, ACTCOSS continues to point to best practice models which support a residential and separate facility to a men's facility, where women's ongoing roles as carers can be maintained, and women are able to access appropriate supports and services. We reiterate that, particularly for women, custodial sentences

must be only used as the option of last resort and every effort must be made for placement in community-based programs before considering a custodial sentence.

ACTCOSS will continue to support informed community debate and input into the discussion regarding the development of a prison for the ACT, through support for mechanisms such as the Community Coalition on Corrections and Women in Prisons Group.

**ADOPTED BY THE ACTCOSS GENERAL COMMITTEE APRIL 2006.**

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