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

committed to preventing tragedy that arises from illicit drug use

Web www.ffdlr.org.au

SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY OF THE SENATE LEGAL AND CONSTITUTIONAL AFFAIRS COMMITTEE INTO THE VALUE OF A JUSTICE REINVESTMENT APPROACH TO CRIMINAL JUSTICE IN AUSTRALIA

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INTRODUCTION

Families and Friends for Drug Law Reform are most grateful for the opportunity to provide the committee with a submission, and the indulgence of additional time to prepare it, on the important subject of our present prison system and justice reinvestment.

Justice reinvestment

1. It has become fashionable to speak of justice reinvestment as a good thing. Like any new term that comes into fashion its ingredients should be analysed carefully. One needs to be prepared to acknowledge that while the term may be new, it raises issues that have long been the subject of attention. Crime and its causes are the most obvious ancillary issues: there is no need for a correctional system if there is no crime. The concept of Justice reinvestment thus embodies what has been encompassed by the familiar term of crime prevention. Indeed it should give a fillip to that concept. It would be a much more efficient deployment of scarce community resources if they could be deployed on programs reduced crime to the point of making the exercise of criminal justice unnecessary.

2. Similarly, consideration of Justice reinvestment demands an audit of the effectiveness of existing policies in promoting or reducing crime. Indeed this submission will argue that much public policy in the area of crime and corrections is dysfunctional and promotes the very social harms that it ostensibly seeks to prevent.

3. In short, framing familiar issues in a new way like "justice reinvestment" is useful if it stimulates new ways of looking at familiar problems but we should not expect it to be the proverbial magic bullet. There are unlikely to be any short cuts to bypass the thorny political issues that have prevented progress in solving big social problems. Families and Friends asks that the committee approach with an open mind the difficult issues

raised by its terms of reference and that it commits itself to seek out and apply the best available evidence in framing its recommendations.

4. As Families and Friends for Drug Law Reform understands it, the push for Justice reinvestment arose in the United States where the fiscal pressure on budgets caused public policy makers to question the apparently remorseless expansion of the United States prison system to accommodate the biggest prison population in the world. So costly has it been to develop and run the system that states like California came to be spending more on corrections than on education.

Families and Friends for Drug Law Reform

5. Families and Friends for Drug Law Reform was formed in April 1995 by a group of people in the Australian Capital Territory who had a child, relative or friend who had died from a drug overdose. Its membership now extends across Australia. The grief that all shared turned to frustration and anger that those lives should not have been lost when all would be alive today if drug use and addiction had been treated as a social and medical problem and not a law and order one. The criminal law and how it was enforced contributed to the death of these young Australians.

6. Since then the group has been intent on reducing the tragedy from illicit drugs, reducing marginalisation and shame, raising awareness of the issues surrounding illicit drugs and encouraging the search for and adoption of better drug policies. The increasingly evident links between mental health and substance abuse has led it to make submissions that deal with mental health as well as substance abuse (e.g. FFDLR 2003 & FFDLR 2002). Indeed Families and Friends has come to realise that the tentacles of drugs and drug policy have a large bearing on virtually all of Australia's big social problems.

7. In preparing this submission we have been informed by the experienced gained in the development of the new and first prison in the Australian Capital Territory. Indeed, for 10 years, Families and Friends for Drug Law Reform took a leading role among community organisations in providing input to government for the project through an ACT Community Coalition on Corrections.

8. Families and Friends for Drug Law Reform does not promote the view that currently illicit drugs should be freely available. Indeed it believes that they are too available now in spite of their illegality. Their distribution is in the hands of organised crime deriving wealth from them that can corrupt or influence all levels of society and government. Illicit drugs are an industry beyond the capacity of democratic governments to control. As this submission will explore, experience points to reliance on the criminal law to control their availability being ineffective and, in fact, counterproductive yet intensified reliance upon the processes of the criminal law is at the heart of what Drug Free Australia is calling the Committee to endorse.

This submission

9. The formulation of policy for the reduction or redeployment of funding on corrections demands an understanding of who is in prison and why they are there. The submission commences with an overview of incarceration in Australia in the last century

and the social trends and policies which have had an impact on the imprisonment rate. As the terms of reference of the committee acknowledge, our prisons are typically populated by the disadvantaged: there is a gross overrepresentation of Aboriginal and Torres Strait Islander peoples and people experiencing mental ill-health, cognitive disability and hearing loss.

10. Families and Friends refers to the firmly established explanations of this state of affairs provided by learning on the impact of risk and protective factors on people's lives and of the social determinants of health and well-being championed by Sir Michael Marmont and the World Health Organization internationally and the likes of Prof Fiona Stanley and Prof Ross Homel in Australia.

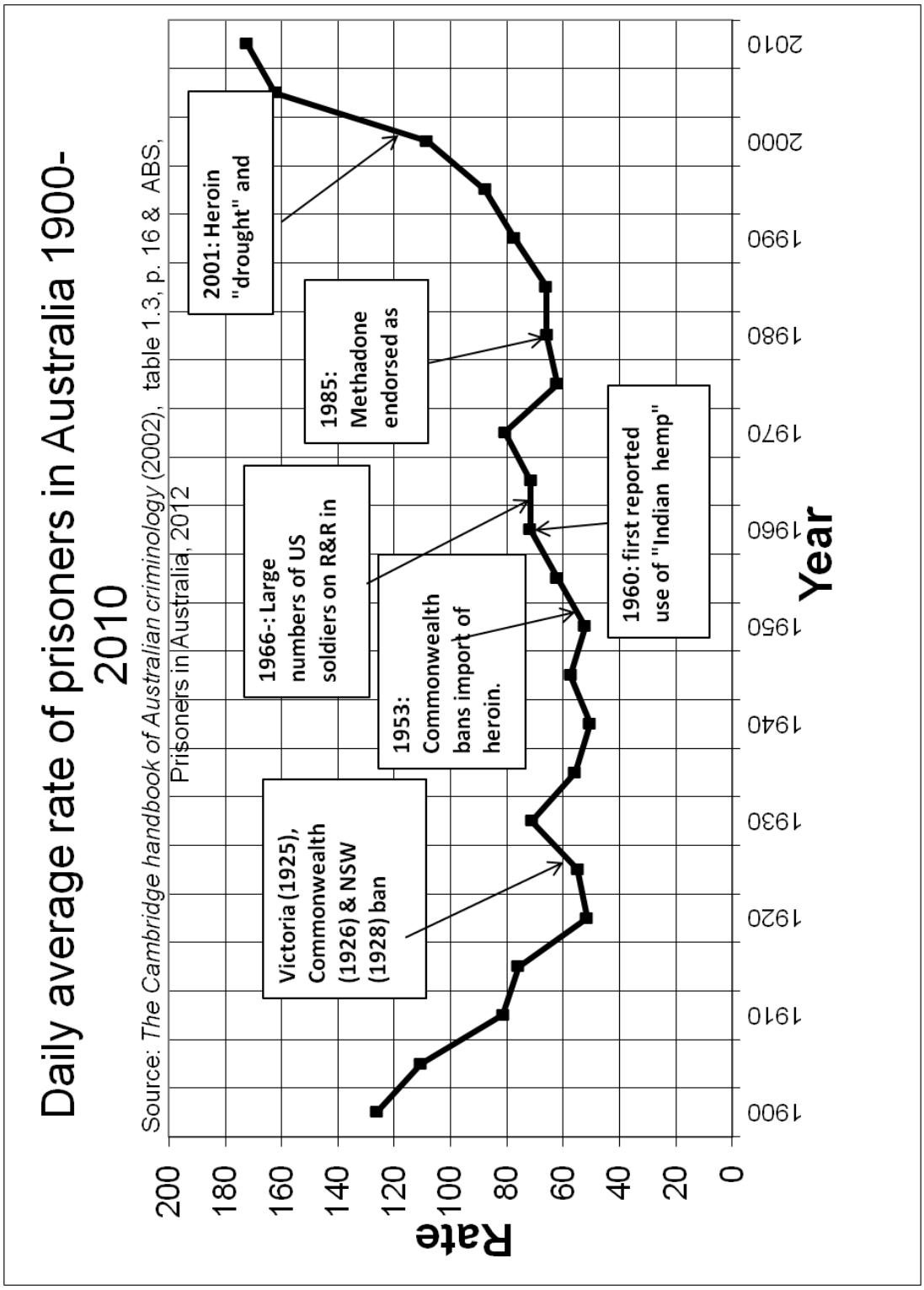
THE DRIVERS BEHIND THE PAST 30 YEARS OF GROWTH IN THE AUSTRALIAN IMPRISONMENT RATE;

THE GROWTH IN IMPRISONMENT

11. For 80 years of the 20th century to the early 90s Australia had an incarceration rate of below 80 prisoners per 100,000 of the population. As the following chart shows the century was book ended by much higher incarceration rates. In 1900 we incarcerated 126.8 Australians for every 100,000 of the population and this incarceration rate was falling and in 2000 the rate was 108.39 and rising sharply.

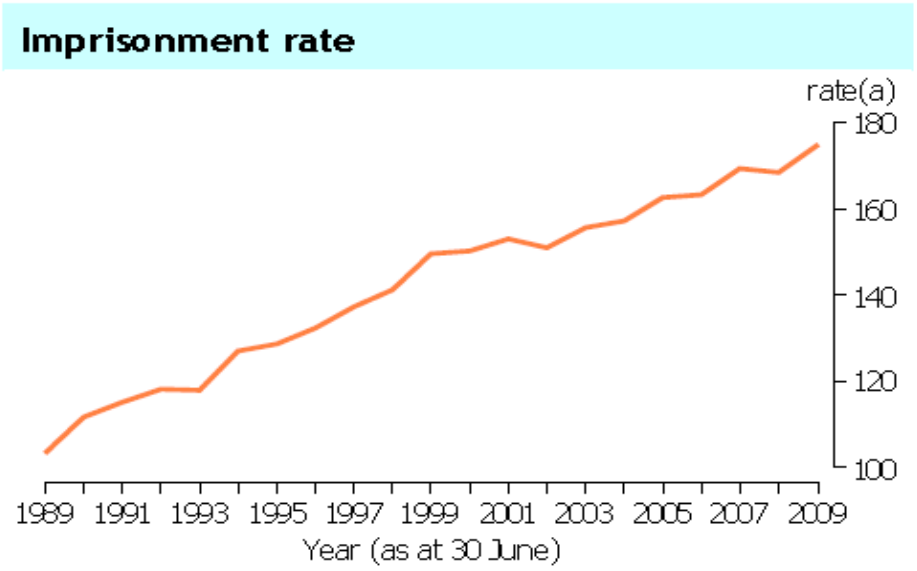
12. The rate of increase may have slackened somewhat in the last few years but prisons remain as huge and costly burden on the government, the people in them, their families and the broader community. According to the latest report on corrective services of the Productivity Commission, in 2011-12, on average, 29,213 people per day were held in Australian prisons – an increase of 1.7 per cent from the 2010-11 (p. 8.5). Nationally, 18.9 per cent of the total prisoner population (excluding periodic detainees) were held in privately operated facilities (Productivity Commission (2013a) p. C.5).

Chart 1: the chart daily average number of prisoners in Australia 1900 – 2010 expressed as a rate per 100,000 of the population



13. In its most recent facts and figures summary of Australian crime, the Institute of criminology remarks that: “Between 1984 and 2005, the overall imprisonment rate increased from 88 to 163 per 100,000 adult population.” (AIC (2006), p. 84). The Bureau of Statistics reckons that an imprisonment rate of 175 adults on 30 June 2009 represents an increase "by round two-thirds" since 1989 (ABS (2010) p. 1). This amounts to an increase of 85% or, as the Institute of ,Criminology puts it, “an average 5% a year since 1984” (ibid). If the Institute of Criminology’s Handbook of Australian criminology is to be believed, the incarceration rate in 1985 was 66.06 per 100,000 rather than 88 (Graycar & Grabosky (2002), table 1.3 p. 16) thus producing an even more alarming surge in imprisonment at the end of the century of 147%. As of 30 June 2012 there were ABS 29,383 people in Australian prisons. This constituted a rate of 167 per 100,000 (ABS (2012)).

Chart 2: Imprisonment rate 1989 – 2009



(a) Prisoners per 100,000 people aged 18 years and over. From 1989 to 1993 rate is for people aged 17 years and over.

Source: Australian Prisoners: results of the National Prison Census, 30 June, issues 1989-1993, Australian Institute of Criminology; Prisoners in Australia, 2004 and 2009 (ABS cat. no. 4517.0)

SOURCE: ABS (2010) p. 1.

14. This surge led to a boom in prison-building because Austyear to the or the ralia had outgrown the capacity which had dated from an earlier boom in prison-building between 1852 and 1880 (Graycar & Grabosky (2002), p. 17).

15. Unlike the trend in recent years when incarceration rates continued to rise while crime rates were falling (AIC (2012)), the tickup in the prison population from the 1970s matched an increase in the crime rate. As a 1990 study pointed out that:

Short-term trends (1973 – 74 to 1986 – 87) indicate that:

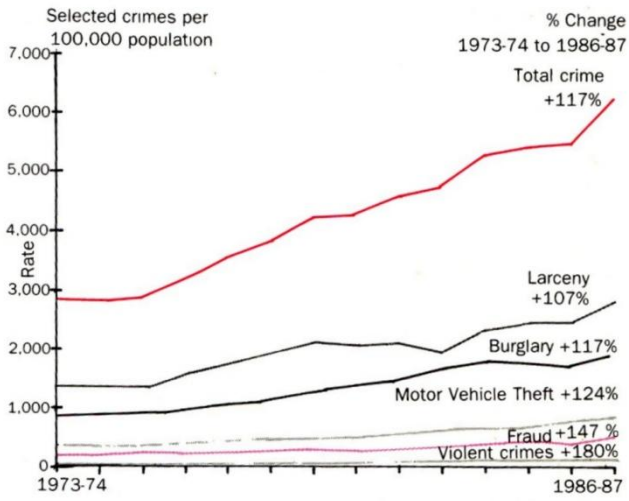
“Total numbers of crimes have increased.

- Per capita rates of crimes reported to police generally show increases….
- Among the violent crimes, serious assaults increased by 236% ,…. And robbery by 78%
- Property crimes, of which stealing accounts the half, increased by 89%". (Mukherjee, Neuhaus & Walker (1990) p.7).

16. A decade later the Institute of Criminology was commenting that crime was still rising: "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" (Makkai (2002) p. 111).). In 2010 Australia was still experiencing "high levels of property crime" (AIC (2012) p. 5.)

Chart 3: Crime statistics 1973 – 74 to 1986 – 87 Total crime, Larceny, Burglary, Motor vehicle theft, Fraud and violent crimes

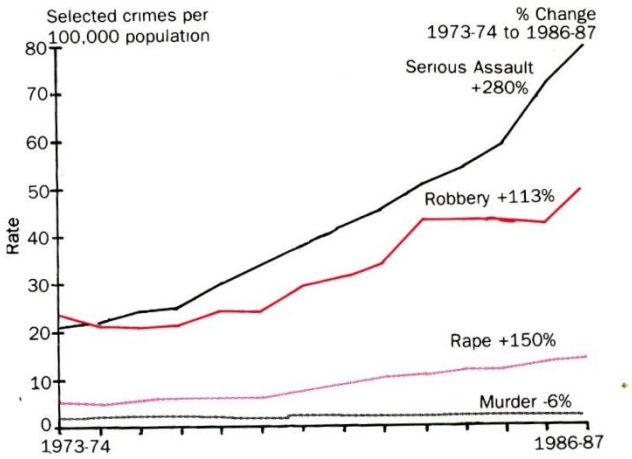
Figure 1.3 **Selected crime statistics show increases in most crimes - 1**



Source: Mukherjee, Neuhaus & Walker (1990) p. 7.

Chart 4: Crime statistics 1973 – 74 to 1986 – 87 on the serious assault, robbery, rape, murder

Figure 1.4 **Selected crime statistics show increases in most crimes - 2**



Source: Police Departments, *Annual Reports*, 1973-74 to 1986-87.

Source: Mukherjee, Neuhaus & Walker (1990) p.7.

17. The correlate of crime associated with high incarceration at the beginning of the twentieth century was not the same as at the end. The *Handbook of Australian Criminology* points out that alcohol predominated at the beginning of the century while the new presence on the block at the end was illicit drugs: “alcohol-related crime was a predominant cause of criminal justice involvement in 1900. Today, while it is substance abuse in general, alcohol remains a major factor in criminal activity” (Graycar & Grabosky (2002), p.9).

18. In the latter part of the 20th century Australia's experienced a surge in the rate of imprisonment and a surge in property crime and assaults coinciding with a growth in illicit drug use. This replicated the experience of other countries in Europe and in North America Kleiman (2009:

> “Drug use and the emergence of public drug-using sites were followed by rapidly rising crime rates in western Europe throughout the 1970s and 1980s. In Switzerland, for example, burglaries and robberies increased by several hundred percent during that period” (Killias, Aebi & Ribeaud (2005) p. 193).

19. As chart 1 shows the rise in the crime rate and the Australian prison population coincided with the growth of illicit drug use. Prohibition of drugs preceded the development of widespread illicit drug use in the 1960s thanks to the counter culture of the time and the presence from the end of that decade of "large numbers of young, alienated United States soldiers on rest and recreational leave from service in the

Vietnam War, who brought with them, attracted, consumed, sold, and gave away considerable quantities of cannabis and heroin" (Manderson (1993) p. 144).

20. The overwhelming majority of people in Australian prisons suffering from a substance abuse disorder are dependent upon an illicit drug possibly in combination also with an alcohol disorder. The detailed 2003 mental health survey by New South Wales Justice Health 63.7% of men and 74.5% of women had a substance use disorder. In the same group some 22% of men and 37% of women suffered from alcohol dependence or alcohol use (Butler & Allnutt (2003) the table 3, p. 14). The 2009 New South Wales inmate health survey suggested that even more inmates were using illicit drugs:

> "The proportion of IHS participants who reported having ever used an illicit drug increased from 71% in 1996 to 81% in 2001, and then increased again slightly to 84% in 2009 (Table 5.6.1). Reported lifetime prevalence of illicit drug use increased steadily among men (from 69% to 80% to 86%), while decreasing slightly among women, from 82% in 1996 to 78% in 2009" (Indig *et al.,* (2010a) p.107).

21. The health survey in 2010 of the new ACT prison revealed that 79% of inmates had been under the influence of alcohol or other drugs at the time of committing the offence that led to their imprisonment, that 67% had ever injected drugs and that 53% were currently on a methadone maintenance program - a pharmacotherapy appropriate for opiates dependent drug users (ACT Health (2011) table 9, p. 11).

22. The findings of the Drug use monitoring program (DUMA) of police detainees which has been undertaken since 1999 at a number of sites around Australia by the Institute of Criminology have been summarised as follows:

> "In its most recent annual report the AIC presented findings that two in every three offenders (66%) detained by the police tested positive to at least one drug, not including alcohol; female detainees were more likely to test positive (73% vs. 65%) and almost half (47%) of those who had been charged with an offence in the preceding 12 months reported having taken drugs at the time of that prior offending. The findings from the DUMA program leave little doubt that substance misuse is more prevalent among offenders than in the general community" (Payne & Gaffney (2012)).

23. The Institute of criminology also confirms the results of the inmate health surveys such as those mentioned above:

> Among incarcerated offenders, the results are much the same. In a survey of adult male prisoners in 2001, the AIC's Drug Use Careers of Offenders (DUCO) study found that 62 percent of adult male prisoners reported being under the influence of alcohol or illegal drugs at the time of the offence that later resulted in their incarceration (Payne & Gaffney (2012)).

SUBSTANCE ABUSE AS A DRIVER OF CRIME

24. A high correlation between substance abuse and crime and incarceration suggests but does not prove a causative link. For European criminologists this link is

demonstrated by the fact that addicted drug users are known to be much more heavily involved in crime than non-users. As Swiss criminologists have put it: “International comparisons suggest that the extent of involvement in property crime among addicts on any kind of hard drug is about 10 times higher than among non-users. Thus, [these criminologists conclude] the increasing crime trends over the past 30 years may reasonably be seen as a side effect of increasing drug use” (Killias, Aebi & Ribeaud (2005) p. 193). In the Australian context the disparity between the prevalence of substance abuse of those in prison compared to the general population points to a similar situation applying here. In evidence before a House Representative Committee, Dr Richard Matthews, Chief Executive Officer of the NSW Corrective Health Service, stated 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% (Matthews (2002)). The same NSW service has reported similar results for young people in custody in New South Wales:

> Use of alcohol and alcohol abuse are common among young people in custody . . . . Many young people participate in binge drinking and experience impaired control of their drinking. Along with alcohol, nearly all young people reported having used illicit drugs. Cannabis is the most common drug used, particularly among Aboriginal young people, followed by ecstasy. Despite the high rates of problems associated with alcohol and other drug use, only a minority reported that they had ever received treatment (Indig *et al.*, (2011) p. 143).

25. The submission now turns to consider the explanations that have been proposed to to explain the Association between substance abuse and crimes relating to property and violence:

- Offences committed under the influence of substances
- Offences to finance substance dependence
- The comorbid condition of drug dependency and another mental health condition; and
- Substance dependence as an accentuation of other risk factors for crime.

26. The following paragraphs consider these links in some detail. It is important that committee have an accurate idea of these links if it is to formulate measures to reduce the high level of imprisonment.

Offences committed under the influence of substances

27. This proposed link is founded on the hypothesis that drugs leads to crime because of their psychopharmacological effects of the drugs. This link seems evident from the much publicised connection between violence and drunkenness (i.e. of alcohol) on the one hand and the advent in the late 1990s of potent stimulants like crystal methamphetamines or ice. Hostility is common. “Ten per cent of people experiencing clinically significant symptoms of psychosis became severely hostile. Severe hostility included throwing or breaking furniture, threatening people and

assaulting people physically or with a weapon" (McKetin *et al.* 2005, 116). According to a Queensland report:

> ". . . paramedics, health staff and police were experiencing abuse and violence and situations where it was difficult to handle someone because they were on high doses of amphetamine or methamphetamine" (Rose & Najman (2002), 67).

Offences to finance substance dependence

28. The high cost of maintaining a drug habit is associated with property crime. Dependent users without a substantial income often finance their addiction by crime, notably property crime and drug dealing by the users themselves. "Dependence creates a drive to obtain substances to avoid withdrawal symptoms. This drive often forms the basis of the motives for general offending in this population thus increasing the risk of arrest often for minor property crimes (Butler & Allnutt, p. 30). Among higher level dealers violence is associated with the drug trade.

The common comorbid condition of drug dependency and another mental health condition

29. Co-occurring substance dependency and other mental health conditions form a particularly potent risk factor for crime as the gaol population around the country shows. This comorbidity or dual diagnosis regarding mental health is discussed below at pp. 10 ff.

Substance dependency as an accentuation of other risk factors for crime

30. A person's illicit drug use often intensifies other risk factors for crime such as dropping out of school, association with a deviant peer group and unemployment. This postulated link can explain how the regulation of the substances concerned can lead to crime. This important link is examined below at p. 10 ff. but it is worth making the point at this stage that consideration of substance abuse and crime through the prism of learning about the social determinants of health and risk and protective factors avoids the sterile debate that commonly bedevils discussion of causal links. This learning can explain why substance abuse may cause someone to embark on a career of crime even when they committed their first offence before their substance abuse disorder developed.

31. It is worth making the point at this stage that in all probability one or all of the foregoing account for a causal link between substance abuse and crime; that there is not just one link.

32. The surveys of offenders self attribution by offenders have helped tease out the strong correlation between substance abuse and crime and imprisonment actually explains a causal link between the two. According to Institute of Criminology:

> "Nearly half of all police detainees attributed their current offending to alcohol or drugs—alcohol being more frequently attributed to by detainees than all other drugs combined. Of the illicit drugs, heroin users were the most likely to attribute their offending to drug use, while cannabis users were among the least likely.

> Surprisingly, of those who attributed their offending to drug use, only 25 percent attributed their crimes to economic factors, such as the need to fund the drug addictions, whereas being intoxicated or under the influence of drugs or alcohol were reported as the cause by as many as 40 percent".(Payne & Gaffney (2012)).

33. 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 13% of the population at large who have used any illicit drug including cannabis in the last 12 months (AIHW 2007, table 3.16, p. 27) the 2009-10 Drug use monitoring program of police detainees (DUMA) study found that on arrest 66% of detainees who provided a urine sample tested positive to any illicit drug and 41% to a drug other than cannabis .(Sweeney & Payne (2012) table 6 p. 13). Questions on alcohol added to the survey in 2009 captured information on a "concerning" level of alcohol consumption which, the researchers suggested: "may go some way to explaining why detainees are in police watch-houses in the first place." (Sweeney & Payne (2012) p. ii)

34. The DUMA figures are fairly much consistent with the surveys of substance dependence and abuse among people in prison. Australian illicit drug reports show that there are many arrests of people as consumers. In 2010-11 there were 50,845 consumer arrests across Australia compared to 7,694 provider arrests (ACCC (2010-11) table 24, p. 24).

THE LINK BETWEEN MENTAL ILLNESS, SUBSTANCE ABUSE, CRIME AND PRISONS AS A DRIVER OF CRIME AND INCARCERATION

35. When one considers the rise of incarceration in Australia in the latter part of the 20th century it is impossible to avoid developments during the same period in the response by governments to mental illness.

Aggregation of mental illness within prisons

36. So crowded are Australian prisons with people suffering from mental health disorders that prisons are often referred to as latter-day mental asylums. A careful survey of inmates of Australia's largest correctional system, that of New South Wales, bears out the truth of this claim.

Table 1:
Estimates of the prevalence of major disorders among male and female prisoners in New South Wales experienced within twelve months and one month prior to reception

	MALE (N=756)		FEMALE (N=165)	
	12 Month	**1 Month**	**12 Month**	**1 Month**
ICD-10 Diagnosis	%	%	%	%
Psychosis	10.7	-	15.2	-
Affective Disorders				
Depression[1]	16.0	13.5	23.6	20.6
Dysthymia	7.2	6.1	9.7	9.1
Manic episode[2]	2.8	1.3	7.9	5.5
Any Affective Disorder	**21.1**	**17.1**	**33.9**	**30.3**
Anxiety Disorders				
Post traumatic stress disorder	21.7	16.9	43.6	37.6
Generalised anxiety disorder	13.4	12.4	22.4	20.0
Panic disorder	7.3	4.6	17.0	8.5
Agoraphobia	3.0	2.9	3.0	2.4
Obsessive compulsive disorder	2.7	2.3	2.4	1.8
Social phobia	1.5	1.1	0.6	0.6
Any Anxiety Disorder	**33.9**	**28.0**	**55.8**	**47.3**
Any Mental Disorder (above)	**42.0**	**36.5**	**61.8**	**53.9**
Substance Use Disorders				
Alcohol dependence	19.2	8.0	16.5	6.1
Alcohol abuse	3.3	2.3	1.8	1.2
Cannabis dependence	18.7	14.9	23.0	17.4
Cannabis abuse	2.5	1.8	2.5	1.9
Opioid dependence	34.5	26.0	53.4	37.3
Opioid abuse	1.8	0.8	0.6	0.0
Sedative dependence	11.4	9.9	28.6	17.4
Sedative abuse	0.3	0.0	0.0	0.0
Stimulant dependence	27.8	22.8	47.8	34.2

	MALE (N=756)		FEMALE (N=165)	
	12 Month	**1 Month**	**12 Month**	**1 Month**
Stimulant abuse	2.9	1.0	2.5	1.9
Any Substance Use Disorder	**63.7**	**46.6**	**74.5**	**57.1**
Personality Disorders				
Impulsive	21.4	-	31.5	-
Paranoid	19.8	-	27.9	-
Borderline	19.7	-	30.9	-
Anxious	19.0	-	23.0	-
Schizoid	16.3	-	22.4	-
Anankastic	14.6	-	18.8	-
Dependent	11.0	-	21.2	-
Histrionic	6.6	-	11.5	-
Dissocial	2.5	-	2.4	-
Any Personality Disorder	**40.1**	**-**	**57.0**	**-**
Neurasthenia	3.6	3.2	10.3	7.9
Any Psychiatric Disorder	**78.2**	**66.7**	**90.1**	**84.6**

1 Includes mild, moderate and severe depression.

2 Includes Mania, hypomania, and bipolar affective disorder.

SOURCE: Butler & Allnutt (2003) table 3, p. 14 and evidence to a House committee by the head of Justice Health (Matthews (2002).

37. Juvenile detainees are in a similar situation:

> "Mental health concerns are among the most prominent needs of young people in contact with the juvenile justice system, particularly those entering custody."(Indig *et al.*, (2011), p. 144). Indig *et al.*, (2011).
>
> Of those surveyed, 86.7%, had some form of psychological disorder and 72.7% had two or more such disorders (Indig et al., (2011), p. 144 & table 6.1.2 p. 145).

38. It is a similar story in the new ACT prison where, *per capita,* more money than anywhere else in the country is lavished on detaining offenders in what are purportedly human rights compliant conditions:

> About [70% of inmates participating in the survey] . . . had a formal psychiatric assessment at some time in their lives. Among those being assessed, 27% were told that they had Attention Deficit Hyperactive Disorder. Further, a notable proportion of the participants (40%) had suicidal thoughts. Among those who had suicidal thoughts, 69% of them had attempted suicide. About 62% of the participants had experienced a head injury where they became unconscious." (ACT Health (2011), p. 12)"

The deinstitutionalisation of mental health and growth of the prison population

39. The growth of the prison population coincided with a transformation in how the community should respond to mental illness. Writing in 2006 the Senate Select Committee noted:

> Care for people experiencing severe mental illness has undergone a revolutionary transformation over the last few decades. Australia had around 30,000 acute care psychiatric beds in the 1960s. The number of public beds had fallen to around 8,000 at the time of the development of the National Mental Health Strategy (NMHS), and is now around 6,000 (Senate (2006a) ¶8.4, p. 183)

40. The concomitant of this well meant change was a corresponding expansion in community care that would ensure "that people no longer in institutions have adequate care in their communities" (Senate (2006a) ¶8.4, p. A83). The Senate Select Committee received an avalanche of evidence that this change of policy was inadequately implemented:

> ". . . there is a general sense that mainstreaming and community care have not kept up with the pace of deinstitutionalisation. There are widespread problems with adequate accommodation, quality of care in the new settings, and perhaps most clearly of all, problems of people in gaining access to care in the new environment. In this environment, it is not surprising that the current policy direction is sometimes called into question. The strong consensus continues to exist around deinstitutionalisation may be threatened, if the policy is not fully and properly implemented and community-based services significantly expanded "(Senate (2006a) ¶8.7, p. 187).

41. The net result is a large and larger pool of people in the community without access to adequate treatment. Quoting Father Peter Norden, Policy Director, Jesuit Social Services, the Senate described the illicit drugs, mental health and crime link in the following terms:

> "Much of the recent dramatic increase in the Australian prison population can be explained by the relationship between untreated mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention by instrumentalities of the criminal justice system" (Senate (2006a) ¶14.23 p. 370).

The high prevalence of mental illness in prison seems to be increasing

42. Inmates are far "more likely to have a psychotic illness, major depression, and a personality disorder than the general population" (Butler and Allnut (2003) p.6). The prevalence of mental health problems among people in prison is not only high but seems to be growing higher. The 2009 inmate health survey (IHS) conducted by NSW Justice Health observed that: "The proportion of IHS participants who reported having ever received assessment or treatment by a psychiatrist or doctor for an "emotional or

mental problem" steadily increased, from 39% in 1996, to 43% in 2001, and again to 49% in 2009" (Indig et al. (2010b), p. 135).

Substance abuse and dependence are recognised mental health conditions

43. Addiction or dependence are health disorders. The generally recognised criteria that are used for dependence on illicit drugs are the same criteria as are used for all psychoactive substances: the *International Classification of Diseases* (ICD-10) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) of the American Psychiatric Association. The similarity in the criteria stands as recognition by the most eminent authorities that the effects of dependence on illicit substances are similar to dependence on other psychoactive substances such as alcohol and tobacco. It is a question for this committee to consider what the justification is for treating people with a similar medical condition in such hugely different ways - criminals on the one hand and people worthy of compassionate and expert medical care and attention on the other.

44. It should be stressed that the levels of mental disorders reported in table 1 (p. PAGEREF MajorDisorders \h 12do not take into account all substance use. In accordance with the classification system of substance abuse or dependence, moderate use is not included:

45. "Substance use disorders exclude moderate use of drugs (ie. casual, experimental or social). Substance dependence means that over time the person has become tolerant (ie. requires larger quantities of the substance to have the same effect) to, or dependent on (unable to cope without), the substance or both tolerant and dependent. Abuse and dependence are on a spectrum with each other. Abuse precedes dependence. Dependence creates a drive to obtain substances to avoid withdrawal symptoms. This drive often forms the basis of the motives for general offending in this population thus increasing the risk of arrest often for minor property crimes" (Butler & Allnutt, p. 30).

46. The pharmacological effect of addictive substances can lead to some crime but so can the regulatory policy response to those substances aggravate the situation. It is to these two drivers of crime and incarceration that this submission now turns.

PHARMACOLOGICAL LINKS BETWEEN MENTAL ILLNESS OR DISORDERS AND ILLICIT DRUGS

47. There are reports of use of illicit drugs causing mental illness or disorders and that many people who have a mental illness or disorder use illicit drugs as self medication. The inquiry should be guided by the best expert advice about whether pharmacologically the use of particular illicit drugs causes or aggravates mental illness or disorders. There is particular concern about possible links between cannabis use and schizophrenia and between potent methamphetamines and psychoses. We will refer briefly to these two issues.

Cannabis

48. A summary of research findings on links between cannabis use and mental health is provided in an article by Prof Wayne Hall and to Dr Louisa Degenhardt in an article published in *The Lancet.* The harms to health associated with cannabis seem to dwarf those from the legal drugs of alcohol and tobacco.

> "A meta analysis of these longitudinal studies reported a pooled OR 1.4 (95% CI 1.20 – 1.65) of psychotic symptoms or psychotic disorders in those who had ever used cannabis. Risk of psychotic symptoms or disorders was higher in regular cannabis users than in non-users (OR 2.09, 95% CI 1.54 – 2.84). . . .
>
> "Evidence is conflicting on whether incidence of schizophrenia increases as cannabis use increases in young adults, as would be expected if the association was causal. An Australian study did not show clear evidence of increased psychosis incidence despite steep increases in cannabis use during the 1980s and 1990s. A similar study suggested that it was too early to see any increased incidence in England and Wales in the 1990s." (Hall & Degenhardt (2009), p.1,388).

49. The authors conclude that:

> "The public health burden of cannabis use is probably modest compared with that of alcohol. Tobacco, and other illicit drugs. A recent Australian study estimated that cannabis used caused 0.2% of total disease burden in Australia – a country with one of the highest reported rates of cannabis use. Cannabis accounted for 10% of the burden attributable to all illicit drugs (including heroin, cocaine, and amphetamines). It accounted for around 10% of the proportion of disease burden attributed to alcohol (2.3%), but only 2.5% of that attributable to tobacco (7.8%)" (Hall & Degenhardt (2009), p. 1,389).

Methamphetamines

50. Increased mental health problems dominated comments about the potent stimulants like crystal methamphetamine after it became widely available at the end of the 1990s. Across Australia ". . . there [was] a dramatic rise in the number of psychotic disorders due to stimulant use from 200 in 1998-99, to 1,028 in 1999-00 and a further but smaller increase to 1,252 in 2000-01" (McKetin & McLaren the of the 2004, 16). It is estimated that ". . . the prevalence of psychosis among regular methamphetamine users was 11 times higher than that seen in the general population" (McKetin *et al.* 2005, 120).

> "The emergence of more pure forms of crystalline methamphetamine 'ice' and the so-called 'base' methamphetamine product (poorly purified crystalline methamphetamine), has been associated with an increase in psychotic behaviour among methamphetamine users in Australia. Psychotic symptoms can be induced in healthy subjects with no history of psychosis or substance use and in patients previously dependent on amphetamines. Psychostimulant use can exacerbate psychotic symptoms in people with schizophrenia" (Baker *et al.* 2004, 156).

51. The advent of potent methamphetamine appears to be a big factor behind the near collapse of Australia's mental health system into which the Senate Select Committee inquired (Senate (2006a)). An Australian text published in 2004 on intervention and care for psychostimulant users stated that:

> "It is well established that a psychostimulant-induced psychosis may occur following either prolonged use of the psychostimulant or after binge use. The symptom profile is similar to that found in other non-drug induced psychoses and typically the psychostimulant-induced psychosis resolves after discontinuation of psychostimulant use. Psychosis is higher among psychostimulant users than amongst the general population and is higher after amphetamine use than after cocaine use.
>
> "The emergence of more pure forms of crystalline methamphetamine 'ice' and the so-called 'base' methamphetamine product (poorly purified crystalline methamphetamine), has been associated with an increase in psychotic behaviour among methamphetamine users in Australia. Psychotic symptoms can be induced in healthy subjects with no history of psychosis or substance use and in patients previously dependent on amphetamines. Psychostimulant use can exacerbate psychotic symptoms in people with schizophrenia" (Baker *et al.* 2004, 156)

52. An American text, referring to the base form of methamphetamine which can be smoked (and known there as ICE), states:

> ". . . prolonged cocaine use can result in psychoses resembling paranoid schizophrenia. A similar pattern of acute delusional and psychotic behavior occurs after smoking ICE. However, unlike cocaine, ICE-induced psychosis can persist for days or weeks and can occur much earlier" (Julien 1998, 143).

53. It is particularly worrying that the onset of serious psychiatric problems is so rapid as a result of heavy use of potent methamphetamines. According to workers in the field

> "It was . . . unanimously agreed that the users of the more potent forms of methamphetamine reached these states of chaos far more quickly into their use careers than do users of methamphetamine powder. It was perceived by [key informants] that users of the more potent forms start to experience serious physical and psychological side-effects after only a few months of heavy use, and therefore tend to present requesting help after a relatively short period of time. Users of methamphetamine powder may take some years of heavy chronic use before they reach such states of disorder" (Darke *et al.* 2002, 33).

The Co-occurrence of drug dependency and other mental health condition is common

54. A common reason why people with a mental health disorder end up in prison is because they also have a substance abuse disorder. So prevalent is this that the Senate Select Committee on the mental health declared that this dual diagnosis or comorbidity is the expectation rather than the exception:

> "Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system. Police cells, courts and jails are filling with those experiencing mental illness, who are getting inadequate treatment or none at all in environments that are anything but therapeutic" (Senate (2006a) ¶2.29 p. 18).

55. So far in this submission has made the point that the surge in both crime and imprisonment in the last decades of the 20th century was principally related to widespread growth in use of illicit drugs and the criminalisation of their possession and supply. These factors – the presence of the drugs and the government's response to them – constituted drivers of crime supplementing the long-standing potent impact of alcohol which has been responsible for the high rates of incarceration at the beginning of the century. In addition to what might be termed the direct consequences of illicit drugs and their prohibition, crime and incarceration were boosted by the deinstitutionalisation of mental health and the increasing use of illicit drugs by people with mental health disorders. The submission has thus addressed term (a) of the committees terms of reference which called information on the drivers behind the past 30 years of growth in the Australian imprisonment rate. This submission now turns to consider measures of the effectiveness of prisons (they clearly are not) and the explanation for their failure to achieve their objectives.

INEFFECTIVENESS OF THE CURRENT LAW ENFORCEMENT SYSTEM

Recidivism

56. Sending people to prison inflicts a pain or harm upon them, namely it deprives them of the fundamental right to freedom. Furthermore, doing so comes at a very high economic cost to the community. It is thus fundamental that the infliction of this harm and the large investment in imprisonment should be effective in making the community safer. This effectiveness is, of course achieved, while an offender is incarcerated – imprisonment thus disables those detained from committing crimes in the community while they are detained. On the other hand the community has a right to expect much more from its prisons.

57. The Australian bureau of statistics neatly summarises the effect that imprisonment is intended to have and goes on to note an unfortunate collateral effect:

> Imprisonment aims to prevent crime and enhance community safety by removing offenders from the public arena and acting as a deterrent to potential offenders, as well as meeting society's need for reparation or retribution for crimes committed.[1] However, while a period of imprisonment may deter some people from re-offending, in others it may foster further criminal behaviour. (p. 1)

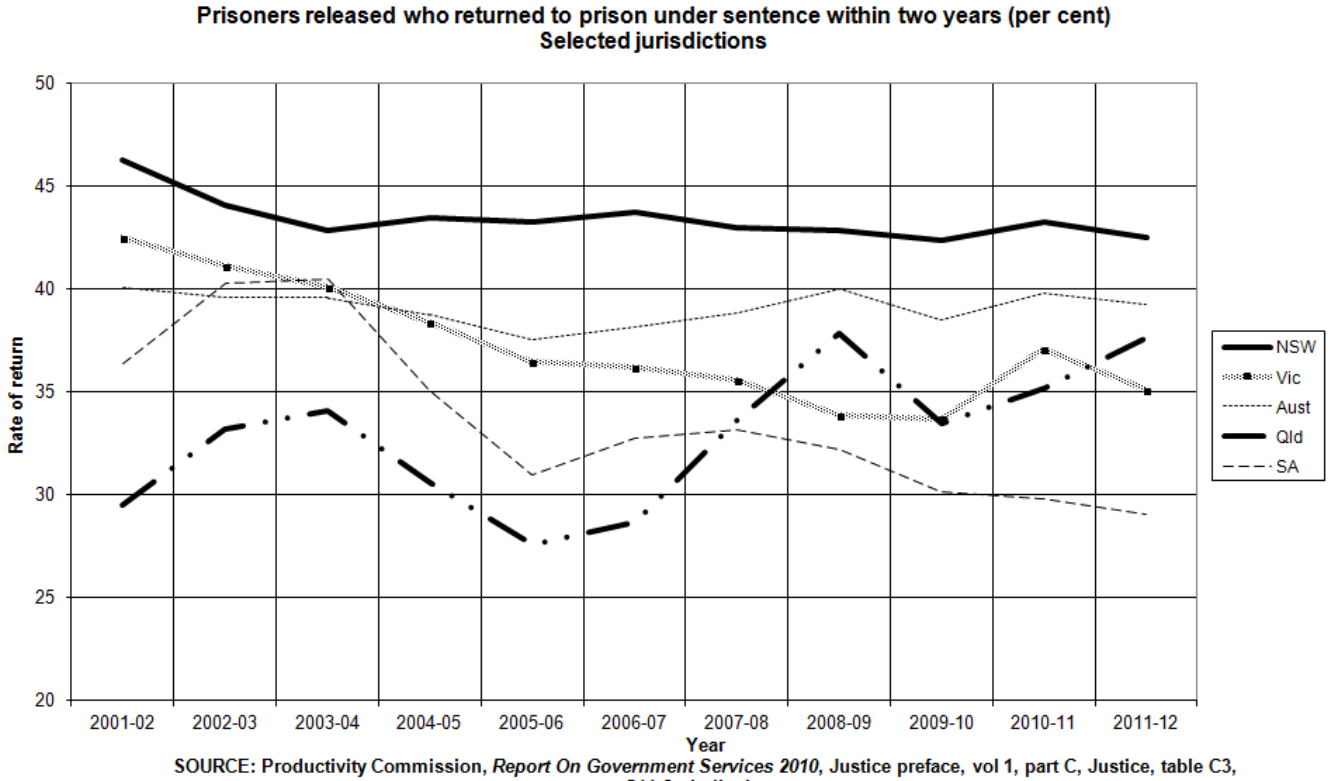
58. The sad fact is that the threat of imprisonment is an ineffective means of deterring offending in the first place and, worse than that there is strong evidence that imprisonment in the Australian system increases the likelihood of reoffending by those who graduate from a prison. All too often imprisonment is justified in the eyes of politicians and the public as simply a means of making people suffer in revenge for crime that they may have committed.

59. As a means of reducing crime there is little room for doubt but that incarceration as practised in Australia is a very inefficient social intervention. This is evident from the following table and chart of recidivism (expressed as the rates of return of prisoners and offenders) as reported in Part C on Justice of the *Report of Government Services* compiled by the Productivity Commission (http://www.pc.gov.au/gsp/reports/rogs/2007/justice).

Table 2: Prisoners released who returned to prison under sentence within two years (per cent)

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
2001-02	46.3	42.5	29.5	41.2	36.4	37.7	..	33.6	40.1
2002-03	44.1	41.1	33.2	37	40.3	38.8	..	37.1	39.6
2003-04	42.9	40.1	34.1	38.2	40.5	39.3	..	40.4	39.6
2004-05	43.5	38.4	30.6	40.6	35.1	37.7	..	44.2	38.8
2005-06	43.3	36.5	27.6	40.3	31	37.2	..	46.4	37.6
2006-07	43.8	36.2	28.7	43.3	32.8	37.1	..	44.6	38.2
2007-08	43	35.6	33.6	42.3	33.2	36	..	44.8	38.9
2008-09	42.9	33.9	37.9	44.7	32.2	36.4	..	47.3	40
2009-10	42.4	33.7	33.5	45.3	30.2	31.7		47.9	38.5
2010-11	43.3	37.1	35.2	44.2	29.8	36.2	..	47.1	39.8
2011-12	42.5	35.1	37.7	36.1	29.1	36.4	40.8	52.4	39.3

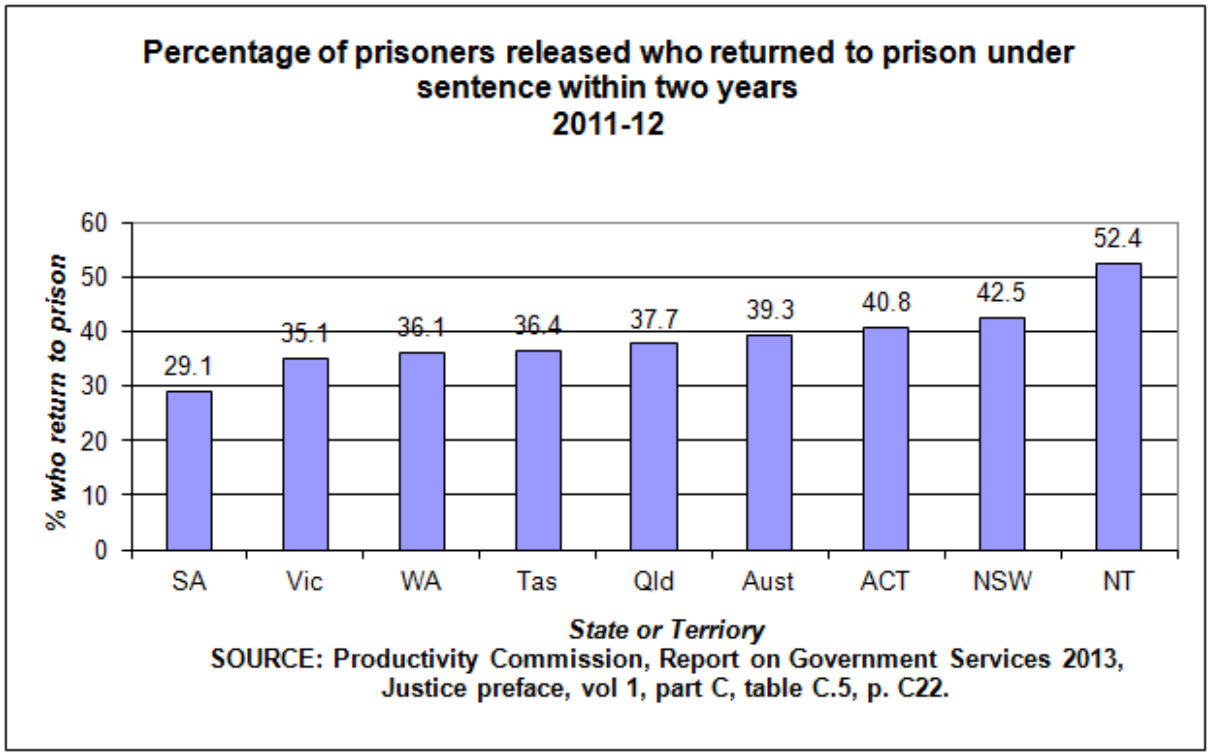
Chart 5: Percentage of Prisoners released who returned to prison under sentence in two years: selected jurisdictions



SOURCE: Productivity Commission, *Report On Government Services 2010*, Justice preface, vol 1, part C, Justice, table C3, p. C11 & similar issues.

60. The rate of return to prison varies greatly between jurisdictions. The rate in the Northern Territory (the highest) is almost twice that of South Australia (the lowest). The National average is 35% higher than that of South Australia. Clearly some Australian prison systems perform much better than others. Victoria has the distinction of eight year of successive reductions in its return to prison rate. The foregoing chart shows that this ended in 2010-11 suggesting something changed in the corrections system there a generation of prisoners before that (Families and Friends understands that the average length of imprisonment is less than a year).

Chart 6: percentage of prisoners released who returned to prison under sentence within two years 2011 – 12.



SOURCE: Productivity Commission, Report on Government Services 2013, Justice preface, vol 1, part C, table C.5, p. C22.

61. The Bureau of Statistics undertook a more exact measurement of return to prison. It followed a cohort of people released from prison between 1994 and 1997 and measured whether they had returned to prison within 10 years of their release. The result was an even greater indictment of the inefficiency of the Australian prison system. It found that two in five of those release had been reimprisoned within 10 years (ABS (2010) p. 1).

62. The rate of re-imprisonment for those who had earlier served time for property offences – crimes that we have seen are particularly associated with illicit drug use – was even higher:

> "Members of the 1994–1997 release cohort who had been in prison for burglary or theft had the highest reimprisonment rates (58% and 53% respectively)" ABS (2010) p. 4).

63. Perhaps the gravest indictment of imprisonment revealed in the ABS study was that the more one has been in prison the more likely one is to reoffend: "reimprisonment was strongly associated with already being a recidivist prisoner, as opposed to being in prison for the first time . . . Younger prisoners were more likely than older prisoners to be reimprisoned following release. Within 10 years of being released, the

reimprisonment rate for the teenager group (those aged 17–19 years when released) was 61%, compared with 23% for those aged 35 years and over." (ABS (2010) p.2).

64. This study lends credence to the folk wisdom that prisons are colleges of crime.

Harms associated with imprisonment

65. Prisons in conflict not just the intended harm of deprivation of liberty, but also aggravate and even create many of the problem is that were a factor in people being sent to prison in the first place. Not least among these is the presence of illicit drugs within prison to such an extent that non-drug users unknown to commence drug use while in prison.

PRISON AND RISK AND PROTECTIVE FACTORS ASSOCIATED WITH MENTAL DISORDERS AND CRIME

66. Each day in prison is the next day in the life of the human beings who are imprisoned. Their prison environment and experience will influence how they lead the rest of their life, their relations with their families and the community. They may or may not have a mental health problem. Most of them will have. Recognised environmental and other factors will influence whether their mental health deteriorates, improves or remains the same. A similar set of recognised factors influences whether those in prison reoffend or become model citizens. Prison itself is a drastic intervention in the life of people intended to have beneficial outcomes for both the people detained and the community. From the point of view of the future life of detainees, what happens in prison is thus an early intervention that will lead to good or bad outcomes.

67. Recognised risk factors potentially influencing the development of mental health problems include many that are commonly associated with traditional prisons. The following risk factors to do with life events and situations and with community and culture are taken from a study by a national mental health working party of an Australian Health Ministers' Advisory Council (DOHAC (2000) p. 16):

Socioeconomic disadvantage – most people in prison are disadvantaged socially and economically. Prison will not reduce that disadvantage unless it provides intense and effective education and other programs.

Poverty and economic insecurity – imprisonment generally intensifies poverty and economic insecurity not only because of the generally damaged employment status of being an ex-prisoner but also because of the harm to the economic status of the prisoner's dependants with the loss of a wage-earner.

Isolation – prison, involving as it does the deprivation of liberty and removal from society, will most likely lead to increased isolation from beneficial social support. In fact imprisonment will very likely lead people to associate closely with a deviant peer group. Such association is a known risk factor for mental health problems among school students.

Neighbourhood violence and crime – an ambience of violence, intimidation and crime is commonplace in many prisons.

Population density and housing conditions – crowded conditions and extended detention in cells commonly experienced in prison are examples of these risk factors.

Lack of support services – prisoners in existing correctional facilities report difficulties in accessing support services including health services, services to support their families and recreational facilities. Stresses brought about by inadequate access to these services constitute a risk factor for mental illness.

Physical, sexual and emotional abuse –prison environments are typically characterised by high rates of physical, sexual and emotional abuse. For example, there is likely to be much:

- bullying by prisoner of prisoner, sometimes also involving correctional staff;
- sexual abuse inflicted by prisoners against one another and incidentally inflicted against women by prison procedures such as strip searching;
- peer rejection;

Abuse of this sort is compounded by inadequate behaviour management and reinforced by an authoritarian prison regime.

Family break-up – family break-up often accompanies the separation and other stresses associated with incarceration.

Unemployment and homelessness – imprisonment disrupts employment and housing arrangements and a record of imprisonment makes it much harder to gain employment on discharge. Housing in the ACT is very scarce and difficult for people discharged from prison to access.

Incarceration itself is a risk factor for mental illness.

68. Complementing the large number of risk factors, prisons customarily provide an environment which precludes or undermines factors having a protective influence on the development of good mental health. These protective factors involving life events, community and culture include (DOHAC (2000) p. 15):

Involvement with significant other people like a partner or mentor.

Economic security.

Good physical health – those in prisons have markedly poor physical as well as mental health.

Attachment to networks.

Sense of connectedness within the community.

Participation in church or other community group.

Strong cultural identity and ethnic pride.

Access to support services.

Community or cultural norms against violence.

69. Many of these risk and protective factors influencing mental health problems are also acknowledged risk and protective factors for crime. A report, *Pathways to prevention*, commissioned by the Commonwealth Government, list many of the same or similar risk and protective factors. The following factors are drawn from those lists (NCP (1999) pp. 136 & 138:

Table 3: Risk and protective factors associated with crime

RISK FACTORS ASSOCIATED WITH CRIME	PROTECTIVE FACTORS ASSOCIATED WITH CRIME
Socioeconomic disadvantage	Meeting significant person
School failure - illiteracy	Access to support services
Isolation	Community networking
Neighbourhood violence and crime	Attachment to the community
Cultural norms concerning violence & crime as acceptable responses to frustration	Participation in church or other community group.
Population density and housing conditions	Community or cultural norms against violence.
Lack of support services	Strong cultural identity and ethnic pride.
Abuse	
Bullying	
Peer rejection	
Inadequate behaviour management	
Divorce & family breakup	
Psychiatric disorders, especially depression	

70. The co-incidence of risk and protective factors for mental illness and crime point to the benefits in these two domains and probably in others of ensuring that measures are taken targetting those factors. The operational as well as the physical environment of prisons should be crafted in a way that minimises the known risk factors for mental health problems and crime and maximises the protective factors.

Key Points

- ❖ Prisons are populated by those with an accumulation of known risk factors for mental ill-health.
- ❖ Common risk factors include physical, sexual and emotional abuse and poverty and economic insecurity.
- ❖ Many risk and protective factors influencing mental health problems are also acknowledged risk and protective factors for crime.
- ❖ The usual prison environment further damages mental health because it is replete with many known risk factors for mental ill-health and crime.
- ❖ Improvement in mental health and reduction of recidivism requires the cultivation of protective factors like sense of connectedness and minimisation of existing and additional risk factors.

71. The submission now discusses common aspects of characteristic of penal regimes that damage mental health.

Prison regime factors impeding access to mental health treatment

72. mental health services. Provision of even the best such health services is thus wasted if there are barriers in the way of those who need them. Those whose condition is obvious and whose behaviour causes a problem are more likely to receive treatment. Others tend not to receive the treatment they need.

73. The Senate Select Committee on Mental Health observed that "relatively few prisoners with a mental illness are so seriously ill that they require inpatient treatment, but they still require treatment, and that treatment, if provided, will generally be in gaol" (Senate (2006a) §13.96). It added that: "[a]lthough anxiety and depressive conditions appear to be common among prisoners, corrections and health authorities devote most resources to the treatment (or control) of prisoners with relatively low incidence disorders, in particular, psychoses" (*ibid.* §13.112).

74. The Senate Select Committee saw the prison culture as creating a barrier between the health service providers and those in need of treatment which can particularly affect access to necessary treatment by prisoners.

> "Nevertheless there are difficulties involved in providing treatment in a setting that is not necessarily conducive to effective treatment of people with mental illness. Effective treatment in prison may be impossible because prison officials focus on security and placement issues rather than treatment. The Mental Health Legal Centre stated that men and women with mental health issues report that they are reluctant and even frightened to reveal them because there is little support and lots of discrimination. The Australian Doctors' Fund submitted that imprisonment of the mentally ill is a barrier to the delivery of good psychiatric care" (Senate (2006a) §13.102).

75. A survey of mental health in NSW prisons noted that mentally ill inmates ". . . may have difficulty accessing regular psychiatric follow-up due to frequent

transfers, and in some cases, [are] less likely to assert themselves to obtain treatment out of fear of stigmatisation" (Butler & Allnutt (2003) p. 50). The same report described the conflict between security and clinical needs in the following words:

> "The majority of mental health providers within the NSW correctional environment are obligated to operate in accordance with the correctional ethos. This is fertile ground for conflicting priorities between clinical needs (the health priority) and security (the custodial priority). The correctional approach to the management of difficult behaviour can be the antithesis of the mental health approach" (Butler & Allnutt (2003) p. 50).

76. The Senate Select Committee on Mental Health also quoted this passage (Senate (2006a) §13.95).

77. Professor Mullen of *Forensicare* in Victoria has described in the following terms the impediment to treatment associated with the prison culture:

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

78. According to the *Adult Corrections Health Services Plan* identified the following elements for a:"A successful Mental Health program within the AMC will:

- Ensure that every prisoner with a diagnosed or diagnosable mental illness has a care plan through the service that includes a release plan that allows for the successful engagement with services in the community;
- Have an emphasis and support for mental health promotion, prevention and early intervention;
- Have an emphasis on access, quality and coordination of services both during and post incarceration;
- Adopt a recovery orientated treatment service that includes improved links between the AMC and community based services such as supported accommodation, training and rehabilitative services; and
- Include enhanced data collection, monitoring and planning." (ACTH (2008) pp. 25-26).

79. These conditions for adequate mental health treatment are achievable only if the correctional cultural problems mentioned earlier are overcome. This will require close co-operation between health providers and ACT Corrections to implement a regime that is developed to meet health care needs.

Key Facts

- There are barriers in the typical prison environment against detainees accessing mental health services.
- 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.
- Treatment is typically concentrated on the relatively small proportion of detainees whose condition is obvious and whose behaviour causes management problems. Others tend not to receive the treatment they need.

The general stresses of detention damaging of mental health

80. Imprisonment itself is typically stressful in the disruption it causes to those detained. Its coercive routines are also stressful for many. These stresses can harm the mental health of these people. Some others who do reasonably well subject to the routines of prison life can also be harmed. This is because prison is likely to reduce their capacity to function well in the world outside on their release.

81. A report on mental health in NSW prisons noted that "incarceration results in a sudden disruption in the individual's life, characterised by loss of freedom and liberty, loss of social and family support" (NSW Mental Health, p. 49). Social and family support, it will be recalled, is a protective factor against mental problems.

82. The same report also stated that incarceration results in "exposure to an unfamiliar and sometimes threatening environment, frequent and unexpected transfers to new correctional environments, loss of control, and a highly regimented daily routine. Such an environment poses a challenge, particularly for those inmates with a mental illness who have a higher likelihood of cognitive disability, poor insight, and problem solving skills. Mentally ill inmates may experience increased feelings of paranoia, anxiety, and despair, which can exacerbate a mental illness" (NSW Mental Health, pp. 49-50).

83. In the words of Professor Paul Mullen of *Forensicare* in Victoria, "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" (Mullen p. 36).

84. He also explained how prisons can render some people unfit to survive outside prisons. "[T]hey provide," he said, "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 p. 36).

85. The culture of the prison, including the administration of discipline, is a powerful influence on the extent that it is possible to ameliorate the aspects of detention that are harmful to mental health. Coercion is always in the background of prison life in that

detention, which occurs against people's will, deprives people of their liberty. The more that coercion intrudes into the foreground, the more harmful the detention is likely to be. As expressed by the then Commissioner, NSW Corrective Services, Mr Ron Woodham, the ideal of a coercive model of discipline is meek conformity and compliance:

> "I've been against them, they know that. They also know that I and my senior staff are fair but firm if they want to conform. So even if they're going against us and they decide at some stage to ... come back into a compliant mode of operation that will help them" (ABC (2005)).

86. Mere compliance and conformity induced by force or the threat of force is inconsistent with mental well-being. If that well-being is to be taken seriously, it must be a key consideration in the development and monitoring of prison regimes. An important element of that should be the implementation of, a regime of "dynamic security" or "direct supervision", which experience shows creates a healthier prison environment, should be implemented. "Dynamic security" or "direct supervision" relies on the establishment of good professional relationships between staff and detainees rather than the traditional reliance upon physical barriers, uses of force and the use of restraints" (AHRC (2007) p. 8).

87. The paper now turns to particularly harmful examples of the exercise of coercion that are part of standard prison practice, namely strip searching and seclusion. The harm caused by boredom for want of meaningful activities is also examined.

Key facts

- The typical stresses of imprisonment are harmful to the mental health of those detained. The stresses include:
  - +The sudden disruption in people's life;
  - +The separation from family support; and
  - +The coercive and highly regimented daily routine.
- The regimented routine of the usual prison directed at conformity and compliance within which some who are mentally disordered thrive reduces their capacity to cope with the contradictions and complexities of the world outside.

Recommendation

- To counter these effects, the new ACT prison must do much more than aim for conformity and compliance.

Strip searches

88. Strip searching is common in prisons and is psychologically damaging. It is degrading and destructive of self worth for anyone, male or female, and particularly for a vulnerable prison population in poor mental health. It is a practice of the gravest concern for women. An overwhelming number of women in prison have been traumatised by sexual abuse. Strip searches serve to perpetuate and intensify that.

89. The Human Rights Commission Audit has documented the practice in the ACT before the establishment of its prison. "Detainees," the Commission wrote, were " . . . subjected to numerous strip-searches. If regularly visited, for example, it would be possible that a detainee could be subjected to ten strip-searches a week. Five visits in one week would involve ten strip-searches – one before each visit, and one afterwards. Three visits in one week, a court attendance and a cell search would involve nine strip-searches. Detainees who were receiving regular visits from family members said they were strip-searched several times each week." (AHRC (2007) p. 43). Prisoners at high risk of self harm were "to be strip-searched every night before they [were] locked in their cell" (*ibid.* p. 82). Taking of urine samples for drug testing, which occurs on a routine, random and compulsory basis, involves further stripping. "The detainee is strip-searched and then has to urinate, in the presence of two officers" (*ibid.* p. 46).

90. The Commission described how strip searches are conducted:

> "The procedures describe an invasive procedure where all clothing is removed (although the person is now to be half-clothed at all times), the mouth is checked, including under the tongue, the detainee has to run their hands through their hair and to pull their ears forward, to lift genitals or breasts, present the soles of their feet for inspection, and finally to squat and cough." (p. 43).

Rationale for strip searching

91. Corrections drug policy appears to dictate the need for strip searching. It is presented as an integral part of drug supply reduction. ACT Corrections drug strategy acknowledge that strip searching "is a traumatic activity", especially for women (ACS (2007a) p. 24).

92. ACT Corrections drug policy thus provides for the continuation in the new prison of a regime of strip searching that will perpetuate and intensify serious harm to a set of human beings who already suffer from serious mental health problems. Not least of these is the chronic, relapsing condition of substance dependence. Moreover, the ACT Corrections purports to do this, in part at least, on the ground that to do so is in the best interests of the people themselves:

> "The immediate goals of prisoner and offender drug and alcohol interventions, which must be linked to those for mental health problems, is to improve the prisoner's ability to function, to reduce drug use, and to minimise the health and social consequences of that drug use" (ACS (2007a) p. 10).

93. As the ACT Corrections drugs strategy admits, this is wishful thinking. The bottom line is a perception of security and community expectations:

> "While the Alexander Maconochie Centre will have a commitment to prisoner habilitation or rehabilitation, it is to be a prison. It is not a hospital, not a hostel, and not a secure forensic mental health facility. Because it is a prison, its major concern, and the major concern of the community, is one of security. A major factor in the security of prisons is the introduction of illicit drugs, and the violence and intimidation that this causes" (ACS (2007a) p. 9).

94. Thinking like this leads down a dead end road. It is fanciful to believe that acting on this mindset will improve the mental health and well-being of those within the new prison. It will not. Serious consideration must be given to getting the balance between security and health concerns right. Corrections authorities must work with health and mental health experts in pursuit of this objective.

Key Facts

- Strip searching is common in prisons including ACT remand centres and would continue at a significant level even with the permanent introduction of body scanning.
- Strip searching is psychologically damaging. It is degrading and destructive of self worth for anyone, male or female, and particularly for a vulnerable prison population in poor mental health.
- It is a practice of the gravest concern for women. An overwhelming number of women in prison have been traumatised by sexual abuse. Strip searches serve to perpetuate and intensify that.
- The damaging regime of strip searching flows from a perception of security and community expectations that drugs can and must be kept out of prisons.
- The evidence is there that dependent drug users are capable of leading functional lives while still dependent.
- Their capacity to do so is dependent upon accessibility to pharmacotherapies and other treatments that are either prohibited (e.g. medical prescription of heroin) or constrained by policy or want of funding (e.g. methadone and buprenorphine).

Recommendation

- The priority of the correction more system and indeed of public policy generally should be capacity of detainees to lead functional lives and not an a priori insistence that they should become drug free.

Seclusion

95. Seclusion is a pervasive, coercive measure of the standard prison whether it be by confining people separately or otherwise drastically limiting the extent that they can interact with others. In the words of Dr Paul Mullen of *Forensicare* in Victoria:

> "Separation and seclusion are all too often the response of correctional systems to troublesome prisoners, irrespective of whether those difficulties stem from bloody mindedness, distress, mental disorder or even suicidal and self damaging behaviours" (Mullen (2001) p. 36).

96. Prison authorities have recourse to seclusion for different reasons. It occurs in the name of security, discipline, the welfare of the person secluded and to meet administrative needs.

97. The *Corrections Management Act* 2007 (ACT) gives a sense of the range of reasons. The Act permits "segregation" which may, and in standard penal practice frequently does, include "separate confinement" and other forms of seclusion. Decisions by the correctional authorities to order segregation may occur:

1) for "the safety of anyone else at a correctional centre; or security or good order at a correctional centre". (s. 90(1));

2) for the protection or safety of the detainee (s. 91(1));

3) on grounds of health of the detainee and, in order to prevent the spread of disease, of others (s. 92(1));

4) by a correctional officer who believes that the detainee has committed a breach of discipline (s. 156(2)(d));

5) by an investigator who is given a report about an alleged disciplinary breach by the detainee (s. 157(2)(f));

6) by an administrator who is given a report about an alleged disciplinary breach by the detainee (s. 158(2)(g));

7) by the chief executive for the purpose of investigation if, among other things, he believes that there is a danger that the association of a detainee with others would "undermin[e] security or good order at a correctional centre" (ss. 160 & 161).

98. Health and well-being of the detainee is a consideration in ordering segregation under ss. 91 & 92 (safety and health) but is not mentioned as a consideration in ordering segregation under ss. 90, 156, 157, 158 and 160-61.

99. Without being acknowledged as such, seclusion is part of the daily routine of the ACT remand centres. Presently, detainees spend at least thirteen hours overnight in their cell (from 6 pm or 6.30 pm in summer until 7.30 am) plus an hour and a half over lunch time. For various reasons, including staffing shortages, detainees frequently spend an even longer time in their cells. The Human Rights Commission observed that "these unscheduled 'lockdowns' are in effect a form of separate confinement – although there is no restriction on association with other prisoners when released from the cells – but they are largely unregulated because prison authorities do not regard them as a form of separate or solitary confinement and legislation generally does not refer to lock-downs" (AHRC (2007) p. 34)

100. Detainees often complained to the Human Rights Commission ". . . about the early time they were locked in cells in the evening and overnight, at lunchtime, and the extra time spent locked down for various staffing reasons. A number of detainees complained that on one day during the last quarter of 2006 they had been locked in their cells for a period of 21 hours. According to the records kept by ACT Corrective Services, there were 41 lockdowns between July 2006 to 4 December 2006. By comparison, during the same period in 2005, there were only 12 lockdowns" (AHRC (2007) p. 34)

101. Whatever its perceived benefits by the prison administration, seclusion is generally harmful to detainees and particularly for a population group that already suffers from substantial mental health problems. The harm of seclusion is most obvious in its links to suicide and other forms of self harm. The tragedy is that ordering seclusion is often motivated by a concern to avoid self harm. This is examined below (p. 30).). The flaw in this approach is clear: by focussing only on the physical prevention of suicide and removing access to social supports, the risk to mental health is increased.

102. In therapeutic settings it is recognised that seclusion should be avoided in all but exceptional circumstances and so should it be avoided in prisons. In the words of the Mental Health Council:

> "Detention/seclusion are practices to be avoided if possible. Neither is compatible with the central dictum of mental health best practice guidelines, specifically that treatment must occur in the least restrictive setting in individual circumstances." (MHCA (2005) p. 926).

103. Indeed, in the Australian mental health system including that of the ACT there is currently a cultural shift happening surrounding seclusion. More and more seclusion is viewed as a failure of the system to respond in an adequate and timely manner to the mental health consumer's needs. Mental Health ACT has embraced this new thinking quite enthusiastically and is currently running a so-called Beacon Demonstration Site project to reduce instances of seclusion in the psychiatric unit at Canberra Hospital.

104. The ACT Human Rights Commission makes the point that: "The interrelationship between time out of cells and other activities important to a detainee's physical and mental health and well-being – education and work, visits with family and so on – requires a reasonable time out of cells." (AHRC (2007) p. 35). It added that "lock-downs result in loss of association, even with other detainees, for those in one-out cells. The adverse impact of confinement alone in a cell on a person's mental health is well understood" (*ibid.,* p. 34). It also reported "concern that segregation was frequently used as an inappropriate response to challenging behaviour by Indigenous detainees with mental illness" (*ibid.*, p. 89).

105. Extended seclusion in terms of solitary confinement is particularly harmful. The Australian Medical Association has branded the practice as "inhumane". Its position statement on health care of prisoners and detainees states:

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

106. In spite of this known harm of the practice, the *Correction Management Act* 2007 provides for the practice in the new prison. Under s. 187, the correctional authorities can order separate confinement "as an administrative penalty for a disciplinary breach" (s. 187(1)). "Separate confinement" is defined in s. 151 as "confinement of the detainee in a cell, away from other detainees." Separate confinement as an "administrative penalty" may be for 3 days, 7 days or 28 days (s. 184(d)).

107. It is clear that if prisons are to promote the mental well-being of those detained in them there needs to be a minimum of seclusion. To achieve this will require initiatives on different fronts including resourcing and the development of a regime of dynamic security (see p. 28).

Beyond a focus on preventing physical self harm

108. There is no greater demonstration of the injury to mental health by the prison environment than the high level of suicide and other self harm by detainees. The extent that it happens and the degree of mental distress in prisons that it demonstrates is alarming.

"The rate of suicide in prisons is estimated to be between 2.5 and 15 times that of the general population. . . . It has been estimated that for every suicide there are 60 incidents of self-harming behaviour. It is evident that inmate self-harm has become endemic in many correctional institutions." (McArthur *et al.* (1999) p. 1)

109. It is thus "inescapable that suicide is a longstanding, major issue for correctional authorities" (*ibid.*).

110. Prompted by a string of inquiries and inquests, correctional authorities have taken firm steps to reduce successful suicide attempts. Seclusion in cells without hanging points and under continuous or regular monitoring is effective in preventing this. However, the same measures may further harm the mental health of the person confined making it more likely that he or she will attempt suicide again.

111. According to a leading manual on the management of mental disorders, "individuals who have a depressive or bipolar illness are more likely to commit suicide than individuals with any other psychiatric or medical illness. The rate of death from suicide among individuals with a bipolar illness is high, with a mean of 19% (rates vary across studies) and the rates in Major Depressive Disorder may be similar" (WHOCC (2004) p. 22). Bipolar illness and depressive disorders fall into the category of affective disorders. As the table at p. 12 shows, on reception to the NSW corrections system, 33.9% of women and 21.1% of men had an affective disorder of some kind.

112. Under standard prison practices including, it would seem, those in the ACT, efforts through seclusion to prevent suicide take place at the expense of the mental health of those concerned. The words of Professor Mullen from *Forensicare* succinctly go to the heart of the matter:

> "Placing potentially suicidal prisoners in isolation cells stripped of furniture, clear of hanging points and subject to the constant gaze of prison staff may be a cheap and, in the very short term, effective suicide prevention strategy, but should remain unacceptable to a mental health professional concerned with the state of mind and long term mental health of their patient" (Mullen (2001) p. 37).

113. The Human Rights Commission in its audit quoted a coroner's report that "safe cells are generally stark, sterile environments which can in themselves engender in detainees feelings of depression and a desire to self-harm" (AHRC (2007) p. 42)

114. The same point was a matter of concern to the Senate Select Committee on Mental Health which reported:

> "The process of isolating such persons and placing them in seclusion appears effectively to prevent suicide and may prevent disruption to other inmates, but is hardly therapeutic for people who are mentally ill. A former visiting general practitioner to the [Brisbane Women's Correctional Centre], Dr Schrader, made the following observations about the use of the isolation cells at the Centre:
>
> > The treatment is the opposite of therapeutic. The use of seclusion is inappropriate for those of risk of self-harm and suicide. Observation alone does little to help the woman overcome her distress and suicidal or self-harming feelings and is alienating in itself . . . . A key element in suicide prevention is the presence of human interaction.

"The committee heard similar evidence about the use of seclusion facilities for prisoners assessed to be "at risk" in other jurisdictions. Mr Strutt, a member of Justice Action, a prisoners' activism organisation, referring to the use of isolation cells in NSW, stated that:

> If you are a prison officer and you see a prisoner who seems to be seriously depressed your No. 1 priority is to make sure that that person does not kill themselves while you are on duty. So basically you put them in a strip cell. For all the talk about care and attention they are getting in prisons and hospitals, the way those institutions are structured means they are not getting the appropriate care and attention" (Senate (2006a) §§13.110-111).

115. In fact, the practice of seclusion is the opposite of the "key element in suicide prevention", namely human interaction, that Dr Schrader mentioned in her words that the Senate Committee quoted.

116. Positive human interaction and support are fundamental for suicide prevention (WHOCC (2004) p. 23). Prisons may not be therapeutic environments, but their operational regime should be designed to reflect therapeutic principles. The ACT Human Rights Commission identifies a recognised set of measures that should be implemented to improve suicide prevention practices:

> "It would be preferable to focus on suicide prevention measures, including those identified by Liebling as follows:
>
> - family support and visits;
> - constructive activity within the prison system;
> - support from other prisoners;
> - support from prison visitors and other services;
> - having hopes and plans for the future;
> - being in a system with excellent inter-departmental communication; and
> - staff who are professionally trained and valued by the system" (AHRC (2007) p. 82).

Key Facts

- Seclusion is widely used in prisons including ACT remand centres to confine people separately or otherwise drastically limit the extent that they can interact with others.
- It occurs in the name of security, discipline, the welfare of the person secluded and to meet administrative needs including lengthy unscheduled lockdowns.
- Seclusion injures mental health and in the mental health system is viewed as a failure to respond in an adequate and timely manner to the needs of people who are mentally ill.
- Solitary confinement, which ACT legislation permits for up to 28 days, is particularly harmful.
- Use of seclusion in padded cells under surveillance to prevent suicide or other self harm promotes later suicide attempts.

Recommendation

- The prison's operational regime should be designed to reflect the therapeutic principle that positive human interaction and support are fundamental for suicide prevention.
- Corrections and other prison staff should receive lay training in understanding and working with detainees who have mental disorders.

Boredom

117. With resources and a modicum of innovation, boredom in correctional institutions should be the easiest thing to fix. The practical benefits of doing so from the point of view of both discipline and the mental well-being of detainees are patent yet, as the Human Rights Commission's audit of remand centres shows, boredom is pervasive.

> "All detainees expressed feelings of frustration about the lack of activities available in the remand centres. Many described the effects of acute boredom as leading to higher tension levels, as well as feelings of depression for some detainees. They usually described it as doing 'head miles'. Often detainees seemed unable to take responsibility for their actions, even in cases where they acknowledged they had done something wrong, because of the mounting anger and frustration brought on by the unsatisfactory conditions at the remand centres, particularly the long periods spent in cells and the lack of purposeful activities. Both the presumption of innocence, and the eventual need for rehabilitation for those convicted of crime, support the provision of organised activities. Activities assist remandees to survive the time in custody without feelings of anger and resentment, feelings that do nothing to foster a sense of responsibility for their actions or victim awareness in the case of those eventually convicted. The comments by the Watchhouse review team, made in the context of the far shorter periods of detention at the Watchhouse are pertinent:
>
> 'Isolation in a cell with little or no stimulation is boring. Commonsense, supported by experience in other custodial facilities, suggests that boredom is likely to lead to inappropriate detainee behaviour, particularly if detainees are emotionally disturbed or in custody for more than 8 hours'" (AHRC (2007) p. 37)

118. The Commission reported that "the use of the activities room [at the Belconnen Remand Centre] dropped when the position of activities officer was not filled." It added that: "Failure to resource activities properly is unacceptable, particularly given the interrelationship between exercise and other activities and detainees' physical and mental health" (AHRC (2007) p. 38)

119. Boredom is, of course, related to the time that people spend inside their cells as well as activities in which they can engage when they are out such as education, work and family visits. The Commission considered that the likely impact of boredom on those in the remand centres was so serious that the government may have contravened its obligation to provide humane treatment:

> "The Human Rights Commission concludes that the lack of organised activities in the ACT's remand centres, when combined with other factors such as the relatively small size of two-out cells and the additional lock-downs to which detainees have been subjected may contravene the right to humane treatment in detention in s.19 of the HR Act, given the likely impact on detainees' mental health." (AHRC (2007) p. 38).

120. Corrections authorities are generally conscious of the need to combat boredom in the new prison:

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

121. Given this acknowledgment of the need for a well designed program of activities, the focus needs to be on ensuring that the Government provides the resources that make such a program possible. The lack of a gymnasium when the prison opens is of concern, a concern that is not completely balanced by the announcement that detainees may be engaged in the construction of those buildings.

Key Facts

- ❖ Lack of meaningful activities is common in correctional institutions.
- ❖ Boredom makes for an unhealthy environment that stimulates anger and frustration impeding those detained from accepting responsibility for their actions.

Recommendation

- ❖ The prisons should have a well designed and resourced program of activities.

SUMMARY OF THE LINKS BETWEEN SUBSTANCE DEPENDENCE, CRIME AND PRISON

122. Illicit drugs actually causing mental illness is only one of the pathways between illicit drug use and mental illness and probably not the most important one. Even so heavy use of some illicit drugs such as crystal methamphetamines can cause mental illness.

123. Other pathways:

- Those with mental illness e.g. depression and anxiety disorder are increasingly drawn to abuse illicit substances;
- Stresses on those with a dependence associated with scrounging the wherewithal to pay for habit;
- Association of people with or prone to a mental illness with a deviant peer group associated with illicit drug dealing and related crime;
- Stresses from accepted procedures of the criminal justice system bringing about a mental illness or aggravating an existing one e.g. harassment by police, arrest, court hearings, conviction, fines and imprisonment.

Poverty

- High cost of maintaining a habit.

- Those with a dependence on illicit substance tend to be unreliable employees and are thus likely to be unemployed.

Crime

124. Links between illicit drug abuse and crime include:

- Crimes committed under the influence of illicit drugs.
- The high cost of maintaining a drug habit lead many to finance their addiction by crime, notably property crime and drug dealing.
- Likelihood of regular users of stimulants like methamphetamines to be engaged in violent offending such as physical assault.
- Substance abuse is a potent risk factor for mental illness, another big correlate of criminal behaviour.
- A person's illicit drug use often intensifies other risk factors for crime such as dropping out of school, deviant peer group and unemployment.

COSTS OF THE PRESENT CRIMINAL JUSTICE SYSTEM

125. The Australian correctional system does not come cheaply. The latest report on government services by the productivity commission observes that:

> Net operating expenditure on corrective services including depreciation was $3.1 billion in 2011-12 — an increase of 4.8 per cent over the previous year (table 8A.12)" (Productivity Commission (2013b), chapt 8, p. 8.4)

126. The states and territories bear the lion's share of government budgetary costs of crime ($2,212.3 million) (Collins & Lapsley (2008) tables 46 & 47, p. 73) – a case of states and territories shouldering burden in an area where the policy is determined principally at the federal level.

Accentuation of risk factors for crime

NEGATIVE IMPACT OF DRUG POLICY ON THE MENTAL HEALTH OF ILLICIT DRUG USERS

127. The link between illicit drugs and mental illness or disorders arises not only from their pharmacological effect but from the very strategies that are adopted to counter their availability. The strategies designed to deter illicit drug use bring about risk factors that are known to influence the developmental of mental health problems.

Criminal processes creative of mental health risk factors

128. The criminal law is the overriding characteristic of current drug policy. Even if use itself is not a criminal offence in some jurisdictions, activities intimately associated with use uniformly are – activities such as possession and supplying drugs to fellow users. In some respects with drugs the rigour of the traditional processes of the criminal law have been ameliorated in recognition that the problem has a health dimension. Thus the distribution of sterile syringes is permitted, some states have set up drug courts and police have ceased, as a matter of course, attending non-fatal overdoses. Even so, the essentially criminal character of the

policy response to drugs has serious impacts on the mental health of users by virtue of:

(a) the stresses and dangers associated with securing and using illicit drugs;

(b) the ease with which criminal peer groups associated with drugs can lead astray young people with or prone to a mental illness or disorder;

(c) the rigours of imprisonment brought about by offences linked to their drug use.

129. The harms to drug users associated with the criminal processes and their associated illicit status have been extensively documented. The report of a committee inquiring into serious drug offences contains as good a summary as any:

> ". . . it has become increasingly apparent that significant elements in the harm which results from habitual use of illicit drugs are a consequence of criminal prohibitions and their effects on the lives of users. Quite apart from the risks of arrest and punishment, there are risks to health or life in consuming illicit drugs of unknown concentration and uncertain composition. The circumstances in which illicit drugs are consumed and the widespread practice of multiple drug use add to those risks. Medical intervention in emergencies resulting from adverse drug reactions may be delayed or denied because associates fear the criminal consequences of exposing their own involvement. The illicit consumer's expenditure of money, time and effort on securing supplies may lead to the neglect of other necessities. It will often impose substantial costs on the community, and the user, if the purchase of supplies is funded from property crime. Further social costs result from the stigmatisation of habitual users as criminals and their alienation from patterns of conformity in employment, social and family life.
>
> "Risks are inherent, of course, in habitual use of most, if not all, recreational drugs. But criminal prohibitions amplify those risks. They amplify, for example, the risk of death from overdose" (SCAG (1998),pp. 6-7).

130. In addition to the literature mentioned in that report, the inquiry is referred to the following examples of more recent literature documenting the harms:

Campbell Aitken, David Moore, Peter Higgs, Jenny Kelsall & Michael Kerger, "The impact of a police crackdown on a street drug scene: evidence from the street" in *International journal of drug policy*, vol. 13, pp. 193-202 (2002)

J.L. Fitzgerald, S. Broad & A. Dare, *Regulating the street heroin market in Fitzroy/Collingwood* (Issues series) (Department of Criminology, University of Melbourne & VicHealth, 1999)

Maher *et al.* 1998: Lisa Maher, David Dixon, Michael Lynskey and Wayne Hall, *Running the risks: heroin, health and harm in south west Sydney* (NDARC monograph no. 38) (National Drug and Alcohol Research Centre, University of New South Wales, 1998)

Maher 2002: Lisa Maher, "Don't leave us this way: ethnography and injecting drug use in the age of AIDS" in *International journal of drug policy,* vol. 13, pp. 311-25 (2002)

131. The stresses of criminal prohibitions and their effects on the lives of users themselves constitute known risk factors potentially influencing the development of mental health problems and mental disorders. One can pick out many from the list, particularly relating to children, in the National mental health strategy monograph on promotion, prevention and early intervention for mental health. A selection of these factors include:

- alienation and social isolation
- experiencing rejection
- lack of warmth and affection,
- deviant peer group,
- physical illness/impairment
- unemployment, homelessness
- poverty/economic security; and
- neighbourhood violence and crime (DOHAC (2000), p.16).

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

132. 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 DOHAC (2000) pp. 3 &105). 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 neighbourhood” (Mullen (2001) pp. 7-8).
- 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%)."[1] "In those with schizophrenia who did not have a problem with substance abuse, there was only a modest increase in offending." (FORENSICARE (2000) p. 407).

- 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." (Mullen (2001) p. 11 & FORENSICARE (2000) pp. 406-07).
- 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." (Mullen (2001) p. 14).
- 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" (Mullen (2001) p. 15).

133. 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.(Switzerland (1999) part VII, paras. 2.2 & 3).

134. 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

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1. Summary of study in Mullen (2001) fn **Error! Bookmark not defined.**, p. 8

of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995."(Mullen (2001) p. 17).

135. The combination of both Is the expectation rather than the exception. Substance dependence, chiefly of dependence on illicit drugs is such a common comorbid condition with other serious mental health problem afflicting those caught up in the corrections system that the Senate select committee on the mental health in 2007 termed the dual diagnosis as "the expectation rather than exception." In evidence before a House Representative Committee last year Dr Richard Matthews, Chief Executive Officer of the NSW Corrective Health Service

The impact on particular populations

People with mental disorders

136. 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. (DOHAC (2000) pp. 49, 74).

(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. (DOHAC (2000) p. 16)

(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. (DOHAC (2000) p. 16).

Women

137. The imprisonment that is particularly severely upon women not only because of their high vulnerability to section abuse but also they are separated from their children, there being relatively little provision in Australia for children to be with their mother whilst in prison.

Strip searching and the special situation of women prisoners

138. Prison bears particularly heavily upon women who in this country but not necessarily overseas are separated from their children and prison practices such as

strip searching conducted in an attempt to keep contraband and particularly drugs out off prisons. Women prisoners have a much higher level of mental illness than even the high level of male prisoners (see p. **Error! Bookmark not defined.**).In the words of Professor Mullen of *Forensicare*, their particular problems "include the impact of abuse (child sexual, physical and emotional abuse, domestic violence and sexual assault in adult life) and the impact of separation from children." (Mullen (2001) p. 35).

139. The extent of sexual abuse is huge. A Queensland survey revealed that "a high number of female prisoners report sexual abuse prior to the age of 16 years (37%). An even higher number reported some form of non-consensual sexual activity (42.5%). In a number of cases, the abuse occurred before the age of 10 years (35%). More than a third of these abused women were subject to multiple episodes of attempted or completed intercourse before the age of 10. Among the women who had been sexually abused, the abuse continued in some cases for more than five years. By contrast in the greater population, 8.8% of Queensland women aged 18 or more report being the victim of rape or sexual assault" (ADCQ (2006) p. 72).

140. The severe impact on women of strip searching has been described in the following terms by Anti-Discrimination Commission Queensland:

> "Being compulsorily required to strip-search in front of prison officers is a demeaning and humiliating experience for any human being, male or female. Even if a strip-search is conducted in a totally professional and impersonal manner, the humiliation is compounded by the fact that prisoners then have to be supervised and relate on a daily basis with prison officers who have observed them in a naked and vulnerable state. In our western society where public nakedness is far removed from the accepted norm, this immediately reduces the dignity of any relationship between the prison guard and prisoner.
>
> "However, for a woman who has been sexually abused, strip-searching can be more than a humiliating and undignified experience. In some instances, it can re-traumatise women who have already been greatly traumatised by childhood or adult sexual abuse. The vast majority of [p. 73] female prisoners who spoke to the ADCQ said strip-searching diminished their self-esteem as human beings and greatly emphasised feelings of vulnerability and worthlessness. Strip searching can greatly undermine the best attempts being made by prison authorities to rehabilitate women prisoners, through programs and counselling to rebuild self-esteem, cognitive and assertiveness skills.

A number of women, including those serving long sentences, told the ADCQ they elected not to have contact visits at all because of their strong objections to being strip-searched. This is almost an impossible choice for women with children, who, in their attempts to maintain their relationships with their families, must have contact visits." (ADCQ (2006) pp. 72-73).

The indigenous community

ALTERNATIVE APPROACHES

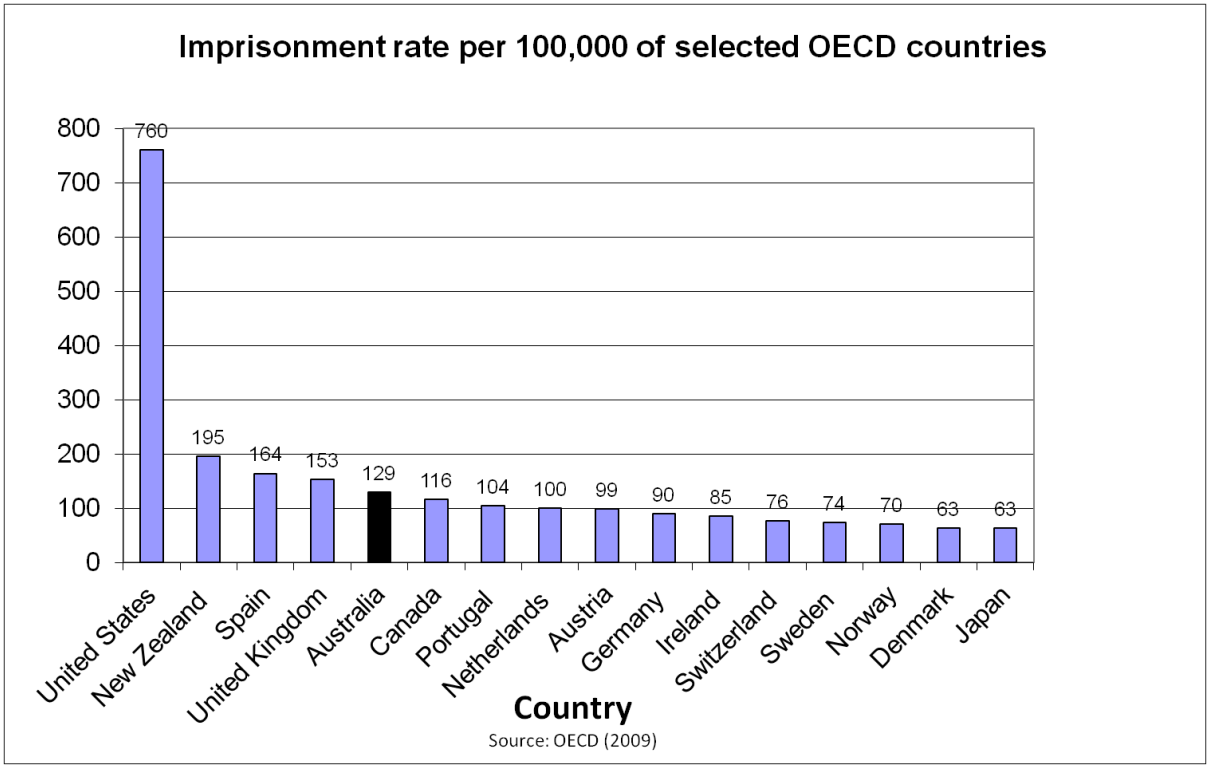
Comparing the crime rate and rate of imprisonment in Australia with that of other countries

141. Australia stands to learn from both the better and worse performance of other comparable countries in running prisons and dealing with crime. The OECD publishes information on both prisons and crime rates in Australia and other OECD countries.

Prison rates across the OECD.

142. The latest OECD compilation flatters Australia. It was published in 2009 but using 2005 figures when there were 125 Australians in prison for every 100,000. The Bureau of Statistics reports that on 30 June 2012 the rate had risen to 167 (ABS (2012)).

Chart 7: Prison and rate per 100,000 in selected OECD countries



143. The Bureau of Statistics has commented as follows on the different incarceration rates:

In Australia in 2008 there were 129 adults in prison per 100,000 people. This was the 12 the highest prison rate out of 30 OECD countries. Iceland had the lowest prison population rate of any OECD country (44), followed by Japan (63). The United States by far the highest prison population rate in the world in 2008 with 760 prisoners per 100,000 people.

Australia's prison population rate was slightly lower than the average across the OECD (139 prisoners per 100,000 people). However, this average is inflated by the US rate, which is more than three times as high as the next highest country, Poland (225). Without the US, the average prison population rate among the remaining 29 OECD countries in 2008 was 117 per 100,000 people, below the rate in Australia. Research suggests that sentencing policies were a big factor in high prison rates in the United States.

For example, property offenders and drug users are rarely imprisoned in European countries, while non-violent offenders make up more than half of the US prison population. However, violent offenders in the US spend five to ten times as long in prison as those in countries such as France.

Over the past 15 years prison rates have risen in most OECD countries. Between 1992 and 2008, the average prison population rate across OECD countries rose by 26%. In Australia the increase was slightly higher (31%). The greatest rise in proportional terms over this period (ABS (2009) p. 30).

Crime rates across the OECD.

144. Contrary to a common self- image that we have of our country, Australia does not enjoy a low crime rate when judged by reference to many other comparable countries:

> "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."(Makkai (2002) p. 111).

Since a surge in crime in the last decades of the 20th century, the crime rate in Australia has tended to decline (AIC (2012)). In this it has followed the trend in other OECD countries where it is reported that "Conventional" crime fell across the OECD, from 20001 to 2004/05. Even so the Institute of Criminology in its most recent summary of crime in the country has written of property crime:

"Despite the number of victims decreasing since 2009 across all three categories, Australia still experienced high levels of property crime in 2010" (AIC (2012) p. 5).

145. The following chart compares victim surveys of a range of crimes particularly associated with illicit drug abuse, namely burglary with entry, robbery and theft of personal property and pick-pocketing **(**OECD (2009b)). In the case of robbery, Australia is at the OECD average. This is three times more than the rate in Switzerland, The Netherlands and the Scandinavian countries. Australia experiences the sixth highest rate of burglary in the OECD – a rate substantially above the OECD average. The rate of theft and pick–pocketing is around the OECD average. Portugal, Spain and the Scandinavians are substantially lower. It is would be instructive for the committee to consider the response to these crimes of countries with substantially lower crime rates for these offences. Thy are they so different to

Australia?. Most of them have much more relaxed drug policies than Australia and Sweden which does not, spends a very large amount on drug treatment and rehabilitation.

Chart 8: Percentage of the population reporting being the victim of robbery in OECD countries

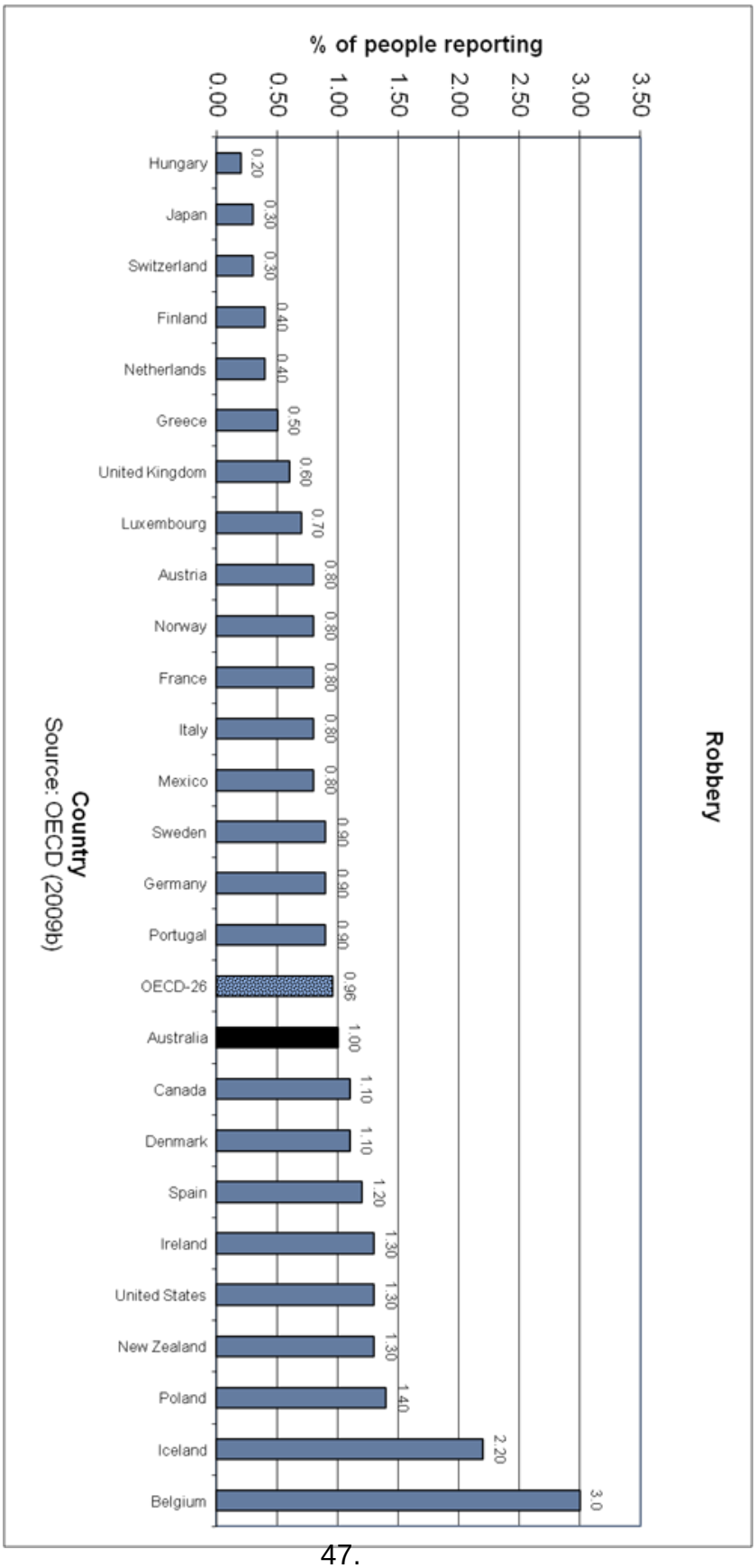


Chart 9: percentage of the population in OECD countries reporting being the victim of burglary

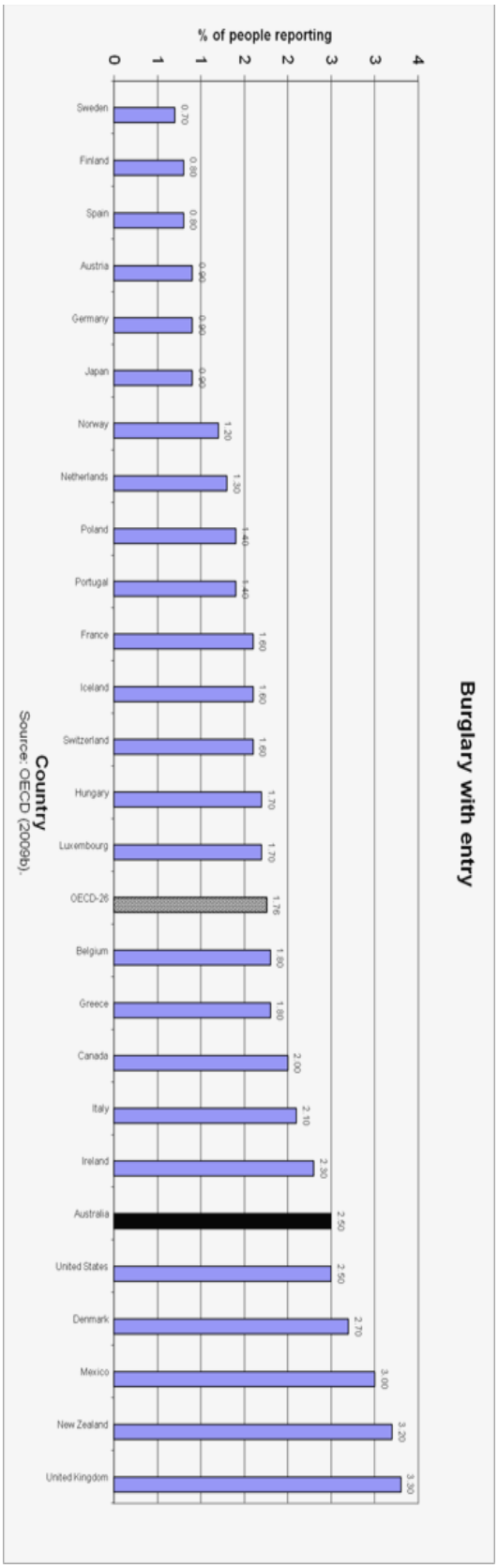
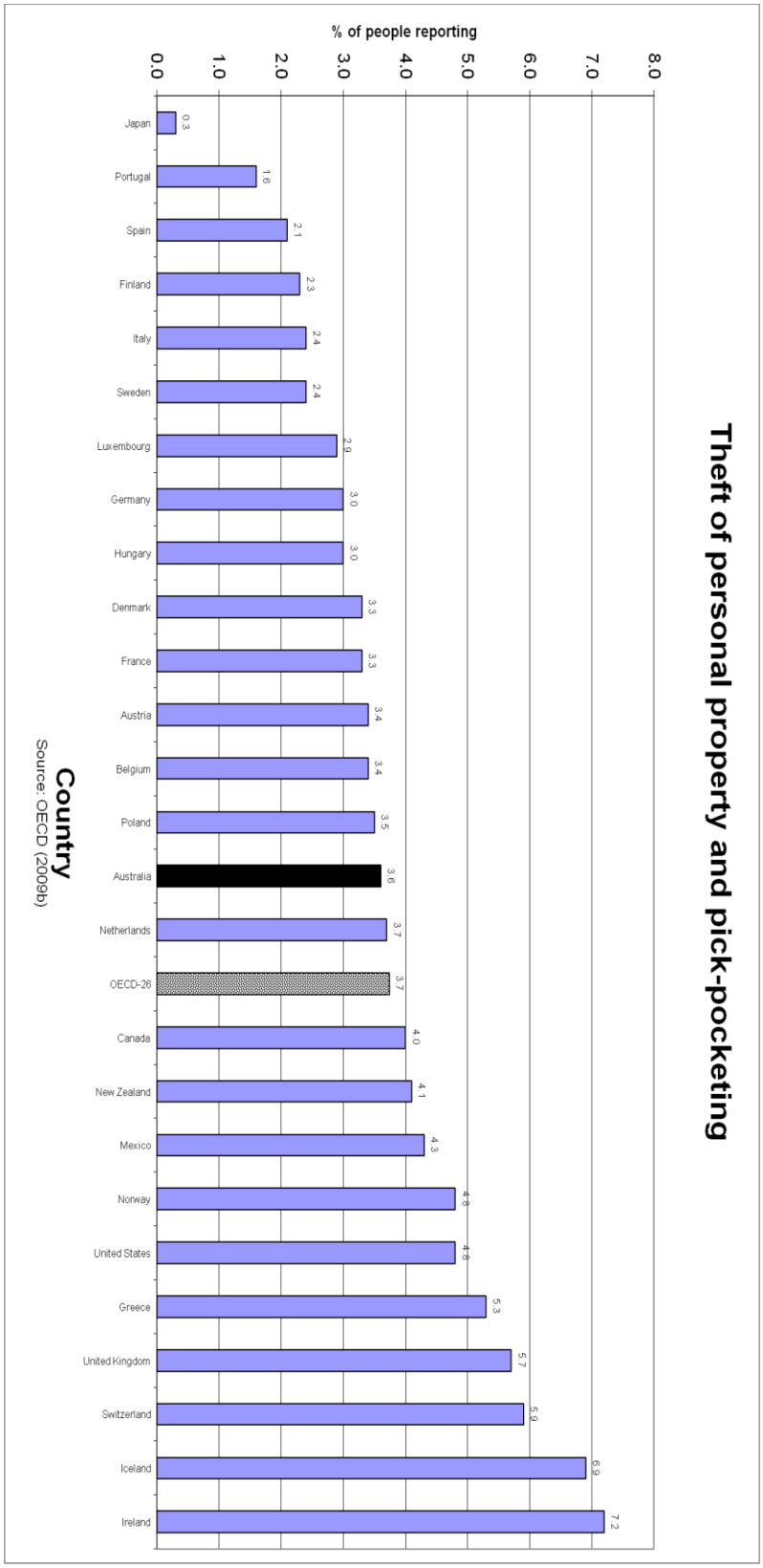


Chart 10: Percentage of the population in OECD countries reporting being the victim of theft of personal property and pick-pocketing



Correlation of crime with inequality

146. We Australians often think of ourselves as living in a secure, low crime society. This self image is far from being fully justified. Property crime and violence are two categories of crime particularly associated with illicit drugs and substance abuse. By world standards Australia has a high level of property crime. According to the Institute of Criminology:

147. Australia's homicide rate of about 17 million is far far below that of the outlyer, the United States, where the homicide rate is about 65 per million. Even so Australia's rate is well above countries which it would like to compare itself with like the Netherlands, Germany, Belgium, Denmark, Norway and Japan. There is an unmistakable correlation between violence and a society inequality. "The violent crimes are almost unknown in some societies. In the USA a child is killed by a gun every three hours." (Wilkinson and Pickett (2010) p. 132). Despite our much lower rate than the United States, Australia is a violent society compared to many other countries. As the following figure shows, homicides are more common in more unequal societies. Despite some exceptions which probably relate to fire arm ownership, this correlation between inequality and higher homicide rates "is well established" (Wilkinson and Pickett (2010) p. 136).

148. And the connection goes deeper than correlation. Violence is associated principally with young men and mostly by young men at the bottom of the social scale. The violence is “most often a response to disrespect, humiliation and loss of face, and is usually a response to these triggers." (Wilkinson and Pickett (2010) p. 140). This causal connection between the lack of status, commons among those at the bottom of the pecking order in unequal societies. Such iolence is a pattern identified in "a wealth of books, chapters and articles [using]) statistical, anthropological and historical data. [These] show how young men have strong incentives to achieve and maintain as high a social status as they can because their success in sexual competition depends on status." (Wilkinson and Pickett (2010) p. 134).

149. There is an even clearer correlation between incarceration and income inequality. As the following figure shows, more people are imprisoned in more unequal countries and that more unequal societies are more punitive. Australia with an incarceration rate of near 134 per 100,000 is again at the more punitive end of the scale of comparable countries. (Figure 11.1).

150. The causative links between the illicit drugs and substance abuse on the one hand and crime and incarceration on the other have been examined above at pp. 37ff. Property crime is, of course, the most common correlates of illicit drug abuse. Punishment by incarceration ensures that a property offender graduates as a violent one as an American criminologist has put it "the most effective way to turn a non-violent per person into a violent one is to send him to prison." (Quoted at Wilkinson and Pickett (2010) p. 154).

151. We have seen above at pp. 18 ff. that incarceration is a fairly ineffective way to reduce crime. While it can incapacitate an offender from committing further crime in the community while he or she is in prison, it is singularly ineffective in deterring people from committing crime and rehabilitating those who are imprisoned. These considerations apply particularly to drug crimes. Prof Mark Kleiman has shown that the deterrence effect of drug laws and drug law enforcement are extremely low

because only a small percentage of those who deal in or use drugs are ever caught and if caught are the rarely punished. (The lack of punishment at least avoids the harm that punishment by imprisonment often entails. A lesson that some may draw from this finding is that we should intensify drug law enforcement but the evidence is that doing so will not get us out of the woods:

> "We might expect countries with lower overall rates of imprisonment to have higher rates of the offending. In fact, there appears to be a trend towards higher rates of re-offending in more punitive systems (in the USA and UK, reoffending rates are generally reported to be between 60 and 65%) and lower rates in less harsh environments (Sweden and Japan are reported to have recidivism rates between 35 and 40%)." (Wilkinson and Pickett (2010) p. 155).

Addressing the social factors that are known to intensify risk factors for crime

Reform of drug policy

152. Effective treatments are known or likely to improve the physical and mental health and social wellbeing of dependent drug users and minimise related community harms.

Methadone treatment

153. Crime reductions accompanying methadone maintenance treatment has been carefully assessed in a lot of studies. Most likely people on methadone programmes will have been dependent on heroin. Dependency continues while receiving the artificial opiate, methadone. Even so, offending behaviour of patients is shown to decline while in opiate maintenance treatments. Two examples of the many trials are mentioned here. The first is the Treatment Outcome Prospective Study (TOPS) carried out in the United States from 1979 into the early 1980s. This was a large prospective study of over 11,000 illicit drug users who applied for treatment in 41 programs.

> "Criminal activity was assessed by self-reported predatory crimes such as breaking and entering and robbery. Among patients in methadone maintenance, one-third reported committing a predatory crime in the year before treatment. This dropped to 10% during the first month of treatment. . . . Methadone treatment . . . was associated with a reduction in criminal activity during treatment but did not permanently change the behaviour of the more criminally involved patients in the post-treatment period" (Ward, Mattick & Hall 1992, p. 31).

154. The second example is the results of a large-scale outcome study of methadone maintenance treatment involving six methadone maintenance programs, two in each of Baltimore, Philadelphia and New York, over a three-year period between 1985 and 1987. The study found that methadone maintenance had "a dramatic impact" on crime among the 388 patients who remained in treatment:

"The reduction of crime associated with retention in methadone maintenance . . . appeared impressive. The study sample had an extensive criminal history prior to entering methadone: a total of 4,723 arrests, with a mean of nine

arrests for the 86% of the sample who had been arrested. Sixty-six per cent of the group had spent some time in gaol, 36% having been incarcerated for two years or more. Although these figures indicate extensive criminal involvement, they seriously underestimate criminal activity which is better estimated by self-reported crime.

"The sample admitted to 293,308 offences per year during their last period of addiction. Among those who admitted committing criminal acts, each person committed an average of 601 crimes per year (range 1 to 3,588), and had committed criminal offences on an average of 304 days per year during their last addiction period. After entry to methadone, the number of self-reported offences declined to 50,103 crimes per year and the mean number of 'crime days' per year decreased from 238 in the year prior to entry to 69 crime days during the early months of methadone maintenance. The number of crime days continued to decline with the number of years spent in treatment. In terms of the number of crimes committed, the reduction during methadone maintenance was 192,000 offences per year. As [the authors of the study] remark, such a substantial reduction in criminal activity among heroin users is usually only achieved by incarceration" (Ward, Mattick & Hall 1992, 35).

155. More recently, according to a large Australian evaluation of pharmacotherapies for opioid dependence:

> "Property crime was reported at baseline by a significantly greater proportion of Heroin Users (20%) than Methadone Patients (5%), as was drug dealing (23% vs. 8% respectively); fraud (8% vs. 2% respectively); and violence (3% vs. 1% respectively).

Criminal behaviour among Heroin Users was halved at the three month follow-up.

156. Heroin Users' average monthly expenditure on heroin decreased from $2,611 at baseline to $572 at three-month follow-up, consistent with the decreases in heroin use" (Mattick *et al* 2001, pp. 4 & 41).

157. The cautious conclusion from a survey of all studies is that: "The relationship between methadone maintenance and a reduction in . . . criminal behaviour is, on average, a reasonably strong one" (Jeff Ward, Richard P. Mattick and Wayne Hall (eds.), *Methadone maintenance treatment and other opioid replacement therapies* (Harwood Academic Publishers, Amsterdam, 1998 second printing) p. 47).

Prescription Heroin

158. In a number of countries including the United Kingdom, heroin may be prescribed for treatment of opioid addiction. This pharmacotherapy has led to even more crime reduction than methadone and other pharmacotherapies used in Australia.

159. Trials in The Netherlands, and Germany have shown it to be even more effective than methadone in stabilising those suffering from with a dysfunctional drug dependence. Heroin prescription is now part of the suite of standard treatments available in Switzerland, The Netherlands, Germany and Denmark. Heroin prescription in The Netherlands resulted in "strong reductions in illegal activities" (Netherlands 2002 p. 148). The changes in offending measured in more detail for those being prescribed heroin in Switzerland have also shown this. Reductions that

can only be described as spectacular were documented using different measurements. These measurements were:

(a) self-report by those on the programme of the extent they engaged in crime before and during treatment;

(b) self-report of the extent that these same patients on the programme were themselves victims of crime before and during treatment; and

(c) the changes in offending behaviour for those on the programme as reflected in their contacts with police.

160. A summary of the outcomes for just the first year of treatment compared to the six months before are set out in the following table. It records a reduction of 94% in the number of patients on the programme engaged in serious property offences (the prevalence rate). It also shows an even greater reduction in the frequency with which each individual offended (the incidence rate). Such offences particularly associated with illicit heroin use. This is in contrast to the small reduction in offences such as assault which are committed relatively rarely by opiate users.

Table 4: Prevalence and incidence rates of self-reported criminality, after one year of treatment in the Swiss programme of heroin prescription, compared to the time before admission

(reference period of 6 months, N=305).

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
serious property offences[1]	11.2	0.7	<.001	94%	0.388	0.007	<.001	98%
other property offences[2]	39.9	17.4	<.001	56%	7.238	0.954	<.001	87%
selling “soft” drugs	26.3	12.5	<.001	52%	8.960	2.162	0.001	76%
selling “hard” drugs	46.9	8.2	<.001	83%	25.297	2.030	<.001	92%
assault[3]	1.0	1.0	ns	ns	0.017	0.016	ns	ns

1 burglary, muggings, robbery, pick-pocketing

2 thefts, shoplifting, receiving or selling stolen property

3 with or without weapon

Source: Killias, Aebi & Ribeaud 2005 pp. 193-98 table 1 at p. 195.

1. Victimisation is recognised as being closely correlated with delinquency. In this domain the Swiss trial produced a particularly strong diminution in offences connected with the life of drug dependent people namely victimisation in terms of robbery, theft and fraud involved in the purchase of drugs.

2. So spectacular has been the reduction in crime of those receiving prescribed heroin that a noted Swiss criminologist has written: “In all, heroin treatment constitutes without doubt one of the most efficacious crime prevention measures of ever trialed.” (Killias *et al* 2002 p. 80).

Poverty

3. Pharmacotherapies have helped dependent users to reintegrate into the community in other domains ways. “Financial debts constitute a serious impediment to social integration; they represent a major obstacle and have a demoralising effect. . . . Debts decreased continuously during the [pharmacotherapy] treatment period. After 18 months of treatment, one third of patients were debt free and a further quarter were only moderately indebted” (UCHTENHAGEN *et al.* (1999)).

4. Given effective treatments, improvements can be expected in domains as diverse as general health including blood borne diseases and mental illness, crime, corruption, poverty, child protection, public housing, dependence on social welfare, special needs education and even in the design of our towns.

5. In Switzerland, treatment in the form of heroin prescription is estimated to have produced a net saving to the community of 45 Swiss Francs per user per day.

> "The average cost in the ambulatory treatment centres is estimated at 51 francs per patient per day. The general economic benefit flowing from saving realised in criminal prosecutions and prison sentences and from the improvement in the level of health is estimated at 96 francs. After deduction of the costs, an average benefit of 45 francs per patient per day is obtained" (Swiss Federal Office of Public Health, April 1999 & Gutzwiller & Steffen 127-28).

Making the present system of deterrence work more effectively

161. A quite different approach was urged by Professor Mark Kleiman, a professor of Public Policy in the UCLA School of Public Affairs on a recent visit to Australia in the course of which he gave a presentation in Parliament House on Tuesday 26th February 2013 at a gathering hosted by Andrew Leigh MP, Member for Fraser (http://www.andrewleigh.com/blog/wp-content/uploads/2013/01/Kleiman-Invitation.pdf). His visit to Australia was sponsored by the Foundation for Alcohol Research and Education and the NSW Bureau of Crime Statistics and Research (BOCSAR).

162. Prof Kleiman has studied how to make law enforcement more effective as a mechanism to change behaviour: a science of corrections. In aid of this he has applied game theory to explain the ineffectiveness of American drug law enforcement. Such enforcement is ineffective because it is neither swift nor sure nor just – these being the criteria enunciated by *Beccaria* in Italy in the mid 18th century. So ubiquitous is drug offending that the chance of any offender being apprehended is negligible. He writes of "the average number of days incarcerated per offence." He computed that the "low point of the punishment-to-offence ratio,” occurred in 1974 when "on average, then, each burglary resulted in about 1% of the year – about four days – behind bars." The reasoning goes that the rational criminal (generally young men) view these "rather trivial punishment levels” as a reason for doing crime (Kleiman (2009)). If apprehended, the offender is placed on probation under the supervision of probation officers who have an impossibly large number of offenders

to supervise. Only occasionally are such offenders brought back to the court for breach of the terms of their probation and there they customarily receive stern lectures and a never ending series of “final chances”. Prof Kleiman showed graphically using a chess board like matrix (technically a “systems dynamic model”) how the number of offenders in such a system where there is a low chance of punishment is likely to rise and rise. Drug dependent offenders who are known to prefer immediate gratification above long term benefits will look rationally at the situation and choose to continue drug use.

163. Prof Kleiman proposes that the solution lies in getting serious with such offenders or, in other words, carrying through the threats of punishment which the law and courts lay down. He proposes that a case officer be limited to a manageable caseload of offenders who they will be expected to supervise closely. This would be achieved by insisting on regular urine drug testing or the use of technology such as ankle bracelets fitted with GPS recorders or wrist bracelets that detect from sweat the use of drugs and broadcast information back to their probation officer.

164. If a relapse is detected the probationer should be brought before the court that put him or her on probation. There would be none of the interminable negotiations with the offender that are typical of drug courts. Rather, the offender would be ordered to be detained typically overnight in the local lock up (like Canberra’s Periodic Detention Centre) rather than prison time thus making good the threats of punishment of the laws and the courts. Although Kleiman did not go into this, I am told that consistent punishment of this sort has been demonstrated in well-controlled studies in a number of settings to induce offenders to change their behaviour. Once the offender is thereby freed from his dependency, a probation slot is freed up which will be filled by another offender on the list. By this means the existing correctional and court resources will work methodically through the offending population effectively reducing demand for illicit drugs. Kleiman illustrated this with his chess board matrix which showed a gradual bleeding of the board of red, symbolising offending, until the board was entirely bleached.

165. Kleiman reported promising results from well-controlled studies in South Dakota and Hawaii among other locations. “Surprisingly”, according to Kleiman, a poll of offenders exposed to this rigorous regime had supported it by a majority of 75%. He speculates that they may be grateful for a fair and just if strict parental figure in their life which drug users mostly lack. He implied that “bad parenting” was a common cause of drug abuse.

166. Worries about the Kleiman approach.

1. The relies upon deterrence in the criminal law and law enforcement to bring about changes in people's behaviour.
2. To be effective, Kleiman's proposal assumes that potential offenders act in a rational way. This is described well by Prof Becker of the University of Chicago and crime":

> Criminal activity, like all human activity, reflected the responses of selfishly rational actors to the incentives created by their desires and opportunities. People would offend, according to Becker, if and only if the rewards of offending, net of the risks of being punished, exceeded the rewards of not offending."

This reflects a very narrow and some would say distorted view of human nature. Moreover, it is unclear the extent to which the assumptions of behaviour would apply to people with a mental health problem – the very people with complex needs who perform such a high proportion of our prison population.

3. Even if a certain and prompt punishment induces avoidance of crime, it is unlikely to address as many of the other problems in the lives of the people concerned as would correctional policies fashioned on the basis of what is known about the determinants of health and well-being and of risk and protective factors and protective factors. It is likely that other approaches would give more value for money from the public purse.

   (a) What Kleiman advocates, intensifies the micro-management of people as lives that the existing correctional system already does. Indeed it relies upon in tennis management of the daily routine of human beings which, as we have seen, tends to undermine rather than build up their capacity to function in the world outside.

   (b) Kleiman does not seem to give credence to the clearly demonstrated benefits of different drug policies in Europe. For example, at the Parliament house gathering, he maintained that the Swiss heroin prescription was far too costly whereas a careful cost benefit analysis has a daily saving of 45 Swiss francs per patient per day (Swiss Federal Office of Public Health, April 1999 & Gutzwiller & Steffen 127-28).

   He writes that "making usable drugs more easily available will tend to lead to more abuse and addiction, with predictable should not only to those who get into trouble with drugs but also their families, friends, and neighbours." (Kleiman (2009). The experience of Switzerland of heroin is quite the opposite. Since the introduction there of prescription heroin in 1995, a study reported in *The Lancet* of the canton of Zurich has shown a large decline in the recruitment of new heroin users:

   > “The incidence of regular heroin use in the canton of Zurich started with about 80 new users in 1975, increased to 850 in 1990, and declined to 150 in 2002, and was thus reduced by 82%” (Nordt & Stohler).

   (c) The degree and nature of harm from a substance is heavily impacted by how it is regulated. The marketing of both illicit drugs and alcohol have a lot in common. The distribution of illicit drugs via peers is an extraordinarily effective and resilient form of marketing that is that is highly resistant to law enforcement effort. In practice it is as free from constraint as is the weakly regulated retail alcohol industry. The regulation of tobacco provides lessons from which public policy in relation to illicit drugs and alcohol could both benefit.

   (d) Even if Kleiman’s swift and sure response to drug related crime is effective, one wonders whether it would be as efficient as others responses described above. Kleiman's scheme requires the intense deployment of resources; it can process only a small number of offenders at any one time; the pool of offenders is very large. In contrast, pharmacotherapies such as methadone, buprenorphine or medically

prescribed heroin could be dispensed simultaneously to a much higher proportion to the the target population. For a greater net consolidated benefit even if the individual transformation is not quite as successful.

Monday, 25 March 2013

ABBREVIATIONS

ABS Australian Bureau of Statistics,
ACS ACT Corrective Services

AHRC ACT Human Rights Commission

ACCC Australian Crime Commission

AIC Australian Institute of Criminology

AIHW Australian Institute of Health and Welfare,

ICD International Classification of Diseases of the World Health Organization

IHS Inmate health survey

DSM Diagnostic and Statistical Manual of the American Psychiatric Association

DUMA Drug use monitoring program of police detainees

MHCA Mental Health Council of Australia

OECD Organization of Economic Co-operation and Development

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