HEALTHY OR HARMFUL?

MENTAL HEALTH AND THE OPERATIONAL REGIME OF THE NEW ACT PRISON

ACT COMMUNITY COALITION ON CORRECTIONS

Canberra
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"Who can turn skies back and begin again?" (*Peter Grimes*)

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SUMMARY

It would make little sense to provide a first class medical team and a state of the art hospital to treat illnesses brought about by an unsanitary water supply, yet this is what so often passes for sensible action with prisons and mental health. Certainly, there needs to be a crisis support unit in the new prison and a separate forensic mental health facility for the ACT but above all the prison environment should not be unsanitary from a mental health point of view.

It is a prodigal waste of resources as well as being inhumane if the prison precipitates mental health crises, yet this is what the traditional prison environment does. Such an environment is characterised by seclusion and degrading and traumatising practices like frequent strip searching. Steps taken to put it out of the physical power of distressed people to take their own life are generally the opposite of satisfactory therapeutic practice. Suicide may be prevented by the confinement of a depressed person in a padded cell with no hanging points and under constant remote surveillance but the person's mental illness will probably be made worse and the likelihood increased of a successful suicide attempt after release.

This paper puts forward ways by which this counterproductiveness can be avoided. Mental health expertise needs to be brought into the design and operation of the prison regime. The regime should not reproduce well documented risk factors for poor mental health, factors like isolation and physical, sexual and emotional abuse. Rather, it should reflect the known protective factors like a sense of connectedness with the community, good physical health and access to support services. To develop, operate and monitor a healthy operational regime like this will require mental health expertise to be engaged in a formalised standing arrangement like a corrections board akin to the board of directors of a company.

At the same time, the system of "direct supervision" or "dynamic security" that ACT Corrections is talking of introducing, should be encouraged and implemented from day one. This system involves a close interaction between custodial officers and detainees rather than relying on barriers and control. It focuses on meeting the needs of detainees through, for example, programs of activities.

A healthy prison is also dependent on the adoption of a different mind set about drugs. A big majority of those in the new prison will be dependent on substances which will be combined with another mental disorder. Addiction is a chronic, relapsing mental health condition and must be treated as such. The governing prison mind set that places a higher value on abstinence than on life and well being erects an oppressive operational regime in an attempt to stamp out the use of substances within the prison. Those steps which are presented as being in the best interests of

detainees in fact greatly contribute to the typical unhealthy prison environment. Strip searches and restrictions on family visits are examples. A balanced drug policy with first class drug treatment will help reduce the frighteningly high overdose death rate of recently released prisoners.

The paper points out that it will be possible for the new ACT prison to fulfil its objectives only if political parties are committed to positive outcomes such as reduced recidivism and restorative justice. This, of course, means that the health of those who pass through the prison needs to be surveyed so that the success of the prison can be evaluated. The paper discusses what evaluation should involve in the area of mental health. Evaluation must be done by reference to the real world after release: so often, perceived gains of imprisonment quickly vanish because the traditional prison has reduced the capacity of those detained to make their way and fulfil their responsibilities in the world outside.

What does all this mean for victims? The paper points out in its final section that a healthy prison regime is essential if the government's commitment to restorative justice for the benefit of victims and the community is to be implemented in the context of the new prison. There will be less crime and thus fewer victims if the poor mental health of those sent to prison is improved and not further damaged by the prison experience. Improvement in mental health builds the capacity of people to function as responsible members of the community. So often the prison gate is a revolving door of mentally ill human beings sent out and returning from the community. It also must be remembered that people who offend are themselves typically the victims of crime. Imprisonment should not revictimise them as the prison regime so often does to women and men who have been the victim of childhood and other sexual abuse.

ABOUT THE ACT COMMUNITY COALITION ON CORRECTIONS

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

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

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

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

- To monitor developments in ACT corrections, including ongoing adherence to the principles on which the Alexander Maconochie Centre was founded;
- To highlight issues faced by detainees and their families;
- To inform Government policy making processes relating to corrections;
- To conduct advocacy on corrections issues through submissions to Government, correspondence with Government Ministers, community forums and media advocacy;
- To enable the exchange of information between members of the Coalition, build relationships between organisations and thereby improve coordinated service delivery to prisoners;
- To provide a forum for relevant community organisations to engage in collaborative projects to secure better outcomes for offenders and the community; and
- To encourage open and positive relationships between all stakeholders in the corrections system.

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I. INTRODUCTION

This paper argues that the operation of the prison regime must promote improvement in the poor mental health of those detained. To achieve this the damaging operational regime of the traditional prison must not be replicated in the ACT. This can be achieved only if the regime is designed, operated and monitored with the close oversight of those with a deep understanding of how to promote mental well being. This approach goes beyond what is presently planned for forensic detainees or the treatment of mental illness in the prison population in its Crisis Support Unit or otherwise under the *Adult Corrections Health Service Plan*. Without an environment that promotes mental well being, rehabilitation will remain a pious dream and the new prison a costly institution that further entrenches disadvantage and does little to reduce crime.

Imprisonment is a response to crime in the community. It is an expensive response, costing something like $70,000 for each detainee per year. If it is to be money well spent it must lead to a substantial reduction in re-offending by those sent to prison. Imprisonment should lead to less crime and fewer victims.

The ACT Government has committed itself to the goal of rehabilitation for those who graduate from the prison in both public statements and its enactment of the *Human Rights Act* 2004. Indeed, Australia (and the ACT Government) is committed to this objective under international law. Art. 10(4) of the International Covenant on Civil and Political Rights requires that: "The penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation."

At the core of any successful project to reduce reoffending must be measures that effectively address the two most widespread characteristics of the prison population, namely, mental illness and addiction. These conditions are not only themselves well recognised risk factors for offending behaviour but are also closely correlated with a bundle of other risk factors including homelessness, poverty, unemployment, family violence and dysfunction that also characterise the prison population.

It is therefore imperative not only that the new ACT prison have first class treatment of substance abuse but that it be a healthy environment for the mental as well as physical well-being of detainees. The mental illnesses that are the focus of this paper are not the acute and florid ones associated with forensic detainees. The Government has committed itself to provide the means of meeting the demanding needs of these people outside the correctional environment

under the direction of ACT Health. Nor does the paper focus directly on the acute needs that arise for those in the general detainee population in the prison's Crisis Support Unit. Although this unit "is not a health facility and will be exclusively staffed and run by ACT Corrective Services", Mental Health ACT clinicians will provide support for those in it (ACTH (2008) p. 31). Nor does the paper focus directly on the mental health treatment that will be provided under the *Adult Corrections Health Services Plan*. That plan encompasses services that include:

- clinical management of the mental health of remandees and people in detention;
- ongoing psychological assessment;
- individual counselling; and
- mental health counselling (ACTH (2008) p. 13).

What the paper focuses upon is the extent that the general prison environment will be conducive to the improvement in the poor state of mental health of the general prison population.

The ACT Community Coalition on Corrections is concerned that mental health implications of the prison environment are not receiving the attention that they should and that, for example, no formalised standing arrangement is envisaged for the expert opinions of the mental health sector to be reflected in the development, maintenance and monitoring of the operational regime of the new prison.

The Coalition understands that whereas ACT Corrections have consulted ACT Mental Health on the Crisis Support Unit, they have not consulted it on the general prison regime. It would be inhumane as well as a gross waste of scarce mental health resources if the general regime precipitated mental health crises that require the services of the Crisis Support Unit. It would sabotage the professed rationale for the prison if its regime led to detainees emerging in worse mental health than that in which they entered.

The Coalition's concerns are heightened by the findings of the recent audit by the ACT Human Rights Commission of existing remand centres (AHRC (2007)). That report reveals a most unhealthy psychological environment which extends beyond the crowded and otherwise inadequate physical dimension of the existing remand centres. It is imperative that a similar damaging regime not be replicated in the new prison. Among other things, the system of "direct supervision" or "dynamic security", which the Coalition understands ACT Corrections is seeking to implement, should indeed be carried through thoroughly.

This paper first outlines the extent and types of mental ill-health, including substance dependence, that can be expected among ACT detainees. It will then identify the risk and protective factors associated with both mental disorders and offending which characterise the backgrounds of those sent to prison. The paper then compares characteristics of the standard prison regime with those risk and protective factors. These prison characteristics include the widespread practice of seclusion and strip searches, pervasive boredom and other customary stresses of detention.

This survey leads to the identification of four requirements for a healthy operational regime. These are, firstly, a formalised, standing arrangement in the form of a corrections board for mental health professionals to be involved in decisions on the operational regime; secondly, the introduction of a comprehensive system of dynamic security; thirdly, the acceptance that addiction is a mental health problem and should be treated as such and, fourthly,

a commitment by political parties to achieve positive outcomes from the prison such as reduced recidivism and restorative justice.

The paper makes the point that evaluation of the effectiveness of the prison must measure the capacity of those who emerge from it to function as responsible citizens in the real world outside the prison. A healthy operational regime within the prison must be complemented by a coherent plan for the managed return of those released from the prison to the community. Finally, the paper points out that improving the mental health of those detained serves the interests of victims. It will mean that there is less crime and thus fewer victims. The position of those who have been victimised will also be improved. The sorts of measures to improve mental health in the prison will also provide a basis for the introduction of restorative justice conferencing in the prison, a healing process that offers deeper satisfaction to victims than the regular processes of the criminal law.

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KEY RECOMMENDATIONS

- A corrections board should be established with mental health expertise to be responsible for the prison's operational regime. At the very least this board should include the persons holding the positions of Director of Mental Health, ACT and Chief Psychiatrist, ACT and the Corrections Medical Officer. *Page 27.*
- A comprehensive system of dynamic security should be introduced into the new prison involving:
  * close interaction between custodial officers and detainees rather than relying on barriers; and
  * a focus on meeting the needs of detainees with activities, services and practices. *Page 28.*
- Addiction should be regarded as the mental health problem that it is and should be managed as such. *Page 29-30.*
- Rather than giving top priority to making detainees drug free, priority should be given to people emerging from prison with the physical and mental capacity to take their place in society as responsible members who are capable of fulfilling their obligations both to those dependent on them and to the community at large.
  Page 29-30.
- As a priority, all political parties should commit themselves to a corrections system that:
  * reduces recidivism in the ACT community;
  * rehabilitates those subject to it; and
  * bases measures to achieve these outcomes on the best available evidence.

  Page 31.
- There must be put in place standing arrangements to monitor and evaluate the effectiveness of the prison by reference to what occurs to people after and not just on their release.
  Page 33.
- There should be whole of government planning to set in place a seamless set of measures in support of those detained to be taken within the prison and out into the community. These measures should include adequately resourced community services and, in particular, prearranged mental health support. *Pages 37-38.*

KEY POINTS AND ADDITIONAL RECOMMENDATIONS

- An overwhelming majority of detainees have pre-existing mental health disorders even without taking into account substance use disorders. *Page 8.*
- A somewhat smaller majority has a substance use disorder. *Page 9.*
- Detainees with both a substance use and some other form of mental disorder are the expectation in prison rather than the exception. *Page 10.*
- Dependence and substance abuse are forms of mental disorder. *Page 8.*
- Prisons are populated by those with an accumulation of known risk factors for mental ill-health. *Pages 12-14.*
- Common risk factors include physical, sexual and emotional abuse and poverty and economic insecurity. *Pages 12-14.*
- Many risk and protective factors influencing mental health problems are also acknowledged risk and protective factors for crime. *Pages 12-14.*
- The usual prison environment further damages mental health because it is replete with many known risk factors for mental ill-health and crime. *Pages 12-14.*
- Improvement in mental health and reduction of recidivism requires the cultivation of protective factors like sense of connectedness and minimisation of existing and additional risk factors. *Page 14-16.*
- There are barriers in the typical prison environment against detainees accessing mental health services. *Page 14-16.*
- Those who do seek mental health treatment are at risk of being seen by staff as attempting to evade the rigours of prison and by fellow prisoners as weak and unacceptably alien. *Page 14-16.*
- Treatment is typically concentrated on the relatively small proportion of detainees whose condition is obvious and whose behaviour causes management problems. Others tend not to receive the treatment they need. *Page 14-16.*
- The typical stresses of imprisonment are harmful to the mental health of those detained. The stresses include:
  * The sudden disruption in people's life;
  * The separation from family support; and
  * The coercive and highly regimented daily routine. *Page 16.*
- The regimented routine of the usual prison directed at conformity and compliance within which some who are mentally disordered thrive reduces their capacity to cope with the contradictions and complexities of the world outside. *Page 16.*

- To counter these effects, the new ACT prison must do much more than aim for conformity and compliance. *Page 17.*
- Strip searching is common in prisons including ACT remand centres and would continue at a significant level even with the permanent introduction of body scanning. *Page 18.*
- Frequent use of scanners gives rise to radiation concerns. *Page 19.*
- Strip searching is psychologically damaging. It is degrading and destructive of self worth for anyone, male or female, and particularly for a vulnerable prison population in poor mental health. *Page 18.*
- It is a practice of the gravest concern for women. An overwhelming number of women in prison have been traumatised by sexual abuse. Strip searches serve to perpetuate and intensify that. *Page 18.*
- The damaging regime of strip searching flows from a perception of security and community expectations to keep drugs out rather than promotion of the well-being of detainees. *Page 19-20.*
- Seclusion is widely used in prisons including ACT remand centres to confine people separately or otherwise drastically limit the extent that they can interact with others. *Page 21-21.*
- It occurs in the name of security, discipline, the welfare of the person secluded and to meet administrative needs including lengthy unscheduled lockdowns. *Page 21.*
- Seclusion injures mental health and in the mental health system is viewed as a failure to respond in an adequate and timely manner to the needs of people who are mentally ill. *Page 22.*
- Solitary confinement, which ACT legislation permits for up to 28 days, is particularly harmful. *Page 22.*
- Use of seclusion in padded cells under surveillance to prevent suicide or other self harm promotes later suicide attempts. *Pages 23-24.*
- The prison's operational regime should be designed to reflect the therapeutic principle that positive human interaction and support are fundamental for suicide prevention. *Page 24.*
- Corrections and other prison staff should receive lay training in understanding and working with detainees who have mental disorders. *Page 24.*
- Lack of meaningful activities is common in prisons including ACT remand centres. *Page 25.*
- Boredom makes for an unhealthy environment that stimulates anger and frustration impeding those detained from accepting responsibility for their actions. *Pages 25-26.*
- The new ACT prison should have a well designed and resourced program of activities. *Pages 25-26.*
- Many of the prison practices that are most injurious to mental health are taken out of concern to keep drugs from prisoners. *Pages 19-20.*

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- It is unrealistic to expect that prison will be able to "cure" many prisoners of addiction, which is a chronic relapsing condition, but realistic that with good treatment their condition can be stabilised. *Pages 30-30.*
- Within the interlinked domains of self harm, overdosing and mental illness, the failings of the traditional prison regime in rendering people fit to resume their place in the community are obvious. *Page 33.*
- There is a sharp rise in the suicide deaths of men in the first weeks after release from prison. *Pages 34-34.*
- There is a high rate of overdose, including overdoses leading to death, among addicted people released from prison. *Pages 35-36.*
- Without good support within the community released prisoners with a mental health disorder are at high risk of reoffending and suffering a deterioration in their mental health. *Page 36-38.*
- Victims stand to benefit from a healthy operational regime through:
  * less crime and thus fewer victims if the poor mental health of those sent to prison is improved and not further damaged by the prison experience;
  * less revictimisation of people who have offended and who have themselves suffered as victims of crime. A high proportion of people in prison have been victims of crime themselves;
  * the healthy prison regime establishing the conditions for implementation of the government's commitment to restorative justice. *Page 39.*
- The conditions required for restorative justice to work in a prison setting are respect, the assumption of responsibility and the freedom to solve the problems by those involved in the conflict. These conditions will not exist in the new prison if it replicates those of the typical prison. *Pages 39-41.*

II. EXTENT OF MENTAL ILL-HEALTH AMONG DETAINEES

As the ACT Human Rights Commission has observed, "prisons have become substitute accommodation for people with mental health problems" (AHRC (2007), pp. 32 & 98). This is evident in comparisons of the mental health of the NSW prisoner population and the mental health of the community at large. Dr Richard Matthews, Chief Executive Officer of NSW Corrective Health Service presented the following table illustrating this in evidence in 2002 to a House of Representative Committee which showed that:

- 10.7% of men had a psychosis compared to 0.43% in the community;
- 16.0% had depression compared to 3.4% in the community;
- 33.9% had an anxiety disorder compared to 7.1%; and
- 39.9% had a personality disorder compared to 6.83%;
- the extent of mental illness or disorders among women was even higher. All told, on reception in NSW, 78.2% of men and 90.1% of women have a psychiatric condition.

Table 1: Comparison of selected mental health conditions in the Community and on Reception in the NSW Corrections System

Receptions (n = 756m/165f)
Community (n = 6,627m/6,837f) from National Mental Health Interview.

	Male %		Female %	
	Reception	Community	Reception	Community
Psychosis	10.7	0.43	15.2	0.41
Depression	16.0	3.4	23.6	6.8
Anxiety	33.9	7.1	55.8	12.1
Personality	39.9	6.83	56.4	6.13
Any Mental disorder	78.2		90.1	

SOURCE: From overhead shown by Dr Richard Matthews during his evidence to House of Representatives Standing Committee on Family and Community Affairs at Committee Hansard, Friday, 6 August 2002, pp. FCA 1,230-1,238

A detailed table of mental disorders from the New South Wales survey is set out in appendix A below.

Substance use disorders, which the foregoing table does not include, are also recognised as mental health conditions under both the International Classification of Diseases (ICD-10) of the World Health

Organization and Diagnostic and Statistical Manual (DSM-IV) of Mental Disorders of the American Psychiatric Association.

Substance use disorders are the most common diagnostic group among both male and female prisoners. Dr Richard Matthews, gave evidence to the House Representative Committee 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% in the community compared to 63.3% in prison. The drugs concerned are interesting. 20.5% of the men were dependent on or abused cannabis, 35.2 % on an opioid, 11.9% on a sedative, 30.8% on a stimulant and 22.4% on alcohol. The levels of dependency or abuse by women was much higher for all categories of drug.

Table 2: Comparison of prevalence of dependence or abuse of Drugs & Alcohol over 12 months in the Community and prior to Reception in the NSW Corrections System

Receptions (n = 756m/165f)
Community (n = 6,627m/6,837f) from National Mental Health Interview.

		Male %		Female %	
		Reception	Community	Reception	Community
Alcohol	Dependence	19.2	5.2	16.4	1.8
	Abuse	3.2	4.3	1.8	1.8
Cannabis	Dependence	18.1	2.4	22.4	0.7
	Abuse	2.4		2.5	
Opioid	Dependence	33.3	0.2	53.4	0.2
	Abuse	1.9		0.6	
Sedative	Dependence	11.6	0.4	28.6	0.3
	Abuse	0.3		0.0	
Stimulant	Dependence	27.9	0.3	47.8	0.1
	Abuse	2.9		2.5	
Any disorder		63.3	7.1	74.5	2.8

Note: Dependence and abuse are in accordance with DSM-IV.

SOURCE: From overhead shown by Dr Richard Matthews during his evidence to House of Representatives Standing Committee on Family and Community Affairs at Committee Hansard, Friday, 16 August 2002, pp. FCA 1,230-1,238

It should be stressed that these figures do not take into account all substance use. In accordance with the classification system of substance abuse or dependence, moderate use is not included.

> "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." (Butler & Allnutt, p. 30).

The foregoing table shows that the majority of those with a diagnosis of a substance use disorder are dependent on substances rather than just abusing them. This indicates the severity of drug problems among prisoners. Moreover, it is the rule rather than the exception that prisoners will have some other mental health disorder in combination with a substance abuse problem. The Senate Select Committee on Mental Health made much of this development which it termed the "the expectation not the exception". That committee lamented that:

> "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." (Senate Mental Health §2.29).

The report pointed out the increase in dual diagnosis which was seen as flowing from the failure to meet mental health needs and the increased focus on law and order to control behavioural problems:

> "In recent years the rising incidence of co-morbidity, as it is also termed, has supported a substantial increase in the number of people with mental illness in gaol. Predominating among these are young men and Indigenous people, a disproportionate number being women. Submissions to this inquiry took the view that this trend is a direct consequence of the failure to adequately respond to the mental health needs of people with dual diagnosis, combined with an increased focus on law and order models to control perceived behavioural problems." (Senate Mental Health §5.36).

The increasing association between crime on the one hand and the combination of substance abuse and other mental disorders on the other is a point made by Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University. He has written of the growing recourse to substance abuse by people with mental illnesses:

> "The evidence is mounting that the frequency with which those with mental disorder are resorting to the abuse of drugs and alcohol is increasing. In one of our own studies the rate of recorded problems with substance abuse among first admissions increased from 10% in 1975 to 35% in 1995" (Mullen 2001, 17).

In a more recent study, known substance abuse problems among persons with schizophrenia increased from 8.3% in 1975 to 26.1% in 1995 (Wallace *et al.* 2004, 721).

The growing association between mental health, illicit drug use and crime was also stressed in much evidence put to the Mental Health Council's *Not for service* report. For example, the Victorian Network for Carers Of People With A Mental Illness made the point that:

> "During the past decade, there has been a 50% expansion in the Australian prison system yet those close to grassroots services argue that much of the recent increase in the Australian prison population can be explained by unmet mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention of the criminal justice system" (MHCA (2005) p. 436)

In this way, the use of illegal substances has become a common pathway by which people with a pre-existing mental health problem end up in the criminal justice system. Often abuse of a substance starts as a form of self-medication to alleviate symptoms of a mental health condition. Substance abuse can thus mask the mental health condition in the eyes of other people.

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Mental health problems that are a pharma cological result of some substances, such as the potent forms of methamphetamine like "ice", only compound the problem.

Whatever the pathway to imprisonment, the ACT's prison will be populated with a sizeable majority of people with both a substance abuse and some other mental health problem. It is the consequences of this rising trend of co-morbidity that the ACT Government and community must address in the new prison.

In summary, those in the new ACT prison will be in a poor state of mental health with high medical needs. These needs of these people will be made particularly demanding by the high level of dual diagnosis of substance abuse and dependence and other mental disorders. This co-morbidity will be "the expectation rather than the exception".

Key Points

- ❖ An overwhelming majority of detainees have pre-existing mental health disorders even without taking into account substance use disorders.
- ❖ A somewhat smaller majority has a substance use disorder.
- ❖ Detainees with both a substance use and some other form of mental disorder are the expectation in prison rather than the exception.
- ❖ Dependence and substance abuse are forms of mental disorder.

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

Each day in prison is the next day of 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.

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 removed 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 recognised as a risk factor for mental illness.

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.

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	Participation in church or other

RISK FACTORS ASSOCIATED WITH CRIME	PROTECTIVE FACTORS ASSOCIATED WITH CRIME
frustration	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	

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 the new ACT prison should be to 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.

The paper now identifies common aspects of penal regimes damaging of mental health and which the new prison should ameliorate.

Prison regime factors impeding access to mental health treatment

The prison environment can often be a barrier for those detained to access 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.

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 (2006) §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).

The Human Rights Commission made a similar observation in its recent audit:

> "One of the health services in highest demand at the remand centres is mental health services. The secure forensic mental health facility to which the ACT has committed itself . . . will only be for the most severe cases. Mental illness and related problems such as personality disorders affect many detainees (AHRC (2007) p. 74).

And again:

> "Although psychologists from Mental Health ACT visit the remand centres, and they take requests from any detainee, they only involve themselves in ongoing management of detainees with mental illnesses or mental disorders. However, many remandees were suffering psychological problems of a less serious nature and would benefit from therapies, such as acceptance and commitment therapy" (*ibid.* p. 78).

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 (2006) §13.102).

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).

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

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).

The *Adult Corrections Health Services Plan* boldly sets out what needs to be done to achieve the mental health service required for the new prison:

> "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).

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

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.

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.

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).

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).

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).

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 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)).

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 the regime for the new prison. In particular, a regime of "dynamic security" or "direct supervision", which experience shows creates a healthier prison environment, should be implemented. As explained later (see p. 28), security under this concept is "based on good professional relationships between staff and detainees rather than physical barriers, uses of force and the use of restraints" (AHRC (2007) p. 8).

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

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.

The Human Rights Commission Audit has documented the current practice in the ACT which could well be replicated in the new prison. "Detainees," the Commission wrote, "are . . . 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 "are to be strip-searched every night before they are 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).

The Commission also describes 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).

Strip searching and the special situation of women prisoners

Women prisoners have a much higher level of mental illness than even the high level of male prisoners (see p. 8). 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).

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).

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).

Rationale for strip searching

Corrections drug policy appears to dictate the need for strip searching. The practice 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). Corrections have undertaken a trial of a SOTER RS X-Ray Body Scanner to reduce the use of strip searching. The ACT Radiation Council has specified that the equipment may not be used on females. Women were excluded from the trial out of concern for radiation injury to foetuses and unfertilized ova. Men may not be exposed to it more than 20 times a month (AHRC (2007) p. 43). On this basis, even for men the equipment would reduce merely by about a half the frequency of strip searching. The Coalition

understands that there is medical concern about the extent of radiation exposure from the scanning, meaning that it is unlikely that permanent installation of the equipment will ever do away with a continuing need, dictated by the existing drug policy, for frequent strip searching.

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).

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).

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.
- Frequent use of scanners gives rise to radiation concerns.
- 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 to keep drugs out rather than promotion of the well-being of detainees.

Seclusion

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).

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.

The *Corrections Management Act* 2007 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).

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.

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)

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)

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. 21).). 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.

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).

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.

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).

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).

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)).

It is clear that if the new ACT prison is to promote the mental well-being of those detained in it there will need to be a large scale reduction in the extent to which seclusion occurs. 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

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)

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

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.

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. 8 shows, on reception to the NSW corrections system, 33.9% of women and 21.1% of men had an affective disorder of some kind.

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).

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)

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 (2006) §§13.110-111).

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.

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).

MENTAL HEALTH AND OPERATION OF THE ACT PRISON

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

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)

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)

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).

ACT Corrections is well aware 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).

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 prisons including ACT remand centres.
- ❖ Boredom makes for an unhealthy environment that stimulates anger and frustration impeding those detained from accepting responsibility for their actions.

Recommendation

- ❖ The new ACT prison should have a well designed and resourced program of activities.

IV. PUTTING A HEALTHY OPERATIONAL REGIME IN PLACE

What needs to be done to put in place an operational regime in the new prison that promotes rather than damages the mental health of those detained? The deleterious impacts of practices found in standard prison routines will need to be addressed: the impacts from strip searching and seclusion. There needs to be a full program of activities to eliminate chronic boredom. Then too the threatening and highly regimented aspects of general prison routine need to be changed and the impediments to access of mental health treatment removed. All these aspects of prison life so harmful to the mental well-being of the human beings detained are outlined above. This section seeks to identify the steps that should be taken to establish a healthy operational regime for the new prison that lives up to the Government's commitments that the Alexander Maconochie Centre will promote the well-being of the community at large as well as those detained and their families. There needs to be:

- A corrections board with mental health expertise to be responsible for the operational regime;
- Introduction of a comprehensive system of dynamic security;
- Acceptance that addiction is a mental health problem and should be managed as such; and
- Commitment by political parties to positive outcomes from the prison such as reduced recidivism and restorative justice.

A corrections board with mental health expertise to be responsible for the operational regime

It is futile as well as inhumane and a prodigal waste of resources if the prison environment manufactures mental health crises that a Crisis Support Unit and a forensic mental health institution have to deal with. It is akin to conducting a program of arson while expanding fire services to put those fires out. Self-defeating as that may sound, this is just what research on promotion, prevention and early intervention for mental health tells us that the very expensive standard prison regime does.

It follows that the operational regime of the new prison should be developed, maintained and monitored with the input of those who have expertise in the mental health sector as well as those who have a particular focus on the operation of a secure detention centre. This will require a formalised standing arrangement with representation independent of Corrections of qualified mental health professionals. Accordingly, there should be established a corrections board with responsibility for the prison's operational regime. This board would have a role akin to a company's board of directors. At the very least this board should include the persons holding the positions of Director of Mental Health, ACT & Chief Psychiatrist, ACT and the Corrections Medical Officer.

Introduction of a comprehensive system of dynamic security

The standard prison regime is fundamentally coercive with the threat and occasional use of force to ensure compliance. Under this approach conformity and compliance are the outcomes sought. Such an approach is injurious to the mental well-being of prisoners and, having adapted well to it as a number do, reduces their capacity to make their way in the world outside upon their release. It is therefore pleasing to know that ACT Corrective Services is moving to a system of "dynamic security" or "direct supervision". Essentially this involves close interaction between custodial officers and detainees rather than relying on barriers and a focus on meeting the needs of detainees with activities, services and practices. ACT Corrections has stated that:

> "The Operating Model of the AMC will be located on a continuum from indirect supervision to direct supervision. The major features of the former are a heavy reliance on distant electronic surveillance and the confinement of officers to secure stations. In contrast, the direct supervision model of the AMC is based on extensive staff (as role models) and prisoner contact, the development of positive relationships with attendant improved surveillance and security and institutional 'climate'" (ACS (2007c), pp. 16).

ACT Corrections has not specified how far along the supervision continuum towards "direct supervision" it plans to move.

A British prison handbook that recommends "dynamic security" quotes the following evidence of effectiveness in the United States of its "direct supervision" counterpart:

> "Studies in the United States report that direct supervision jails have resulted in better control of prisoners with a significant reduction in violence, noise and vandalism. The increased interaction between staff and prisoners has meant that officers are able to anticipate problems and deal with them proactively. It is also suggested that prisoners in direct supervision jails have a better chance of leading productive lives after they finish their sentences" (Coyle (2002) p. 65).

A United States report adds:

> "The impact on safety is impressive. The National Institute of Corrections conducted the most comprehensive study to date of direct supervision. Its 1989 research showed that those who run direct supervision facilities gave their own facilities higher safety ratings, compared with those who operate facilities that use 'indirect' supervision. The in-depth case studies concluded that prisoners appear to feel considerably safer in direct supervision facilities and seem neither to have nor to need weapons to protect themselves. The study's authors noted that using direct supervision carries no greater cost and requires no additional staff yet appears to produce a safer, more livable environment. Another study put some numbers on the improvements: 'Compared to traditional jails of similar size, the Metropolitan Correctional Centers and other direct supervision jails report much less conflict among inmates, and between inmates and staff. Violent incidents are reduced 30 to 90 percent'. Colonel David Parrish, Commander of the jails in Hillsborough County, Florida, agrees: 'Direct supervision is recognized by progressive jail administrators as the most practical way to build and operate a detention facility. They are more staff efficient, cost-effective, and safer than traditional jails,' he told the Commission" (CSAAP (2006) p. 30).

The British handbook makes clear that with dynamic security force recedes into the background:

> "Good professional relationships between staff and prisoners are an essential element of dynamic security. Where such relationships exist they can be put to good effect in de-escalating potential incidents or in restoring good order through a process of dialogue and negotiation. Only when these methods fail or are considered inappropriate should physical methods of restoring order be considered" (Coyle (2002) p. 71).

The ACT Human Rights Commission reported the heartening development that Corrections here is moving towards the introduction of that system:

> "The culture of a correctional facility will influence the number of times that coercion such as use of force or disciplinary action will be required. Many ACT Corrective Services officers recognise that the emphasis should be on 'dynamic security' – that is, security based on good professional relationships between staff and detainees rather than physical barriers, uses of force and the use of restraints. Consistent with the ethos of a healthy prison, ACT Corrective Services is in the process of shifting from a culture that favours control and security over detainees' needs. Instead, meeting detainees' needs are to be acknowledged as assisting to maintain security and order in the prison." (AHRC (2007) p. 8)

For all the obvious benefits of dynamic security, the Commission made it clear that there is a way to go to make the necessary cultural change in the ACT system.

> "In interviews, many officers spoke of the importance of maintaining a working relationship with detainees so that uses of force would be unnecessary. In other words, it was recognised that 'dynamic security' – that is security that is not dependent on physical restraints or barriers – was important. However, it was clear that some officers had a lower threshold than others when it came to seeing that their authority had been undermined" (AHRC (2007) p. 85).

Acceptance that addiction is a mental health problem and should be managed as such

As the discussion of strip searching shows, "all inmates' entire sentence time is heavily influenced by those who are on drugs and by policies that try to curtail that abuse" (Easteal (2001) p. 97). Corrections has thereby imprisoned itself inside a cell of its own imagining. The governing assumption is that keeping prisoners off drugs is essential to promote their welfare as well as the security of the prison. The result is an edifice of harsh disciplinary measures including strip searching deemed necessary to keep drugs away from prisoners. This leads to measures being taken in the name of welfare of prisoners which do grave harm to their mental health. What is the way out of the prison of this dilemma? It is to recognise that addiction is fundamentally a mental health issue.

ACT Correction's Drug, Alcohol and Tobacco Strategy is undermined by contradictions. On the one hand it sets an impossibly high standard for detainees while on the other it reconciles itself to appallingly low outcomes. On the one hand it speaks of "the manifold problems and distress associated with" alcohol and drug use, of "the goal of abstinence" being "an essential element" of drug strategy and of drugs being a "major threat" in a prison setting. On the other hand it states that it is "unreasonable to expect that corrective service agencies in general, and the AMC in particular, can

bring to an end prisoner disadvantages in multiple domains, particularly given the short duration of the average sentence".

Viewing addiction as a mental health problem would indeed tell Corrections that it is hopeless to expect that all but a small proportion of the many drug dependent detainees will be "cured" of their addiction by their imprisonment. As a chronic relapsing condition it can be expected that most will relapse even if they have been abstinent while in prison. Indeed they will certainly relapse if the prison regime intensifies their associated depression or other mental health problem as will generally occur as a result of zealous efforts to keep the institution free of drugs.

Moreover, achieving abstinence in the prison setting produces next to no community benefit. What is important for the community is that people should emerge from prison with the physical and mental capacity to take their place in society as responsible members capable of fulfilling their obligations to those dependent on them as well as to the community at large. We know, though, that the standard prison regime is failing the community and those released in falling short of these outcomes. Those facing readaptation to the stresses of life beyond prison are dying at alarming rates from accidental overdoses after relapsing or from suicide. We also know that lack of preparation for release and lack of support within the community which are both characteristic of the standard prison regime, are recipes for high rates of recidivism.

From the point of view of personal and community well-being, the goal needs to be stabilisation and management of the chronic mental health condition of addiction and not the ideological insistence on abstinence that imbues ACT Correction's Drug, Alcohol and Tobacco Strategy. Insistence on permanent abstinence, which is impossible for all but a small proportion of people, will produce death or a rapid resumption of the chaotic life style that originally led to imprisonment.

Being realistic about the extent that dependence can be cured does not mean giving up on achieving large improvements in the mental and general health of those in the prison and in their capacity to function as responsible citizens back in the community. If the well-being of those detained and of the community is put first, the mental trap in which Corrections obviously find themselves caught will largely disappear. There are a range of interlinked measures that will do this:

- The strong desire or sense of compulsion to take the substances which contributes so much to security concerns of prisons will be greatly ameliorated by a healthy operational regime and system of dynamic security. The standard prison system intensifies that desire and sense of compulsion.
- Giving priority to treatment of the most urgent mental health problem of those detained which may not be drug dependence.
- Implementing a range of first class drug treatments including therapeutic programs in drug-free wings and opioid substitution that evidence shows works in a prison environment (Larney et al. (2007)).

MENTAL HEALTH AND OPERATION OF THE ACT PRISON

Key Facts

- ❖ Many of the prison practices that are most injurious to mental health are taken out of concern to keep drugs from prisoners.
- ❖ It is unrealistic to expect that prison will be able to "cure" many prisoners of addiction, which is a chronic relapsing condition, but realistic that with good treatment their condition can be stabilised.

Commitment by political parties to positive outcomes such as reduced recidivism from the prison

A corrections system cannot develop a regime that rehabilitates those subject to it or markedly reduces recidivism unless political parties themselves are committed to those goals. A system that focuses on improving the mental health of detainees will be vulnerable to cheap political jibes that authorities are being "soft on crims". Such a system will involve reduction in the stresses of traditional prisons in matters such as strip searching, discipline and seclusion. It will maximise community contact, particularly with families. All these elements will expose the authorities to uninformed criticism. The safe political response in those circumstances is to give top priority to the security of the correctional institution which is what is done in the standard prison. Doing so may serve short term interests of the institution but not that of the community at large.

The Coalition therefore calls on all political parties to commit themselves to the following for the ACT corrections system:

- The system should be effective in reducing recidivism in the ACT community;
- The system should be effective in rehabilitating those detained in it; and
- The measures taken to achieve these outcomes should be framed on the best available evidence.

ACT COMMUNITY COALITON ON CORRECTIONS

Recommendations

- A corrections board should be established with mental health expertise to be responsible for the prison's operational regime. At the very least this board should include the persons holding the positions of Director of Mental Health, ACT and Chief Psychiatrist, ACT and the Corrections Medical Officer.
- A comprehensive system of dynamic security should be introduced into the new prison involving:
  * close interaction between custodial officers and detainees rather than relying on barriers; and
  * a focus on meeting the needs of detainees with activities, services and practices.
- Addiction should be regarded as the mental health problem that it is and should be managed as such.
- Rather than giving top priority to making detainees drug free, priority should be given to people emerging from prison with the physical and mental capacity to take their place in society as responsible members who are capable of fulfilling their obligations both to those dependent on them and to the community at large.
- As a priority, all political parties should commit themselves to a corrections system that:
  * reduces recidivism in the ACT community;
  * rehabilitates those subject to it; and
  * bases measures to achieve these outcomes on the best available evidence.

V. EVALUATION WITH REFERENCE TO THE REAL WORLD AFTER RELEASE

Evaluation of the effectiveness of the prison regime must involve evaluation of the capacity of those who graduate from it to function in society. Prison must not be evaluated as a closed system – on how well people function within it – but on whether it enhances people's capacity in the real world. Prison will not be rehabilitative unless it serves to enhance that capacity. Standing arrangements to monitor and evaluate the effectiveness of the prison must therefore assess what occurs to people *after and not just on their release*. If people return to the community with no measurable improvement in social and economic outcomes, the new prison will have failed its own objectives. Even worse, if it turns out that people released are at greater risk of committing suicide, of overdosing because of an addiction or are in worse mental health, the Government and the community must both acknowledge and address this. The Government and community must also know whether the prison will reduce recidivism which will, of course, track success in rehabilitation.

The alarming fact is that, within these interlinked domains of self harm, overdosing and mental illness, the failings of the traditional prison regime are patent. The Government will be wasting the community's resources as well as failing its human rights obligations unless the new ACT prison does much better than replicate the traditional regime. It will be flying blind unless it puts in place standing arrangements to monitor and evaluate the effectiveness of the prison by reference to the condition of people after their release.

Monitoring and evaluation of this sort must, of course, respect ethical research principles including the privacy of those concerned. The need to meet this requirement should not be used as a pretext for declining to undertake the monitoring and evaluation.

A brief account of the lamentable record of prisons in the domains of post-release self harm, overdosing, mental illness and recidivism will now be given. It illustrates the vital need for evaluation of the post release outcomes of those who leave the new ACT prison.

Key fact

- Within the interlinked domains of self harm, overdosing and mental illness, the failings of the traditional prison regime in rendering people fit to resume their place in the community are obvious.

Recommendation

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

Death from suicide or overdose

Study after study has shown that "released prisoners are at greater risk of death compared with the general population, particularly in the first few months after release" (Hobbs *et al.* (2006) pp. 2 & 7). A Victorian study of unnatural deaths in people released from prisons "found a relative risk of death that was ten times greater than in the general population, with the greatest risk occurring in the first few weeks after release" (*ibid.* p. 56). A Finnish study of a representative sample of 900 released male prisoners compared with age-matched community controls found a nearly four-fold increased risk of all causes of mortality. "For 'natural' diseases (predominantly cardiovascular disease) the risk was nearly three times greater, and for deaths due to injury or poisoning (including suicide and homicide) it was more than five times greater" (*ibid.*). Among these post-release deaths, suicides and overdose deaths have particular association with mental health.

Suicide

There is a sharp rise in the suicide deaths of men in the first weeks after release from prison. A large Australian study now supports findings of similar American and British ones. The American study found that "the risk of suicide within the first 2 weeks after release was over four times greater than that observed during other periods. In the British study, over one-fifth of all suicides occurring within 1 year of release from prison took place within 4 weeks of release (Kariminia *et al.* (2007) p. 389).

The NSW survey of all 85,203 adults who had spent some time in full-time custody in prisons there between 1988 and 2002 found that the suicide rate in men in the 2 weeks after release was 3.87 times higher than the rate after 6 months when the rate approaches that observed in custody. Male prisoners admitted to the prison psychiatric hospital had a threefold higher risk than non-admitted men both in prison and after release (Kariminia *et al.* (2007)).

> "Suicide peaked in men during the first 2 weeks after release at a rate of 507 per 100 000 person-years, declining to 118 per 100 000 person-years after 6 months (adjusted relative risk, 3.87; 95% CI, 2.26–6.65). In men, the association between time after release and suicide was not uniform among different age groups. The highest increased risk in the first 2 weeks after release was for those aged 45 years or older (adjusted relative risk, 13.38; 95% CI, 5.37–33.37). The excess risk was reduced during subsequent weeks but remained significant for those aged 35 years or older. No suicides occurred among women in the first 2 weeks after release." (Kariminia *et al.* (2007) pp. 388-89)

The NSW study observed no rise in the first 2 weeks after release in the already high suicide rate among Aboriginal Australians.

The authors of that study commented that:

> "Suicides in prison receive considerable attention from prison authorities. Programs, policies, and even architectural considerations are in place to minimise the risk of suicide during incarceration. In contrast, far less attention is paid to the post-release period, when the duty of care shifts from the custodial authorities to the community. Release from prison may not increase the overall risk of suicide compared with being in prison, but the first few weeks after release are a period of intensified risk.
>
> "Our findings suggest that the initial adjustment period after release is a time of extreme vulnerability, particularly for men. It is possible that on return to the

> community, historical variables associated with suicide such as hopelessness, significant loss, social isolation, lack of support, and poor coping skills are especially significant for this group, as a considerable number of them are already predisposed to suicide because of mental illness and/or substance misuse" (Kariminia *et al.* (2007) pp. 389)

One might add to the comments that responsibility of the Government for the well-being of those who are detained should not end upon release, particularly in the light of the Correction Coalition's understanding that:

- Physical measures like seclusion taken to prevent self harm within prisons may well harm the mental health of those subject to it thus making suicide more likely when those physical safeguards are not present;
- The detention, through the disruption it brings about of the life of those detained, itself undermines their capacity to function in the community;
- There is a need to compensate for the disruption of detention through the provision of support in the community after release in co-ordination with support within the prison. The Corrections Coalition is concerned at an apparent lack of whole of government planning for this.

Overdose

Research demonstrates that there is a high rate of overdose, including overdoses leading to death, among addicted people released from prison. A Scottish study found that "at present, one in 200 adult male injectors is likely to die in the fortnight after release from an imprisonment of 14+ days" (Bird & Hutchinson (2003) p. 189) In fact the drugs-related death rate of those recently released from prison outnumbers prison suicides by 2.8 to 1. This "argues for at least as much effort on designing and evaluating prison-based initiatives to reduce recently released drugs-related deaths" (Bird & Hutchinson (2003) p. 189)

The Scottish study found that:

> "Drugs-related mortality in 1996–99 was seven times higher (95% CI: 3.3–16.3) in the 2 weeks after release than at other times at liberty and 2.8 times higher than prison suicides (95% CI: 1.5–3.5) by males aged 15–35 years who had been incarcerated for 14+ days. We estimated one drugs-related death in the 2 weeks after release per 200 adult male injectors released from 14+ days' incarceration. Non-drugs-related deaths in the 12 weeks after release were 4.9 times (95% CI: 2.8–7.0) the 4.3 deaths expected" (*ibid*. p. 185).

A Western Australian study produced a similar finding that the first weeks after release were particularly dangerous:

> "Deaths due to injury or poisoning or acute and chronic effects of alcohol or drug addiction accounted for over 60 percent of all deaths and much of the excess risk in mortality in released prisoners. The risk of death was greatest soon after release from prison, with death rates in the first six months being four times greater than after one year. Deaths related to alcohol and drug addiction or from injury and poisoning were eleven and five times greater respectively in the first six months than after one year. This temporal relationship supports the suggestion that the excess mortality in prisoners is due principally to the effects of alcohol and drug addiction or injury and poisoning. Multivariate analysis found that within the cohort, the risk of death increased with age, was 37 percent greater in Indigenous prisoners, and

> increased by 27 percent with each additional release from prison." (Hobbs *et al.* (2006) p. 4).

The NSW study of the 85,203 adults released from prison between 1988 and 2003 made similarly clear findings. It found that:

> "After release, there were 1431 drug-related deaths in men and 196 in women, giving mortality rates of 286 and 348 per 100 000 person-years, respectively. The mean (SD) age at death from overdose was 33.0 (7.7) years for men and 30.6 (7.2) years for women. In men and women, 58% of all drug-related deaths were classified as being caused by 'mental and behavioural disorders' due to psychoactive substance use and misuse of non-dependence-producing substances. The adjusted relative risk of fatal drug overdose in the first 2 weeks after release, compared with the risk after 6 months, was 9.30 (95% CI, 7.80–11.10) in men and 6.42 (95% CI, 3.88–10.62) in women" (Kariminia *et al.* (2007) p. 389).

Other studies of those released from prison in Geneva, the United Kingdom and Victoria tell a similar tale (Hobbs *et al.* (2006) p. 56).

The big rise in overdose deaths following release most probably occurs because of relapse by people who in prison were abstinent and thus had lost their tolerance of the drug concerned.

> "The increased risk of death from drug overdose directly after prisoners are released is likely due to a reduced tolerance to opioid drugs following prolonged abstinence or infrequent use while in prison. Studies have demonstrated that methadone maintenance treatment reduces overdose mortality in opiate injectors in the community" (Kariminia *et al.* (2007) p. 390).

The stress that the ACT Corrections drug strategy places on abstention may thus contribute to overdose death and other injury from overdose. Given that addiction is a chronic, relapsing condition, there is a high risk that a relapse will occur in the midst of the stresses that people experience in attempting to reintegrate into life outside the prison.

Recidivism and improvement in mental health

Improvement of the mental health of those in the new prison will have intrinsic merit because assisting people to overcome illness is what society should do to comply with its human rights obligations. Self interest also dictates that society should ensure that people emerge from the prison better. Improved mental health increases the capacity of people to contribute to society: it is vital for rehabilitation and reduction of recidivism. Reduction in recidivism and with it a reduction in crime is the public dividend of rehabilitation. The Senate Select Committee on Mental Health stressed these points. "There is," it reported, "a high rate of recidivism among former prisoners with a mental illness (Senate (2006) §13.130). The Senate Committee saw the mentally ill revolving through prisons (*ibid.*, §13.131) and quoted from the following big study of mental health in NSW prisons:

> "The mentally ill often revolve through prisons, with periods of incarceration interspersed with spells in the community and place high demand on services. Mentally ill prisoners are doubly stigmatised, suffering from a psychiatric illness in addition to labelling as an 'offender'. They are often disenfranchised, frequently itinerant, suffer chronic illness with acute symptoms, have poor physical health,

> lack social supports, have co-morbid substance abuse, and are frequently without community care." (Butler & Allnutt (2003) p. 50).

In contrast to this typical correctional outcome, ACT Corrections emphasise "throughcare" which it describes as "a model for the integrated Case Management of offenders". It is "aimed at ensuring an integrated and seamless approach to the delivery of services for offenders as they move between prison, community corrections and the community and to provide continuity of knowledge of the offender, programs and other services" (ACS (2007b) pp. 4 & 13-14). Corrections add that:

> "This aspect of the Operating Philosophy for the AMC will contribute to the achievement of whole of government objectives for crime prevention and community safety and to the principles of Restorative Justice" (*ibid.*, p. 14).

Implementation of such a concept is of vital importance if the revolving door of mentally ill human beings through the prison system is to be avoided.

So far as mental health is concerned, the admirable objectives of throughcare can be achieved only if the operational regime is not injurious and, by improving the health status of those detained, builds their capacity to function as responsible members of the community. This indeed requires a seamless set of measures, quite different from those applied in the standard Australian prison, to be taken within the prison and out into the community. This is why there needs to be a formalised, standing arrangement involving mental health expertise to be responsible for the operational regime as described on page 27 and for close co-operation with adequately resourced community services. The Corrections Coalition is aware of no whole of government planning to put these necessary arrangements in place.

A Queensland study of release policies and practice set down a number of principles for best-practice release of prisoners. The Senate Select Committee on Mental Health, which referred to this study, stressed that for throughcare to work there needs to be "a solid partnership between prisons and community mental health providers":

> "The . . . study found that in a number of re-entry programs that exist throughout the world, the key feature is a solid partnership between prisons and community mental health providers. . . . [C]ommunity health services in Australia appear to be inadequate. As a result, the adoption of enlightened re-entry programs would require not only the wholehearted cooperation of corrections authorities, but significant allocations of additional resources for community health" (Senate §13.125).

If the cost of holding people in prison is regarded as an investment, the investment is a poor one if the known risk factors that would have influenced the imprisonment in the first place are not addressed. The environmental and other factors mentioned at p. 12 that contribute to the mental health problems of those sent to prison must be addressed in prison and on release:

> "The difficulties facing ex-prisoners after release into the community are many. They include problems relating to housing, employment and gaining access to appropriate supportive services. Released prisoners are widely recognised as having poor health compared with members of the general population. Access to health services in general and maintaining continuity with treatment programs that may have been initiated in prison may thus be particularly important." (Hobbs *et al.* (2006) p. 7).

Forensicare informed the Senate Select Committee on Mental Health, in relation to patients suffering with schizophrenias, that:

> "Repeat offending in schizophrenia is critically dependent on whether the individual had the ongoing structure provided by open employment, but failing that, sheltered workshop or day centre support. Services have been withdrawn from programs of active work rehabilitation in recent years, but this is a critical element in patient functioning and in reducing offending. Ignored, mismanaged, released unprepared, rapidly re-offending and returning to prison. This is all too often the story of the mentally ill offender, repeated and repeated" (Senate (2006) §13.130)

All these comments have particular relevance to women who are imprisoned. The study of prisoners after release from prison in Western Australia ". . . found that all female prisoners are at substantially greater risk of death and hospitalisation than male prisoners. Not only were female prisoners more likely than male prisoners to have multiple hospital admissions, they were also admitted to hospital much sooner after release than male prisoners, with 66 percent of Indigenous women and 54 percent of non-Indigenous women being admitted to hospital within two years after first release compared with 38 percent of Indigenous males and 30 percent of non-Indigenous males. Non-Indigenous female prisoners had the highest rate of hospital admission for mental disorders and poisoning, while Indigenous female prisoners had the highest rates of admission for all other conditions" (*ibid*., pp. 58-59).

In the words of *Forensicare* quoted by the Senate Select Committee: "At the point of release, coherent plans for a managed return to the community with prearranged mental health support almost never occur" (Senate (2006) §13.123). Without such coherent plans the new prison will not improve the situation of the large majority of people who will be in the new prison who have mental health problems.

Key Facts

- There is a sharp rise in the suicide deaths of men in the first weeks after release from prison.
- There is a high rate of overdose, including overdoses leading to death, among addicted people released from prison.
- Without good support within the community released prisoners with a mental health disorder are at high risk of reoffending and suffering a deterioration in their mental health.

Recommendation

- There should be whole of government planning to set in place a seamless set of measures in support of those detained to be taken within the prison and out into the community. These measures should include adequately resourced community services and, in particular, prearranged mental health support.

VI. A POSTSCRIPT ON VICTIMS

The nub of this paper is that the operational regime of the prison must be framed so as to promote the mental health of those detained if the promise of rehabilitation of the new prison is to be realised and that that promise will not be realised under a standard prison regime. The benefits for victims of this focus as well as for the community at large should be self evident but it would be well to conclude by making this point explicitly.

The benefits for victims of a healthy operational regime may be summarised as follows:

- There will be less crime and thus fewer victims if the poor mental health of those sent to prison is improved and not further damaged by the prison experience. Improvement in mental health builds the capacity of people to function as responsible members of the community. Where the standard prison regime exists, there is a revolving door of mentally ill human beings through the prison system.
- There will be less revictimisation of people who have offended and who have themselves suffered as victims of crime. A high proportion of people in prison have been victims of crime themselves. Imprisonment should not revictimise these people as, for example, practices of the standard prison regime do for the high proportion of imprisoned women who have been the victim of childhood and other sexual abuse.
- A healthy prison regime is essential if the government's commitment to restorative justice for the benefit of victims and the community is to be implemented in the context of the new prison. The explanation for this follows.

Restorative justice

Restorative justice is a process that seeks to mend the hurt caused by crime. It involves typically a conference with a facilitator involving the victim, the offender and their supporters. Reintegrative shaming is the core dynamic. The offender faces up to the hurt he or she has caused the victim. In that process the offender is heard, and makes amends, is forgiven and is reintegrated into the community. In the words of the annual report of the Department of Justice and Community Safety:

> "Restorative justice is a community response to crime. Those most affected by a crime, together with others from their community, come together in face-to-face or indirect restorative justice processes to talk about what happened, identify who has been affected and how they have been affected, and discuss ways to make amends for what has happened" (JACS, *Annual report 2006-07*, vol. 1, p. 28).

Experience with the process here and elsewhere shows that, compared to the usual criminal process of prosecution and a court hearing, it can lead to a remarkable level of satisfaction for both victim and offender.

Although the present conferencing scheme is still in its early days and does not apply where people are sentenced to prison, the Government places great store on it. The Chief Minister is on record that restorative justice should apply in the new prison in the

context of throughcare. He has told the Assembly:

> "Throughcare is also concerned with continuity of knowledge of the offender and continuity of care, program and other service delivery. This aspect of the Operating Philosophy for the ACT prison will contribute to the achievement of whole of government objectives for crime prevention and community safety and to the principles of Restorative Justice."

So optimistic is the Government of the benefits of restorative justice, that it has assumed in planning for the new prison that the ACT imprisonment rate which has grown in recent years will decline in part because of it:

> "Given the increasing feeling of safety throughout the ACT community, in addition to the reduction in personal and household victimisation rates, if these trends continue and are supported by the implementation of a Restorative Justice program within the ACT correction system it is indeed very likely that prisoner population growth rates will in fact decrease beyond 2010" (Cyrene (2004) p. 18).

Such assumptions raise the question of the introduction of restorative justice processes to the new prison. In fact this is being done in some overseas prisons (Liebmann & Braithwaite (1999)).

A number of conditions have been identified for restorative justice to work in a prison setting. "Restorative justice requires respect, the assuming of responsibility and the freedom to solve the problems by those involved in the conflict" (Newell (ND)). There are obstacles in the typical prison to the establishment of these conditions. The following are drawn from those identified by Daniel W. Van Ness, executive director of the Centre for Justice and Reconciliation at Prison Fellowship International:

1) Prison regimes closely control the lives of prisoners, making it difficult for them to exercise personal responsibility. Yet, responsibility is a key value of restorative justice. The Human Rights Commission audit of ACT remand centres pointed out the link between conditions of detention and responsibility: "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" (AHRC (2007) p. 37).
2) The sub-culture of the typical prison is deviant, making rejection of deviance more difficult for prisoners. Inviting them to participate in a process of restoration and transformation requires tremendous strength on their part to move against the prevailing culture.
3) The peaceful resolution of conflict involved in restorative justice is at odds with the threat and use of physical violence and psychological coercion pervasive in the typical prison. Force is used or threatened to keep prisoners from escaping and to control their movement in the prison. Furthermore, life among prisoners is typically characterised by threatened or use of violence. These realities work against efforts to instil in prisoners a strong value for conflict resolution.
4) Prison administrators, staff and prisoners seldom have the same goals, making it difficult to maintain a single restorative purpose. Restorative justice programme directors may be victim-centred, while the prisoner is interested in getting his

sentence reduced. The prison administration may resist the programme because of the increased burden on staff.

5) Prisons are authoritarian and hierarchical, making it difficult to develop prisoner autonomy. This is related to the issue of prisoner responsibility and to the reality of power imbalances in the prison setting (Van Ness (2005)).

These obstacles which are so much part of the standard prison regime are closely aligned to what needs to be avoided in the new ACT prison if it is to promote the mental well-being of those detained. Moreover, poor mental health largely undermines the capacity of those who have offended to participate to the benefit of both themselves and the victims in the conferencing process. Achieving mental well-being of those in prison is thus at one with the interests of victims in restorative justice.

Key Facts

- Victims stand to benefit from a healthy operational regime through:
  - less crime and thus fewer victims if the poor mental health of those sent to prison is improved and not further damaged by the prison experience;
  - less revictimisation of people who have offended and who have themselves suffered as victims of crime. A high proportion of people in prison have been victims of crime themselves;
  - the healthy prison regime establishing the conditions for implementation of the government's commitment to restorative justice.
- The conditions required for restorative justice to work in a prison setting are respect, the assumption of responsibility and the freedom to solve the problems by those involved in the conflict. These conditions will not exist in the new prison if it replicates those of the typical prison.

APPENDICES

APPENDIX A

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

The following detailed table of mental disorders is from the survey of people in New South Wales prisons. It adds detail to the information at pages 8 to 11 on the poor state of mental health that the ACT can expect of its prison population.

	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
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	-

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	MALE (N=756)		FEMALE (N=165)	
	12 Month	**1 Month**	**12 Month**	**1 Month**
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.

APPENDIX B
ABBREVIATIONS

ACS	ACT Corrective Services
AHRC	ACT Human Rights Commission
ICD	International Classification of Diseases of the World Health Organization
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
MHCA	Mental Health Council of Australia

APPENDIX C
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