LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY
Mr Jeremy Hanson MLA (Chair), Dr Marisa Paterson (Deputy Chair), Ms Jo Clay MLA

Submission Cover Sheet

Inquiry into Community Corrections

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

1. Executive Summary

1.1. How the submission addresses the terms of reference

1. Families and Friends for Drug Law Reform approaches this inquiry on the assumption that it was set up to identify how the corrections system can more effectively achieve the social goals of the ACT. In doing so, the submission addresses a set of fundamental questions:

Table 1: Fundamental questions that the submission addresses

Where do Community Corrections fit in ACT's vision of itself? (sections 5 & 11) • Are the existing forms of community corrections likely to reduce reoffending to the level that the government has committed itself to achieve in its 25 x 25 commitment? (section 11 & 15 pp. 59ff.) • Existing forms are outlined in section 10 - Community Corrections programs now in the ACT.
Does drug treatment render law enforcement largely redundant (sections 15.1 & 21)?
Why not invest more in holistic drug and mental health treatment which can be delivered at a fraction of the price that it costs to deliver the same drug treatment programs in a correctional is setting (section 15.1)?

2. The submission concludes that current community correction programs have already shown their inability to improve the situation (subsection 7.1.1 - The rates of incarceration have grown 111% p. 18). The rate of return to corrections tops the country and the mix of existing and new programs is likely to fail (section 11 - Are current community corrections programs likely to reduce reoffending? (p. 46). In short, existing measures will fall well short of achieving the 25 X 25 goal and with it the aspiration in its social plan that "Canberrans are able to fully participate in community life and that the most vulnerable in our community are respected and supported" (subsection 5 - Canberra's vision: where does Community Corrections fit?).

- Long-running community corrections programs have shown themselves to be incapable of reducing reoffending to meet the government's own targets
- New community corrections programs like the drug court are unlikely to improve the situation materially

3. The submission adds that the extent to which corrections are drawing on services outside the corrective system risks the capacity of those services to address the needs of the marginalised populations that have recourse to them on a voluntary basis (section 12 - Impact of drug diversion programs on existing Drug and Alcohol treatment services (p. 54)).

4. The submission makes the obvious point that if reoffending is to be reduced to the level the government hopes, steps must be taken that have a realistic chance of addressing the needs of the largest marginalised groups within the correctional system.

5. The biggest marginalised groups are those who are substance dependent (subsection 8.8 - Summary of the links between illicit drug use and crime (p.36)) and those who have other mental health conditions (subsection 8.2 - Those with mental health conditions (p. 25)); more often than not these two conditions co-occur (section 8.6, p. 31).

6. This co-occurrence is at its most intense among Aboriginal and Torres Strait Islanders where substance dependency and mental ill health compound an historical legacy of dispossession, disadvantage and marginalisation (sub section 8.4 - Gross overrepresentation of indigenous Australians (p. 28)).

7. The submission concludes that unless these drivers are effectively addressed, reoffending rates will remain stubbornly high fed by a cycle of intergenerational disadvantage. More often than not that is initiated, perpetuated and intensified by the stigmatising and marginalising impact of a drug policy that exposes anyone who uses those drugs and even more so those who have developed a substance dependency, to the harmful processes of the criminal law (subsection 9.2 - the coincidence of risk factors for crime, mental illness and substance dependency (p. 40)).

8. The submission rebuts claims that existing drug diversion steps taken within the prison and community corrections diversion systems are capable of turning around this dynamic. This is proven by the decade or more of rising rates of incarceration (subsection 7.1.1, p. 18) and of return of these marginalised groups to corrections (subsection Executive Summary7.1.4, p. 21).

The submission identifies the way forward in its four annexes (pp. 57ff:

9. The ACT should follow the example of other countries that are showing how the application of public health principles is far more effective than law enforcement in crime prevention and in limiting the supply of illicit substances (Annex 1 section 15.1 - Public health measures reduce reoffending far more effectively than Corrections, p. 59-62). Doing so is the only realistic way by which the government can meet and exceed its own ambitious offending reduction targets;

10. Hope is misplaced that the drug court will materially reduce reoffending by dependent drug users. It works well for those motivated enough to stick at the program but high dropout rates from the New South Wales drug court (subsection 11.1, p. 47) point to the need to expand drug treatment options beyond unsuitable pharmacotherapies (Annex 1, section 17, p. 63).

11. So expanding treatments available to the drug court might improve its effectiveness but nevertheless raises a more fundamental question. Wouldn't the effort be better put to expanding the under resourced drugs treatment sector which cannot meet the demand for those seeking treatment voluntarily? Adequate resourcing of the drug treatment sector would largely avoid the need for any involvement of coerced treatment under the criminal justice system (Annex 1, section 17 p. 63). Coerced treatment is far inferior to public health informed drug treatment interventions in engaging and retaining in treatment serial re-offenders.

12. Low threshold drug treatment services within the community do improve mental health and should be considered as much a mental health as a drug treatment service (Annex 2, sub-section 22.4 pp. 82 ff). Those low threshold drug treatment services apply public health principles to undermine stigma and facilitate wraparound psychosocial support. The Productivity Commission has identified these wraparound psychosocial services as key factors behind the crisis in the mental health system (Annex 2, section 22 p.79); low threshold services need to focus on engagement and retention of people in an environment that provides an opportunity for their complex needs to be addressed.

13. Coerced and involuntary treatment that underpins the approach of both imprisonment and community corrections should be narrowly confined because of its long-term fatal consequences from accidental overdose deaths and suicide. Sustainable recovery relies upon voluntary engagement of people; mandatory treatments drive them away from engagement and community connection

14. The committee's inquiry is launched in the context of the ACT government's commitment to achieve a 25% reduction in reoffending by the year 2025 – 25 x 25 and deep dissatisfaction at the performance of the prison to live up to its founding ideals as a human rights compliant institution that would promote rehabilitation and the goals of the ACT social plan for a safe community in which all could achieve their potential.

15. This submission of Families and Friends for Drug Law Reform will therefore focus on the settings to achieve the reduction in the recidivism rate. It will conclude that the existing settings including existing measures of community corrections to achieve that ambitious goal are insufficient so that the territory will come up short in 2025.

16. The submission argues that inadequate attention is focused on key correlates of offending behaviour: substance dependency; mental health disorders which more likely than not are co-occurring and the grossly disproportionate Indigenous representation in the ACT corrections system. Very often mental health and substance dependency come together in the indigenous population where they are twinned with economic and social disadvantage and a legacy of dispossession and loss of culture. Reoffending will not be reduced unless strategies are put in place that effectively address overlapping substance dependency and mental health and psychosocial issues.

17. The opportunity is now more favourable than it has ever been to address these issues. The recommendations of the recent Productivity Commission report identify stigma as a leading factor behind the crisis in the Australian mental health system. It

identifies the need for psychosocial support around factors like poverty, housing and unemployment to be integrated in mental health care. It is clear from the Productivity Commission's work, and that of the Victorian Royal Commission into mental health and years of experience, that these same factors also impede recovery of people experiencing drug dependency. Surveys tell us that stigma often originates and is undoubtedly intensified by the labelling of people who have become drug dependent as deviants who bring shame to themselves and their families and who need to be straightened out by the stressful processes. These process have exactly the opposite effect. They impede recovery and intensify, if not initiate, mental health problems.

18. The submission puts the case for public health principles to be applied if the reoffending rate is to be reduced to achieve the goals set by the government. A public health approach is also an efficient crime reduction measure. The submission posits the daring conclusion that you have the opportunity in your remit to look at community corrections to transform how corrections are done in this territory. It also avoids the high level of mortality of dependent drug users associated with coerced choice and involuntary treatment associated with community corrections as well as prison.

19. Immense savings are to be gained from the reduction of law enforcement services from situations best handled by health and coordinated psychosocial services. This idea is not as radical as it may first sound. Long-time police support of crime reduction measures have enlisted harm reduction measures administered by other agencies of government. Moreover, the social and fiscal opportunities released underpin the commitment to justice reinvestment.

20. We are not suggesting that law enforcement services have no role. Clearly, where violence and public safety is involved, they do, but their role needs to be reframed as that of supporter and backup for health and other services that need to take the lead. All the territory's efforts need to be pulling in the same direction, not in opposite ones. One sector should not be undermining the efforts of the other. The end result is that we all need to contribute to a vision of "social cohesion, social inclusion, equity of opportunity, access to justice, and physical safety."

> Recommendation 0: By adopting an approach based on public health principles it should be possible to limit the role of corrections to where violence and public safety is involved. One sector should not, as at present happens, undermine the efforts of the other. The resources of both Government and civil society can and should be harnessed to contribute to a vision of "social cohesion, social inclusion, equity of opportunity, access to justice, and physical safety."

1.2.TABLES

1.3.TABLE FIGURES

2. RECOMMENDATIONS

Recommendation 0: By adopting an approach based on public health principles it should be possible to limit the role of corrections to where violence and public safety is involved. One sector should not, as at present happens, undermine the efforts of the other. The resources of both Government and civil society can and should be harnessed to contribute to a vision of "social cohesion, social inclusion, equity of opportunity, access to justice, and physical safety."

Recommendation 1: If the ACT is to meet it's 25% by 2025 goal of the reduction in reoffending, attention must be focused on these disadvantaged groups of dependent drug users, those suffering from a mental health condition and Aboriginal and Torres Strait Islanders. (page 22)

Recommendation 2: There should be more support of mental health services within the community and significantly increased services in Justice Health Services. (Page 28)

Recommendation 3: The effectiveness of a crime reduction measure should take into account the measure's capacity to reduce reoffending by people with a high risk profile. (page 54)

Recommendation 4: In drawing on the drug and alcohol sector to support community corrections, care should be taken not to disrupt the therapeutic model of care of those services. (page 55)

Recommendation 5: Within the constraints of limited resources funding the shortfall in voluntary treatment places should have priority. (page 55)

Recommendation 6: Criminal justice spending should be subject to the same scrutiny as all other major government programs. (page 57)

Recommendation 7: To address opiate dependency, mental health and reduce crime, the ACT should trial hydromorphone (page 72)

Recommendation 8: The capacity to deliver Cognitive Behavioural-like Therapies in prison and as part of ACT community corrections programs should be enhanced. (page 76)

Recommendation 9:The ACT should closely monitor the outcomes of trials of pharmacotherapies for the treatment of stimulant dependencies with a view to supplementing CBT and other existing treatments. (page 77)

Recommendation 10 The committee should consider the likelihood that drug policies based on public health principles will be more effective than law enforcement to reduce reoffending and thereby free up substantial resources for justice reinvestment programs. (page 77)

Recommendation 11: Like the best drug treatment services, mental health should focus upon addressing in an holistic way longer term recovery rather than rectifying short term deficits or problems. (page 87)

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Recommendation 12: People in the care of mental health services should have coordinated access to care from substance dependency professionals. (page 88)

Recommendation 13: Programs should be readily accessible, effective and non-stigmatising:

- programs should have a focus on long-term well-being and recovery rather than abstinence;
- coerced or involuntary treatments should be minimised because of the elevated risk of mortality that they present;
- engagement and stabilisation rather than abstinence should be the primary objectives. (page 91)
- Recommendation 14: First-class treatment programs should be readily accessible, effective and non-stigmatising:
- removed from the stigmatising processes of the criminal law;
- low threshold to facilitate voluntary engagement;
- involve peer support services to facilitate engagement and retention and post treatment support;
- have the flexibility to provide access when and where consumers and their carers need them;
- integrate treatment with wraparound psychosocial support;
- able to meet the needs of those dependent on stimulants like ice and sedatives like opiates. (page 91)

Recommendation 15: People subject to the corrections system should have access to the same drug treatments as are available in the community. (page 96)

Recommendation 16: To minimise the risk of fatal overdose the initiation and administration of pharmacotherapies should be subject to specialist medical supervision. (page 96)

Recommendation 17: Drug treatments for people subject to corrections systems should have the capacity to engage and retain people after they transition out of the correctional system. (page 96)

3. FINDINGS

Finding 1: The Corrections sector presently serves to entrench marginalistion and stigma that are potent risk factors for anti-social and criminal activity. Finding 1: The Corrections sector presently serves to entrench marginalistion and stigma that are potent risk factors for anti-social and criminal activity. (page 17)

Finding. 2 In the profile of people caught up in the correctional system three disadvantaged groups stand out:

- drug users who have become dependent;
- those with a mental health condition; and
- Aboriginal and Torres Strait Islanders. (page 22)

Finding. 3: The risk of death of people leaving prison is 10 times greater than in the general population, with the greatest risk occurring in the first few weeks after release. (page 24)

Finding. 4: The relationship between mental illness and drug abuse is bidirectional and mutually reinforcing. Substance dependency is a risk factor for mental illness as can psychological distress be a risk factor for a substance abuse disorder. (page 28)

Finding. 5: The coincidence of disadvantage associated with substance dependency and mental health problems found in the general community are concentrated even more intensely in the indigenous community where they are accentuated by the legacy of historical dispossession from land and breakdown of traditional society. (page 31)

Finding. 6: Among many of the most vulnerable people, substance use disorders co-occur with other mental health disorders. These people are overrepresented at every stage of the justice system. (page 32)

Finding. 7: Suicide is intimately linked to prisons as a response to the twin conditions of substance dependency and mental ill-health. (page 33)

Finding. 8: Illicit drug dependence is a powerful driver of suicide. Intravenous drug users are between 13 and 14 times more likely and polydrug users 16 to 17 times more likely than the general population to take their own life.) page 36

Finding 9: Crime perpetrated by people who use drugs comes about in the following ways:

- offences committed while under the influence of drugs;
- offences committed to raise funds to support a drug habit;
- socialisation with a dysfunctional peer group involved in supplying drugs;
- accumulation of risk factors for crime like school dropout, unemployment and other indicies of disadvantage that can follow on from dependent drug use. (page 36)

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Finding. 9:ACT rates of reoffending are unacceptably high whether measured in terms of return to prison or to community corrections. (page 37)

Finding 11: Incarceration has little if any deterrent impact and may actually increase the likelihood of reoffending. (page 37)

Finding 12: The high rate of ACT reoffending whether measured in terms of return to prison or to community corrections makes it extremely unlikely that the ACT will achieve its goal of a 25% reduction in reoffending by 2025. (page 37)

Finding 13: Since the ACT prison was officially opened in 2008 the ACT number of people detained has increased 180% from 67.8 per 100,000 to 133.8 and the rate of imprisonment has almost doubled. (page 39)

Finding 14: Substance dependency, mental illness and crime share many of the same risk and protective factors. Those factors interact with each other so that alleviating one condition is thus likely to alleviate the others. (page.41

Finding 15: Stigmatising people who use drugs as criminals is a potent driver of generational disadvantage. (page 41)

Finding 16: It is most unlikely that existing community corrections programs can reduce reoffending to the government's objective of a 25% reduction by 2025. (page 47)

Finding 17: Drug courts have very mixed success in reducing reoffending, because of low numbers will have little impact at a population level and are unlikely to produce the reductions in reoffending that the ACT is committed to. (page 48)

Finding 18: The effectiveness of a drug court to reduce reoffending depends in a large part on its capacity to engage and retain people in treatment. The New South Wales drug court has yet to demonstrate that capacity. (page 49)..... 49

Finding 19: Intensive Correction Orders in NSW have reduced the risk of reoffending by 30 percent and similar treatment oriented programs in the United States have reduced reoffending by an average of 16.7%. (page 49)

Finding 20: Heroin assisted treatment constitutes one of the most effective measures of crime prevention that has ever been trialled. (page 71)

Finding 21: Paranoia and psychotic behaviours often manifest themselves in people who become dependent on powerful stimulants like ice. (page 73)

Finding 22: Abusive and aggressive behaviour notoriously associated with ice dependency is mostly avoidable by skilled low threshold counselling/psychological support and other low threshold services like medically supervised consumption rooms (page 74)

- Finding 23:Characterisation of people who use drugs as criminals stigmatises and marginalises them which in doing so:
- leads to more harmful drug use and likelihood of dependency;
- serves to initiate and compound mental health problems; and
- impedes recovery from both substance dependency and co-occurring mental health conditions. (page 80)

Finding 24: Existing community corrections programs focus on harmful consequences of substance use and largely overlook the mental health dimensions which flow as much from subjecting people to the stressful processes of the criminal law as from any use of addictive substances. (Page 80)

Finding 25: Shared common risk factors drive and intensify the substance use and mental health problems problems. (page 80)

Finding 26: Prominent among these drivers are:

- stigma and marginalisation of people who use drugs as criminals; and
- frequently co-occurring psychosocial problems like homelessness, poor education, unemployment and child abuse and neglect which are themselves in the fruit of stigma and marginalisation.(page 80)

Finding 27: The Productivity Commission identified the importance of reducing stigma and psychosocial factors contributing to the poor Australian mental health system. It is equally important for these factors to be addressed if problems arising from substance dependency are to be addressed. (page 80

Finding 28: The addition of a diagnosis of a mental illness on top of that of substance dependency can add to the burden on patient and carer without promoting recovery (page 81)

Finding 29: There is insufficient evidence to justify the establishment of a Youth Drug Court in the ACT. (page 82)

Finding 30: Tension exists between the models of care commonly used in the mental health and drug and alcohol services. Mental health services tend to focus upon rectifying short term deficits or problems rather than addressing in an holistic way the longer term recovery of patients as the drug sector tends to do. (page 87)

Finding 31: First-class programs to treat substance dependencies are as much mental health services as they are drug and alcohol ones. (page 91)

Finding 32: Mandatory treatment is associated with high rates of death from both accidental overdose and suicide in the time following treatment. (page 94)

Finding 33: Released prisoners are at greater risk of death compared with the general population, particularly in the first few months after release. (page 95)

Finding 34: The risk of death of those on Heroin assisted Treatment in Switzerland has been just 1% tracked over 3 years. (page 96)

Finding 35: Some pharmacotherapies like methadone and heroin assisted treatment while effective in stabilising many opiate dependent people, are associated with an elevated risk of overdose which is minimised by specialist medical assessment and supervision. (page 96)

Finding 36: The risk of death is unacceptably high for those who have been subjected to compulsory abstinence based programs. (page 98)

4. Families and Friends for Drug Law Reform – who we are

1. Since its establishment in 1995, Families and Friends for Drug Law Reform (FFDLR) has devoted a lot of its attention to improvements in the criminal law. It made submissions to House of Representatives and Assembly inquiries on the relationship between drug policy and crime and argued in 1999 that the ACT would be better advised to reform its drug laws than establish its own prison. If we didn't win that argument it was important that governance arrangements for the prison should be framed in the best possible way to prevent people leaving it being more harmed human beings than entered it. Thus for 10 years it took a leading role in the ACT Community Coalition on Corrections and was represented on the Crime Prevention Committee of the Department of Justice and Community Safety Directorate where we tried hard to have JACS recognise the crime prevention potential of an approach that gave primacy to what is known as the social determinants of health and wellbeing.

2. The history of our organisation, together with commentary on drug law reform, has been encapsulated in the book published by FFDLR entitled *The Drug Law Wars: Twenty years of families fighting at the front.* The book, edited by founding members Brian and Marion McConnell, was published in 2015 and launched in the ACT by Senator Katy Gallagher. Both Brian and Marion received Order of Australia Medals for their work. Brian died in 2016 from mesothelioma. Many of the FFDLR members have had the tragic experience of losing family members and friends through drug overdoses. This waste of life is directly caused by the supply of illegal substances being entirely in the hands of criminals. With no possibility of ascertaining the quantity of a drug in a "deal", its purity or admixtures, those using the drug are playing Russian roulette. In this context FFDLR strongly supports all measures that move the paradigm from a coercive approach reliant on the criminal law to one that sees drug use as a health and social problem.

3. Families and Friends has also long been aware of the intimate link between drug policy and the failings of the mental health system. To that end it made submissions in 2004 and 2005 to inquiries by *Mental Health Council of Australia* and to a Senate Select committee on mental health. More recently it has made submissions to the Productivity Commission's reference into mental health, the report of which is basic reading for you on this inquiry.

5. Canberra's vision: where does Community Corrections fit?

4. Canberra's aspirations are proudly high. Its social plan articulates a vision of Canberra as a place where "all people reach their potential, make a contribution and share the benefits of an inclusive community."[1] The government doubled down on this in the plan for the next century which had as its objective ensuring that all Canberrans:

1. Australian Capital Territory, Chief Minister's Department, Canberra Social Plan 2011 (Canberra City, 2008) at http://www.cmd.act.gov.au/__data/assets/pdf_file/0010/216559/2011CanberraSocialPlan_Print_Version.pdf visited 05/09/2021.

enjoy the benefits of living in a community that is safe, socially inclusive and respectful of human rights, that all Canberrans are able to fully participate in community life and that the most vulnerable in our community are respected and supported."[2]

5. Something has gone amiss when a member of the community has done something that hurts others enough for the processes of the criminal law to become involved. When this happens we are clearly not a safe community nor one where respect, cohesion and equality of opportunity prevail.

6. It is therefore fitting that the term "corrections" should be applied to the effort of government to rectify the situation by recourse to measures that aim not to entrench marginalisation and stigma but endeavour put to rights a hurt to society and the individuals and to reclothe ("rehabilitate") the offender rather than just deter and dispense punishment.

Finding. 1

Finding 1: The Corrections sector presently serves to entrench marginalistion and stigma that are potent risk factors for anti-social and criminal activity.

Recommendation 0

By adopting an approach based on public health principles it should be possible to limit the role of corrections to where violence and public safety is involved. One sector should not, as at present happens, undermine the efforts of the other. The resources of both Government and civil society can and should be harnessed to contribute to a vision of "social cohesion, social inclusion, equity of opportunity, access to justice, and physical safety."

6. Terms of reference

7. The Standing Committee on Justice and Community Safety resolves to inquire and report on the operation of community corrections, with particular reference to:

1. Parole system,
2. Intensive correction orders,
3. Sentence Administration Board,
4. Drug and alcohol treatment orders,
5. Recidivism outcomes,
6. Experiences of offenders and their families,
7. Experiences of victim survivors, and
8. Any other relevant matter.

2. *The Canberra Plan: Towards our second century* (2008) p. 34 at http://www.cmd.act.gov.au/__data/assets/pdf_file/0013/120217/canberra_plan_text_V5.pdf

7. The ACT prison

7.1. The prison has failed to live up to Canberra's vision of itself

8. Your consideration of community corrections is in the shadow of the most obvious failure of the Australian Capital Territory live up to its ideals namely in its expectations of of a human rights compliant prison. In the words of its proud champion, the Chief Minister on 24 August 2004:

> "Our aim, through the ACT prison, is to change the fate of prisoners, offer them a better "future and equip them with skills to live successfully in the community after their release. We have a responsibility to the ACT community, to our prisoners and to their families to provide opportunities for persons sentenced to imprisonment to turn their lives around."[3]

9. The Chief Minister of the day, Mr Stanhope, quoted of the British Chief Inspector of Prisons who memorably observed that Criminal behaviour emerges as a result of "joint failures of the individual and the society of which he or she is part." The statistics bear out bleakly the failure of the dream. In the prison's existence:

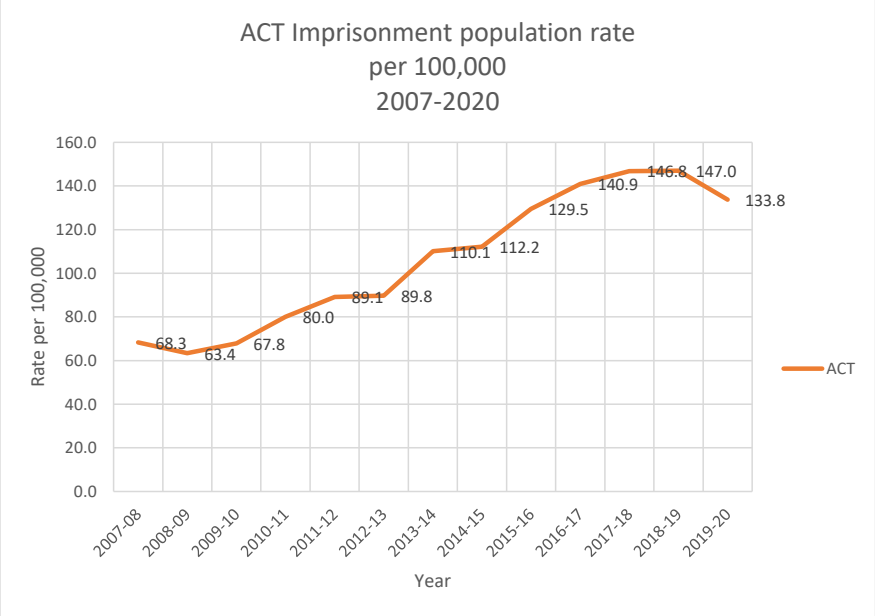
- The rates of incarceration has grown 111%:
- The rate of recourse to community corrections declined;
- The capacity of the prison was increased by 56% since it opened; and
- the rate of return to corrections tops the country:

7.1.1. The rates of incarceration have grown 111%

10. The imprisonment rate in the ACT has led the country.[4] It grew by 111% since the prison was opened in in September 2008. This has been the steepest rise of any jurisdiction in the country.

3. ACT Assembly, fifth Assembly, Weekly Hansard, *24 August 2004*, pp. 4046–47.

4. Blake Foden, ACT records fastest growth in prisoner numbers after near doubling, The Canberra Times, April 28th 20019 at **https://www.canberratimes.com.au/story/6088716/near-doubling-gives-act-fastest-growing-prison-population/** visited 05/09/2021.

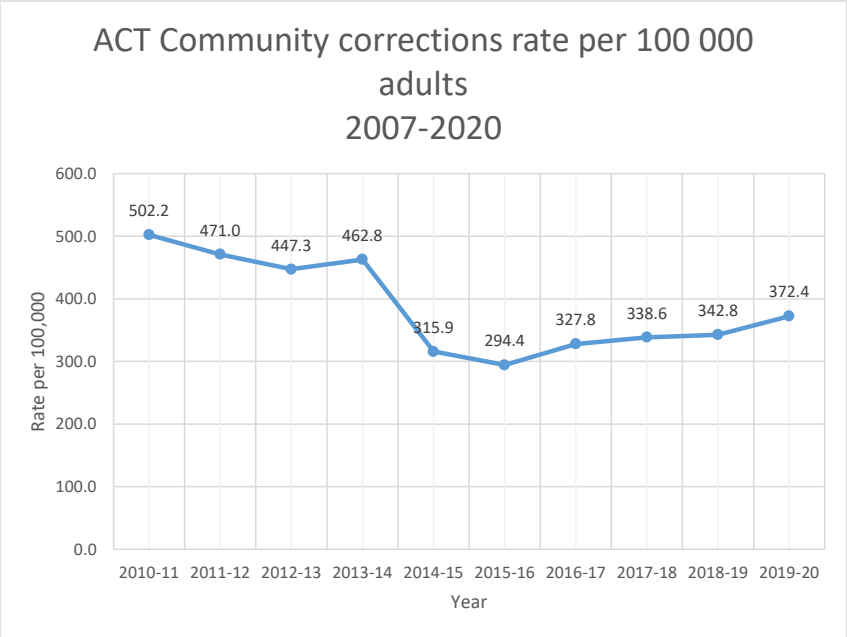


SOURCE: Productivity Commission: *Report on Government Services 2021*, chapter 8: Corrective services — Data tables contents, table 8A-5 at [file:///C:/DRUGS/Federal%20Government/ProductivityComsn/Rogs/rogs-2021-partc-section8-corrective-services-interpretative-material.pdf visited 10/06/2021](file:///C:/DRUGS/Federal%20Government/ProductivityComsn/Rogs/rogs-2021-partc-section8-corrective-services-interpretative-material.pdf) & : Productivity Commission, Report on government services 2018, corrective services, Table 8A.5.

7.1.2. The rate of recourse to community corrections declined;

11. The ACT has experienced a 35% decline in recourse to community corrections since the Productivity Commission began tracking community corrections 10 years ago

Figure 1: ACT Community corrections rate per 1000 000 adults 2007-2020



7.1.3. The capacity of the prison was increased by 56% since it opened

12. Its design capacity was 300. In July 2019 it had risen 56% to 467. Even so, the ACT Inspector of Correctional Services reported that of these "43 beds are not available for general use (special units), which means that there are only 424 beds to cater for the general detainee population, which has often exceeded 450 in 2019."[5]

5. ACT Inspector of Correctional Services, Report of a review of a correctional centre, *Healthy prison review of the Alexander Maconochie Centre 2019 (*ACT Inspector of Correctional Services, Canberra 2019) p. 28 at https://www.ics.act.gov.au/__data/assets/pdf_file/0007/1429495/191120-OCIS-AR-Final-Web-Version.pdf

13. The 2021 Report on Government Services noted that in 2019-20 utilisation of the secure design capacity was 103.8%.[6]

7.1.4. The rate of return to corrections tops the country

Figure 2: Adult offenders released from prison who returned to corrective services within two years of release

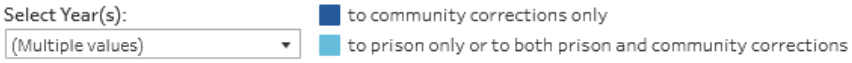
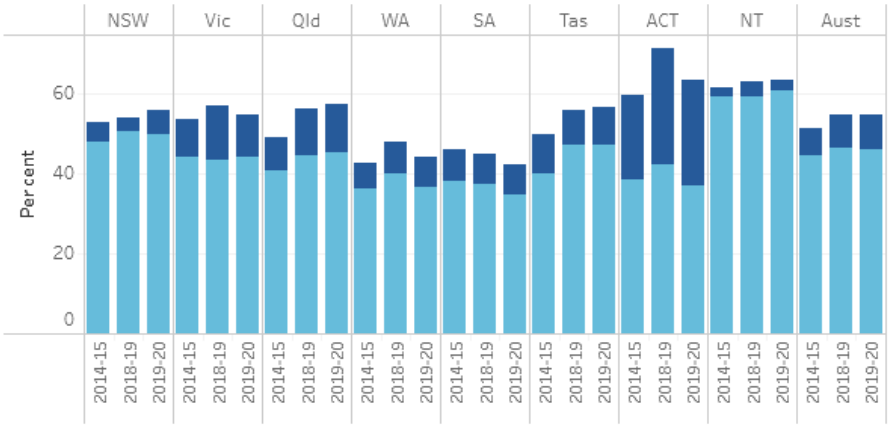


Figure C.3 **Adult offenders released from prison who returned to corrective services within two years of release**

by jurisdiction, by year



Source: table CA.4

Data tables are referenced above by a 'CA' prefix and all data (footnotes and data sources) are available for download from the supporting material below (both in Excel and CSV format).

SOURCE: Productivity Commission, Report on Government Services 2021, PART C: Released on 22 January 2021 https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/justice visited 20/11/2021.

14. The expansion in recent years of community corrections suggests a strong need to improve this shameful trajectory. Measured by the incarceration rate, there are hopeful signs that the rate of increase has levelled off and even started to decline.

15. But reducing the prison population while increasing the number of people in community corrections needs to be more than an accounting trick. The vision of Canberra becoming a safe and cohesive community where respect, cohesion and

6. Productivity Commission: *Report on Government Services 2021*, chapter 8: Corrective services — Data tables, Table 8A.15at file:///C:/DRUGS/Federal%20Government/ProductivityComsn/Rogs/rogs-2021-partc-section8-corrective-services-interpretative-material.pdf visited 10/06/2021

equality of opportunity prevails eludes us while so many of our so fellow citizens are caught up in the criminal justice system.

16. If you as legislators are to make a difference, the obvious focus of your attention, is the make-up of those who are caught up in that system. It is to be expected that those on community corrections mirror the proportion of those in prison:

8. The concentration of marginalised groups within Corrections system

17. The composition of those in the Corrections system and shows that overwhelmingly they fall into three groups that have much in common:

a) those who are substance dependent;

b) those with mental health conditions; and

c) Indigenous Australians.

Finding. 2

In the profile of people caught up in the correctional system three disadvantaged groups stand out:

- drug users who have become dependent;
- those with a mental health condition; and
- Aboriginal and Torres Strait Islanders.

Recommendation 1

If the ACT is to meet it's 25% by 2025 goal of the reduction in reoffending, attention must be focused on these disadvantaged groups of dependent drug users, those suffering from a mental health condition and Aboriginal and Torres Strait Islanders.

8.1. Those who are substance dependent

18. If you want to reduce the call on corrections services pay attention to these demographies and seek more effective community responses.

19. Between 70 and 80 per cent of imprisoned offenders report using illicit drugs in the months leading up to their incarceration"[7]

20. Even though drugs are meant to be excluded from prison, no prison in the world including the ACT prison has managed to achieve that objective. Indeed, the 2016, and latest health survey reported that drug use was prevalent in the ACT prison:

7. Craig Jones, Intensive judicial supervision and drug court outcomes: Interim findings from a randomised controlled trial; Contemporary Issues in Crime and Justice Number 152 (Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research (BOCSAR), November 2011) at file:///C:/Users/Bill/AppData/Local/Temp/intensive-judicial-supervision-and-drug-court-outcomes.pdf visited 29/08/2021.Citing Kevin, M. (2010). Drug-related patterns and trends in NSW inmates: Overview of the 2007-08 biennial data collection (Research Bulletin No. 27). Sydney: Corrective Services New South Wales.

> Nineteen respondents (19%) reported injecting any drugs in prison during their current incarceration, with no significant differences between Indigenous and non-Indigenous respondents. Among the respondents reporting injection drug use in prison during their current incarceration, 8 reported injecting heroin, 18 meth/amphetamines, and 5 other illicit drugs (with multiple responses permitted). Of the respondents reporting injecting during their current incarceration, 7 reported injecting illicit drugs five times or fewer whereas over half (n=10) reported injecting illicit drugs 20 times or more during their current incarceration. Among respondents who reported injecting in prison during their current incarceration, 4 reported that they did not inject with other people the last time they injected a drug in prison, 10 with two or fewer other people, and <5 reported injecting with three or more other people.[8]
>
> "The most frequently reported illicit drugs ever used in prison were cannabis (37%), methamphetamines/amphetamines (32%), heroin (29%), and other opiates (19%)."[9]

21. It is understandable that the stresses of prison life lead people to take up drug use in prison.[10] 14% commenced smoking while there[11]

22. Among the first things that people do upon release from prison is relapse into drug use, often with fatal consequences. 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".[12] The problem is accentuated by the likely reduction in tolerance so that the dose taken on the relapsing can easily bring about a fatal overdose.

23. A prospective cohort study in Queensland looked at mortality over 4.7 years of people released from prison: "Those at greatest risk of death are characterised by social disadvantage, poor physical and mental health, and a history of risky substance use." The study:

> Observed 42 deaths (3.2%) during follow-up, giving a crude mortality rate of 10 (95%CI=7.5-14) deaths per 1000 person years. The age and sex adjusted all-

8. Young J.T., van Dooren, K., Borschmann R., & Kinner S.A.(2017), ACT Detainee Health and Wellbeing Survey 2016: Summary results. (ACT Government, Canberra, ACT.) p.43 at https://stats.health.act.gov.au/sites/default/files//2016%20ACT%20Detainee%20Health%20and%20Wellbeing%20Survey%20Report.pdf visited 12/11/2018.

9. The same, p. 42.

10. A Boys, M Farrell, P Bebbington, T Brugha, J Coid, R Jenkins, G Lewis, J Marsden, H Meltzer, N Singleton, C Taylor, Drug use and initiation in prison: results from a national prison survey in England and Wales, *Addiction*,. 2002 Dec;97(12):1551-60. doi: 10.1046/j.1360-0443.2002.00229.x. at https://pubmed.ncbi.nlm.nih.gov/12472639/ visited 31/08/2021

11. Young *et al*, fn 8, pp.39 & 54.

12. The same, p. 56.

cause standardised mortality rate was 4.0 (95%CI=2.9-5.4) times higher for ex-prisoners than for the general population of Queensland (Table 2).[13]

Finding. 3

The risk of death of people leaving prison is 10 times greater than in the general population, with the greatest risk occurring in the first few weeks after release.

8.1.1 The continued marginalisation and stigmatisation of people who use drugs continues to show that we are not a cohesive community;

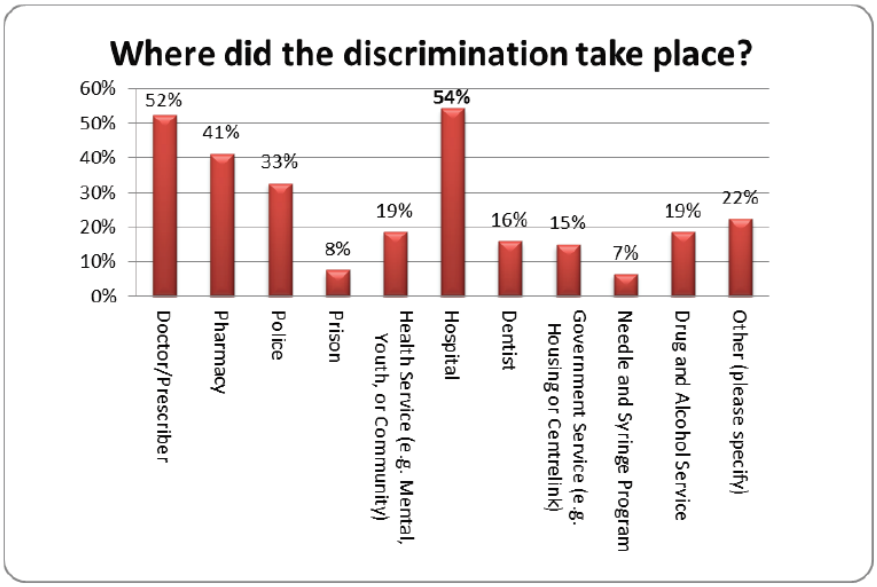
24. The marginalisation of people who use drugs shows that we do not stand up for equality of opportunity. People are denied opportunity to access the best that our community has to offer. Negative attitudes towards drug users flow from deep seated fears that dependency saps people of their self-control and even autonomy which some construct as being the essence of what it is to be human.

25. The pervasiveness of stigma against drug users is reflected in surveys of the extent that drug users experience discrimination when they seek help. Negation of the humanity of drug users offends the core values of the ACT's vision for itself and the worth of the marginalised for whom Families and Friends has championed throughout its existence of 26 years. They are values articulated in the Uniting Church's fair treatment campaign: “We all want to live in a world where everyone is treated with dignity and respect, including people who use drugs”.

26. People who use drugs often encounter discrimination from the very services and people to whom they apply to for help.

13. I Simon J Forsyth, Megan Carroll, Nicholas Lennox, Stuart A Kinner, Incidence and risk factors for mortality after release from prison in Australia: A prospective cohort study, *Addiction*, Volume113, Issue 5 May 2018, Pages 937-945.doi: 10.1111/add.14106. Epub 2017 Dec 19 and https://research-repository.griffith.edu.au/bitstream/handle/10072/386894/Kinner79958.pdf;jsessionid=26B05AB027E23841E7B033EC38FFE788?sequence=2 visited 02/09/2021

Figure 3: Where injecting drug users experienced discrimination



SOURCE: AIVL regular bulletin on BBV & injecting drug use related research and policy, issue 12, Apr - Jun 2012 at http://www.atoda.org.au/wp-content/uploads/AIVL-Research-Policy-Update-Issue-12_0.pdf visited 22/05/2021.

27. Self respect is another casualty. People who use drugs often feel bad that they have failed to live up to the expectations of themselves and of those who love them. This is an insidious dynamic that reinforces problems of dependency. Entanglement in the criminal justice system only compounds the negativity and, all too often, extinguishes hope.

8.2. Those with mental health conditions

28. It is commonly said that the co-occurrence of substance dependency and other mental health conditions is the expectation rather than the exception and no more so than in the justice system. The Productivity Commission stressed this overlap in its report on mental health:

> "Among those who formally enter the justice system, people with mental illness are overrepresented at every stage. Among police detainees, about 43% of men and 55% of women were reported to have a previously diagnosed mental disorder; while about 40% of prison entrants have been told they have a mental health disorder (including substance use disorder) at some stage in their life — double the rate among the general population. Rates of mental illness are even higher for particular demographic groups within correctional facilities, such as women and Aboriginal and Torres Strait Islander people. While the majority of prisoners with mental illness spend relatively short periods of time in custody

before returning to the community, inadequate healthcare in correctional facilities and poor transition support services are likely to raise the burden on the community healthcare system and increase recidivism."[14]

The ACT has proposed a Disability Justice Strategy[15] to address these concerning findings, however the 10 year plan progress has been incredibly slow , with delays already identified.[16]

Commented [AC1]: https://www.communityservices.act.gov.au/disability_act/disability-justice-strategy https://www.communityservices.act.gov.au/__data/assets/pdf_file/0007/1626631/Disability-Justice-Strategy-Annual-Progress-Report-2019-2020.pdf

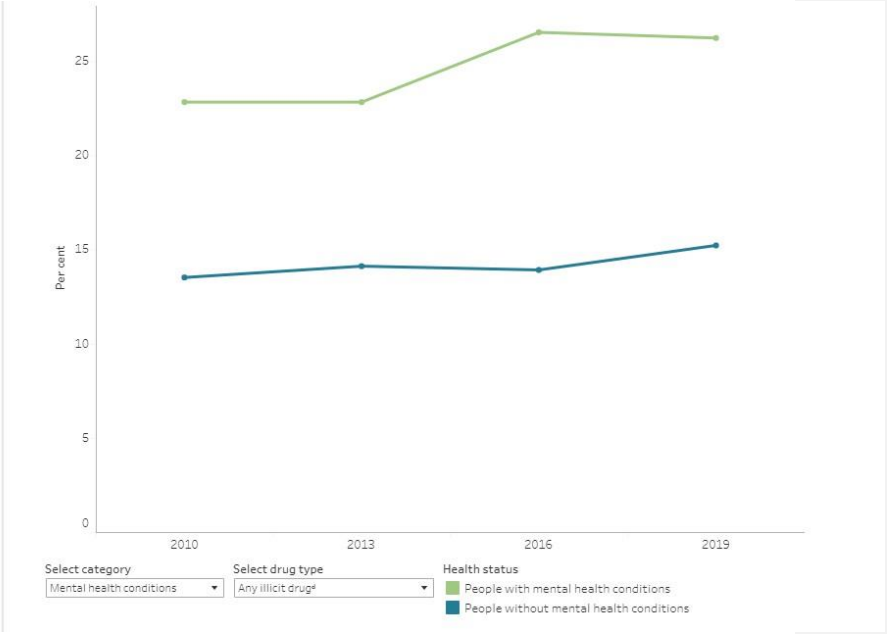
29. The disproportionate prevalence of people with mental health conditions in the corrections system reflects the similar prevalence of recent illicit drug use by those in psychological distress.

14. Productivity Commission, Report Mental Health vol. 1, No. 95, 30 June 2020 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020.Vol. 1, p. 46 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020.

15. ACT Community *Disability justice strategy 2019–2029 a strategy to address unequal access to justice in the ACT* (2019) at https://www.communityservices.act.gov.au/__data/assets/pdf_file/0008/1397924/Disability-Justice-Strategy_v2.pdf visited 29/01/2020.

16. Community Services Directorate and Justice and Community Safety Directorate, *Disability Justice Strategy; first Annual Progress report 2020*, August 2020 at https://www.communityservices.act.gov.au/__data/assets/pdf_file/0007/1626631/Disability-Justice-Strategy-Annual-Progress-Report-2019-2020.pdf visited 29/11/2021.

Figure 4 Use of specific illicit drugs among people with mental health conditions and high psychological distress 2010-2019



SOURCE: Australian Institute of Health and Welfare 2021, *Alcohol, tobacco & other drugs in Australia, People with mental health conditions* (AIHW,Canberra, last updated 16/04/2021 v11.0) at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions visited 19/05/2021

30. Substance dependency is a risk factor for mental illness as can mental illness be a risk factor for a substance abuse disorder. In other words, the relationship between mental illness and drug abuse can be bidirectional and mutually reinforcing.

> "The relationship between the different anxiety disorders and drug disorders is likely to be complex and bidirectional. One disorder can frequently mimic, and exacerbate and worsen, the symptoms of the other, and, as such, have an impact on prognosis and treatment. People with co-occurring drug use and anxiety disorders often have a more severe level of disability over time, and a poorer treatment response."[17]

31. Dr Paul Mullen, clinical director of the Victorian Institute of Forensic Mental Health and Professor of Forensic Psychiatry at Monash University has written of the growing recourse to substance abuse by people with mental illnesses:

17 . Richard P. Mattick and Susannah O'Brien, "Alcohol and drug use disorders and the anxiety disorders: co-occurrence, relationship, assessment and treatment implications" in Steve Allsop ed, *Drug use and mental health: effective responses to co-occurring drug and mental health problems,* (2008) p. 129.

"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."[18]

Finding. 4

The relationship between mental illness and drug abuse is bidirectional and mutually reinforcing. Substance dependency is a risk factor for mental illness as can psychological distress be a risk factor for a substance abuse disorder.

8.3. Summary of the links between illicit drug use, mental health conditions and crime:

- Illicit drugs are seen by many people with mental health conditions as a means of coping with their condition, relieving stress and giving them a sense of control in their life;
- procuring drugs and the friendship network of fellow drug users can tend to draw users into the orbit of a dysfunctional, criminal network while at the same time distancing them from family and a non-drug using support network;
- consequently people who use drugs and have other mental health conditions are grossly overrepresented in the criminal justice system to the extent that prisons are effectively current mental health institutions;
- prisons are about the most unhealthy place for anyone with a mental health condition to be in, in terms both of undermining their capacity to function in the broader society, intensifying marginalisation and stigmatisation and making it more likely that they will reoffend;

Recommendation 2

Recommendation 2: There should be more support of mental health services within the community and significantly increased services in Justice Health Services.

8.4. Gross overrepresentation of indigenous Australians

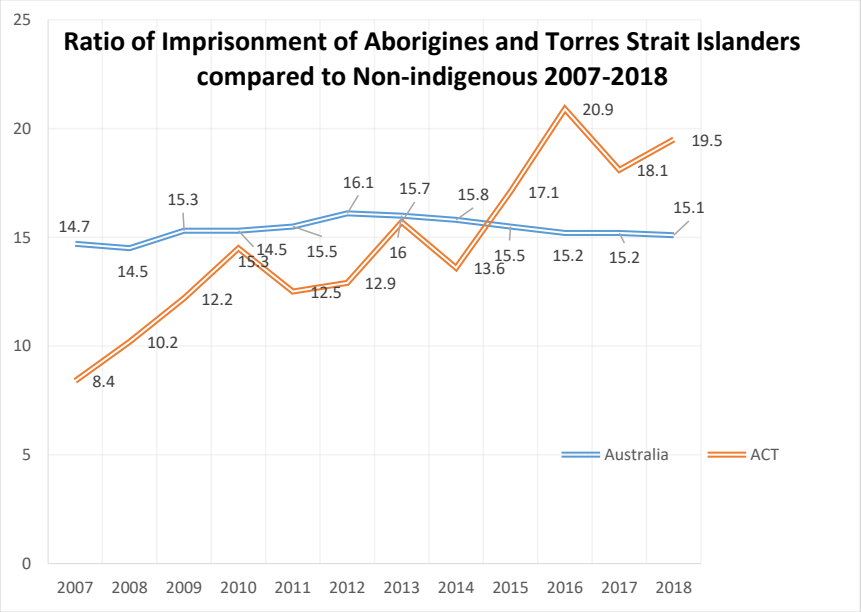
32. Indigenous Australians are grossly overrepresented in the ACT prison. In 2019-20 the crude imprisonment rate for Aboriginal and Torres Strait Islanders in the ACT was 1,988.1 offenders per 100,000 of the relevant adult population, compared with 102.4 for the non-Indigenous population.[19] After adjusting for differences in population

18. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services, p.17 (2001) at http://crg.aic.gov.au/reports/mullen.pdf visited 18/04/2019

19. Productivity Commission, *Report on Government Services 2021*, chapter 8: Corrective services — Data tables table 8A.6, at file:///C:/DRUGS/Federal%20Government/ProductivityComsn/Rogs/rogs-2021-partc-section8-corrective-services-interpretative-material.pdf visited 10/06/2021

age structures, the rate per 100,000 Aboriginal and Torres Strait Islanders in 2019-20 was 1,500.5, compared with a rate of 99.9 for the non-Indigenous population.[20] While constituting only 1.9% of the ACT population,[21] indigenous Australians make up 24.1% of people in the ACT prison.[22] The following chart shows how the situation has grown worse over the years, regressing from a time when the ACT could boast a smaller proportion of the indigenous population incarcerated.

Figure 5 Ratio of Imprisonment of Aborigines and Torres Strait Islanders compared to Non-indigenous 2007-2018



SOURCE: Embedded ABS data in Michael Inman and Elizabeth Byrne, One in five inmates in Canberra's jail are Indigenous, but one program is offering hope (ABC news, updated 26 May 2019) at https://www.abc.net.au/news/2019-05-26/canberra-program-breaking-the-cycle-of-indigenous-disadvantage/11149594 visited 19/06/20.

33. Drug use is more prevalent among Indigenous Australians than in the general community.

> "Other than ecstasy and cocaine, Indigenous Australians aged 14 or older used illicit drugs at a higher rate than the general population. In 2016, Indigenous Australians were: 1.8 times as likely to use any illicit drug in the last 12 months; 1.9 times as likely to

20. The same, table 8A.5.

21. ABS, Estimates of Aboriginal and Torres Strait Islander Australians AT https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release visited 9/09/2021.

22. The same, table 8A.4.

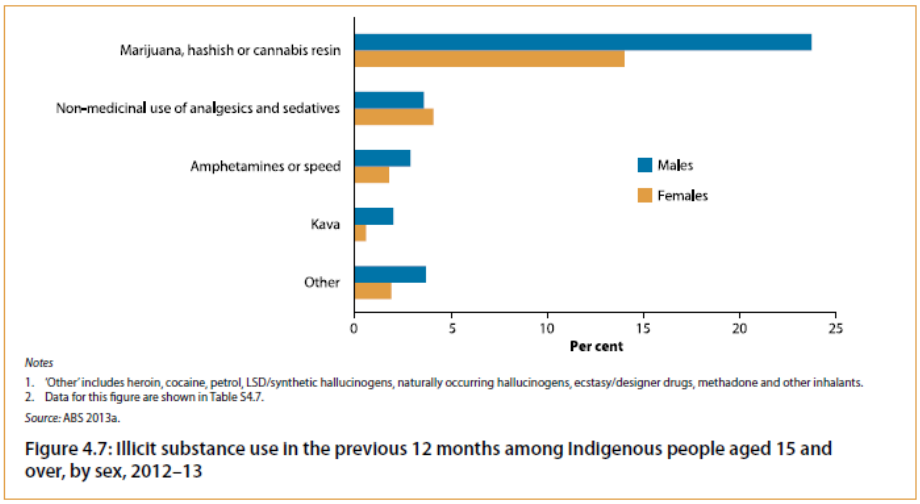
use cannabis; 2.2 times as likely to use meth/amphetamines; and 2.3 times as likely to misuse pharmaceuticals as non-Indigenous people. These differences were still apparent even after adjusting for differences in age structure. There were no significant changes in illicit use of drugs among Indigenous Australians between 2013 and 2016."[23]

34. This usage is summarised in the following chart from the 2015 report of Australia's Aboriginal and Torres Strait Islander peoples by the Australian Institute of Health and Welfare.[24]

8.5. Summary of the association between indigenous offending and illicit drug use and other mental health conditions:

- All the factors that underpin the disproportionate representation in the criminal justice system of all people who use drugs and suffer from mental health conditions apply to indigenous Australians;
- to these are added disadvantage arising from historical dispossession from land and breakdown of traditional society.

Figure 6: Illicit substance use in the previous 12 months among indigenous people aged 15 and over, by sex, 2012-13



Notes
1. 'Other' includes heroin, cocaine, petrol, LSD/synthetic hallucinogens, naturally occurring hallucinogens, ecstasy/designer drugs, methadone and other inhalants.
2. Data for this figure are shown in Table 54.7.

Source: ABS 2013a.

Figure 4.7: Illicit substance use in the previous 12 months among Indigenous people aged 15 and over, by sex, 2012–13

35. There is a community of suffering that unites Indigenous Australians with the most disadvantaged members of the general community except that factors particular to

23. AIHW 2016, Australian Institute of Health and Welfare, *National Drug Strategy Household Survey 2016: Detailed findings;* Drug Statistics series no. 31. (AIHW, Canberra, 2017) p. 108 at https://www.aihw.gov.au/getmedia/15db8c15-7062-4cde-bfa4-3c2079f30af3/aihw-phe-214.pdf.aspx?inline=true visited 20/06/2020.

24. Australian Institute of Health and Welfare 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW , p. 58 at https://www.aihw.gov.au/getmedia/584073f7-041e-4818-9419-39f5a060b1aa/18175.pdf.aspx?inline=true visited 21/06/2020.

indigenous Australians go to explain this high prevalence of substance use and mental health problems.

> "The NSW Health Aboriginal Mental Health and Wellbeing Policy cites the high prevalence of grief, trauma and loss in Aboriginal communities, as well as a rate of suicide and self harm that is at least twice the national rate. It has been reported that the rate of mental illness in these communities is affected by "socio-cultural, socio-economic and socio-historical factors"[25]

Finding. 5

The coincidence of disadvantage associated with substance dependency and mental health problems found in the general community are concentrated even more intensely in the indigenous community where they are accentuated by the legacy of historical dispossession from land and breakdown of traditional society.

8.6. High co-occurrence of substance dependency and other mental health issues

36. The Productivity Commission's draft report has described this close association in the following terms:

> "Substance use (alcohol and other drugs) disorders often co-occur with other mental health disorders. It is an area inhabited by some of the most vulnerable people in Australia (Penington Institute, sub. 264, p. 3). In 2007, about one in three Australians with a substance use disorder also had an anxiety disorder and about one in five had an affective disorder (Teesson, Slade and Mills 2009, p. 608). The strength of this association varies between drug types. At the upper end in 2013, the majority (58%) of adults who had used methamphetamines for non-medical purposes in the previous 12 months had at least moderate psychological distress (AIHW 2014, table S5.18). Substance use comorbidities are more prevalent among some population subgroups, such as Aboriginal and Torres Strait Islander people (Wilkes et al. 2014, p. 129)."[26]

37. In its final report, the Commission doubled down on this conclusion:

> "Among those who formally enter the justice system, people with mental illness are overrepresented at every stage. Among police detainees, about 43% of men and 55% of women were reported to have a previously diagnosed mental disorder; while about 40% of prison entrants have been told they have a mental

25. NSW Reform Commission, *People with cognitive and mental health impairments in the criminal justice system: Diversion,* Report 135 (June 2012) p.17 at https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-135.pdf visited 25/04/2020.

26. Productivity Commission, *Draft Report Mental Health,* (October 2019) vol. 1, p. 323 fn 14 14

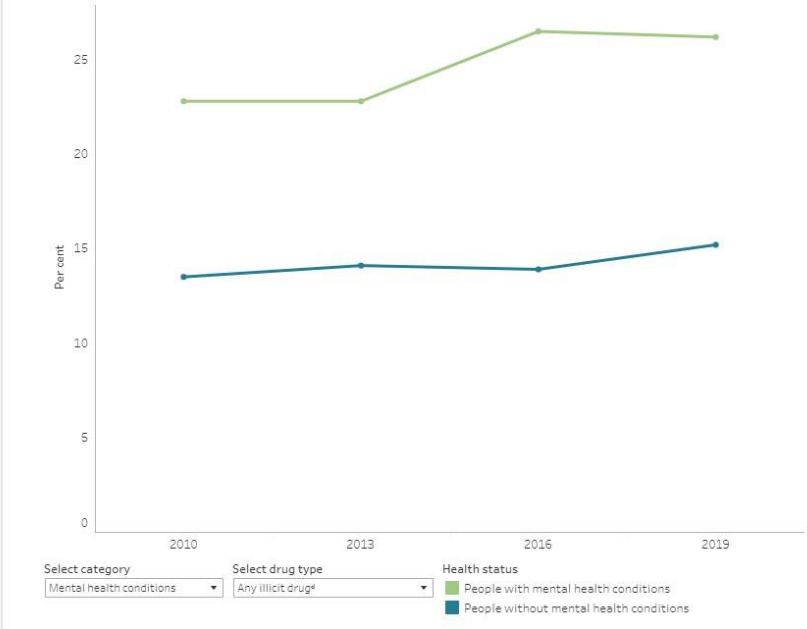
health disorder (including substance use disorder) at some stage in their life — double the rate among the general population."[27]

"People with mental illness are over-represented throughout the justice system, including in correctional facilities and as victims of crime. There is considerable scope for improved mental healthcare for people in all parts of the justice system, and improved access to justice for people with mental illness and legal needs."[28]

Finding. 6

Among many of the most vulnerable people, substance use disorders co-occur with other mental health disorders. These people are overrepresented at every stage of the justice system.

Figure 7: Recent illicit drug use, by self-reported mental health condition and psychological distress, 2010 to 2019 (per cent)



SOURCE: Australian Institute of Health and Welfare 2021, *Alcohol, tobacco & other drugs in Australia, People with mental health conditions* (AIHW,Canberra, last updated 16/04/2021 v11.0) at https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-with-mental-health-conditions visited 19/05/2021

27 . Productivity Commission, Report Mental Health vol. 1, No. 95, p. 46, 30 June 2020 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020

28. The same, vol. 1, no. 95, rec. 21 p. 80, 30 June 2020.

8.7.Suicide and co-ocurrence

38. There is no greater demonstration of the need to move away from a prison based system of corrections than consideration of the harm inflicted by the prison environment evidenced by the high level of suicide and other self harm by detainees. This section touches on the long history of this connection, showing that like incarceration itself it is intimately linked with the twin conditions of substance dependency and mental ill-health.

Finding. 7

Suicide is intimately linked to prisons as a response to the twin conditions of substance dependency and mental ill-health.

39. There is widespread evidence that illicit drug dependence is a powerful driver of suicide. In the words of Suicide Prevention Australia: “Alcohol and other drug (AOD) abuse confers a high risk of suicide” (SPA 2011, p. 3).[29] The 2010 Senate report into Suicide in Australia noted that:

> "The role of alcohol and drug abuse in completed suicides was frequently mentioned during the inquiry. Alcohol or substance abuse disorders are often comorbid with other conditions which have an increased risk of suicide".[30]

40. The suicide/drug policy link is shown by a meta analysis of 64 papers published in 2004. It applies the statistical concept of standardized mortality ratios that reveal the extent to which death in a study population exceeds the rate of the population at large:

> The meta-analysis showed that while Alcohol use disorder was a high risk factor for suicide, it was far exceeded by risk factors associated with the consumption of illicit drugs. Someone with an alcohol use disorder was almost 10 times more likely to attempt suicide than a member of the community at large (being just a heavy drinker raises one's risk of suicide by a mere 3.5 times), the risk factor for those with an opioid use disorder were 13 more times more likely, intravenous drug users were between 13 and 14 times more likely and mixed drug users (those we would refer to as polydrug users) an astounding 16 to 17 times more likely.[31]

41. The extent that this happens and the degree of mental distress in prisons that it demonstrates is alarming.

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29. Suicide Prevention Australia, *Alcohol, Drugs and Suicide Prevention, Position statement,* (Suicide Prevention Australia, Leichhardt NSW, June 2011) p. 3 at https://www.mengage.org.au/images/Suicide-Prevention-Australia-Alcohol-Drugs-and-Suicide-Prevention-2011.pdf visited 16/10/2021.

30. The Senate, Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (Canberra, The Senate, June 2010) para. 620, p. 86 at http://www.aph.gov.au/~/media/wopapub/senate/committee/clac_ctte/completed_inquiries/2008_10/suicide/report/report_pdf.ashx visited 11/04/2016

31. Holly C. Wilcox, Kenneth R. Connerc, & Eric D. Cainec, Association of alcohol and drug use disorders and completed suicide: an empirical review of cohort studies in *Drug and Alcohol Dependence*, vol. 76, supplement, 7 December 2004, pp. S11–S19.

> "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."[32]

42. More recently the Institute of Criminology has described the association between prisons and suicide in the following terms:

> "prison inmates have a higher rate of suicide than their counterparts in the general community, with prison suicide rates typically three to five times those of the general community. Offenders enter the prison system with more risk factors for suicide than those that apply to members of the general community, and remain at elevated risk of suicide following their release".[33]

43. 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 upon release. The words of Professor Mullen of Forensicare in Victoria 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".[34]

Other common practices of Corrections also harm vulnerable people who are detained. 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.[35] Those serving a Community Corrections order are exposed to this practice while held on remand if not otherwise.

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32. Morag McArthur, Peter Camilleri & Honey Webb, "Strategies for Managing Suicide & Self-harm in Prisons" in Australian Institute of Criminology, *Trends & Issues in crime and criminal justice,* no. 125 (August 1999) at http://www.aic.gov.au/publications/tandi/tandi125.html visited 14/10/2007.

33. Willis M et al. 2016. Self-inflicted deaths in Australian prisons. *Trends & issues in crime and criminal justice no. 513*. Canberra: Australian Institute of Criminology at https://www.aic.gov.au/publications/tandi/tandi513 visited 16/10/2021.

34. Paul E Mullen, Mental health and criminal justice: a review of the relationship between mental disorders and offending behaviours and on the management of mentally abnormal offenders in the health and criminal justice services (2001) at https://www.semanticscholar.org/paper/Mental-health-and-criminal-justice-%3A-a-review-of-on-Mullen/16d6f1d7b318c134d7ebeda01e44e2108b04b0bd visited 16/10/2021.

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

44. Particularly for men there is a sharp rise in suicide deaths in the first weeks after release from prison. 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.[36]

45. The authors of that study commented:

> "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."[37]

46. 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."[38]

47. The humiliating, punishing and marginalising focus of corrections, whether in prison or in the form of community corrections, contributes to the sense of failure of drug dependent offenders and inclines them to viewing taking their own life as the only way out of their distress.

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and discussion at http://correctionscoalitionact.org.au/Campaigns/StripSearching.htm.

36. Azar Kariminia, Matthew G Law, Tony G Butler, Michael H Levy, Simon P Corben, John M Kaldor and Luke Grant, "Suicide risk among recently released prisoners in New South Wales, Australia" in *The Medical Journal of Australia*, 1 October 2007, vol. 187, pp. 387–390.

37. The same, p. 189.

38. Australia, Parliament, Senate, Select Committee on Mental Health, *A national approach to mental health: from crisis to community, First report* (March 2006) §13.110 at https://www.aph.gov.au/~/media/wopapub/senate/committee/mentalhealth_ctte/report/report_pdf.ashx visited 13/11/2018.

Finding. 8

Finding. 8: Illicit drug dependence is a powerful driver of suicide. Intravenous drug users are between 13 and 14 times more likely and polydrug users 16 to 17 times more likely than the general population to take their own life.

8.8.Summary of the links between illicit drug use and crime

- offences committed while under the influence of drugs;
- offences committed to raise funds to support a drug habit;
- socialisation with a dysfunctional peer group involved in supplying drugs;
- accumulation of risk factors for crime like school dropout, unemployment and other indicators of disadvantage that can follow on from dependent drug use.

Finding. 8

Finding 9: Crime perpetrated by people who use drugs comes about in the following ways:

- offences committed while under the influence of drugs;
- offences committed to raise funds to support a drug habit;
- socialisation with a dysfunctional peer group involved in supplying drugs;
- accumulation of risk factors for crime like school dropout, unemployment and other indicies of disadvantage that can follow on from dependent drug use.

9. Recidivism

48. Judged by the high proportion of people in the corrections system who return to that system, ACT corrections does a poor job in enhancing community safety (subsection 7.1.4, Figure 2 p.21above). The 2021 Productivity Commission Report on Government Services (ROGS), using figures for 2019-20[39], show that 37.1% of those released from prison returned to prison within two years and a fearful 63.4% of those released from prison returned to corrections with a new correctional sanction within two years (table CA.4). The discrepancy between those two figures helps explain the modest uptick in recourse to community sentences in the last few years. Community corrections do a better job than prison with about a fifth of those discharged from community corrections orders returning to prison or corrections. In 2019-20 around 18.3% graduated to prison from community corrections and 20.8% returned for another stint of community corrections (CA5). Even so, that is not a stellar record in securing a low rate of recourse to "corrections" or the prevention of crime.

39. Productivity Commission, *Report on Government Services 2021*, Justice sector overview — Data tables contents at https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/justice/rogs-2021-partc-section-C-Justice-data-tables.xlsx visited 17/10/2021.

Finding. 10

Finding. 9:ACT rates of reoffending are unacceptably high whether measured in terms of return to prison or to community corrections.

49. This high rate of reoffending of people who have been to prison is consistent with the findings of the NSW Bureau of Crime Statistics and Research and elsewhere. Incarceration has little if any deterrent impact and may actually increase the likelihood of reoffending:

> ” . . . prison exerts no significant effect on the risk of recidivism for burglary. The effect of prison on those who were convicted of non-aggravated assault seems to have been to increase the risk of further offending. These findings are consistent with the results of overseas studies reviewed in the introduction to this bulletin, most of which either find no specific deterrent effect or a criminogenic effect.’”[40]

Finding. 10

Finding 11: Incarceration has little if any deterrent impact and may actually increase the likelihood of reoffending.

Finding. 11

Finding 12: The high rate of ACT reoffending whether measured in terms of return to prison or to community corrections makes it extremely unlikely that the ACT will achieve its goal of a 25% reduction in reoffending by 2025.

50. The focus of the committee's enquiry is the superiority or otherwise of community corrections compared to incarceration for crimes. But crime prevention is at the heart of your mandate: Corrections, whether in prison or in the community, only arises in response to criminal action. By all means consider the superiority of various measures and techniques of community corrections in reducing reoffending but do not ignore the opportunities offered by successful strategies that address the notorious drivers of offending of co-occurring substance dependency and other mental health issues. With no crime there is no need for corrections of any sort.

1. Section 10 at pp. 41 ff. surveys the different forms of community corrections presently applied in the ACT and their failure to produce the results hoped for.

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40. Don Weatherburn, “The effect of prison on adult re-offending” in Crime and Justice Bulletin, contemporary issues in crime and Justice, (NSW Bureau of Crime Statistics and Research) *Crime and Justice Bulletin*, no. 143, August 2010 p.10 at https://www.bocsar.nsw.gov.au/Documents/CJB/cjb143.pdf visited 17/08/2021.

SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM
TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

ANNEX I: DRUG TREATMENT AS A MEANS OF REDUCING REOFFENDING AND OF CRIME PREVENTION

Annex I: , pp. 59ff assembles evidence of the crime prevention capacity of public health informed measures. Drug treatment is much more effective in preventing crime than prison or community corrections.

9.1. Imprisonment

51. In 1965 which was when drug law enforcement began to be ramped up, the Australian incarceration rate as a whole was 71.64 per 100,000.[41] The Productivity Commission now report it to be 171.5. Unlike the United States which is seeing a distinct downturn since a peak of 755 in 2008, the Australian rate continues to rise.[42] The situation in the United States is attributable in part to a perception that the rate of incarceration is financially unsustainable.[43] The decline followed the Global Financial Crisis and a 2011 order of the Supreme Court to reduce overcrowding.[44]

52. While the imprisonment rate in the ACT is substantially less than for Australia as a whole, its increase represents a shattering of the vision for a human rights compliant, rehabilitative correctional institution that guided the territory's decision to establish in 2008 its own prison rather than continuing to transport prisoners to New South Wales. This vision was reflected in according it the name of the great 19th-century penal reformer, Alexander McConachie.

53. Measured by the number of people per 100,000 in the population, the incarceration rate in the ACT has shot up in the decade from 2009–10 when a mere 67.8 Canberrans found themselves behind bars. This had grown to 147 in 2018–19, an

41. Adam Graycar & Peter Grobosky eds, *The Cambridge handbook of Australian criminology* (Cambridge UP, 2002) table 1.3, p. 16.

42. OECD comparative survey of imprisonment rates in OECD countries https://books.google.com.au/books?id=2xFYQLiLlSUC&pg=PA105&lpg=PA105&dq-=Prison+population+rate+and+composition,+and+occupancy+level,&source=bl&ots=nq8mW9DrMn&sig=ACfU3U2DJfLTnSM_-lLHiWkhZmPqyh8Fgg&hl=en&sa=X&ved=2ahUKEwiNsYPz1L7oAhWlILcAHQdjBg0Q6AEwAHoECAkQAQ#v=onepage&q=Prison%20population%20rate%20and%20composition%2C%20and%20occupancy%20level%2C&f=false

43. Jacobson *et al., op.cit*. p. 12.

44. David Biles, No Excuse for complacency: bar problems with jail systems in Australia pale by comparison, the US reminds us of the mistakes to avoid, *The Canberra Times,* Monday, May 7, 2012 p 9

increase of 117%. The 2021 Report on Government Services recorded an encouraging reduction in the incarceration rate to 133.8 per hundred thousand. One must, of course, wait to see whether this heralds a continuing trend. Since the ACT prison was officially opened on 11 September 2008 the ACT rate of incarceration has increased by 132%. In terms of numbers: "the prison commenced operations in 2009. Since that time the prison population at AMC has expanded rapidly, from 158 detainees in July 2009 to a daily average of 444 in 2019-20 and the prison has increased its capacity from approximately 270 to 539 through the addition of new accommodation units."[45]

Finding. 12

Finding 13: Since the ACT prison was officially opened in 2008 the ACT number of people detained has increased 180% from 67.8 per 100,000 to 133.8 and the rate of imprisonment has almost doubled.

54. The following table compares the ACT incarceration rate with that of other jurisdictions where heroin assisted treatment is available. The smaller rate of imprisonment in those countries would be attributable to many factors but drug policy would be a factor with others like less disadvantage that are themselves linked to substance dependency and historic indigenous disadvantage. These considerations should give cause for reflection.

55. Noted in the table are the percentage differences in the rate of these other jurisdictions compared to that of the ACT as well as the number of detainees that that difference represents. The following data are taken from the World Prison Brief at https://www.prisonstudies.org/highest-to-lowest/prison-population-total:

Table 2: Reduced ACT imprisonment if the rate in countries with HAT existed here

	Rate per 100,000	As % of ACT rate	Difference in rate	Fewer ACT prisoners per day	Amount saved per day	Amount saved per year
Canada	107	80%	26.8	88.93	$37,514	$13,692,466
British Columbia	66	49%	67.8	224.99	$94,904	$34,639,896
The Netherlands	61	46%	72.8	241.58	$101,903	$37,194,461
Switzerland	81	61%	52.8	175.21	$73,907	$26,976,202
Germany	77	58%	56.8	188.48	$79,506	$29,019,854
Denmark	81	61%	52.8	175.21	$73,907	$26,976,202

45. Karen Toohey, Gabrielle McKinnon, & Ingrid Osmond, Review of the opioid replacement treatment program at the Alexander Maconochie Centre: Report of the ACT Health Services Commissioner, (ACT Human Rights Commission, March 2018) p.9 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0009/1185057/Alexander-Maconochie-Centre-Review-of-the-Opioid-Replacement-Treatment-Program.pdf visited 2/06/2020, p.13

9.2. the coincidence of risk factors for crime, mental illness and substance dependency

56. In our 2003 submission on Support services for families of people in custody, Families and Friends drew attention to the interplay between risk and protective factors of substance dependency, mental illness and crime.[46]

> These immediate causal links between illicit drug use and crime [when a user is moved to commit a crime when under the influence of the drug or in order to raise the funds required to support their habit], though obviously potent, are probably only the superficial links between illicit drug use and crime. The main contribution of illicit drugs to crime seems to lie in the introduction and intensification of risk factors in the life of offenders. This is where families come in.
>
> It is now widely recognised that why someone commits a crime cannot be adequately explained by the circumstances at the time it was committed. Whether a risk factor like illicit drug use leads to crime is likely to depend on an accumulation of other risks factors and countervailing protective factors throughout the life of a person rather than the existence of one risk factor in isolation. Risk and protective factors feed back into each other.
>
> Substance abuse is one of many potent risk factors for crime yet it is particularly influential because of the extent that it heightens other risk factors.
>
> Thus use of an illicit substance by a young person may contribute to poor school performance. Poor school performance may lead to the intensification of substance abuse which could increase the likelihood of drop out from school, the onset of depression and other physical and mental health disorders.
>
> Substance abuse by people other than the child can increase the risk factors for that child by degrading the child's influential family and wider social environment. Family violence and disharmony, long term parental unemployment, abuse and neglect of children, low birth weight and school failure are among the risk factors that are often associated with parents whose life is out of control because of their illicit drug use. In other words, use of illegal drugs has a big indirect as well as a big direct influence on criminal behaviour. Much of the crime today is the fruit of a crop sown thirteen or more years ago by substance abuse affecting the family and other social environment of children who are now adults in trouble with the criminal law.

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

Finding. 13

Finding 14: Substance dependency, mental illness and crime share many of the same risk and protective factors. Those factors interact with each other so that alleviating one condition is thus likely to alleviate the others.

57. Accordingly, Families and Friends recommended on that occasion that:

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

58. A particularly insidious stigmatising consequence of characterisation of people who use drugs as criminals is the initiation and perpetuation of generational disadvantage. The 2003 submission went on to note that young people can get into trouble with drugs even if they come from a family or environmental background with few risk factors and robust protective factors. This is because of the personalities they have been born with: as risk takers given to push boundaries as is expected of young people moving into adulthood they may also find drugs as a comfort that helps them negotiate the challenges of that stage in their life. Indeed studies have shown a good half of personality types are at significant risk of dabbling with drugs.[47]

Finding. 14

Finding 15: Stigmatising people who use drugs as criminals is a potent driver of generational disadvantage.

10. Community Corrections programs now in the ACT

59. The imperative to reduce indigenous incarceration, the recognised harm of imprisonment and the primacy of substance dependency as a factor in offending, stand out as foci of the existing community corrections programs in the ACT. The programs recognise the importance of health rather than narrow sentencing objectives of punishment and deterrence of the criminal law. The plan to reduce recidivism by 25% by 2025[48] identifies the following broad range of health and social factors that lead to repeat offending. They include “social isolation, inadequate housing, drug and alcohol dependence and poor mental health."[49] The recidivism plan also acknowledges the need for multi-agency cooperation across government and the community to achieve this end: "a combined effort across a range of government, community and academic

47. Blue Moon Research & Planning Pty Ltd, *Illicit drugs: research to aid in the development of strategies to target youth and young people* prepared for the Commonwealth Department of Health & Aged Care, Population Health Social Marketing Unit (June 2000).

48. ACT Justice and Community Safety, Reducing Recidivism in the ACT by 25% by 2025: 2020 to 2023 (released 31/8/2020) at file:///C:/Users/Bill/AppData/Local/Temp/Plan%20-%20RR25by25%20-%20Plan%20for%20printing%20-%20web-%20Final_0-1.PDF visited 11/09/2021.

49. ACT Justice and Community Safety, Reducing Recidivism, at https://justice.act.gov.au/justice-programs-and-initiatives/reducing-recidivism at 11/09/2021.

agencies within the justice and human services systems will help us reduce recidivism and improve community safety."[50]

60. This section briefly considers existing community corrections programs in the ACT. In recognition of the health deficits of highly marginalised people and the pervasiveness of substance abuse disorders that those programs are intended to alleviate, the list is drawn mainly from the website of the ACT Department of Health rather than from the directorate of Justice and Community Safety. The common theme is that they seek to ameliorate the full rigours of the criminal justice system. People are eligible for any of these services only if they have been "apprehended or charged with an alcohol and/or drug related offence."[51]

61. That the criminal law serves as gatekeeper of these diversion services rules them out for parents who, desperate to secure support for their child to overcome an addiction, refuse to see them as criminals.

10.1. Orders

62. In the ACT a range of orders may be made by a court and the Sentence Administration Board, namely a Parole Order, Parole Time Credit, Intensive Corrections Order, Good Behaviour Order, Community Service Work Order and a Bail Order. Most of the orders are served in the community under the supervision of the ACT Corrective Services Community Corrections team.[52]

10.2. Diversion programs

63. The Diversion Service programs are aimed at diverting people arrested and/or charged with drug or alcohol related offences out of the judicial system into the health system.

64. The Aboriginal and or Torres Strait Islander Liaison Officer is a valuable member of the Diversion Services Team.

10.3. Aboriginal and or Torres Strait Islander Liaison Officer

65. The Aboriginal and or Torres Strait Islander Liaison Officer works to support Aboriginal and or Torres Strait Islander clients across Alcohol and Drug Services (ADS). The officer:

- Provides support and case management to Aboriginal and or Torres Strait Islander clients;

50 The same.

51. ACT Health, Diversion services (last updated on: 13 Nov 2018) at https://www.health.act.gov.au/services-and-programs/alcohol-and-drug-services/diversion-services visited 03/09/2021.

52. ACT Corrective Services, *Orders* (ND, Canberra) at https://correctiveservices.act.gov.au/community/orders visited 16/10/2021.

- Assists clients to negotiate and develop appropriate and achievable treatment plans with AOD sector services;
- Works with Aboriginal and or Torres Strait Islander clients referred to ADS Diversion Service programs and Gambarri Court;
- Liaises with clients, their families and other treating professionals;
- Conducts community education and development activities in the delivery of health promotion services;
- Participates in the support and education of other staff and students; and
- Provides case management and support and assists clients with referral and advocacy accessing other AOD sector services, Mental Health and Aboriginal and or Torres Strait Islander services; and
- Provides support and education to other services to assist them to provide appropriate care to Aboriginal and or Torres Strait Islander clients.

10.4. Indigenous restorative justice programs

66. These programs encompass circle sentencing courts. These are specialised courts within the ACT Magistrates or Children's court where Aboriginal and Torres Strait Islander people can have their sentencing matters heard by a Magistrate, alongside a panel of respected Aboriginal and Torres Strait Islander Elders.

67. Galambany Court – a circle sentencing court since 2004 for adults who had pleaded guilty in the Magistrates Court.[53]

68. Warumbul Circle Sentencing Court; for Aboriginal and Torres Strait Islander youth. To be eligible the young person must have pleaded guilty. It is an extension for young people of the Galambany Court.[54]

10.5. Yarning Circles for Justice;

69. Yarrabi Bamirr - This is the ACT's first formal Justice Reinvestment project. It is a family-centric support model working with Aboriginal and Torres Strait Islander families to improve life outcomes and reduce or prevent contact with the justice system, particularly trans-generational offending. The program is delivered by Aboriginal and Torres Strait Islander organisations to assist with referrals of potential clients from the Alexander Maconochie Centre.[55]

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53. ACT, Magistrates Court, GalambanyCourt, at https://www.courts.act.gov.au/magistrates/about-the-courts/areas-in-the-act-magistrates-court/galambany-court visited 13/09/2021.

54. ACT Magistrates Court, Warrumbul Circle Sentencing Court at https://courts.act.gov.au/magistrates/about-the-courts/areas-in-the-act-magistrates-court/warrumbul-circle-sentencing-court#:~:text=Warrumbul%20Circle%20Sentencing%20Court%20Circle%20sentencing%20courts%20are,of%20respected%20Aboriginal%20and%20Torres%20Strait%20Islander%20Elders visited 07/11/2021.

55. ACT Justice and Community Safety, Yarrabi Bamirr, at https://justice.act.gov.au/justice-programs-and-initiatives-reducing-recidivism/building-communities-not-prisons/yarrabi visited 13/09/2021

10.6. Early Intervention Pilot Program (EIPP)

70. The Early Intervention Pilot Program (EIPP) is a national initiative run in conjunction with the AFP, aimed at providing AOD education (and referral and treatment) to young people under 18 years caught on underage drinking offences.

10.7. Police Early Diversion

71. The police early diversion program provides for those who have been apprehended by the Police for possession of a small amount of illicit drugs (or licit drugs used illicitly). It is the police who refer clients to early diversion rather than charging them. Police can thus divert them to the health sector.

72. The client is referred to the Alcohol & Drug Program Diversion Service for assessment, and then referred to an approved ACT agency for treatment (education, counselling, withdrawal, pharmacotherapy, or residential rehabilitation). Compliance is determined by the Diversion Service staff. Non-compliance is reported back to the AFP, and the AFP determine what action should be taken (if any).

10.8. Court Alcohol and Drug Assessment Service (CADAS)

73. The Court Alcohol and Drug Assessment Service (CADAS) is a scheme in use in the Magistrates, Children's and Supreme Courts to engage clients in treatment plans during Court proceedings and as part of their Orders on sentence.

74. CADAS Clients are referred by the Magistrate or Judge only (in the ACT Magistrates, ACT Children's or ACT Supreme Courts), but anyone (self, lawyers, police) can ask the Magistrate or Judge to refer someone. Clients are case managed and supported with referral to treatment services facilitated. The goals of this service are to reduce recidivism and to engage the client in treatment.

75. CADAS clinicians monitor attendance and report all outcomes to the Courts. Non-compliance does not necessarily result in a penalty, but is taken into account by the Magistrate or Judge.

10.9. Intensive Correction Orders (ICOs) Administered by Corrections

76. ACT corrections described these orders as

> ". . . a custodial sentence of up to four years that is served in the community. An assessment for suitability is conducted by a Community Corrections Officer who considers the offender's willingness and ability to comply with the requirements of the order, and undertakes a home visit assessment. Offenders must reside in the ACT to be eligible for an ICO.
>
> "Offenders with an ICO may have to undergo regular drug testing and home visits, and will need to apply for permission to leave the ACT. Conditions relating

to community service work, curfews, attendance at rehabilitation programs, or reparation, may also be included in an ICO".[56]

10.10. Intensive Correction Orders (ICOs)

77. Courts may make Intensive Correction Orders under Chapter 5 of the *Crimes (Sentence Administration) Act* 2005. Section 11(2) of that Act provides that if someone's sentence of imprisonment is for not more than 2 years the court may order that the sentence be served by intensive correction in the community (an Intensive Correction Order). [57] In more limited circumstances under s. 11(3) the court may make an ICO on those sentenced of imprisonment is "for more than 2 years but not more than 4 years".

10.11. Drug and Alcohol Sentencing List (DASL) aka Drug Court

78. The Drug and Alcohol Sentencing List (DASL) of the Supreme Court came into operation on 3 December 2019. [58] Section 12A of the *Crimes (Sentencing) Act* 2005 permits the Supreme court to make an order when it "imposes a sentence of imprisonment of at least 1 year but not more than 4 years" provides the court may make such an order for those sentenced "for not more than 2 years". The order is to be served "in the community". A treatment order team is established to" collaboratively formulate a treatment order following consultation with any relevant treatment provider and with the participant's informed consent" and then to administer the protocol and "work with the participant to support him or her to achieve their goals within the program."[59]

79. Under section 42 of the *Crimes (Sentence Administration) Act* 2005 "the offender" is likely to be directed to undergo drug testing which must not return a positive.

80. "Those sentenced under the DASL must engage in an intensive treatment program, which is overseen by a judge." Participants are closely supervised and encouraged by a regime of carrots and sticks including a regime of drug tests (s. 43). Failure to live up to expectations can incur short-term stints in prison. The reducing recidivism paper describes the program in the following terms:

"Offenders can be subject to intensive judicial supervision as well as treatment for their substance use disorders with progress rewarded and breaches

56. ACT Corrective Services, fn 52
57. The same.
58. ACT, Supreme Court, Drug and Alcohol Sentencing List, at https://www.courts.act.gov.au/supreme/law-and-practice/criminal/drug-and-alcohol-sentencing-list visited 26/08/2021
59. ACT, Supreme Court, The treatment order team protocol at https://www.courts.act.gov.au/supreme/law-and-practice/criminal/drug-and-alcohol-sentencing-list visited 31/08/2021.

sanctioned, through a system of swift, certain and proportionate consequences. The aim is to achieve behavioural change in offenders to reduce reoffending and maintain social connections leading to improved social inclusion and community safety. The ACT DAC model is based on the successful NSW, QLD and Victorian models and will be independently evaluated."[60]

81. Andrew Fraser, an ACT criminal lawyer, observed that "the court . . . is a relatively new creation. It is a sentencing list for offenders being dealt with by the ACT Supreme Court for offending in which drugs or alcohol were a major factor. At its commencement, it had only 10 places available. Those who were found eligible became part of a system of rehabilitation tightly monitored by the judiciary. Unsurprisingly, the places were quickly filled, leaving dozens of others to be sentenced in the broad flow of the general sentencing lists of both the Magistrates and Supreme Court".[61]

82. Treatment options include abstinence and methadone and buprenorphine programs conducted in either the community or residential rehabilitation settings. Ongoing psychiatric treatment is provided.

83. The following looks at the experience of other drug courts in the fields of, reoffending, mortality and mental health and well-being.

11. Are current community corrections programs likely to reduce reoffending?

84. The Committee's inquiry takes place against the background of a bold commitment of the government to reduce recidivism in the ACT by 25% by 2025.[62] What evidence is there that the foregoing measures of community corrections will bring about this improvement and if not what other measures should be implemented?

85. Assessing whether one form of community corrections is more effective than another in reducing reoffending is a fraught exercise. The elements of each program differ and from time to time individual programs are adjusted thus making it hard to compare programs. This possibility makes it important that specific ACT programs be assessed. As things stand, the high reoffending rates shown in Figure 2, p. on page 21 up to 2018 – 19 do not suggests that community protection programs have to that point been very effective.

60. Reducing Recidivism in the ACT by 25% by 2025 fn 48 above. p.14.

61. Andrew Fraser, Drugs and Rehabilitation of Offenders, at https://www.armstronglegal.com.au/criminal-law/act/penalties-sentencing/drugs-rehabilitation-of-offenders/ visited 4/09/2021.

62 Reducing Recidivism in the ACT by 25% by 2025 fn 48 above.

Finding. 15

Finding 16: It is most unlikely that existing community corrections programs can reduce reoffending to the government's objective of a 25% reduction by 2025.

11.1. Drug court

86. The ACT drug court has not been operating long enough to assess its impact on reincarceration. A meta analysis of 57 Assessments of adult drug courts in the United States where they originated found they reduced crime by 8%. The reduction effected by juvenile drug courts was a mere 3.5%.[63]

87. Two assessments have been made of the effectiveness of the New South Wales Drug Court in reducing recidivism. The first was in 2002.[64] It compared a group otherwise eligible for the drug Court program but who were balloted out for want of places. This, the control group, underwent conventional court processing. "Recidivism was measured in terms of the time to the first drug-related offence (which was dealt with in court), and the frequency of such offences, after referral to the Drug Court program". As against those on the drug Court program there was a relatively small difference between the time that elapsed to reconviction, (279 days, compared with 325 days). "The only difference in offending frequency that "reached statistical significance, . . . was that involving drug offences."

88. On the other hand those who completed their drug court program "performed better than treated subjects whose program had been terminated, and better than control group subjects, in terms of both free time to the first offence and offending frequency (per unit of free time) for shop stealing, other larceny, and unlawful possession" (p. vii).

89. The second assessment was "of all those offenders who made it through the ballot process and into the eligibility assessment phase between February 2003 and April 2007."[65] It conducted two sets of analysis: The first a comparison between those

63. Steve Aos, Marna Miller, and Elizabeth Drake. (2006), Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates (Olympia: Washington, State Institute for Public Policy) exhibit 4 at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwiakbKCifzyAhUVSX0KHXxYDhIQFnoECAUQAQ&url=http%3A%2F%2Fwww.wsipp.wa.gov%2FReportFile%2F1033%2FWsipp_Evidence-Based-Public-Policy-Options-to-Reduce-Crime-and-Criminal-Justice-Costs-Implications-in-Washington-State_Full-Report.pdf&usg=AOvVaw0eKocH6w94v-PqMvtzKMci visited 13/09/2021

64. Bronwyn Lind, Don Weatherburn, Shuling Chen, Marian Shanahan, Emily Lancsar, Marion Haas and Richard De Abreu Lourenco, New South Wales Drug Court evaluation: Cost-effectiveness Legislative Evaluation No. 15 (January 2002) at https://www.bocsar.nsw.gov.au/Pages/bocsar_publication/Pub_Summary/Legislative/L15-NSW-Drug-Court-evaluation-Cost-effectiveness.aspx visited 31/08/20.

65. Don Weatherburn, Craig Jones, Lucy Snowball & Jiuzhao Hua, The NSW Drug Court: a re-evaluation of its effectiveness Crime in *Justice Bulletin* no. 121 September 2008 p. 6 at

balloted onto the drug court program and those who weren't; the second between those who completed the drug court program and those whose participation was terminated or lapsed or were never balloted onto the program.

90. In the first set of analyses, there was no significant difference between the proportion of Drug Court and Comparison Groups who had a conviction for any offence during follow-up. The Drug Court Group, however, were significantly less likely to have a subsequent conviction for an offence against the person or a drug offence but significantly more likely to have a subsequent conviction for a property offence.[66]

91. The second set of analyses attempted to control for differences between the groups by taking into account hazard ratios. In the analyses the drug court program comes out as superior:

> They were 17 per cent less likely than the Comparison Group to be reconvicted of any offence. It can be seen that they were also 30 per cent less likely to be convicted of an offence involving violence and 38 per cent less likely to be reconvicted of a drug offence. No significant difference was found, however, between Drug Court and Comparison Groups in the likelihood of being reconvicted during the follow-up period for a property offence.[67]

Finding. 16

Finding 17: Drug courts have very mixed success in reducing reoffending, because of low numbers will have little impact at a population level and are unlikely to produce the reductions in reoffending that the ACT is committed to.

92. These favourable outcomes appear to accrue only to the so-called "Drug Court Completed Group" and not those whose participation in the drug court group was terminated (the Drug Court Terminated" Group").[68] The attrition rate among the original drug court Group was very high: of the original 645 members of that group only 241 completed treatment with 359 being included in the Terminated Group – 56% of the original Drug Court Group.

93. Even then “only three out of the four outcomes [offences of violence, property, drugs and any other offense] showed a significant result in favour of the Drug Court.” If those who completed the drug court program are compared with the control group and with those whose participation was terminated, the outcomes favour the drug court. Whatever the statistical merits of compensating for the different profiles of those in the various groups, it is hard to see the more recent New South Wales analysis as a resounding demonstration of the real world efficacy of drug courts.

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http://www.bocsar.nsw.gov.au/lawlink/bocsar/ll_bocsar.nsf/vwFiles/CJB121.pdf/$file/CJB121.pdf visited 31/8/2012.

66. The same, p. 7.

67. The same, p. 9.

68. “The second analysis compared three groups: the Control Group, the Treatment Group and a modified Treatment Group (Treatment Completion Group) that excluded those who did not complete the program and those who were removed from it” (the same pp. 3 & 11-12).

94. The capacity of drug treatment programs to attract and retain clients in treatment are key indicators of the efficacy of those programs. In the same way the efficacy of programs to reduce recidivism should also be judged by their capacity to engage and retain offenders. In this light, the fact that "Fifty-six per cent of those placed on the Drug Court program did not complete the program"[69] is not a ringing endorsement of the drug court program

Finding. 17

Finding 18: The effectiveness of a drug court to reduce reoffending depends in a large part on its capacity to engage and retain people in treatment. The New South Wales drug court has yet to demonstrate that capacity.

11.2. Supervised suspended sentences

95. The New South Wales System of Intensive Correction Orders has been compared with supervised suspended sentences and simple suspended sentences. ICOs have shown themselves to be much more effective in reducing recidivism. From the date (the index date) that the court finalised the ICO or other order:

> ". . . an offender on an ICO had around 30 percent less risk of re-offending than an offender on periodic detention. Twelve months from the index finalisation 29 per cent of those who received a supervised suspended sentence but only 19 per cent of those who received an ICO had re-offended. From the time of the index finalisation an offender on an ICO had 33 per cent less risk of re-offending than an offender on a supervised suspended sentence."[70]

96. An American meta-analysis of 11 treatment-oriented intense supervision programs found an encouraging 16.7% reduction in recidivism[71].

Finding. 18

Finding 19: Intensive Correction Orders in NSW have reduced the risk of reoffending by 30 percent and similar treatment oriented programs in the United States have reduced reoffending by an average of 16.7%.

97. In the ACT, Intensive Corrections Orders[72] appear to be both stand alone orders and orders linked to the new Drug Court[73] (Section 10.10, p.45 - 10.11 p. 45) whereas in New South Wales interventions with that name are a program from the Drug Court.[74] [

69. The same, p. 10.
70. Clare Ringland and Don Weatherburn, The impact of intensive correction orders on re-offending, Contemporary Issues in Crime and Justice Number 176 (Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research (BOCSAR), December 2013) at 04/09/2021
71. Aos, Miller & Drake, fn 63.
72. Part 5.2, Crimes (Sentence Administration) Act 2005,
73. S. 11 of the Crimes (Sentencing) Act 2005.
74. NSW, Judicial Commission, Last updated: Intensive correction orders (ICOs) (alternative to full-time imprisonment), (last updated SBB 47, Feb 21) at https://www.judcom.nsw.gov.au/publications/benchbks/sentencing/intensive_correction_orde

98. As described in the assessment of its effectiveness, offenders placed on ICO's of New South Wales were required to:

- complete a minimum of 32 hours of community service work per month;
- participate in programs to address his or her offending behaviour;
- submit to drug testing; and
- comply with all reasonable directions from a NSW Corrective Service supervisor.[75]

11.3. Aboriginal and Tourist Strait Islander circle sentencing

99. The so-called cost benefit analysis of the Galambany Court published in November last year, was based on benefits arising from an assumed reduction in reoffending rather than on a survey of the court's actual performance. For all that, the assumed reduction was very small: the study "assumes 1 Aboriginal and Torres Strait Islander offender does not reoffend and receive a custodial sentence due to Galambany Court's diversion to community based sentences".[76] The study is thus of little practical relevance to the achievement of the government's 25 x 25 objectives. It is, however, a very useful compilation of the benefits that can accrue to people who are kept out of the criminal justice system and thus is at one with the public health approach urged in this submission.

100. The success in reducing reoffending among the suite of community corrections programs implemented by the ACT is summarised below in tabular form. Subject to the caveat that many of the ACT's programs have not been assessed and that their content and thus effectiveness will differ from those elsewhere that have been assessed, one has little faith that the capacities of what the ACT is doing is likely to meet its goal of reducing reoffending by 25% by 2025.

101. In assessing effectiveness it is important to take into account the capacity of the program to engage and retain people on the program (Sections 19 Crime prevention through opiate drug treatment (p.64) & 20 Crime prevention through treatment for stimulant dependency (p.72)). Sections 18 and 19 of what??? The effectiveness of any drug treatment service depends on its capacity to retain and engage people in that treatment. The same considerations should be applied to community corrections programs addressing reoffending. This observation applies with particular force to the Drug and Alcohol Sentencing List (DASL) otherwise known as the Drug Court. Even if it achieves the spectacular rates of reduction in reoffending of the New South Wales drug court, those rates have been achieved only for its graduates and those still engaged in the NSW program. Its high attrition rate (56%) undermined its effectiveness (subsection

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rs.html visited 26/08/2021 and Michelle Makela, Intensive Correction Orders (ICOs) at https://www.armstronglegal.com.au/criminal-law/act/penalties-sentencing/intensive-correction-orders/ visited 4/09/2021.

75. Ringland and Weatherburn fn 70.

76. Anne Daly, Greg Barrett, Rhiân Williams, *Cost Benefit Analysis of Galambany Court* (November 2020, Canberra) p. 110 at GalambanyCoordinator@act.gov.au visited 13/09/2021

11.1 pp. 47-49). In short, it is most likely the ACT will fall well short of achieving a 25% reduction in reoffending by 2025.

Table 3: likely capacity of existing ACT community corrections measures to reduce reoffending
Not a direct description of the table's NSW and American assessments

Study & comparison criteria where known	Delay in reoffending	Reoffending frequency
US Drug Court Meta analysis of 57 assessments (see section 11.1, p. 47ff)		8%
US Juvenile Drug Courts (see section 11.1, p. 47ff)		3.5%
NSW Drug Court 2002 (see section 11.1, p. 47ff) participants in the NSW Drug Court program compared to offenders deemed eligible for the program but sanctioned in the usual way	Treated subjects were found to take significantly longer than the control group to their first shop stealing and their first drug offence (p. vii).	Treated subjects outperformed the control group in having lower rates of offending for most categories of offence (p. vii). Treated subjects, on the other hand, were found to have significantly higher rates of fraud offences than the control group (p. vii).
NSW Drug Court 2002 (see section 11.1, p. 47ff) Those retained on the Drug Court program, compared to those rejected from the program (after placement on it), and those placed in the control group.	Non-terminated Drug Court participants performed better than treated subjects whose program had been terminated, and better than control group subjects (p. vii) Drug Court was as cost-effective as conventional sanctions in delaying the time to the first offence (p. 62)	Non-terminated Drug Court participants performed better than treated subjects whose program had been terminated, and better than control group subjects (p. vii) Drug Court was as cost-effective as conventional sanctions in reducing the frequency of offending (p. 62)
NSW Drug Court 2002 (see section 11.1, p. 47ff) Those retained on the Drug Court program [graduated or still participating], compared to those rejected from the program (after placement on it), and those placed in the control group (p. 35)	Small difference between the time that elapsed to reconviction, (279 days, compared with 325 days) (p. 38).	Only for drug offences was there a significant difference between the treated and control subjects. However, the offending frequency was very low; less than one offence per year of free time. (It should be remembered that these are offences dealt with by a court; the actual number of offences committed is certain to be underestimated by these data.) Nevertheless for all offence types except fraud, larceny other than shop stealing, and motor vehicle theft, the offending frequency for control subjects was greater than that for treated subjects (p.44)

Study & comparison criteria where known		Reoffending frequency
NSW Drug Court 2007 (see section 11.1, p. 47ff) Those retained on the Drug Court program [graduated or still participating], compared to those rejected from the program (after placement on it), and those placed in the control. Those retained on the Drug Court program [graduated or still participating], compared to those rejected from the program (after placement on it), and those placed in the control group (p. 35		No significant difference between the proportion of Drug Court and Comparison Groups who had a conviction for any offence during follow-up. The Drug Court Group was, however, significantly less likely to have a subsequent conviction for an offence against the person or a drug offence but significantly more likely to have a subsequent conviction for a property offence. (p. 7). Reductions of about 6% for some offences but an increase in property offences by those admitted to the drug Court program.
NSW Drug Court 2007(see section 11.1, p. 47ff) comparison between those balloted onto the drug court program and those who weren't When we controlled for differences between the groups (the Intention to treat analysis)		Members of the Drug Court Group were 17 per cent less likely than the Comparison Group to be reconvicted of any offence. They were also 30 per cent less likely to be convicted of an offence involving violence and 38 per cent less likely to be reconvicted of a drug offence. No significant difference was found, however, between Drug Court and Comparison Groups in the likelihood of being reconvicted during the follow-up period for a property offence (p. 9).
NSW Drug Court 2007 (see section 11.1, p. 47ff) Those who successfully completed the Drug Court program (the as-treated analysis)		Controlling for other factors, members of the Drug Court Completion Group were: 37 per cent less likely than Comparison Group participants to be reconvicted of any offence at any point during the follow-up period (compared with a 17 per cent advantage for the Drug Court Group in the intention-to-treat analysis); • 65 per cent less likely than Comparison Group participants to be reconvicted of an offence against the person (compared with a 30 per cent advantage for the Drug Court Group in the intention-to-treat analysis); • 35 per cent less likely than Comparison Group participants to be reconvicted of a property offence (compared with no significant effect for the Drug Court Group in the intention-to treat analysis); and • 58 per cent less likely than Comparison Group participants to be reconvicted of a drug offence (compared with a 37 per cent advantage for the Drug Court Group in the intention-to-treat analysis) (pp. 11-12).

Study & comparison criteria where known		Reoffending frequency
NSW Intensive Correction Orders (ICOs) Comparison with supervised suspended sentences and simple suspended sentences (see section 11.2, p.49)		An offender on an ICO had around 30 percent less risk of re-offending than an offender on periodic detention. Twelve months from the index finalisation 29 per cent of those who received a supervised suspended sentence but only 19 per cent of those who received an ICO had re-offended. From the time of the index finalisation an offender on an ICO had 33 per cent less risk of re-offending than an offender on a supervised suspended sentence."
American meta-analysis of 11 treatment-oriented intensive supervision programs (see section 11.2, p.49)		16.7% reduction in recidivism

102. The success in reducing reoffending of any diversion program should take into account the profile of those on the program. A diversion program should be judged more effective if it is able to reduce reoffending by people with a higher risk profile of offending than those with a lower one. The foregoing survey of ACT community corrections programs tend to limit eligibility to people whose offence is relatively minor. Thus, only exceptionally may the Drug Court make an Intensive Correct corrections Orders for anyone sentenced to imprisonment "for more than 2 years but not more than 4 years" (section 11 (3), *Crimes (Sentencing) Act* 2005). It is designed principally for those sentenced "for not more than 2 years" (section 11 (2)). In contrast, one would have doubted if any of those selected for heroin assisted treatment in Switzerland would have come near to qualifying for admission to the ACT drug court list. They appear to have been selected on the basis of a long criminal record and failure to engage with drug treatment services (Section 19.2 below p. on page 66).

Recommendation 2

Recommendation 3: The effectiveness of a crime reduction measure should take into account the measure's capacity to reduce reoffending by people with a high risk profile.

12. Impact of drug diversion programs on existing Drug and Alcohol treatment services

103. One of the many cultural differences that separate the drug and alcohol sector from the mental health sector is that the mental health sector practises a medical model of care whereas the drug and alcohol sector adopts principally a psychosocial approach. The Productivity Commission made clear that these approaches should be integrated. It usefully pointed out that addressing stigma and providing needed psychosocial support must be integrated in a holistic way if the mental health crisis in the country is to be addressed.

104. Engagement with existing drug and alcohol services is voluntary. Clients are free to leave when they choose which could, of course, be after less than an optimal course of treatment. Their premises are not secure. Consigning to them involuntary treatment would disrupt their model of care including the dynamics of group interactions. Disruptive behaviour by someone who does not wish to engage could well degrade the efficacy of the program for the other participants. Families and Friends has heard that this is already happening with at least one rehabilitation centre in which reluctant people (all males), transitioning before release from the prison, are required to participate. At the very least, to burden existing drug and alcohol sector with involuntary clients would require a big boost in physical and human resources. This would be money far better spent in expanding existing services which are able to accommodate only about half the number of people want to avail themselves of their services. As the ATODA put it in its submission to the Select Committee Considering the Decriminalisation Bill:

> The Australian Government commissioned a review of AOD treatment services in Australia which found that nationally, treatment places would need to double to meet demand. This research estimated that approximately 200,000 people receive AOD treatment in any one year in Australia. At the same time, modelled projections of the unmet demand for AOD treatment (that is, the number of people in any one year who need and would seek treatment) were conservatively estimated to be up to 500,000 people over and above those in treatment in any one year.[77.]

105. Far better to expand treatment places to meet the large shortfall in treatment by those who seek it rather than coerce people into treatment. Providing for unmet demand is likely to head off law enforcement engagement.

Recommendation 3

Recommendation 4: In drawing on the drug and alcohol sector to support community corrections, care should be taken not to disrupt the therapeutic model of care of those services.

Recommendation 5

Recommendation 5: Within the constraints of limited resources funding the shortfall in voluntary treatment places should have priority.

13. Financial Considerations

106. The Institute of Public Affairs notes the sharply rising costs of criminal justice and calls for investigation and implementation of "more cost-effective approaches to criminal justice."

> "The costs of criminal justice in Australia are rising sharply. In 2014-15 alone governments spent over $15 billion on criminal justice. The growth in prison numbers has seen an attendant explosion in prison costs. Australia spends nearly $4 billion each year on the construction and operation of prisons. This

77. Alcohol Tobacco and Other Drug Association ACT (ATODA), Submission to Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021, no. 27, 16 June 2021.

equates to $300 per prisoner per day, or $110,000 per year. This adds up to approximately $1.8 billion annually to incarcerate nonviolent offenders. It is vital that criminal justice spending is subject to the same scrutiny as all other major government programs. This means investigating and implementing more cost-effective approaches to criminal justice-and this implies a reconsideration of the role of prisons."[78]

107. The following table consists of the recurrent expenditure of ACT corrective services according to the 2021 Report on Government Services of the Productivity Commission.[79] The table does not include prisoner health costs as these are incurred by health departments or other agencies.

78. Bushnell & Wild fn80.

79. Productivity Commission, *Report on Government Services 2021*, chapter 8: Corrective services — Data tables, Table 8A.2.

Table 4: ACT recurrent expenditure on Corrective Serevices

Prisons						
	Total operating expenditure (f)				$'000	68 167
	Operating revenues				$'000	–
	Net operating expenditure					
		Open plus periodic detention			$'000	353
		Secure			$'000	67 814
		Total			$'000	68 167
	Capital costs, all prisons					
		User cost of capital (g)				
			Land		$'000	535
			Other assets		$'000	14 865
		Debt servicing fees (h)			$'000	–
		Depreciation			$'000	7 065
		Total capital costs			$'000	22 465
	Total net operating expenditure and capital costs				$'000	90 632
	Other operating expenditure (i)				$'000	2 161
	Transport and escort services (j)				$'000	2 161
	Health expenditure (k)				$'000	–
	Payroll tax (l)				$'000	–
Community corrections						
	Total operating expenditure (f)				$'000	17 248
	Operating revenues				$'000	–
	Net operating expenditure				$'000	17 248
	Capital costs				$'000	–
	Total net operating expenditure and capital costs				$'000	17 248

SOURCE: Productivity Commission, *Report on Government Services 2021*, chapter 8: Corrective services — Data tables at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjG47L4slrzAhVF3jgGHRgGCKEQFnoECAoQAQ&url=https%3A%2F%2Fwww.pc.gov.au%2Fresearch%2Fongoing%2Freport-on-government-services%2F2021%2Fjustice%2Fcorrective-services%2Frogs-2021-partc-section-8-corrective-services-data-tables.xlsx&usg=AOvVaw0WObcX5lWkHdIFixhMX1YX visited 10/06/2

Recommendation 6

Recommendation 6: Criminal justice spending should be subject to the same scrutiny as all other major government programs.

14. Annexes

108. The conclusion reached in Section 11 (Are current community corrections programs likely to reduce reoffending?, p. 46) is that what is being done now will not reduce recidivism to the level hoped The pessimistic conclusion should not be the end of the matter. Other options are available to the ACT government to reducing rates of reoffending whilst meeting mental health needs and reducing the unconscionably high

mortality rates associated with the existing law enforcement focused approach. These ideas are developed in the following annexes.

- ANNEX I - DRUG TREATMENT AS A MEANS OF REDUCING REOFFENDING AND OF CRIME PREVENTION
- ANNEX II - MENTAL HEALTH – EFFECTIVE DRUG TREATMENT IMPROVES MENTAL HEALTH
- ANNEX III - MORTALITY AND INVOLUNTARY DRUG TREATMENTS

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committed to preventing tragedy that arises from illicit drug use

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

ANNEX I: DRUG TREATMENT AS A MEANS OF REDUCING REOFFENDING AND OF CRIME PREVENTION

15. Annex I: Drug treatment as a means of reducing reoffending and of Crime Prevention

15.1. Public health measures reduce reoffending far more effectively than Corrections

109. We have seen that community corrections work to reduce reoffending when twinned with effective drug treatments. We've also seen that prison and the standard procedures of the criminal law contribute to the stigma and marginalisation that erect barriers to dependent drug users getting their lives back on track. Indeed, arrest, trial and punishment albeit by community corrections could, like imprisonment, lead to unemployment, family breakdown, disadvantage and other risk factors for crime, drug use and mental ill-health.

110. So yes, let us invest more in programs of community corrections that work but what value does the “corrections” element add to this process? When serious offences of violence are in play, corrections have to be there but why not invest more in holistic drug and mental health treatment which can be delivered at a fraction of the price that it costs to deliver the same drug treatment programs in a correctional setting?

111. In other words, if you see your prime responsibility as the reduction of recidivism so as to meet or beat the government’s commitment to reduce reoffending by 25% by 2025 you need to consider what changes will bring about that result . It is pretty clear that on the basis of the existing settings this target will not be reached. It is also clear

that with the application of programs based on sound and proven public health principles it would be. To put it bluntly, traditional approaches to corrections compound drug and other mental health problems. Indeed, attempting to address mental health problems in a correctional setting is equivalent to attempting to treat malaria in a swamp. Traditional approaches to corrections are at the heart of the scandalous level of indigenous disadvantage in the ACT. This so because a corrections approach undermines the capacity of members of the community to take responsibility for themselves. Do not take our word as wishful-thinking utopians for this but that of the hard-headed Institute of Public Affairs:

> "Unnecessary incarceration can also have downstream effects that lessen public safety and increase waste. Prisons have a poor record for rehabilitating criminals. Nationwide, 59 percent of prisoners have been previously incarcerated. Incarceration is associated with unemployment and worse lifetime economic outcomes. Imprisoning nonviolent, low-risk offenders can inadvertently turn them into hardened criminals who may never return to productive society. Criminal acts need to be punished. But where appropriate we should look to alternatives to prison that might better incentivise criminals to choose the right path in the future."[80]

112. Were the ACT to commit itself to public health principles it would lead the nation rather than trail it. In this project the role of corrections is for the most part like the proverbial fifth wheel on a coach. Sure, prisons serve an important role in incapacitating violent and antisocial offenders but again in the words of the Institute of Public Affairs:

> "Approximately 46 percent of the prison population are incarcerated for nonviolent offences. This may have been manageable in 1975 when there were only 8,900 people in jail. But now that number is over 36,000-an increase of more than 300 percent. Over this same period the total population grew by just 70 percent, resulting in the incarceration rate increasing to 196 per 100,000 adult population. This is higher than most other common law countries and the democracies of continental Europe (though much lower than the exceptional case of the United States)."[81]

15.1.1. Norwegian approach to corrections

113. So yes, by all means come up with ways of improving community corrections in partnership with the application of public health principles but don't stop there. Recognise, like the Institute of Public Affairs comes close to doing, that ultimately the corrections are likely to play a minimal role in the achievement of the objectives of the ACT's Social Plan. We need to put behind us the blighted Anglo-Saxon approach to crime and punishment that we inherited from the convict origins of this country. In this

80. Andrew Bushnell and Daniel Wild, *The use of prisons in Australia: reform directions* (IPA, Melbourne, 2 December 2016) at https://ipa.org.au/wp-content/uploads/2016/12/IPAReport-Criminal-Justice-1122016-1.pdf visited 19/09/2021.

81. The same.

new world, the role of corrections retreat into the background as it does in Norway where it becomes an adjunct to public health oriented re-integrative programs:

> "The inmates of Halden prison [in Norway] each have a room of their own. With underfloor heating. A flat screen TV. A private bathroom. There are kitchens where the inmates can cook, with porcelain plates and stainless steel knives. Halden has a library, a climbing wall in a fully equipped music studio, where the inmates can record their own records. Albums are issued under their own label called – no joke – Criminal Records. To date three of the prisoners have been contestants in the *Norwegian Idol*, and the first prison musical is in the works . . .
>
> "It's really very simple," explains Bastøy warden, Tom Eberhardt. "Treat people like dirt, and there will be dirt. Treat them like human beings, and they act like human beings." . . . "I tell people, we are releasing neighbours every year. Do you want to release them as ticking time bombs?" . . .
>
> How do these kinds of prisons stack up? In the summer of 2018, a team of Norwegian and American economists got to work on this question. They looked at the recidivism rate. . . . [That] rate among former inmates of penitentiaries like Halden and Bastøy is nearly 50% lower than among offenders sentenced to community service or made to pay a fine.
>
> . . . *Almost 50 per cent*! That's unheard of. It means that for every conviction on average 11 fewer crimes committed in the future. What's more, the likelihood that an ex-convict will get a job is 40 per cent higher. Being locked up in a Norwegian prison really changes the course of people's lives.
>
> It is no coincidence that Norway boasts the lowest recidivism rate in the world. By contrast, the American prison system has among the highest. In the US 60 per cent of inmates are back in the slammer after two years, compared to 20 per cent in Norway." In Bastøy it's even lower – a mere 16 per cent – making this one of the best correctional facilities in Europe, perhaps even the world."[82]

15.1.2. Rand Corporation study

114. A highly regarded study on the control of cocaine undertaken by the Drug Policy Research Center of RAND in California compared the relative effectiveness of treatment with various forms of law enforcement in achieving a reduction in the number of users, the quantity of the drug consumed and the societal costs of crime and lost productivity that arise from use of the drug. The study estimated that "the costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment." Domestic law enforcement is the most efficient form of law enforcement. It "costs 4

82. Rutger Bregman, *Humankind: a hopeful history* translated from the Dutch by Elizabeth Manton and Erica Moore (Bloomsbury, London, 2020) pp. 328,330 & 331

times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction."[83]

115. Addiction being a chronic relapsing condition, it is to be expected that many users will leave treatment early or relapse before they achieve long term abstinence. To the objection that for this reason treatments tend to be ineffective, the study has a blunt response:

> ". . . this report concludes that treatment of heavy users is more cost-effective than supply-control programs. One might wonder how this squares with the (dubious) convention wisdom that, with treatment, 'nothing works.' There are two explanations. First, evaluations of treatment typically measure the proportion of people who no longer use drugs at some point after completing treatment; they tend to underappreciate the benefits of keeping people off drugs while they are in treatment-roughly one-fifth of the consumption reduction generated by treatment accrues during treatment. Second, about three-fifths of the users who start treatment stay in their program less than three months. Because such incomplete treatments do not substantially reduce consumption, they make treatment look weak by traditional criteria. However, they do not cost much, so they do not dilute the cost effectiveness of completed treatments."[84]

15.1.3. Elements of effective drug treatment programs.

116. If drug treatment is to prevent crime from occurring in the first place then it must satisfy the following conditions:

- it must be low threshold;
- it should be attractive enough to engage dependent drug users;
- it should be able to retain them until they are stabilised.

117. Addressing the public health needs of vulnerable populations before the crime is committed may not eliminate the need for corrections services but in line with the principle of justice reinvestment to which the government is committed, it will radically reduce the demand on correction services.

16. Credible alternatives to involuntary treatment

16.1. Non-pharmaceutical harm reduction measures focusing upon engagement

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

84. Ibid., pp. xvii-xix.

17. Drug Courts

118. Drug courts in five states have been subject to 12 evaluations with particular attention to the impact on reoffending. There seems to be persuasive evidence that they serve to reduce reoffending by those who complete the course but the results are far less convincing for those who drop out (section 11.1 p. 47 above) than treatments like methadone and heroin assisted treatment (Appendix 1, sections 19.2 below p. on page 66) that manage to engage and keep engaged more dysfunctional dependent drug users, many of whom would be excluded from participation in Australian drug court programs:

> "The most common outcome measured in drug court evaluations was reoffending, with strong evidence that drug courts programs are successful in reducing reoffending rates. A review of 12 experimental or quasi-experimental impact evaluations of Australian drug courts found that drug courts reduce the incidence of reoffending, as well as the frequency and the seriousness of subsequent offending, more than conventional sanctions."
>
> "Remaining engaged in, and successful completion of a drug courts program was a significant factor in reducing drug-related reoffending, and deemed to be a reliable indication that the program was meeting its objective of reducing drug-related offending in both youth and adult models. A systematic review of international drug court programs found that the average reoffending rate among youth program participants (43.5%) is lower than those of non-participants (50%)."[85]

18. Youth Drug Courts

119. The results of the first two years of the pilot program of the NSW Youth Drug Court were indifferent:

- "Data problems make it difficult to be precise about levels of offending by participants. Best estimates suggest that around 60 per cent of participants appeared in court on fresh charges whilst they were on the program.
- Nearly two-fifths went on to receive some form of detention, either in the juvenile or the adult prison system, indicating that diversion from incarceration is often only temporary, but this included only two of the program graduates.
- Around 35 per cent of participants were not recorded as having offended after they left or completed the program, but the post-program offending data are incomplete and only available for a short period after the end of the pilot.

85. Thu Vuong, Alison Ritter, Caitlin Hughes, Marian Shanahan, Liz Barre, Mandatory alcohol and drug treatment: What is it and does it work? Bulletin No. 27 — March 2019; Drug Policy Modelling Program (Social Policy Research Centre, UNSW Sydney DOI:10.26190/5cc258e2a385c) at http://unsworks.unsw.edu.au/fapi/datastream/unsworks:57804/bin864b3668-7ff6-408a-b387-c6b9c126aa92?view=true visited 31/08/2021.

- Graduates were less likely to re-offend than those who did not complete the program."[86]

120. An overview of mandatory treatment has reported that: "A systematic review of international drug court programs found that the average reoffending rate among youth program participants (43.5%) is lower than those of non-participants (50%)."[87]

19. Crime prevention through opiate drug treatment

121. Community corrections programs that reduce reoffending are crime prevention measures. All of the foregoing have been directly linked to the corrections system: the only entry to them is through the doorway of the criminal law. If crime reduction is the principal objective then the committee should consider other approaches that prevent much more crime.

122. There are indications that imprisonment actually increases reoffending. Imprisonment certainly increases the risk factors for offending. Other approaches that have nothing to do with the criminal justice system may more effectively address the factors that lead to crime. Addressing substance dependency and mental health problems and boosting programs that address those factors and reduce disadvantage in the indigenous population hold out the prospect of less crime without the cost and encumbrance of involvement of the justice and corrections systems.

19.1. Methadone

123. The benefits of treatment in reducing illicit drug consumption and acquisitive crime has been demonstrated in Australia by the Australian Treatment Outcome Study for heroin dependency. For example, the report of the combined outcome after twelve months in New South Wales, South Australia and Victoria reported the following reductions in criminal activity at baseline compared to 12 months according to the form of treatment that users were in at the commencement (maintenance therapies of methadone or buprenorphine, detoxification and residential rehabilitation) compared to a group not in treatment then.

> "Reductions in self-reported criminal activity was paralleled by reductions in the percentages of respondents who reported criminal activity as their major source of income. Specifically, the percentage of people reporting criminal activity fell from 14% to 1% among the MT [Maintenance Therapy] group, from 21% to 3% among the DTX [Detoxification] group and from 24% to 3% among the RR [Residential Rehabilitation] group. In contrast, the reduction in the percentage of

86. Tony Eardley, Justin McNab, Karen Fisher and Simon Kozlina, with Jude Eccles and Mardi Flick, Evaluation of the New South Wales Youth Drug Court Pilot Program; Final Report for the NSW Attorney-General's Department, First submitted December 2003 Revised March 2004 at https://www.researchgate.net/publication/277293106_Evaluation_of_the_New_South_Wales_Youth_Drug_Court_Pilot_Program/link/558baa2008ae48b7b56db882/download visited 17/09/2021.

87. Thu Vuong, *et al* (2019) fn 85.

people in the non-treatment group who reported criminal activity as their primary income source was less marked: from 32% to 17%."[88]

124. Thus, maintenance therapies were associated with the most striking reductions in criminal activity.

Table 5: Criminal activity at baseline and 12 months by index group of maintence therapy

	Maintenance Therapies (N=167)			**Detoxification (N=171)**			**Residential rehabilitation (N=104)**			**Not currently in treatment (N=53)**		
	BaseLine	12mth	% reduction	BaseLine	12mth	% reduction	BaseLine	12mth	% reduction	BaseLine	12 mth	% reduction
Any crime in preceding mth (%)	45	19	57.8%	59	28	52.5%	61	27	55.7%	60	40	33.33%
Type of crime committed (%)												
Property	29	7	75.9%	39	13	66.7%	48	11	77.1%	23	27	-17.39%
Dealing	29	7	75.9%	30	17	43.3%	27	16	40.7%	25	38	-52.00%
Fraud	12	1	91.7%	16	6	62.5%	25	7	72.0%	21	15	28.57%
Violent	4	2	50.0%	11	2	81.8%	7	1	85.7%	2	2	0.00%

SOURCE: Joanne Ross *et al.*, *Twelve month outcomes of treatment for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS)*, (Technical report no. 196, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, 200)4 table 8, table 9, p. 30.

125. Crime reduction accompanying methadone maintenance treatment has been carefully assessed in a lot of studies. For example, a large American one reported an 80% reduction in "drug business" among 491 male patients after stabilization in methadone maintenance treatment:

Table 6: Criminal activity at baseline and 12 months of methadone treatment

	Pretreatment: last addiction period		In treatment 6 months or longer		Percent reduction	
Offense	**No. of offenses**	**No. of dependent users**	**No. of offenses**	**No. of patients**	**No. of offences**	**Persons**
Drug business	78,548	284	15,264	80	-80.6%	-71.8%
Total	242,358		50,103		-79.3%	

88. Joanne Ross, Maree Teesson, Shane Darke, Michael Lynskey, Robert Ali, Katherine Mills, Anna Williamson, Allison Ritter & Richard Cooke, *Twelve month outcomes of treatment for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS)* (Technical report no. 196, National Drug and Alcohol Research Centre, University of New South Wales, Sydney, 2004), p.31.

SOURCE: From table 10.4 at John C. Ball & Alan Ross, *The effectiveness of methadone maintenance treatment: patients, programs, services, and outcomes* (Springer-Verlag, New York, Berlin &c, 1991) p. 202.

126. The pharmacotherapies of methadone and buprenorphine which produced the large reduction criminal activity measured in the Australian Treatment Outcome Study have been available in the ACT. One can speculate that the level of crime would have been much higher had these treatments not been available. Clearly though, they have failed to stem the growth in incarceration since the establishment of the ACT prison. You on this committee cook committee should therefore turn your mind to what else needs to be done to reverse this unfortunate trend. The outcome study shows that methadone and buprenorphine are not for everyone. After 12 months only 44% of the original maintenance group was still receiving that treatment.[89] Retention in treatment is a significant factor which points to the need to provide a range of options treatment attractive to a wider group of dependent drug users.

19.2. Heroin Assisted Treatment prevents crime

19.3. Switzerland

127. The carefully monitored trial in Switzerland of heroin assisted treatment tracked striking reduction in crime among the highly marginalised, heroin dependent people selected for the trial. They were drug users who had consistently failed to be engaged by existing drug treatments like methadone. The trial assessors compared the production in crime of those on the trial. “This reduction in crime was verified in three ways: from self-report, reduction in police contacts and reduction in victimisation of those on the trial (as criminologists acknowledge, being a victim of crime is a recognised proxy for criminal activity). The Productivity Commission has observed that people with mental illness are more likely than others in the community to be victims of crime . . . “.[90]

89. Ross *et al.*, fn 88, pp. 19-20.
90. Productivity Commission report on Mental health (2020), vol. 1, p. 46.

128. Table 1: Prevalence and incidence rates of self-reported criminality after one year of treatment compared to the time before admission (reference. Six months, N=305[91]

Table 1: Prevalence and incidence rates of self-reported criminality, after one year of treatment in the programme, compared to the time before admission (reference period of 6 months, N=305).

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

[1] burglary, muggings, robbery, pick-pocketing
[2] thefts, shoplifting, receiving or selling stolen property
[3] with or without weapon

129. Table 2: Prevalence and incidence of rates of self-reported victimisations after one year of treatment compared to the time before admission to the program (N=604)[92]

offence type	prevalence rates				incidence rates			
	before	after	p	drop	before	after	p	drop
robbery	11.5	4.7	<.001	59%	0.273	0.084	<.001	69%
assault	3.6	2.7	ns	–	0.036	0.043	ns	–
sexual offences	1.7	1.4	ns	–	0.092	0.013	ns	–
fraud with drugs	55.3	16.0	<.001	71%	4.465	0.572	<.001	87%
thefts	23.0	13.0	<.001	43%	0.792	0.180	<.001	77%
theft of bicycle	14.1	9.7	.096	31%	0.201	0.128	.063	36%

.91. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" p. 195 in *Heroin-assisted treatment: work in progress* edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen (Verlag Hans Huber, Bern etc, 2005) pp. 193-98.

92. The same.

Table 3: Incidence raised of police contact, by offence type, period of six months before and after admission to the program (N equal 604)[93]

offence type	*before*	*after*	drop	*p**
violent and sex offences	0.023	0.022	4%	ns
shoplifting	0.164	0.078	52%	<.01
burglary	0.041	0.013	68%	<.02
robbery / mugging	0.012	0.002	83%	.06
trespassing	0.028	0.007	75%	<.02
theft of vehicles	0.048	0.020	58%	<.03
other theft and property offences[1]	0.139	0.033	76%	<.01
other criminal code offences[2]	0.023	0.007	70%	<.01
traffic offences	0.040	0.013	68%	ns
use or possession of cannabis	0.131	0.056	57%	<.01
use or possession of heroin	0.689	0.149	78%	<.01
use or possession of cocaine or ecstasy	0.285	0.132	54%	<.01
use or possession of other or several substances	0.166	0.025	85%	<.02
drug trafficking	0.119	0.051	57%	<.01
offences to other laws[3]	0.017	0.005	71%	.07
overall incidence rate	*1.924*	*0.613*	68%	*<.01*

* t test for paired samples, two-tailed significance
1 including receiving stolen property and forgery
2 including fare dodging
3 including searches

130. Swiss researchers observed that " . . . The decrease has been particularly strong for serious property crime and drug trafficking."[94] Contrary to expectations, heroin prescription tended to decline as did the use of other (i.e. not prescribed drugs).

131. The foregoing tables record large reduction in drug trafficking offences. This reduction appears to have disrupted the retail drug distribution system. As mentioned above, a follow up study published a decade later suggests this disruption contributed to a decline in recruitment of new drug users.

132. While beyond the scope of the trial of heroin assisted treatment, on a population wide basis, street robberies, a crime typically committed by dependent drug users dropped in both the city and Canton of Zürich by about 70%.[95]

93. Martin Killias, Marcelo Aebi and Denis Ribeaud, "Key findings concerning the effects of heroin prescription on crime" in *Heroin-assisted treatment: work in progress edited by Margret Rihs-Middel, Robert Hämmig & Nina Jacobshagen* (Verlag Hans Huber, Bern etc, 2005) p. 196.

94 The same, p. 194.

95. The same, p. 197.

133. A consistent finding from this series of randomised trials is of the substantial improvement in health and well-being of the patients receiving SIH compared with those provided with oral methadone treatment. This improvement includes, in particular, a major reduction in the extent of continued injecting of 'street' heroin, improvements in general health, psychological well-being and social functioning, as well as major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs).

19.4. Cochrane review of the impact of heroin assisted treatment as a crime prevention measure.

134. Since the spectacular results of the Swiss trial of Heroin assisted treatment a number of other European countries and Canada have introduced that measure. A Cochrane review of trials in six countries (including Belgium) concluded:

> "Five studies compared supervised injected heroin plus flexible dosages of methadone treatment to oral methadone only and showed that heroin helps patients to remain in treatment, and to reduce use of illicit drugs".[96]

135. In the light of these positive results Denmark in 2010 initiated heroin assisted treatment and in October and November 2019 with strong support of the local police clinics providing for that treatment were opened in Middlesborough and Glasgow respectively.

136. An overview published in 2007 of the "largely positive" outcome of five trials concluded to that point noted that:

> "there is a mounting onus on the realm of politics to translate the—largely positive—data from completed HAT science into corresponding policy and programming in order to expand effective treatment options for the high-risk population of illicit opioid users."

137. The German trial of heroin assisted treatment recorded comparable reductions in crime by participants in the program:

96. Ferri M, Davoli M, Perucci CA, Heroin maintenance for chronic heroin-dependent individuals (Review), *Cochrane Database of Systematic Reviews* 2011, Issue 12. Art. No.: CD003410.

97. Benedikt Fischer, Eugenia Oviedo-Joekes, Peter Blanken, Christian Haasen, Jürgen Rehm, Martin T. Schechter, John Strang, and Wim van den Brink, Heroin-assisted Treatment (HAT) a Decade Later: A Brief Update on Science and Politics, *J Urban Health.* 2007 Jul; 84(4): pp. 552–562 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2219559/ visited 5/04/2020

> "Illegal activities, according to EuropASI formulation of involvement in illegal activities in the last 30 days, decreased [by 2/3] in the first year of treatment, without a further decline in the second year."[98]

138. The reduction in property crime reviewed above by participants in the Swiss trial of heroin assisted treatment was in the region of 90%. The results of that trial led a leading criminologist to conclude that "heroin treatment constitutes without doubt one of the most effective measures ever tried in the area of crime prevention."[99]

139. Delinquency which "decreased rapidly ". . . was associated closely with the decline of illicit drug use and vanished procuring pressure."[100]

140. A 2018 Victorian Parliamentary inquiry strongly endorsed Heroin assisted treatment:

> Heroin-assisted treatment (HAT) is particularly used in overseas jurisdictions, including Switzerland, the UK and Canada, which the Committee visited during its overseas study tour. It involves the prescription and strict clinically-supervised consumption of pharmaceutical-grade heroin (diacetylmorphine or diamorphine). The Committee found there was a strong evidence base for such treatments, with key benefits including improved health and wellbeing, reduced crime rates, and cost effectiveness.[101]

141. Heroin assisted treatment is of course, appropriate only for those who have become opiate dependent whether on illicit heroin or prescription medications which are themselves often available black market. Opiate dependency is widespread among people in the prison. This is attested to by the number of people on methadone revealed in the most recent ACT Detainee Health and Wellbeing Survey reported that "Forty-five percent of respondents indicated that they had been on a methadone program, in the past (7%) or currently (38%)."[102] Not everyone who is opiate dependent wants to use methadone as a pharmacotherapy hence the search for alternatives like

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98. At baseline 69.9% of the participants had been involved in illegal activities in the previous 30 days. At the end of 12 months this had sunk to 23.4%. Verthein, U., Bonorden-Kleij, K., Degkwitz, P Christoph Dilg , Wilfried K. Köhler , Torsten Passie , Michael Soyka , Sabine Tanger , Mario Vogel & Christian Haasen (2008), 'Long-term effects of heroin-assisted treatment in Germany', *Addiction* 103, pp. 960–966.

99. Translation from Martin Killias, Marcelo F. Aebi, Denis Ribeaud & Juan Rabasa, Rapport final sur les effets de *la prescription de stupéfiants sur la délinquance des toxicomanes*, 3rd ed. (Institut de police scientifique et de criminologie, Lausanne, September 2002) p.80.

100. The same.

101. Victoria, Parliament, parliament, Law Reform, Road and Community Safety Committee, *Inquiry into drug law reform,* (Victorian Government Printer, Melbourne, March 2018) p. xxxi at https://www.parliament.vic.gov.au/file_uploads/LRRCSC_58-03_Full_Report_Text_WEB_XQB31XDL.pdf visited 28/03/2018

102. Young J.T., van Dooren, K., Borschmann R., & Kinner S.A. (2017), ACT Detainee Health and Wellbeing Survey 2016: Summary results. ACT Government, Canberra, ACT. at https://stats.health.act.gov.au/sites/default/files//2016%20ACT%20Detainee%20Health%20and%20Wellbeing%20Survey%20Report.pdf visited 12/11/2018.

heroin assisted treatment and hydromorphone. Methadone of course does nothing for those in prison who have become dependent on a stimulant like cocaine or ice. Beyond the demonstrated reduction in engagement in dealing by those on HAT the crime reduction effect of heroin assisted treatment has little if any impact on the behaviour of those addicted to ice.

142. The reduction in property crime reviewed above by participants in the Swiss trial of heroin assisted treatment was in the region of 90%. A leading criminologist concluded that "heroin treatment constitutes without doubt one of the most effective measures ever tried in the area of crime prevention."[103]

Finding. 19

Finding 20: Heroin assisted treatment constitutes one of the most effective measures of crime prevention that has ever been trialled.

19.5. Hydromorphone

143. Hydromorphone is an opioid used as a potent painkiller. Trials in Canada have shown that injectable hydromorphone produces results comparable to heroin assisted treatment among so-called "treatment refractory opioid dependent individuals". A 2010 pilot study compared the "treatment response with injectable hydromorphone [with] diacetylmorphine [heroin]." The result pointed to "Hydromorphone [being] similarly safe and effective as diacetylmorphine as opioid-agonist substitution treatment."[104] A subsequent trial comparing adverse events associated with the same two treatments concluded that "When injectable hydromorphone and diacetylmorphine are individually dosed and monitored, their opioid-related side effects, including potential fatal overdoses, are safely mitigated and treated by health care providers."[105] In the midst of an opioid overdose epidemic, injectable options are timely to reach a very important minority of people who inject street opioids and are not attracted to other treatments.

144. In 2019 the National Health and Medical Research Council proposed a trial by the University of New South Wales which was approved by the Commonwealth Health Minister, Greg Hunt, of a trial of:

103. Translation from Martin Killias, et al., fn 99

104. Oviedo-Joekes E, Guh D, Brissette S, Oviedo-Joekes E, Guh D, Brissette S, et al. Double-blind injectable hydromorphone versus diacetylmorphine for the treatment of opioid dependence: a pilot study. *J Subst Abuse Treat* 2010*;* 38*:* 408–11.

105. Eugenia Oviedo-Joekes, Suzanne Brissette, Scott MacDonald, Daphne Guha, Kirsten Marchand, Salima Jutha, Scott Harrison, Amin, Janmohamed, Derek Z. Zhang, Aslam H. Anis, Michael Krausz, David C.Marsh, Martin T.Schechter, Safety profile of injectable hydromorphone and diacetylmorphine for long-term severe opioid use disorder in Drug and Alcohol Dependence 176 (2017) 55–62.

"Implementation of time-limited parenteral[106] hydromorphone in people with treatment-resistant injecting opioid use disorder: Feasibility, acceptability, and cost."[107]

145. This trial was approved in 2019, after the release in December 2018 of the current ACT drug strategy.[108]

146. Inexplicably the current ACT drug strategy released in December 2018 shortly before approval of the hydromorphone trial did not retain a commitment found in the earlier ones to "support researchers to seek funding to participate in a clinical research trial of hydromorphone in the ACT."[109] In 2018 a Victorian inquiry into drug law reform recommended "a trial of other controlled and pharmaceutical grade opioids (such as hydromorphone) for a small group of people [which] should be conducted, accompanied by robust evaluation."[110] Such a trial and implementation of hydromorphone are being discussed in Victoria.[111]

Recommendation 4

Recommendation 7: To address opiate dependency, mental health and reduce crime, the ACT should trial hydromorphone.

20. Crime prevention through treatment for stimulant dependency

147. This submission observed that no pharmacotherapy comparable to those developed for opiate dependency has yet been developed for the treatment of potent stimulants like ice. Addressing the considerable mental health and crime prevention dimensions of ice will therefore need to have recourse to more time-consuming processes involving a combination of Cognitive Behavioural-Like Therapies (subsection 20.3, p. 75) and low threshold counselling/psychological interventions discussed in annex II sub-section 22.4, p. 82.)

106. Administered or occurring elsewhere in the body than the mouth and alimentary canal. In other words, injectable hydromorphone.

107. National Health and Medical Research Council, 2018 Partnership Projects Third Call for Funding Commencing in 2019 at https://www.nhmrc.gov.au/sites/default/files/documents/attachments/grant%20documents/Partnership-third-call-2019.pdf visited 01/06/2020.

108. ACT Health Directorate, ACT Drug Strategy Action Plan 2018-2021: A Plan to Minimise Harms from Alcohol, Tobacco and Other Drug Use (ACT Health Directorate, Canberra, 2018) at https://health.act.gov.au/about-our-health-systempopulation-health/act-drug-strategy-action-plan.

109. ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014 at http://www.atoda.org.au/wp-content/uploads/2017/09/ACT-Alcohol-Tobacco-and-Other-Drug-Strategy-2010-2014.pdf visited 1/3/2021.

110. Victoria, *Inquiry into drug law reform,* (March 2018) fn 101 p. xxxi.

111. Alex Wodak, Bob Douglas, David McDonald, The case for an Australian heroin trial: strong then, even stronger now (*Pearls & Irritations*) 8 November 2021 at https://johnmenadue.com/the-case-for-an-australian-heroin-trial-strong-then-even-stronger-now/ visited 14/11/2021

20.1. Crime and stimulants

148. Stimulants may be very different drugs to a depressant like heroin but similar considerations apply when considering the link between their use and crime. Ice (crystal methamphetamine) is notorious for its association with aggression and violence. A very different profile of crime is therefore commonly linked to its use. Heroin is most commonly linked to property crime committed by dependent users seeking the means to acquire their next hit. As a depressant someone under the influence of opiates like heroin is typically peaceful so that someone who overdoses on it may simply quietly stop breathing and die. Those under the influence of a stimulant like ice can feel paranoid, believe people want to hurt them, yell or be aggressive or get violent.[112] That said, the underlying principle remains the same. Engagement in treatment offers the most likely prospect of crime prevention. The evidence is not as strong for this proposition as it is for heroin but is still very persuasive.

Finding. 20

Finding 21: Paranoia and psychotic behaviours often manifest themselves in people who become dependent on powerful stimulants like ice.

20.2. Cocaine

149. The first point to note is that little chaotic criminal behaviour is associated with another stimulant, cocaine, compared to ice. That has to do with the typical profile of the consumers of that drug: more often well-resourced cocaine users are able to manage their recreational use of that more expensive drug. They do not so often come to the attention of police.

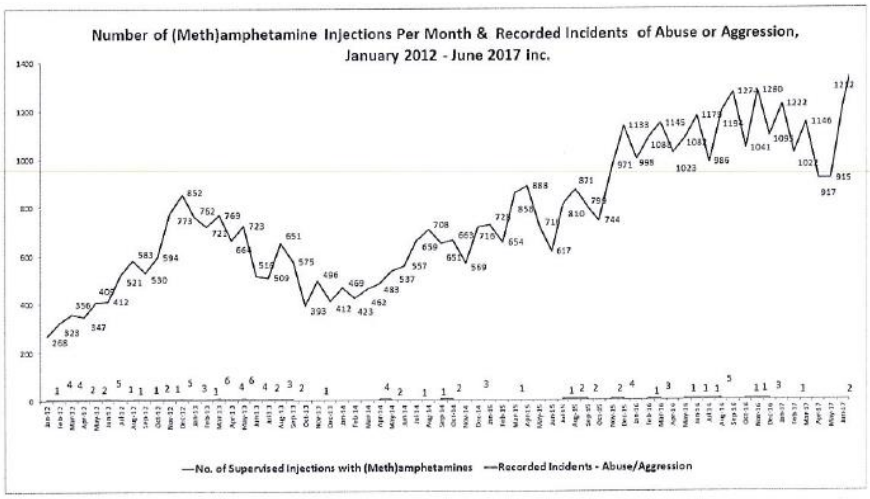
150. A classic 1994 Californian study confirms that engagement in treatment reduces the incentive for cocaine users to engage in dealing to support their habit. The study undertaken by the Drug Policy Research Center of RAND on the control of cocaine found that “the least costly supply-control program (domestic enforcement) costs 7.3 times as much as treatment to achieve the same consumption reduction.” The study compared the relative effectiveness of treatment with various forms of law enforcement in achieving a reduction in the number of users, the quantity of the drug consumed and the societal costs of crime and lost productivity that arise from use of the drug. The study estimated that “the costs of crime and lost productivity are reduced by $7.46 for every dollar spent on treatment.” Described in other terms, domestic law enforcement, the most efficient form of law enforcement, “costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction.”[113]

112. Australian Drug Foundation, Breaking the Ice: Fact Sheet; Crystal meth (ice), A support guide for family and friends (North Sydney, 2017) at ice_use_in_the_family.pdf (adf.org.au) visited 17/10/2021.

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

151. The aggression and violence associated with the poor user of the stimulant ice can be allayed if not eliminated by harm reduction drug strategies involving low threshold services staffed by skilled, patient and understanding workers. This is the experience of the Medically Supervised Injecting Centre in Sydney which has long permitted the injection of crystal meths.

Figure 8: (Meth) amphetamine injections and recorded incidents of abuse or aggression at the medically Supervised Injecting room, Kings cross



SOURCE: Uniting. Marianne Jauncey & Robert Graham, *Uniting Medically Supervised Injecting Centre Submission*; Special Commission of Inquiry into the Drug "ice" (Sydney, 2019)

152. A steady rise in injection of ice did not produce any increase in abusive or aggressive behaviour.

Finding. 21

Finding 22: Abusive and aggressive behaviour notoriously associated with ice dependency is mostly avoidable by skilled low threshold counselling/psychological support and other low threshold services like medically supervised consumption rooms.

153. The foregoing section summarises the large impact that treatment by pharmacotherapies have in reducing reoffending by people dependent upon opiates. The stimulants cocaine and synthetic crystal methamphetamine have replaced heroin as the drugs of greatest concern. Ice in particular is associated with florid mental health behaviours and violence. Ice is so challenging because there are no equivalents of methadone, buprenorphine, hydromorphone or even heroin itself that are able to stabilise those hooked on ice. While counselling is quite effective for many people with less problematic methamphetamine use, we currently don't have a proven medication treatment for severe methamphetamine dependence. The search is, however underway for a pharmacotherapy. These are mentioned below at sub-section 20.4, p. 76 and in

subsection 6.6.4 (p. 74) of the submission of Families and Friends for Drug Law Reform to the inquiry of the Select committee considering the Drugs of Dependence (Personal Use) Amendment Bill, 2021.[114] This committee would be well advised to enquire of the outcome of research into these possible treatments.

20.3. Cognitive Behavioural Therapy (CBT)

154. In the absence of an effective pharmacotherapy, treatment for ice dependency relies principally on skilled psychological counselling practising Cognitive Behavioural Therapy (CBT). That has been shown to be a powerful crime reduction intervention. A survey published in the College of Policing in the United Kingdom succinctly summarises this impact as follows:

> "A meta-analysis of outcomes from all 58 studies in Review 1 showed a statistically significant reduction in reoffending of 25% amongst participants who received CBT compared to those who did not. The meta-analysis, containing 8 studies, from Review 2 showed a similar statistically significant reduction in general (23%) and violent (28%) reoffending among those who underwent CBT."[115]

155. Even the development and evaluation agency of the United States Department of Justice, the National Institute of Justice praises the effectiveness of CBT:

> . . . even high-risk behavior did not reduce the therapy's effectiveness. For example, some of the greatest effects were among more serious offenders. It may be that the therapy's enabling, self-help approach is more effective in engaging typically resistant clients, that it increases their participation and therefore the benefits of participation. The therapy is more effective in reducing further criminal behavior when clients simultaneously receive other support, such as supervision, employment, education and training, and other mental health counseling."[116]

156. CBT helps people address distorted thinking such as: "

- An egocentric viewpoint with a negative view or lack of trust in other people.
- An inability to consider the effects of one's behavior.
- An inability to manage feelings of anger;

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114. Families and Friends for Drug Law Reform, Submission of Families and Friends for Drug Law Reform to the Inquiry of the Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill 2021 (11 June 2021) at https://www.parliament.act.gov.au/__data/assets/pdf_file/0019/1780003/Submission-38-Families-and-Friends-for-Drug-Law-Reform.pdf.

115. College of Policing, Cognitive Behavioural Therapy (CBT) at https://whatworks.college.police.uk/toolkit/Pages/Intervention.aspx?InterventionID=32 visited 17/09/2021.

116. Patrick Clark, Preventing Future Crime with Cognitive Behavioral Therapy: One form of psychotherapy stands out in the criminal justice system, 28 May 2010, NIJ Journal Issue 265, April 2010 at https://nij.ojp.gov/topics/articles/preventing-future-crime-cognitive-behavioral-therapy visited 17/09/2021.

- The use of force and violence as a means to achieve goals.[117]

Recommendation 5

Recommendation 8: The capacity to deliver Cognitive Behavioural-like Therapies in prison and as part of ACT community corrections programs should be enhanced.

20.4. The hunt for Pharmacotherapies for ice dependency

157. No approved pharmacotherapy equivalent is yet available for treatment of dependency on crystal methamphetamine. In other words there has yet to be developed a pharmacotherapy like methadone, buprenorphine, suboxone or heroin assisted treatment that our proven to be effective for an opiate dependency. The hunt, is, however on with research agencies casting around for pharmacotherapies to treat methamphetamine dependency.[118]

20.5. Mirtazapine

158. The Tina Trial announced in May this year. It is described as a Phase III randomised placebo-controlled trial of mirtazapine which will examine whether it can be used safely and effectively in routine clinical care to manage methamphetamine dependence. Mirtazapine is a common antidepressant medication. The trial is headed by Associate Professor Rebecca McKetin. The study will be led by UNSW and conducted in collaboration with the University of Wollongong, Deakin University, the University of Sydney, Monash University, and the University of California Los Angeles (UCLA). It will run for the next two years with results expected in 2024.

20.6. lisdexamfetamine

159. Research (termed the LiMA study) is underway into the suitability of lisdexamfetamine as a treatment to reduce methamphetamine use, cravings and withdrawal symptoms for methamphetamine dependence. Lisdexamfetamine is an existing drug used to treat Attention Deficit Hyperactivity Disorder (ADHD).

160. Lisdexamfetamine is showing “some initial promising results.” In 2018 the LiMA study was recruiting 180 people in specialist Drug and Alcohol treatment centres in Newcastle, Sydney (St Vincent’s Hospital and Western Sydney Drug Health), and Adelaide.[119]

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117. The same.

118. Siefried, K.J., Ezard, N., Christmass, M., Haber, P., Ali, R. and The NCCRED Methamphetamine and Emerging Drugs Clinical Research Network Working Group, (2021), A clinical research priority setting study for issues related to the use of methamphetamine and emerging drugs of concern in Australia. Drug Alcohol Rev. https://doi.org/10.1111/dar.13350 visited 18/08/2

119. University of Newcastle, Study trialling ADHD drug to treat ice dependence; A world-first clinical trial to treat people with problem methamphetamine ('ice') use is now underway in the Hunter University News (University of Newcastle, 30 July 2018) at https://www.newcastle.edu.au/newsroom/featured/study-trialling-adhd-drug-to-treat-ice-dependence visited 08/06/2021.

20.7. N-acetyl cysteine

161. N-acetyl cysteine is another drug being trialled by the National Drug and Alcohol Research Centre of the University of New South Wales. N-acetyl cysteine (NAC) targets "brain changes that underpin craving and addiction. It helps restore balance to those brain systems, and in doing this, it helps reduce the craving for ice." The ICE trial started in mid-2018. It is being conducted in outpatient settings in Melbourne, Geelong and Wollongong. The trial was expected to be completed in June this year. The Committee needs to keep an eye out for the results.[120]

Recommendation 6

Recommendation 9:The ACT should closely monitor the outcomes of trials of pharmacotherapies for the treatment of stimulant dependencies with a view to supplementing CBT and other existing treatments.

21. Does drug treatment render law enforcement redundant?

162. This foregoing review describes the striking capacity of certain drug treatments to reduce reoffending. The evidence points to a marked superiority over law enforcement of drug treatment to prevent crime in the first place. The committee therefore needs to consider how drug treatment as an element in all existing corrections programs should be boosted. That said, the committee cannot avoid posing the more fundamental question of the extent that drug treatment renders law enforcement effort redundant. A reduction in property crime by participants in the Swiss trial of heroin assisted treatment is complemented by large reductions in crimes in supply of drugs. The Californian review of the impact of treatment on supply of cocaine found that the cost of crime and lost productivity were reduced by $7.46 for every dollar spent on treatment and that treatment was 7 times more effective than domestic law enforcement in reducing consumption of cocaine (subsection 15.1.2, p. 61). Drug supply was also reduced by heroin assisted treatment: engagement in drug trafficking fell in excess of 50%. As likely as not this would reduce the supply of ice as much as opiates. The introduction of effective drug policies provides the opportunity for substantial justice reinvestment as a dividend of reduced reoffending and, as shown in the next annex, expenditure on mental health services.

Recommendation 7

Recommendation 10 The committee should consider the likelihood that drug policies based on public health principles will be more effective than law enforcement to reduce reoffending and thereby free up substantial resources for justice reinvestment programs.

120. The N-ICE trial: A randomised controlled trial of the safety and efficacy of N-acetyl cysteine (NAC) as a pharmacotherapy for methamphetamine ('ice') dependence https://ndarc.med.unsw.edu.au/project/n-ice-trial visited 11/06/2021 & Rebecca McKetin et al., A study protocol of the N-ICE trial, a randomised double-blind placebo-controlled trial of the safety and the efficacy, Trials, 2019 Jun 4;20(1):325. at https://pubmed.ncbi.nlm.nih.gov/31164169/ visited 27/11/2021.

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163. It is apparent that the effectiveness of a drug treatment to reduce and prevent crime is in a large measure dependent upon its capacity to engage and retain people who might be thought of as being at high risk of offending. This is clearly behind the success of Heroin Assisted Treatment (subsection 19.2, pp. 66 ff) and the Sydney Medically Supervised Injecting room (sub-section 22.12 p. 88). The latter has been strikingly successful in engaging and stabilising extremely marginalised people with severe co-occurring mental health and substance dependency problems (subsection 22).

164. Drug treatment is a particularly effective crime reduction measure because the best drug treatments are capable of engaging, retaining and stabilising people at high risk of reoffending.

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

ANNEX II: MENTAL HEALTH – EFFECTIVE DRUG TREATMENT IMPROVES MENTAL HEALTH

22. Annex II Mental Health – effective drug treatment improves mental health.

165. As described in subsection 8.2 (Those with mental health conditions), people caught up in the criminal justice system commonly have poor mental health along with their drug dependency issues. Pressure on the ACT to lift its game in this respect comes from the Productivity Commission which observed that "people with substance use comorbidities often do not receive adequate care for both conditions" and that, accordingly "Governments should ensure that mental health and drug and alcohol services address both mental health and substance use needs, by directly providing services, or referring the person to other services where appropriate."[121] The Commission considered that addressing shared key drivers like stigma and providing complementary psychosocial support would alleviate those conditions. The Commission identified "stigma and discrimination . . . directed at both those people with mental illness and those who support them" as among the "Key factors driving poor outcomes in Australia's mental health system."[122] Important for recovery are also coordinated services meeting psycho social needs: "improving the experience of people with mental illness and their carers beyond the healthcare system, recognising that there are numerous gateways in the community through which people enter the mental health

121. Productivity Commission, *Report Mental Health* vol. 1, No. 95, 30 June 2020 p. 39 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf visited 08/12/2020

122. Productivity Commission, *Draft Report Mental Health,* (2019) fn. 26 vol. 1, p. 6.

system and a range of services beyond healthcare — in particular, psychosocial services, housing, and justice — that are important for an individual's recovery."

Finding. 23

Finding 23:Characterisation of people who use drugs as criminals stigmatises and marginalises them which in doing so:

- leads to more harmful drug use and likelihood of dependency;
- serves to initiate and compound mental health problems; and
- impedes recovery from both substance dependency and co-occurring mental health conditions.

Finding. 24

Finding 24: Existing community corrections programs focus on harmful consequences of substance use and largely overlook the mental health dimensions which flow as much from subjecting people to the stressful processes of the criminal law as from any use of addictive substances.

Finding. 25

Finding 25: Shared common risk factors drive and intensify the substance use and mental health problems problems.

Finding. 26

Finding 26: Prominent among these drivers are:

- stigma and marginalisation of people who use drugs as criminals; and
- frequently co-occurring psychosocial problems like homelessness, poor education, unemployment and child abuse and neglect which are themselves in the fruit of stigma and marginalisation.

Finding. 27

Finding 27: The Productivity Commission identified the importance of reducing stigma and psychosocial factors contributing to the poor Australian mental health system. It is equally important for these factors to be addressed if problems arising from substance dependency are to be addressed.

166. The Productivity Commission saw " inefficient funding arrangements and service gaps" in the delivery of psychosocial support as "affecting the recovery of people with mental illness and their families, who can benefit substantially from improved access to psychosocial supports". These inefficiencies hampered "the delivery of needed psychosocial supports which included "a range of services to help people manage daily activities, rebuild and maintain social connections, build social skills and participate in education and employment"[123]

167. One of the many cultural differences that separate the drug and alcohol sector from the mental health sector is that the mental health sector practises a medical model

123. Productivity Commission, *Report Mental Health* vol. 3, No. 95, 30 June 2020 rec. 17, p. 826 at https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume3.pdf visited 08/12/2020

of care whereas the drug and alcohol sector adopts principally a psychosocial approach. The Productivity Commission usefully pointed out that addressing stigma and providing needed psychosocial support must be integrated in a holistic way if the mental health crisis in the country is to be addressed. Best practice drug treatment is known to improve the mental health of patients as well as address their substance dependency. One might ask what benefit accrues to everyone by adding the diagnosis of a serious mental health condition to someone who is obviously struggling with a substance dependency and who is more likely to engage with a low threshold drug treatment service then a mental health one. Low threshold drug treatment services capable of engaging and retaining people with a drug dependency should be considered as much a mental health services as a drug treatment one.

Finding. 28

Finding 28: The addition of a diagnosis of a mental illness on top of that of substance dependency can add to the burden on patient and carer without promoting recovery.

22.1. Methadone Maintenance therapy as assessed in the Australian Treatment Outcome Study

168. The large Australian Treatment Outcome study looking at heroin dependency in New South Wales, South Australia and Victoria concluded that "all treatment groups showed substantial improvement in mental health between baseline and 12 month follow-up . . . Current Major Depression drop from 26% to 11% among those entering MT Maintenance Therapy, from 32% to 18% among those entering Detoxification and from 31% to 13% among those entering Residential Rehabilitation . . . A similar pattern of results emerged for past month suicidal ideation and attempted suicide. Rates of these behaviours fell dramatically in each of the three treatment groups, but remained relatively stable in the non-treatment group."[124]

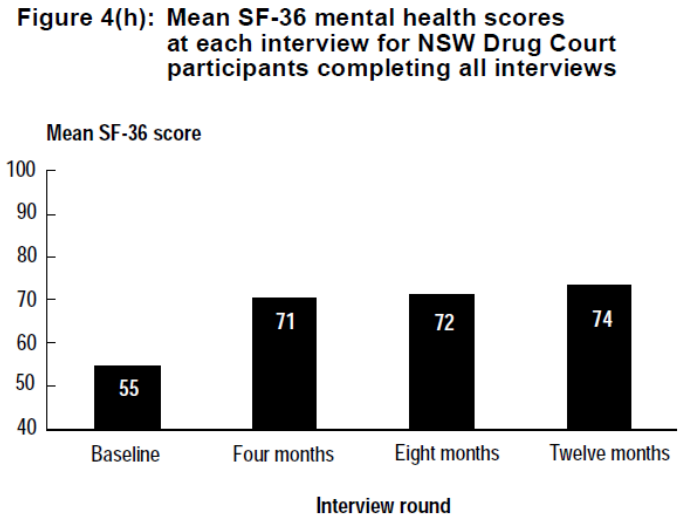
22.2. Mental health and drug treatment offered in drug court programs

169. Even though the New South Wales drug court has not reduced recidivism as much as hoped, the treatment seems to have brought about beneficial improvements in the mental health of participants.[125]

124. Ross *et al.* fn 88, pp. 27-28.

125. Karen Freeman, New South Wales Drug Court evaluation: health, well-being and participant satisfaction (New South Wales Bureau of Crime Statistics and Research, Sydney, February 2002) p. 19 at file:///C:/Users/Bill/AppData/Local/Temp/l14.pdf visited 29/08/2021.

Figure 9 Mental Health score of NSW Drug Court Participants who completed all interviews



Note: *n* = 51 participants

22.3. Youth Drug Court

170. An assessment was made of the first two years to the end of July 2002 of the pilot program of a NSW Youth Drug Court that opened on 31 July 2000. It reported that: "There was some improvement in mental health over the longer term, particularly for young women and those who graduated from the program."[126] Others have commented that: "the NSW Youth Drug Court evaluation was more mixed and found an increase in the level of unemployment among program participants over time and a slight decrease in participants' physical and mental health status."[127]

Finding. 29

Finding 29: There is insufficient evidence to justify the establishment of a Youth Drug Court in the ACT.

22.4. Low threshold interventions based on engagement through motivational interviewing.

171. The service proceeds from initial engagement with the patient and only then uses techniques of motivational interviewing to encourage the person to address the plethora of problems in their life. Recovery and abstinence move from being a hope to a reality rather than something that is imposed as the first hurdle at which the patient will

126. Eardley *et al*, (2003), fn 86.

127. Thu Vuong, *et al* (2019) fn 85.

almost certainly stumble. Bronwyn Hendry, the CEO of Directions drug and alcohol service expressed it this way in her evidence to the Select Committee considering the decriminalisation bill:

> "we will see you, we will provide individual counselling, we will provide case management support even if you cannot see a way to reducing your drug use, we will support you with some other things and some harm minimisation strategies. And we found that is a better way of engaging people than involuntary treatment."[128]

172. The director of Service delivery of that service provider emphasised the effectiveness of a strength-based approach:

> "client outcomes show that if you work with motivation, you make things timely, you make things accessible and if people can have a positive, strength-based experience of treatment, they are more likely to have positive outcomes but also to engage again if they need to.[129]""

22.5. Cognitive Behavioural Therapy

173. In the absence of a pharmacotherapy as exists for the treatment of opiate dependency, treatment for ice dependency relies principally on skilled psychological counselling practising Cognitive Behavioural Therapy (CBT). CBT requires willing cooperation.

The Victorian Department of Health warns that:

- "CBT involves a close working relationship between you and your therapist. Professional trust and respect is important. If you don't like the therapist at the first interview, look for another one.
- While CBT is considered a short-term form of psychotherapy, it may still take months or longer for you to successfully challenge and overcome unhealthy patterns of thinking and behaviour. CBT may disappoint you if you are looking for a 'quick fix'."[130]

174. CBT is currently available in the ACT. The therapy was commented upon in evidence presented to the Select Committee on the decriminalisation Bill by Dr Clara Tuck Meng Soo, a General Practitioner with extensive experience in Addiction Medicine:

> "The standard of care for methamphetamine dependant users – psychosocial interventions – are offered by CatholicCare and ACT Health. Evidence suggests that these treatment models are modestly effective *(Lee & Rawson, 2008)*.

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128. Hansard proof, DDPUAB—21-07-21 p.95 at http://www.hansard.act.gov.au/hansard/2021/comms/ddpuab03a.pdf.

129. Ms Stephanie Stephens, The same.

130. Vic Health, *Cognitive behaviour therapy (CBT*) (reviewed on: 05-09-2019) at https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/cognitive-behaviour-therapy#what-is-cognitive-behaviour-therapy visited 21/08/2021

However, there can be poor engagement in these interventions by heavier users and cognitive impairment from methamphetamine use can limit effectiveness *(Lee & Rawson, 2008*). Indeed, recent research in the ACT suggests that there is poor engagement in psychosocial interventions *(McKetin et al., 2017)*."[131]

22.6. Peer Support

175. The extensive and very effective peer support by the ACT users group, CAHMA, the Canberra Alliance for Harm Minimisation and Advocacy is best described by its CEO, Chris Gough, in evidence he gave in July to another Parliamentary enquiry:

> "We run a number of different programs out of our drop-in centre. But at the very basis, people can come, they can feel safe, they can know that we understand fundamentally on a human level what they are going through in terms of being marginalised, socially isolated and stigmatised. They know that they can, at the very least, come and have a coffee, sit on our couch, use our computers, use our phones and use our office as their office. The idea is to empower them to take control of their health and wellbeing, and that is the first step.
>
> From there we build rapport with them. Community members will then start to talk to us about what is going on their lives and what they need help with. We offer case management, but we call it peer treatment support because we think that people are not cases to be managed but rather people who require support. Navigating healthcare services and the referral system in the ACT is sometimes very complicated, so we provide that support.
>
> Our peer treatment support service means we can transport people to any service they want to go to. We can advocate for them. We can sit in their appointments or doctors' appointments. We can translate between what the doctor, for example, is saying about the treatment and what it is going to look like in their real life and also what the person needs from the treatment and in that way get better treatment outcomes for people.
>
> The other thing we find by doing this program is that, instead of just referring people to services, we can actually track them and make sure they get support to attend the service and then help in following up to provide wraparound support and integrated care. We have people who have been with us for a number of years, providing support."[132]

131. Erika Unsworth, Dr Clara Tuck Meng Soo, Associate Professor Anna Olsen & Dr William Huang, Inquiry into the Drugs of Dependence (Personal Use) Amendment Bill 2021, Submission Number: 18, Authorised for Publication: 16 June 2021 at https://www.parliament.act.gov.au/__data/assets/pdf_file/0010/1779301/Submission-18-Erika-Unsworth,-Dr-Clara-Tuck-Meng-Soo,-Associate-Professor-Anna-Olsen-and-Dr-William-Huang.pdf visited 21/08/2021.

132. Proof Hansard, Select Committee on the Drugs of Dependence (Personal Use) Amendment Bill 2021, Friday, 30 July 2021 at http://www.hansard.act.gov.au/hansard/2021/comms/ddpuab05.pdf

22.7. Assistportal

176. Assist video on brief intervention and referral to treatment in the case of ice is at https://www.assistportal.com.au/resources/.

177. It focuses upon establishing communication with the drug user using an array of counselling strategies that are elements in motivational interviewing:

- Open ended questions to help the drug user think through his present situation;
- **A**ffirming and accentuating the positives in the drug user by recognising the positive actions he had already taken,
- **R**eflection to assure the person using drugs that the counsellor was seeking to understand what he is saying.

22.8. Police, Ambulance & Clinician Early Response (PACER program) and the Mental Health, Emergency Ambulance and Police Collaboration

178. Established in 2019, the PACER team aims to attend call outs requiring a specialist mental health response. The team includes a paramedic, clinician and police officer working together. It operates 7 days a week as a mobile program. It builds upon the Mental Health, Emergency, Ambulance and Police Collaboration (MHEAPC) established in 2011 between ACT Policing, together with the ACT Ambulance Service, ACT Mental Health, Canberra Hospital and Calvary Public Hospital Bruce.[133] The decision whether to call out the PACER combined team is presently in the hands of police. The service would be improved with the triage function being placed in the hands of a mental health professional rather than the police and would also stand to benefit if mental health and a substance use professional worked together as they do in Washington State where law enforcement plays an important but subsidiary role in support of the service.[134]

22.9. Chat to PAT mobile health outreach clinic

179. The ACT should also expand Direction's Chat to PAT mobile health outreach clinic for vulnerable Canberrans along the lines of the American formulated Assertive Community Treatment (A.C.T). Chat to PAT is responsive like the existing PACER program but with a greater health focus.

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133. ACT Policing, PACER and the Mental Health, Emergency, Ambulance and Police Collaboration (ND) at https://www.police.act.gov.au/about-us/programs-and-partners/pacer-and-mental-health-emergency-ambulance-and-police-collaboration visited 10/10/2021.

134. Bales, D., Ellis, A., Drake, E., & Miller, M. (2021). Designated crisis responders and Ricky's Law: Involuntary treatment investigation, decision, and placement (Document Number 21-06-3401). Olympia: Washington State Institute for Public Policy, June 2021 at http://www.wsipp.wa.gov/ReportFile/1737/Wsipp_Designated-Crisis-Responders-and-Rickys-Law-Involuntary-Treatment-Investigation-Decision-and-Placement_Report.pdf visited 06/10/2021.

22.10. Assertive Community Treatment teams

T180. he American formulated Assertive Community Treatment[135] was highly recommended by the Victorian Royal Commission into Mental Health as "best practice". It considered it to be a model of care the availability of which should be expanded.[136] This long term 24hour/7 days a week service "can provide substance abuse services". Its aims include reduction of involuntary and compulsory treatment.

181. The Victorian Royal Commission endorsed the importance of consumer experts who can support staff in understanding the impact of involuntary treatments including seclusion.

> "Ample existing evidence replicated over more than 40 years suggests that complex co-occurring disorders including severe and persistent mental illnesses, ongoing substance abuse and physical illnesses, and unstable housing are best handled in the community by the Assertive Community Treatment (ACT) team approach . . . [137]

22.11. Open Dialogue Psychotherapy or Collaborative Network Approach

182. This model originated in Finland as a form of psychotherapy and a way to organize mental health systems. According to the Victorian Mental Health Royal Commission, "the model helps people and their families feel 'heard, respected and validated'. Its principles include providing immediate help (within 24 hours of first contact), social network inclusion, a flexible approach including often meeting in the consumer's home, the care team being responsible for treatment, care and support for as long as is necessary, and building an environment where all parties feel safe." The commission added:

> "Research indicates that as an alternative to treatment within a hospital, Open Dialogue can be associated with reduced likelihood of involuntary treatment, and small-scale studies suggest it may produce better outcomes than conventional treatment. Open Dialogue's 'largely non-institutional and non-medicalizing approach' aligns with a human rights-based approach to treatment, care and support." [138]

183. Open Dialogue has drawn global interest leading to adaptations worldwide, including in Vermont-US where it is called Collaborative Network Approach"(CNA).

184. The commission went on to observe that "Research indicates that as an alternative to treatment within a hospital, Open Dialogue can be associated with reduced likelihood of involuntary treatment, and small-scale studies suggest it may

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135 Arlin Cincic, The Basics of Assertive Community Treatment (VeryWell Mind Review Board, New York, 2020) at https://www.verywellmind.com/about-us-5184564#contact-us visited 06/08/2021

136 Vict Royal Commission, vol. 1, p. 356.

137. The same.

138 Vict Royal Commission, Vol. 3. p. 105.

produce better outcomes than conventional treatment."[139] An American study published just a couple of months ago provided:

> " . . . evidence that CNA is well-received, appreciated, and for many people an empowering form of mental health care. The findings suggest that elements of Open Dialogue are highly consistent with the vision for recovery-oriented care, in that they are flexible, person-centered, encourage processes of negotiation, and highlight the importance of family and social supports in care."[140]

185. People living with mental illness or psychological distress and advocates put to the Royal Commission:

> ". . . that the narrow focus of the Mental Health Act on compulsory treatment can contribute to the dominance of a biomedical model of care. This model preferences the views of mental health practitioners over those of consumers, focuses on 'deficits' that need to be fixed or managed by medication, and is moulded around a flawed expectation that the system is responsible for managing short-term risk rather than emphasising recovery."[141]

186. Long-standing cultural differences between the mental health and drug and alcohol sectors are at the root of much failure to address co-occurring mental health and substance dependency conditions.

187. A review of the involuntary treatment scheme of Washington State where mental health and drug treatment services did not always work together for the benefit of clients, made the obvious point that "we know we cannot tear the individual in half and just treat one and then the other":

> "facilities that are able to treat for mental health should be able to get substance use professionals in there and facilities that can manage the withdrawal components and actually have the substance use component where it's a one stop shop."[142]

Recommendation 8

Recommendation 11: Like the best drug treatment services, mental health should focus upon addressing in an holistic way longer term recovery rather than rectifying short term deficits or problems.

Finding. 30

Finding 30: Tension exists between the models of care commonly used in the mental health and drug and alcohol services. Mental health services tend to focus upon rectifying short term deficits or problems rather than addressing

139 Vict Royal Commission, Vol. 3. p. 105.

140. Florence, A.C., Jordan, G., Yasui, S. *et al.* "It Makes us Realize that We Have Been Heard": Experiences with Open Dialogue in Vermont. *Psychiatr Q* (2021). https://doi.org/10.1007/s11126-021-09948-1

141. Vict Royal Commission,Vol 4 p 21.

142. Bales and others, fn 134.

in an holistic way the longer term recovery of patients as the drug sector tends to do.

Recommendation 9

Recommendation 12: People in the care of mental health services should have coordinated access to care from substance dependency professionals.

22.12. Medically supervised drug consumption room

188. It is clear from the success of the Medically Supervised Injecting Centre (MSIC) at King's Cross in Sydney in engaging extremely marginalised people with severe mental health problems on top of their substance dependencies that such a facility is as much a low threshold mental health as a drug treatment service. One or more such *services are proposed for the ACT.*

189. Figure 8 below of Mental health indicators reported by MSICI frequently attending clients below reveals that clients of the Sydney MSIC have more severe mental health symptoms and impairment than patients within a mental health facility

> "service that facilitates sustained, ongoing contact with clients, MSIC is uniquely placed to assess and engage with PWID around mental health issues. Indeed, this potential is reflected both in the visit numbers of the frequent attendees described here (up to 321 within a 3-month period) and in the 100 % response rate of clients invited to participate in this study."[143]

190. The King's Cross Medically Supervised Injecting Centre has successfully engaged with a cohort of people with severe mental health conditions: People who inject drugs "have elevated rates of mood, anxiety, personality and psychotic disorders; post-traumatic stress disorder (PTSD); and higher rates of trauma exposure, suicidality and self-harm"[144]. The conditions are listed in the following table of mental health indicators of "frequently attending clients".

143. Goodhew M, Salmon AM, Marel C, Mills KL, Jauncey M., Mental health among clients of the Sydney medically supervised injecting Centre (MSIC). *Harm Reduct J* 2016;13:29.

144. The same. For the prevalence of suicide among people who use drugs see submission section 8.7 at p. 18.

Figure 10 Mental health indicators reported by MSICI frequently attending clients

Table 1 Mental health indicators reported by MSIC frequently attending clients ($N = 50$)

Mental health indicator	% sample
Any mental health diagnosis by a doctor (lifetime)	82
Mood disorder (lifetime)	64
Anxiety disorder (lifetime)	46
Psychotic illness (lifetime)	32
Post-traumatic stress disorder (lifetime)	12
Attention deficit hyperactivity disorder (lifetime)	10
Personality disorder (lifetime)	8
History of suicide attempt/s	54
History of self-harm	44
Currently receiving support from mental health services	24

SOURCE: Goodhew M, Salmon AM, Marel C, Mills KL, Jauncey M., Mental health among clients of the Sydney medically supervised injecting Centre (MSIC). *Harm Reduct J* 2016;13:29, p.2.

22.13. Heroin assisted treatment clinics

191. The Swiss trial of heroin assisted treatment provides another example of the success of another low threshold service to attract and engage with a highly marginalised, treatment resistant, population of illicit drug users with severe co-occurring mental health conditions. The Swiss trial tracked over 18 months a sub-group of more than 200 patients displaying 3 syndromes.

> "The general state of mental health improved on average, and the need for treatment was estimated to be slightly lower compared to the status on admission. In particular, depression and other affective disorders became less frequent, which is not the case for schizophrenic conditions. The schizophrenic psychoses diagnosed at outset (N equals eight), five stayed on the program for at least 18 months. This matches the mean retention rate in the program, in contrast to the high drop-out rates of dual diagnosis patients in general. Affective disorders required psychiatric treatment considerably less often after the second month on the program. The same applies to personality disorders and other behavioural disturbances. The corresponding data for schizophrenia shows no reduced need for treatment. . . . Follow-up this analysis over 18 months showed a reduction in depressive syndromes. Anxiety and delusional syndromes also diminished markedly, as

did aggressive acting-out. The decrease in depressive symptoms occurred primarily in the first 12 months of treatment and then remained stable. The decrease in anxiety and delusional symptoms was continuous and extended beyond the first 12 months of treatment the decrease in aggressive behaviour also showed further improvements after the 12th month of treatment.[145]

22.14. Conclusions

192. The foregoing survey of drug services shows they need to have the capacity to engage people with complex needs from co-occurring mental health conditions and where this is achieved drug services should also be considered as a mental health service. This is most apparent in the case of the Medically Supervised Injecting Centre in Sydney. Figure 10 above of Mental health indicators reported by MSICI frequently attending clients (p. 89) shows that it successfully engaged with drug users who also experienced severe mental health problems. In the case of all of them the threshold for engagement is low with no precondition that the drug user commits themselves to abstinence. They may not see that issue as the highest priority. With a stabilisation first approach the service has an opportunity to engage the drug user on the range of issues they have. Ultimately this will lead to reducing or eliminating their drug use by their own choice thus promoting the longer term recovery and reduction in serious risk of premature death by suicide or accident that Annex III pp.93ff shows is a common correlate of involuntary and coercive drug treatments prioritising abstinence.

193. The foregoing survey outlines programs embodying some but not all the elements that go to make for effective drug programs. The needs of drug services by those dependent on stimulants like ice differ from the needs of those who have become dependent on opiates. Unlike opiates, no reliable pharmacotherapies are yet available for those dependent on ice. The ACT should closely monitor the outcomes of trials of possible pharmacotherapies (Annex 1. Subsection 20.4 pp.73ff). Therapies like CBT which can be successfully deployed for ice dependency are available in some ACT drug treatment programs including those accessed by the drug court and corrections. They do not, however, appeared to be widely enough available and are offered in a context that does not facilitate engagement. People who present themselves to mental health services often do not find that their substance dependency issues are able to be addressed in mental health services and that on discharge from one service they can find themselves at the end of the queue for another service that they need. All required health and psychosocial supports must cohere around the patient. Families and Friends is aware of people in dire need of drug services, being discharged from overstretched mental health services that are unable to meet their needs. In those circumstances the

145. A. Uchtenhagen, A. Dobler-Mikola, T. Steffen, F. Gutzwiller, R. Blättler & S. Pfeifer, *Prescription of narcotics for heroin addicts:* main results of the Swiss national Cohort Study (Karger, Basel, Freiburg, Paris &c, 1999) pp.51-53 being vol. 1 of A. Uchtenhagen, F. Gutzwiller, A. Dobler-Mikola, T. Steffen, M. Rihs-Middel, *Medical prescription of Narcotics for Heroin Addicts* 2 vols. (Karger, Basel, Freiburg, Paris &c, 1999).

patients may have been better advised to seek out low threshold drug programs rather than be left in the lurch after being burdened with the additional problem of a cluster of mental health diagnoses.

Finding. 31

Finding 31: First-class programs to treat substance dependencies are as much mental health services as they are drug and alcohol ones.

Recommendation 10

Recommendation 13: Programs should be readily accessible, effective and non-stigmatising:

- programs should have a focus on long-term well-being and recovery rather than abstinence;
- coerced or involuntary treatments should be minimised because of the elevated risk of mortality that they present;
- engagement and stabilisation rather than abstinence should be the primary objectives.

Recommendation 14

Recommendation 14: First-class treatment programs should be readily accessible, effective and non-stigmatising:

- removed from the stigmatising processes of the criminal law;
- low threshold to facilitate voluntary engagement;
- involve peer support services to facilitate engagement and retention and post treatment support;
- have the flexibility to provide access when and where consumers and their carers need them;
- integrate treatment with wraparound psychosocial support;
- able to meet the needs of those dependent on stimulants like ice and sedatives like opiates.

194. The following table summarises the characteristics of drug treatment services that also address mental health needs. The PACER program mentioned above is the exception in its principal focus is on responding to mental health needs. The shaded cells indicate that the service in the column in the top row of the table embraces the characteristics referred to in the 1st column of each row.

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Table 7: Drug treatment services that also address mental health needs

¤	Methadone¤	Heroin-Assisted-Treatment¤	Hydro-morphone¤	CBT¤	PACER¤	Chat-to-PAT-mobile-health-outreach-clinic¤	Assist-Portal¤	Assertive-Community-Treatment-	Open-Dialogue-Psychothera	Medically-supervised-drug-
Whether-existing¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Type-of-dependency¤	Opiate¤	Opiate¤	Opiate¤	Ice¤	Mental-Health/Ice¤	Ice¤	Ice¤	Ice¤	Ice¤	Ice/Opiate¤
Low-Threshold¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Flexible-place¤	¤	¤	¤	¤	¤	Limited-locations-	¤	¤	¤	¤
Flexible-time¤	¤	¤	¤	¤	¤	Limited-hours¤	¤	¤	¤	¤
Peer-support¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Medical-supervision¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Life-and-well-being-above-abstinence¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Voluntary-engagement¤	¤	¤	¤	¤	Triage-role-of-police¤	¤	¤	¤	¤	¤
Integrate-wraparound-psychosocial-support¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Non-Institutional¤	¤	¤	¤	¤	¤	¤	¤	¤	¤	¤
Proven-efficacy¤	¤	Cochrane-review¤	¤	¤	¤	¤	¤	¤	¤	¤

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SUBMISSION OF FAMILIES AND FRIENDS FOR DRUG LAW REFORM TO THE INQUIRY INTO COMMUNITY CORRECTIONS OF THE STANDING COMMITTEE ON JUSTICE AND COMMUNITY SAFETY

ANNEX III: MORTALITY AND INVOLUNTARY DRUG TREATMENTS

23. Annex III: Mortality and involuntary drug treatments

195. Annex II Mental Health – effective drug treatment improves mental health. Under the International Covenant on Economic, Social and Cultural Rights, 1966, people in a correctional setting are as entitled as anyone else to enjoy "the highest attainable standard of physical and mental health." This is reflected in the so-called principle of equivalence under which health services accessible in the community should be accessible in correctional settings. When it comes to the heightened risk of death associated with corrections, the right to life enshrined in section 9 of the *Human Rights Act* 2004 has particular relevance. It reads: Everyone has the right to life." (S. 9 (1)). These rights apply even if the person concerned continues to use drugs.[146]

196. Mandatory or compulsory treatment comes in numerous forms. All compel someone to undergo treatment through one of two mechanisms:

1. Involuntary treatment such as civil commitment: where the individual has no choice or say in the matter

2. Coerced treatment (sometimes referred to as forced choice): where individuals can choose between a criminal justice sanction and a treatment program, as a means to obtain a lesser criminal justice sanction. Coerced

146. ACT Human Rights Commission, Human Rights Audit on the Operation of ACT Correctional Facilities under Corrections Legislation (ACT Human Rights Commission, Canberra, July 2007.

treatment thus characterises the approaches of the Criminal Justice system exemplified by drug courts and intensive corrections orders.

197. All mandatory treatments are associated with indifferent rates of success if measured in terms of long term abstinence and with unacceptably high rates of death from both accidental overdose and suicide following treatment.

Finding. 32

Finding 32: Mandatory treatment is associated with high rates of death from both accidental overdose and suicide in the time following treatment.

23.1. Imprisonment

198. The greater difficulty in securing a drug supply in prison leads many drug users to cease or at least to decrease their use. While abstinent, their tolerance reduces thus making them vulnerable to overdose when they resume usage after their release. The surveillance in prison and the design which commonly eliminates hanging points reduces the risk of drug overdose deaths and suicide. 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"[147].

199. An American study that for 15 years tracked graduates of the Baltimore drug court found no difference between them and those who had been subject to the usual criminal processes.

> "This study was a randomized controlled trial with 235 participants who were charged with non-violent drug offenses between 1997 and 1998 and assigned to either drug treatment court (n = 139) or adjudication as usual (referred to as "traditional adjudication" by the research team; n = 96) and followed for 15 years to assess long-term mortality risk."[148]
>
> Overall, 20.9% of participants (n = 49) in the study died in the 15 years following randomization, with the average age of death equaling 46.6 years old, and the median time to death following randomization equaling 5.2 years. Participants who were older at the time of randomization were at a higher risk of death due to any cause as well as due to substance use-related causes during the 15 year follow up. Researchers also found higher rates of substance use disorder deaths

147. Michael Hobbs, Kati Krazlan, Steve Ridout, Qun Mai, Matthew Knuiman and Ralph Chapman, *Mortality and morbidity in prisoners after release from prison in Western Australia 1995-2003*, Research and public policy series, no. 71 (Australian Institute of Criminology, Canberra, 2006) pp. 2 & 7 at http://www.aic.gov.au/publications/rpp/71/

148. Recovery Research Institute, Does drug court participation reduce mortality risk? at https://www.recoveryanswers.org/research-post/drug-court-participation-reduce-mortality-risk/ visited 02/09/2021 paraphrasing Brook W Kearley, John A Cosgrove, Alexandra S Wimberly, Denise C Gottfredson, The impact of drug court participation on mortality: 15-year outcomes from a randomized controlled trial, *J Substance Abuse Treatment*, 2019 Oct;105:12-18. doi: 10.1016/j.jsat.2019.07.004. Epub 2019 Jul 18.

among individuals with a higher number of prior convictions at the time of randomization.[149]

200. A 2002 study of the health and social impacts of the still recently constituted New South Wales drug court did not attempt to draw a similar comparison. The study did note that "One of the 202 participants died immediately after commencing the Drug Court program".[150] The high death rate detected by the Baltimore study of people in prison or 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".[151] The problem is accentuated by the likely reduction in tolerance so that the dose taken on the relapsing can easily bring on a fatal overdose. Only 47% were offered Medication assisted treatment like methadone and buprenorphine.[152]

201. A prospective cohort study in Queensland looked at mortality over 4.7 years of people released from prison: Those at greatest risk of death were characterised by social disadvantage, poor physical and mental health, and a history of risky substance use.

> "Observed 42 deaths (3.2%) during follow-up, giving a crude mortality rate of 10 (95%CI=7.5-14) deaths per 1000 person years. The age and sex adjusted all-cause standardised mortality rate was 4.0 (95%CI=2.9-5.4) times higher for ex-prisoners than for the general population of Queensland."[153]

202. This contrasts with the mortality rate of 1% of those tracked over three years of the Swiss heroin trial. Rise [154]

Finding. 33

Finding 33: Released prisoners are at greater risk of death compared with the general population, particularly in the first few months after release.

149. The same.

150. Karen Freeman New South Wales Drug Court evaluation: health, well-being and participant satisfaction (New South Wales Bureau of Crime Statistics and Research, Sydney, February 2002) p.vii at file:///C:/Users/Bill/AppData/Local/Temp/l14.pdf visited 29/08/2021.

151. The same, p. 56.

152. Brook W Kearley, John A Cosgrove, Alexandra S Wimberly, Denise C Gottfredson, The impact of drug court participation on mortality: 15-year outcomes from a randomized controlled trial, *J Substance Abuse Treatment*, 2019 Oct;105:12-18.

153. I Simon J Forsyth, Megan Carroll, Nicholas Lennox, Stuart A Kinner, Incidence and risk factors for mortality after release from prison in Australia: A prospective cohort study, *Addiction*, Volume113, Issue5 May 2018, Pages 937-945.doi: 10.1111/add.14106. Epub 2017 Dec 19 and https://research-repository.griffith.edu.au/bitstream/handle/10072/386894/Kinner79958.pdf;jsessionid=26B05AB027E23841E7B033EC38FFE788?sequence=2 visited 02/09/2021

154. Uchtenhagen *et al*, 1999, fn. 145 pp.73.

Finding. 34

Finding 34: The risk of death of those on Heroin assisted Treatment in Switzerland has been just 1% tracked over 3 years.

Finding. 35

Finding 35: Some pharmacotherapies like methadone and heroin assisted treatment while effective in stabilising many opiate dependent people, are associated with an elevated risk of overdose which is minimised by specialist medical assessment and supervision.

Recommendation 11

Recommendation 15: People subject to the corrections system should have access to the same drug treatments as are available in the community.

Recommendation 12

Recommendation 16: To minimise the risk of fatal overdose the initiation and administration of pharmacotherapies should be subject to specialist medical supervision.

Recommendation 13

Recommendation 17: Drug treatments for people subject to corrections systems should have the capacity to engage and retain people after they transition out of the correctional system.

24. Coerced treatment

203. In the case of most if not all community corrections programs that seek to address substance use, the person involved has a choice of whether to undergo treatment or be processed in accordance with the normal processes of the criminal law. In that sense their treatment is coerced rather than involuntary. “Drug and alcohol treatment orders” that the committee is required to consider involve such a choice. The Drug Policy Monitoring Unit or (D.P.M.U.) distinguishes between coerced treatment where the criminal law is engaged and civil commitment or “involuntary Treatment” where the individual has no choice or say in the matter.

204. With coerced treatment (sometimes referred to as forced choice) individuals can choose between a criminal justice sanction and a treatment program, as a means to obtain a lesser criminal justice sanction.

205. All this lends weight to the opinion of a key witness to the research paper of the Australian National Council on Drugs on compulsory treatment:

> “Very high rates of fatal overdose upon release from prison point to the failure of compulsory treatment”.[155]

155. Emma Pritchard, Janette Mugavin & Amy Swan, Compulsory treatment in Australia; a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs (ANCD research paper 14, Canberra, [2007]) at https://apo.org.au/sites/default/files/resource-files/2008-02/apo-nid8087.pdf.

24.1. Compulsory Drug abstinence Programs

206. Overdosing after conclusion of compulsory abstinence programs, such as any of the foregoing, shows the continuation of drug use and also the raised likelihood of death given that a person who overdoses can easily die. Non-fatal overdoses are thus something of a proxy for mortality associated with treatment programs.

207. A meta-analysis of 8 studies evaluating Compulsory Drug Abstinence Programs (CDAP) comprising 5253 individuals/776 events across 5 countries found a high level of non-fatal overdoses compared to those not on compulsory programs:

> ”found the odds of experiencing non-fatal overdose in lifetime and in the last 6-12 months were 2.02 (95% CI 0.22 - 18.86, p = 0.16) to 3.67 times higher (95% CI 0.21 - 62.88, p = 0.39), respectively, among those with CDAP exposure than those without.”[156]

24.2. Involuntary treatment in Civil commitment

208. This committee's terms of reference focus on community corrections. It does not therefore have within its remit civil commitment but the impact of involuntary treatment under civil commitment is relevant when considering the impact of compulsory drug treatment under different forms of community corrections. In both cases the choice of treatment is limited or denied.

209. Elevated rates of mortality occur for people committed involuntarily. In Massachusetts, where civil commitment (referred to as. “Section 35”) is actively enforced, there has been a substantial increase in the number of commitments since 2014.[157]

> ”Those who had been subjected to civil commitment were more than twice as likely to die from overdose as those who sought treatment voluntarily. Civil commitment treatment facilities have also been the subject of a string of high-profile scandals, including escape attempts and suicides.”
>
> “Data from a 2016 report by the Massachusetts Office of Health and Human Services also showed that those in involuntary treatment had a higher risk of

156. Anh T V, Christopher Maganaa, Matthew Hickman, Annick Borqueza, Leo Beletsky Natasha Cook K. Martin, Javier A. Cepedad, Assessing HIV and overdose risks for people who use drugs exposed to compulsory drug abstinence programs (CDAP): A systematic review and meta-analysis, *International Journal of Drug Policy,* Available online 11 August 2021, 103401; 2021 Aug 10: 103401 at https://www-sciencedirect-com.adf.idm.oclc.org/search?authors=&date=2021&docId=0955-3959&qs=Assessing%20HIV%20and%20overdose%20risks%20for%20people%20who%20use%20drugs%20exposed%20to%20compulsory%20drug%20abstinence%20programs%20%20CDAP%3A%20A%20systematic%20review%20and%20meta-analysis

157. Messinger, J.C., & Beletsky, L. (2021), Forced addiction treatment could be death sentence during COVID-19, *Commonwealth Magazine*, 20 Jan, 2021 at https://commonwealthmagazine.org/criminal-justice/forced-addiction-treatment-could-be-death-sentence-during-covid-19/

fatal overdose in the 1-3 years after the treatment, compared to those who sought treatment voluntarily (RR 2.22, 95% CI 1.85-2.66, p < 0.001)"[158]"

210. "This report is consistent with findings . . . that a history of civil commitment of people who use opioids is associated with increased non-fatal overdose risk (2018).[159]

Finding. 36

Finding 36: The risk of death is unacceptably high for those who have been subjected to compulsory abstinence based programs.

Bill Bush
President
Families and Friends for Drug Law Reform

29/11/2021

158. Anh T V, et al. (2021) fn 156. See too Michael S Sinha, John C Messinger, Leo Beletsky, Neither Ethical Nor Effective: The False Promise of Involuntary Commitment to Address the Overdose Crisis, *J Law Med Ethics*. 2020 Dec;48(4):741-743.

159. Anh T V, et al. (2021) fn 156