

External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre

Final Report

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Numerous community service providers participated in the evaluation and provided extensive and detailed qualitative data about their experiences providing services at the AMC and in the community to post-release prisoners.

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3.0 Executive Summary

The Burnet Institute undertook an evaluation of drug policy and services at the AMC using a mixed methods approach. Guided by the Monitoring and Evaluation Protocol developed by the Evaluation Advisory Group, this approach involved 1) qualitative in-depth interviews with a range of key informants, 2) desktop policy review, 3) literature review, 4) review and analysis of secondary custodial and service provision data, and 5) review and analysis of Inmate Health Survey data (collected in May 2010). Where possible, the report triangulates qualitative and quantitative data sources to describe the characteristics of drug services provided at the AMC, the effectiveness of such services and areas for improvement or change.

The following summary, based on Findings sub-sections of the report (9.0), provides an overview of the key outcomes of this evaluation and describes aspects of drug policy and services at the AMC that are considered in need of attention.

Following written feedback from various Evaluation Advisory Group members, including a comprehensive written response from ACT Corrective Services, the last of which was received 4th January 2011, a final draft of this report was provided to ACT Health on the 10th January 2010. On April 4th 2011 the Burnet Institute received formal advice regarding incorrect urinalysis data provided by ACT Corrective Services. The report was subsequently amended to take these new data into account. This final report was provided to ACT Health on the 6th April 2011.

Policy and governance issues

Key informants discussed their experiences regarding the development and implementation of drug-related policies at the AMC. Overall, there was a perceived lack of ownership of policy by many key informants and a belief that policies did not always meet their intended objectives. In particular, staff felt that there was a lack of consultation with frontline staff during policy development. Disciplinary conflicts between different staff groupings and community service providers about appropriate policy were evident. The evaluation team assessed that there was a lack of leadership and coordination of drug-related activities at the AMC, resulting in limited direction about how to adequately balance harm minimisation interventions.

To provide policy clarity, the development of a specific drug strategy and policy framework for the AMC should be considered, guided by the existing multiple frameworks on which the AMC implementation was based. A governance and leadership structure should be implemented to support policy across custodial, welfare and health activities, and these activities should be closely monitored to ensure they are consistent with principles that underpin the policy framework.

Case management

Case management services at the AMC are delivered by a range of government and community service providers. Corrective Services are the primary provider and responsible for delivering case management to all prisoners, particularly through the development of an individualised case plan for each prisoner. Key informants highlighted a number of issues with the current case management

system, in particular poor communication with prisoners resulting in a perceived lack of access to case management services and low awareness of services being provided. As a result, a number of prisoners are accessing community service providers for case management purposes, resulting in the duplication of services and a fragmentation of the service system. A lack of overall coordination of case management is a major concern. Positive aspects of case management include case conferencing with a range of providers, however this aspect needs to be expanded to be more effective and promote adequate throughcare for prisoners.

Counselling

The evaluation identified limited counselling opportunities available to prisoners at the AMC, despite a high need for such counselling. Individual counselling was considered by key informants to be an important part of the drug service system at the AMC. However, individual counselling is currently not widely available and requires significant expansion to meet the needs of prisoners.

Programs – educational and employment

Key informants noted that employment and education programs at the AMC needed to be expanded, with a particular focus on programs that prepare prisoners for employment in the community and may include pre-release employment arrangements. Educational programs, particularly those that have a practical life skills focus, need to be expanded and improved. Innovative use of the AMC grounds to promote education and employment skills development (e.g., agricultural skills) are suggested.

Programs – recreational

Recreational opportunities at the AMC are currently limited. Expanded recreational opportunities for prisoners are likely to improve prisoner wellbeing and contribute to the security and good order of the prison. Key informants strongly supported the inclusion of a gym at the AMC. The evaluation team is aware that the implementation of a gym has been approved and was in the planning stages at the time of writing this report.

Programs – therapeutic

The evaluation found access and quality limitations regarding therapeutic programs currently delivered at the AMC. Remandees and women experienced particularly poor access to programs. Where programs were offered, they had high non-completion rates and participants raised issues with the perceived quality of program content and facilitation. On a positive note, continuous quality improvement was occurring, however a greater range of programs are needed to address the range of drug issues among AMC prisoners, along with significant improvements to the accessibility of programs.

Therapeutic community and external residential rehabilitation

Access to the Solaris Therapeutic Community is currently limited to male sentenced prisoners housed in a minimum security environment. Access to such a key service should be extended to all prisoners at the AMC, given the high need for such services and the importance of equitable service access. The Solaris Therapeutic Community program is of high quality; both participants and service providers provided feedback to this effect. However, the current location of the program is problematic and an alternative, more secure location for the program needs to be found within the AMC grounds. For those currently unable to access

the Solaris program, more support for accessing external residential rehabilitation services should be provided.

Primary healthcare

Primary healthcare provided at the AMC is of high standard, however prisoners report experiencing significant delays in accessing care. Issues with consistency of care, a lack of care and discharge planning and poor clinical record keeping were highlighted by key informants. Some areas of primary healthcare provided at the AMC lack equivalence with community-based services of a similar nature.

Mental health

There is a high prevalence of mental health issues among prisoners at the AMC, however many affected individuals are unable to access mental health support, or may only be receiving mental health medications when non-medical interventions such as counselling may be warranted. This problem was partly related to the limited resourcing of mental health and related services at the AMC. Limited resources have resulted in a lack of care for prisoners with high prevalence conditions such as depression, anxiety and sleep disorders.

Detoxification

Prisoners at the AMC assessed as being in withdrawal from opioids, benzodiazepines and alcohol receive a medicated withdrawal regime at entry to the prison. The importance of a timely review of the adequacy of this detoxification regime was emphasised by key informants. The opioid detoxification regime is also provided to individuals in opioid withdrawal who request induction on to opioid pharmacotherapy and were not already on a program in the community. This practice is contrary to clinical advice provided to the ACT Corrections Health Program and the evaluation team has identified this practice as problematic and clinically unwarranted, and should be ceased. The provision of non-medication detoxification support, for example counselling, should also be considered.

Opioid pharmacotherapy

Delays in inducting individuals on to opioid pharmacotherapy were raised as a significant issue by key informants. Individuals already on an opioid pharmacotherapy program prior to prison entry are able to be dosed without delay, but unwarranted delays in inducting individuals not on a community program exist (see above). Key informants reported perceived pressure for prisoners to enter the methadone program, and there was considered to be a lack of support for individuals wanting to cease opioid pharmacotherapy. Individuals wanting to adjust pharmacotherapy doses experienced limited opportunities for confidential discussion and advice to guide their decision. The absence of a buprenorphine preparation as an alternative to methadone has resulted in a lack of equivalence with opioid pharmacotherapy services offered in the community and is a potential barrier to commencing treatment for individuals with a preference for buprenorphine. Poor retention in opioid pharmacotherapy post-release was raised as a particular issue requiring further exploration to determine causes and find relevant solutions.

Searches and seizures

Analysis of quantitative data found inconsistent rates of searches being conducted over time. While there was a strong relationship between the number of strip

searches and subsequent drug-related seizures conducted over time there was no relationship between targeted area searches and contraband seized. Key informants raised concerns with the effectiveness and intent of such searches. Prisoners reported having received inadequate advice regarding the safety of the SOTER machine.

Urinalysis

Positive urinalysis results were recorded following both targeted and untargeted tests, however quantitative data analysis found a lack of any meaningful relationship between the number of targeted tests conducted over time and positive tests resulting in disciplinary action. Key informants noted the substantial resources required to undertake urinalysis, but believed that the process was valuable for guiding strategies to address drug issues at the AMC. It was considered that positive urinalysis results should be utilised to inform case management and care planning by identifying individuals that may benefit from expedited referral to therapeutic programs, in addition to disciplinary measures.

Drug use in the AMC prison population

There is a high prevalence of lifetime and current pre-incarceration use of both licit and illicit drugs among prisoners at the AMC. The evaluation found that drug use, including injecting drug use, was occurring at the AMC and this use contributed to disease transmission risk (i.e., injecting with used syringes). Diversion of prescription drugs was reported to the evaluation team, although this appeared less common than the acquisition of drugs that were trafficked into the AMC. Trafficking of drugs into the prison was identified. Supply reduction activities were perceived as interrupting the supply of drugs into the AMC, but not halting supply. High rates of tobacco consumption and pre-incarceration problematic alcohol consumption (among those reporting consumption) among AMC prisoners was reported. Programs that specifically address licit drugs, such as alcohol and tobacco, as well as those that address illicit drug use are required.

Blood-borne viruses

Testing, vaccination and record keeping practices at the AMC relating to blood-borne viruses are inadequate. Current practices do not provide a mechanism to reliably estimate incidence or prevalence of blood-borne viruses among the AMC prisoner population. Testing is predominantly occurring at reception, with little follow up during incarceration or at discharge. Testing algorithms are not best practice and may provide false positive results to prisoners. No accredited pre- or post-test counsellors were on staff at the AMC at the time of conducting this evaluation, representing both a legislative breach and raising issues with the quality of information provided to prisoners during testing processes. Good levels of blood-borne virus-related health promotion are occurring at the AMC. Key informants described the potential for introducing a professional tattooing program at the AMC as a means to reduce blood-borne virus transmission risk.

Overdose

A very low rate of overdose is occurring at the AMC, none of which resulted from illicit drug use. Some instances of heavy sedation following illicit drug use were reported. The provision of naloxone to post-release prisoners, accompanied by an appropriate pre-release education and training program, was identified as a potential overdose prevention strategy for those discharged from the AMC. The importance of encouraging retention in opioid pharmacotherapy post-release was

also highlighted as an overdose prevention strategy. Health staff at the AMC may require further training in naloxone administration procedures.

Bleach provision

A number of issues were identified in relation to the provision of bleach at the AMC. Bleach was not available until 2010 and was described as running out regularly. Accessing bleach by prisoners was associated with a fear of retribution, for example providing a reason for being searched or urine tested. There was consensus that bleach should be available, however bleach provision should be accompanied by appropriate instructions about how to use it effectively.

Needle and syringe program

The evaluation found evidence of injecting occurring in the AMC with used syringes. There was strong support among most stakeholders for the introduction of a trial needle and syringe program (NSP) at the AMC, however there was some opposition to the trial, particularly among custodial officers. Custodial officers' opposition to an NSP trial was based on both ethical and safety concerns. Custodial officers also considered that they had not been adequately consulted about the potential for a NSP trial. Individuals in support of an NSP reported concerns with confidentiality in the provision of such a service. There was broad support among key informants to explore various potential models for an NSP at the AMC, but that a thorough consultation process should occur to explore appropriate and preferred NSP models. The evaluation team considers that data collection and management processes at the AMC need to be improved so that an adequate evaluation of any potential NSP trial can occur.

Key outcomes

Several positive program activities at the AMC go some way to fulfilling drug policy, service and strategic objectives. However, these are best accurately described as 'pockets of effectiveness' and do not represent a comprehensive and consistent response to drug-related issues at the AMC. The most effective drug-related services and activities at the AMC are as follows:

- Inside Out Program provided by Directions ACT;
- Individual relationships between prisoners and NGO service providers (e.g., ACT Women and Prisons, Toora, Directions ACT, Canberra Recovery Services, Canberra Men's Centre, Samaritan House);
- Forensic Mental Health counselling services;
- Basic primary healthcare services provided by the ACT Corrections Health Program, particularly nursing and dental services; and
- Solaris TC program content and facilitation.

Little evidence emerged regarding the effective delivery of other drug services and strategies at the AMC. Furthermore, while the quality of some aspects of the services described above was evident, the overall effectiveness of these activities was compromised by particular shortcomings, especially in relation to service coordination, equivalence and access.

General areas where services have not adequately matched standards and expectations set in strategy and policy framework documents are:

- Awareness of services by prisoners;
- Access to services;
- Implementation of appropriate case management models, including the coordination of services to meet often multiple and complex needs;
- Creation of an equivalent system of health and welfare service provision that matches community standards and service availability; and
- Application of throughcare principles and service approaches.

Overall, the service system intended to address drug-related issues at the AMC suffers from a lack of clear policy direction and practical guidance. This is in part due to the multiple strategy and policy frameworks that inform AMC policy and service, with strategy and policy consolidation recommended. Existing strategic and policy frameworks tend to focus on discrete providers of particular services and any new iteration specific to the AMC should instead provide overarching guidance to all providers that is consistent with harm minimisation principles. A clear governance structure should be established to support these activities and ensure they are effectively balanced across the pillars of supply, demand and harm reduction.

Although the evaluation findings suggest that, in general, services were reaching their target populations, services were not always delivered in a timely fashion and services were not always reaching all of those in need. The predominant drug services at the AMC related to illicit drugs, thus service recipients were predominantly those with illicit drug use issues. Qualitative interviews and quantitative evaluation data suggested that problematic users of licit drugs were less well serviced. The difference in legal status of these drugs may warrant different approaches in the provision of therapeutic programs to those provided for illicit drugs.

In relation to equitable access to services among AMC sub-populations, differential access to services among remand and sentenced and male and female prisoners repeatedly emerged as a concern. Strategic and policy frameworks underpinning drug services at the AMC make no discernible distinction between remand and sentenced prisoners from a strategic point of view; these documents direct that all those with drug-related needs should be provided with services and opportunities to address drug issues during time spent at the AMC. Indeed, female prisoners were described as a priority population for the receipt of services. However, remand prisoners, and in many instances female prisoners, were unable to access particular services due to their classification or gender.

Fragmentation of services and providers was assessed by the evaluation team as being a key issue impeding the effective implementation of drug policy and services at the AMC. Lack of awareness of and access to internal services by prisoners has resulted in individuals accessing external services that duplicate prison-based services (e.g., case management). This duplication and differential access stems from better visibility of external services, the quality of relationships (that may have existed prior to incarceration) and perceived ease of access. Some of these duplicate services delivered by external providers are likely to be unfunded. Service duplication is problematic and not monitored, largely due to a lack of service coordination.

Drug use issues at the AMC should be considered more holistically; that is, to approach drug use as an antecedent and/or sequelae of a range of health and psycho-social issues. Services should focus on individual need, and provide a case managed suite of services for prisoners that are tailored to their needs and not structured according to traditional service provision silos. Addressing other needs (e.g., employment and mental health) will help create an enabling environment to support abstinence from or cessation of problematic drug use and help reduce recidivism.

The recommended holistic approach requires effective case management and service coordination. This case management should be welfare-based. Programs and services should emerge from case planning processes that are explicitly developed and refined in collaboration with prisoners and the relevant range of service providers. This process will help support improved throughcare, including providing transitional support when moving into the AMC, during incarceration and following release, for as long as individuals require support.

4.0 Introduction

Background

Prior to the establishment of the Alexander Maconochie Centre (AMC), prisoners from the Australian Capital Territory (ACT) were incarcerated in prisons operated by New South Wales Department of Corrective Services. The commissioning of a prison within the ACT was intended to allow the ACT to directly influence rehabilitative and therapeutic outcomes for prisoners. In addition, the establishment of the AMC was designed to make prison visits more accessible and less costly for families and friends of prisoners.

The prison has been developed on the basis of human rights principles, in order to meet the objectives of being a 'healthy prison'. The prison is intended to operate in accordance with the *ACT Human Rights Act 2004*.

Overview of evaluation rationale

The *ACT Drug, Alcohol and Tobacco Strategy 2010-2014* and the *ACT Health Adult Corrections Health Services Plan 2008-2012* outline a commitment to evaluating drug policy and services at the AMC after the prison's first 12 months of operation. The intent of the evaluation is to examine the consistency of drug policy and services at the AMC with the principles of harm minimisation that guide these policies and services.

An Evaluation Advisory Group of key stakeholders was formed in 2009 to guide the evaluation. The Group includes representatives from ACT Health, ACT Corrective Services, the ACT Chief Minister's Department and non-government organisations (NGOs). A consultant in social research and evaluation developed a Monitoring and Evaluation Protocol, with input from representatives from ACT Health and ACT Corrective Services, that directly informed the evaluation approach undertaken. The Protocol clearly links drug-related¹ services and policies at the AMC with the principle of harm minimisation, as outlined in the *National Drug Strategy 2004-2009*.

As outlined in this protocol, there are several key issues that should be addressed by drug services and supporting systems at the AMC or facilitated through the AMC. These issues can be characterised under the follow broad areas of activity:

¹ In the context of this report, drug-related policies and services are those that aim to address the harms that arise from individuals using licit and illicit drugs. These may include, but are not limited to, health-related harms, impacts on wellbeing, social disadvantage, offending (effects on offenders and the broader community) and incarceration. The term 'drug-related issues' is also used in the report to describe these harms.

Table 1 Key activities and their relationship to harm minimisation

Issue	Supply reduction	Demand reduction	Harm reduction
Preventing or minimising the availability of unprescribed, i.e., illicit, psychoactive substances in the AMC	x		
Preventing or minimising the uptake and continuation of harmful drug use in prison		x	x
Minimising the level of harm experienced by prisoners, prison staff and others related to drug availability, drug use and responses to drugs in prison			x
Engaging prisoners and, where appropriate, their families, in effective evidence-based therapeutic interventions addressing their problematic drug use		x	x
Designing and implementing throughcare ² programs that address the drug-related needs of detainees, their families and others as they enter prison, during their periods of imprisonment, and following release from prison		x	x

(Source: Monitoring and Evaluation Protocol)

To reduce drug-related harm to prisoners, staff and the wider community and maintain and improve the health of prisoners, consistent with the types of activities described above, a range of alcohol and other drug services and other strategies are provided at the AMC. These include:

Supply reduction

- Intelligence-based interdiction of drug supply
- Random, targeted and non-targeted drug testing
- Searches of prisoners, cells and areas
- Searching and banning of visitors

Demand reduction

- Group counselling (*First Steps...To Recovery, Getting Me Back*)
- Individual counselling

² The term 'throughcare' is used throughout this report to describe the support provided to prisoners to assist them to transition between prison and the community, enabling a smooth reintegration intended to prevent recidivism and contribute to individuals becoming productive members of the community. Throughcare may entail the continuation of services post-release that were provided in prison or the use of in-reach services so that services provided in the community may be continued throughout incarceration and following release.

- Opioid Substitution Treatment
- Detoxification
- Rehabilitation (Therapeutic Community)
- Drug-free wings/areas
- Establishment of throughcare links

Harm reduction

- Health promotion
- Education and resource provision by peer-educators
- Health assessments
- Implementation of care plans
- Provision of general, mental and dental healthcare
- Provision of disinfectant and condoms
- Post-exposure prophylaxis after possible exposure to HIV
- Establishment of throughcare links
- Staff training in universal precautions regarding blood-borne viruses and occupational health and safety (OHS) issues for search procedures

(Source: adapted from Monitoring and Evaluation Protocol)

Evaluation of these activities is intended to inform managers and decision makers in the ACT Corrections Health Program, ACT Corrective Services and ACT Health's Alcohol and other Drug Policy Unit about:

- Whether drug strategies and services are achieving their stated goals;
- Whether policies and services have been implemented;
- The impact of policies and strategies on prisoners and staff; and
- Outputs and outcomes of drug programs and services.

The evaluation project was tendered out in March 2010. The Centre for Population Health at the Burnet Institute was successful in winning the tender and has undertaken this evaluation and authored this report.

5.0 Methodology

The approach used in this evaluation was guided by:

1. The requirements set out in the Request for Proposal to evaluate drug policies and services at the AMC, and was consistent with the logic model underlying the AMC's drug and alcohol services (summarised above as they relate to supply, demand and harm reduction);
2. The draft *Monitoring and Evaluation Protocol for the Alexander Maconochie Centre's Alcohol and Other Drug Services, 2009-2010*;
3. Harm minimisation principles, such as those outlined in the *National Drug Strategy*; and
4. The Evaluation Advisory Group established by ACT Health.

A summary of the activities of this evaluation is described in the table below and elaborated thereafter.

Table 2 Summary of activities

Evaluation question	Data collection method	Data analysis method	Analysis/reporting outcomes
1. What are the main characteristics of the AMC's drug strategies and services?	Desktop review In-depth interviews Observations	<i>Qualitative</i> Policy analysis Content and thematic analysis	Interviews with AMC management and staff, other key stakeholders and researcher observations explored the main characteristics of the AMC's drug strategies and services. Descriptions of the characteristics perceived by informants have been reconciled with descriptions of drug strategies and services contained in relevant strategy and policy documents.
2. What are the characteristics of the services' recipients and how do they compare with the intended recipients?	Service provision data Desktop review In-depth interviews	<i>Quantitative</i> Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic analysis	Interviews with AMC management and staff and other key stakeholders identified the characteristics of recipients receiving in-prison and post-release services as part of the AMC's drug services. Informants asked to reflect on the extent to which services are being provided to intended service recipients identified in relevant strategy and policy documents.
3. What has worked as expected and what has not? What barriers and challenges to implementation emerged, and how were they handled?	Service provision data Desktop review In-depth interviews Observations	<i>Quantitative</i> Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic	Interviews with AMC management and staff, prisoners/ex-prisoners and other key stakeholders examined the services delivered to recipients and identified perceived barriers and enablers to the provision of these services. These reflections have been combined with services and outcome data and reconciled with service contract provisions and other relevant strategy and policy documents to examine the extent to which service provision aims are being met

Evaluation question	Data collection method	Data analysis method	Analysis/reporting outcomes
		analysis	and how potential barriers may be overcome.
4. What assumptions have proved true and what have not? What assumptions are problematic, if any?	In-depth interviews Observations	<i>Qualitative</i> Content and thematic analysis	Interviews with AMC management and staff and other key stakeholders and researcher observations reflected on documented and perceived assumptions made at the commencement of the AMC's drug services program and examined the extent to which they informed subsequent stages of the program. The extent to which problematic assumptions occurred and their potential impact on ongoing services was documented.
5. What has changed from the original design and why? On what basis are adaptations from the original design being made? How are these changes being documented and reflected upon, if at all?	Service provision data Desktop review In-depth interviews Observations	<i>Quantitative</i> Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic analysis	A purposive desktop review of program logic and documented strategies occurred to explicitly develop interview questions designed to examine the extent to which the original service design has been implemented and why deviations from the original design have occurred. Responses to these questions, combined with researcher observations, examined the extent to which changes from the original design have facilitated and/or prevented specific aims of the AMC's drug policies and services.
6. What governance issues have emerged, how are they being handled and what governance modifications, if any, are desirable?	In-depth interviews Observations	<i>Qualitative</i> Content and thematic analysis	Interviews with AMC management and staff and other key stakeholders and researcher observations reflected on current governance structures for the AMC's drug services. The governance of both in-prison and post-release services was examined, including the quality of throughcare and the effectiveness of current governance structures to manage drug services across prison and community environments.
7. To what extent have the	Service provision	<i>Quantitative</i>	Interviews with AMC management and staff, prisoners/ex-

Evaluation question	Data collection method	Data analysis method	Analysis/reporting outcomes
strategies and services attained their stated objectives, including the targets specified in the Key Performance Indicators?	data Desktop review In-depth interviews Observations	Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic analysis	prisoners and other key stakeholders were combined with available secondary data and researcher observations to examine the extent to which services have met their stated objectives and key performance indicator goals. In meeting this evaluation question, the research team examined whether current data collections are capable of adequately determining the extent to which objectives are being met. Where gaps in data collection existed, the research team has made recommendations so that determinations of future program objectives can be adequately measured.
8. Were there any unintended consequences of the implementation of the strategies and services, either positive or negative?	Service provision data Desktop review In-depth interviews Observations	<i>Quantitative</i> Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic analysis	Interviews with AMC management and staff, prisoners/ex-prisoners and other key stakeholders were combined with available secondary data and researcher observations to determine the existence of unintended outcomes resulting from the AMC's drug services. Both actual and perceived potential unintended outcomes were examined, their implications explored, and recommendations made to avoid the potential for future adverse consequences as a result.
9. What were the monetary costs of the services provided, and was value-for-money attained?	Service provision data Desktop review Observations	<i>Quantitative</i> Descriptive and inferential statistics <i>Qualitative</i> Policy analysis Content and thematic	A review of expenditure on particular programs and services has been provided. Combined with researcher observations and reflections on the team's previous work evaluating alcohol and other drug service provision, this review reflects on the adequacy of current expenditure and the extent to which this expenditure is being effectively directed to meet the aims of the AMC's drug services program has been examined.

Evaluation question	Data collection method	Data analysis method	Analysis/reporting outcomes
		analysis	
10. What changes, if any, need to be made to the strategies and services?	In-depth interviews Observations	<i>Qualitative</i> Content and thematic analysis	The outcomes to the above questions, alongside researchers' reflections of their own observations, interviews, secondary data analysis, and desktop review of all relevant documentation were synthesised to provide an overarching implementation and outcome evaluation. This report provides clear and unambiguous recommendations regarding potential changes to the AMC's drug services, grounded in the information collected throughout the evaluation.

(Source: adapted from Monitoring and Evaluation Protocol)

Individual activities undertaken during the project are described in detail below.

1. Expedited ethics application

The Burnet Institute team acknowledges the complex ethical considerations involved in conducting research and evaluations with vulnerable populations such as prisoners and ex-prisoners. While the project had already received ethics approval (submitted to the ACT Health Human Research Ethics Committee ETH.11/09.1015) prior to the evaluation being contracted to the Burnet Institute, amendments to the original application were prepared by the project team to take account of the methodology proposed in the evaluation tender response. The amendments were submitted in May 2010 and approval was received in June 2010.

2. Primary data collection and analysis

In-depth key informant³ interviews

Semi-structured in-depth interview schedules, based on the evaluation program logic outlined in the tender documents, were developed. The interview schedules were designed to address the specific evaluation questions set out in the evaluation protocol (see evaluation summary above).

In summary, interviews addressed:

- Services available at the AMC and through the AMC's drug services program;
- Approaches underpinning the delivery of available services;
- Characteristics of clients of services;
- What's working and what's not working in relation to service delivery;
- Assumptions that informed the development of services and whether these proved accurate and appropriate or were problematic;
- Changes that have occurred during and since the AMC implementation, and reasons for changes and documentation of changes;
- Governance issues;
- Achievement of key performance indicators;
- Unintended consequences of strategy implementation; and
- Solutions to identified issues and recommendations for future action.

Interviews were semi-structured and qualitative in nature. Two different interview tools were developed; one for service providers and one for

³ The term 'key informant' is used throughout the report to refer to individuals who participated in interviews and other stakeholders (for example members of the Evaluation Advisory Group).

prisoners/ex-prisoners. The service provider interview tool was further summarised and adapted for use in a workshop setting as well.

Prisoner and ex-prisoner interviews focused on their experiences at the AMC, with some comparison to other prison experiences where appropriate. Service provider interviews explored experiences providing services to prisoners and other activities undertaken at the AMC.

Interviews with key informants were principally carried out over the course of three separate one week blocks. It was anticipated that 65 interviews would be undertaken for this evaluation according to the following key stakeholder groups:

- Prison management and staff including custodial officers and health service providers (n=20);
- Community-based service providers and other stakeholders (n=15);
- Prisoners (n=20); and
- Ex-prisoners (n=10).

These participant numbers were selected based on the size of the populations being studied and the timeframes in which the project was to be completed. The selection of participants for interviews aimed to provide a representative cross-section of key stakeholders (e.g., corrections staff of varying roles and seniority, clinical staff, and other support service staff).

Interviews took around 60 minutes each and were digitally recorded and transcribed. Prisoners and ex-prisoners were reimbursed for their participation in in-depth interviews.

Numbers of participants in interviews were as follows:

- Prison management and staff including health service providers (n=26);
- Community-based service providers and other stakeholders (n=29);
- Prisoners (n=19); and
- Ex-prisoners (n=9).

These included workshops, group and individual interviews. Quotes from key informant interviews included in the report have been completely de-identified (i.e., all quotes are reported as being from 'key informants' to preserve the confidentiality of individuals who participated and to ensure that all qualitative data is considered with equal standing).

Evaluator observations

As part of the primary data collection, the project team's observations were recorded throughout the project, particularly during the interview stage. Field notes taken during interviews and minutes from project team meetings were utilised, where possible, to respond to the following areas of the evaluation:

- Services available at the AMC;
- Assumptions that informed the development of services and whether these proved accurate and appropriate or were problematic;

- Changes in service delivery and the nature of activities that have occurred during and since the AMC implementation, and reasons for changes and documentation of changes;
- Governance issues;
- Achievement of key performance indicators;
- Unintended consequences of strategy implementation;
- Cost of services and value for money; and
- Solutions to identified issues and recommendations for future action.

Observations aided and influenced the interpretation of data by the project team and were informed by practical and policy experience.

Primary data analysis

A content and thematic analysis of all qualitative data was undertaken. Responses to in-depth interviews, data collected from workshops and evaluator observations were coded and grouped according to the prescribed evaluation questions.

3. Secondary data review and analysis

A secondary data review and analysis was conducted, consisting of two phases – a desktop review of relevant policy and strategic planning documents, followed by specification of and request for service data for analysis.

Desktop review of relevant policy and strategic planning documents

The initial stage of the project involved a review of the following documents relevant to the development and implementation of drug policy and services at the AMC:

- ACT Health (2007) *Adult Corrections Health Services Plan 2008-2012*, ACT Health, Canberra;
- ACT Corrective Services (2007) *ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008*, ACT Corrective Services, Canberra;
- National Drug Strategy (Australia) (2008) *National Corrections Drug Strategy 2006-2009*, National Drug Strategy, Canberra;
- Corrective Services Ministers' Conference, Conference of Correctional Administrators (2004) *Standard Guidelines for Corrections in Australia – revised 2004*;
- ACT Government (2004) *ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008*, ACT Government, Canberra;
- Black, E., Dolan, K. and Wodak, A. (2004) *Supply, Demand and Harm Reduction Strategies in Australian Prisons: Implementation, Cost and Evaluation*, ANCD Research Paper No. 9, Australian National Council on Drugs, Canberra; and

- Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (2008) *Hepatitis C Subcommittee Hepatitis C prevention, treatment and care: guidelines for custodial settings*, MACASHH, Canberra.

Findings from the desktop review were summarised for inclusion in the final report. Components of the desktop review informed the development of interview schedules and subsequent data analysis. The desktop review provided the basis for the evaluation of outcomes and the measurement of success against the intended approach and aims of drug services at the AMC. The document review involved policy analysis to identify common values and principles across documents and activities that would underpin the implementation of drug services at the AMC.

During the preparation of the desktop review, the evaluation team decided to conduct an additional brief literature review for inclusion in the final report. It was considered that this review would assist in identifying common characteristics and issues in prison populations and drug-related interventions commonly utilised in prisons. The evidence base for such interventions is also outlined in the review, which is intended to assist the evaluation team in identifying best practice in particular areas of service delivery.

Specification of and request for service data for analysis

Early consultation with key stakeholders regarding access to secondary data sources determined the nature and extent of secondary data analysis.

The data requested by the project team are described below.

Supply reduction

- Numbers and volumes of contraband seizures;
- Numbers of searches of prisoners and visitors;
- Numbers and results of drug tests conducted;
- Numbers of searches of staff;

Demand reduction

- Episodes of care for alcohol and other drug counselling;
- Episodes of care and retention in opioid maintenance treatment;
- Episodes of any alcohol and other drug care delivered to prisoners prior to, during and after detention;
- Coverage and numbers of screens and care plans for health issues including drug related problems, mental health problems and general health problems;
- Number and type of psychosocial treatments provided;
- Numbers of admissions to, discharges from and successful completions of therapeutic community treatment;
- Percentage of prisoners with discharge plans of different types and extent to which plans are implemented and complied with;
- Prevalence of self-reported drug use in prison;

- Coverage of care and release plans for prisoners with diagnosed mental illness;
- Provision of evidence-based alcohol and other drug treatment and support;

Harm reduction

- Numbers of prisoners tested and results from blood-borne viruses and STI screening;
- Provision of hepatitis B virus (HBV) vaccines;
- Provision of post-exposure prophylaxis;
- Episodes of information and education;
- Episodes of nicotine replacement therapy;
- Numbers of drug overdoses and responses provided;
- Prevalence of self-reported risk behaviours relating to drug use; and
- Level of health and wellbeing of prisoners.

These data came from a number of sources:

- ACT Health
- ACT Corrective Services
- NGOs providing services at the AMC
- The Inmate Health Survey conducted by ACT Health in May 2010⁴

The project team undertook analysis of the quantitative data received from relevant providers of services and requested variables from the Inmate Health Survey. This analysis sought to respond to the evaluation questions by determining whether key performance indicators relating to supply, demand and harm reduction have been met. In particular, this analysis described availability, quality and uptake of services and programs, impact on risk behaviours and drug use and impact on post-release outcomes. Analyses also described the performance of supply reduction activities such as searches and drug tests. The specific evaluation questions addressed by the secondary data analysis included:

- Characteristics of clients of services;
- What's working and what's not working;
- Changes that have occurred during implementation, reasons for changes and documentation of changes;
- Achievement of key performance indicators and adequacy of existing data to measure performance;
- Unintended consequences of strategy implementation; and
- Cost of services and value for money.

⁴ A survey of health and wellbeing indicators undertaken with prisoners at the AMC in May 2010 by staff from ACT Health. Survey data includes information about self-reported drug use, results from blood-borne virus testing and other social demographics.

Quantitative data analyses were performed using Stata Version 11.0.

4. Synthesis of findings

Quantitative and qualitative findings were compared to establish the degree of validity of specific findings and assess the level of consensus on responses to particular questions. Where significant consensus was found to exist, these findings are given greater emphasis in the Findings section and used to guide the Discussion section.

Findings of the evaluation are grouped according to the types of services and activities being described. Within the Discussion section of the report, findings from the two-stage secondary data review and analysis, in-depth interviews and evaluator observations were synthesised to determine how well drug services at the AMC are meeting the intentions specified in the Monitoring and Evaluation Protocol. Each evaluation question was examined, as well the extent to which drug and alcohol-related operations at the AMC meet the overarching principles of supply, demand and harm reduction.

In addition to reporting aggregated findings according to evaluation aims, the report presents clear recommendations regarding the refinement of existing strategies and services and the implementation of future strategies and services for the AMC's drug services program.

5. Reporting

Following synthesis of findings, a draft report was developed. The report included a detailed methodology, a desktop policy review, a brief literature review, a summary of the secondary data review and analysis, in-depth interviews and evaluator observations, recommendations for future implementation and specific responses to the evaluation questions set out in the Monitoring and Evaluation Protocol.

Following written feedback from various Evaluation Advisory Group members, including a comprehensive written response from ACT Corrective Services, the last of which was received 4th January 2011, a final draft of this report was provided to ACT Health on the 10th January 2010. On April 4th 2011 the Burnet Institute received formal advice regarding incorrect urinalysis data provided by ACT Corrective Services. The report was subsequently amended to take these new data into account. This final report was provided to ACT Health on the 6th April 2011.

6. Attendance at Evaluation Advisory Group meetings

Members of the evaluation team attended the Evaluation Advisory Group meetings and the initial meeting with ACT Health management in May 2010. The committee was updated on the evaluation team's progress and canvassed for ideas relevant to project development. Specifically, in the initial stages, the project team sought advice from the Evaluation Advisory Group about appropriate individuals and organisations to consult with as part of the interview phase of the

project. As the project progressed, the project team sought input on preliminary results, and then the draft report.

6.0 Desktop policy review

To contextualise the evaluation of drug policy and services at the AMC, the evaluation team reviewed a number of key policy and strategy documents that informed the development of drug policy and services within the AMC. Here, we summarise the content of these policy and strategy documents. This document review assisted in developing evaluation data collection instruments and is reflected upon when synthesising evaluation findings in the context of the policy environment in which the AMC was established and continues to operate. Whether services implemented are meeting stated policy objectives will be explored later in the report.

National policy

National Drug Strategy

At the national level, Australia's *National Drug Strategy* describes the overarching principles that inform all drug policy developed across the nation; federally and within the states and territories.

The harm minimisation approach that underpins Australia's response to drug use contains the three key principles of supply reduction, demand reduction and harm reduction. The principles are considered the pillars that support strategies to address drug-related issues in Australia. These pillars are detailed here, as stated in the *National Drug Strategy 2004-2009*:

- Supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- Demand reduction strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies and treatment to reduce drug use; and
- Harm reduction strategies to reduce drug-related harm to individuals and communities.

These pillars can be applied to both national and local drug strategy and policy via a range of processes and activities. The application of these pillars is described later in relation to the ACT (see ACT policy section below), where they have been used as a foundation for local strategies and ultimately help guide this evaluation of drug policies and the services at the AMC.

National Corrections Drug Strategy

The *National Corrections Drug Strategy 2006-2009* similarly works from the approach of harm minimisation, recognising the high prevalence of alcohol and other drug issues within custodial populations and the need for specific strategies in these environments. The mission of this *Strategy* is:

'To improve health, social and economic outcomes for adult and juvenile offenders within correctional and community-based facilities and services. The strategy seeks to prevent anticipated and actual harm to individuals, families and to the wider community resulting from drug misuse and drug-related

crime by preventing the uptake or continuation of drug misuse, reducing the harmful effects of drugs, and reducing re-offending.' (ANCD, 2008:3)

This mission statement is a clear articulation of the pillars of harm minimisation, as outlined in the *National Drug Strategy 2004-2009*, and the ways in which they can be applied in correctional settings to reduce harms to prisoners and the broader community. The emphasis here on addressing drug-related problems through improving health, social and economic outcomes for justice-involved individuals indicates the complexity of the relevant issues. This emphasis highlights the need for strategies that address the 'upstream' causes of drug problems, such as social and economic disadvantage, to have an impact on 'downstream' factors such as drug-related offending and incarceration.

Standard Guidelines for Corrections in Australia

At the national level, the other key document reviewed was the *Standard Guidelines for Corrections in Australia* (2004). The guidelines are described as representing "a statement of national intent, around which each Australian State and Territory jurisdiction must continue to develop its own range of relevant legislative, policy and performance standards" (Corrective Services Ministers, 2004:2).

Key principles and practices contained in the *Guidelines* that provide the context to develop legislation and policy responses in Australian correctional facilities are extracted from the *Guidelines* and reproduced below.

The *Guidelines'* overarching principles for the management of prisoners emphasise that prisoners should be treated with respect and dignity, and without discrimination according to individual or group characteristics such as race, religion, or sexual orientation. Indigenous prisoners will be acknowledged as such and recognition will be given to the impact of customary law upon the wellbeing and management of the prisoner. These approaches are intended to preserve the human rights of individual prisoners, while providing opportunities for them to make reparation for offences committed against the community and to be rehabilitated. The *Guidelines* also state that prisoners will be individually assessed and managed according to their specific needs, again emphasising the importance of individual rights.

The *Guidelines* provide an indication of the scope of drug dependence in justice-related populations and the breadth of resources required to effectively address them. The aspects of the *Guidelines* that relate specifically to alcohol and other drug issues are as follows:

1. The need for all prisoners to be screened and assessed on admission to the prison to identify health needs and plan (potentially immediate) responses to address these needs;
2. Once received into the prison, all prisoners should have access to professional counselling services and evidence-based health services provided by appropriately qualified personnel;
3. Appropriate measures must be in place to prevent the transmission of infectious diseases;

4. Where prisoners were receiving alcohol and other drug treatment upon entering a custodial setting, they should be allowed to maintain contact with that service provider while in prison and arrangements should be made for continuation of any medical treatment following discharge from prison.
5. Each prison system should have its own comprehensive drug strategy that addresses how harm minimisation will be implemented. This will include effective systems for detecting and confiscating contraband such as drugs and drug use paraphernalia and means by which to share information with police about contraband where necessary. Any drug testing undertaken on prisoners must comply with relevant standards to ensure integrity of results; and
6. Prisons should also promote and provide a smokefree environment or zones wherever practicable.

Under the *Guidelines*, corrections authorities are also responsible for ensuring that prisoners are case managed through the custodial system, in recognition of changing needs and risk as individuals move across different custodial settings such as remand, prison, community corrections and the general community. Prisoners should also have a sentence plan that is recorded as part of a case management record and regularly reviewed.

These principles and activities relate unambiguously to the AMC and the principles that underpinned its implementation and ongoing operations, by indicating a clear framework in which the drug concerns of individual prisoners and their impact on the broader community can be addressed. They encourage approaches that focus on reducing harm to individuals caused by drugs, improving individual health and wellbeing and reducing the likelihood of recidivism, thereby also benefitting the broader community. The emphasis on human rights described above is relevant considering the human rights basis on which the AMC was intended to be established.

These national drug and corrections strategies and guidelines that emphasise harm minimisation, human rights and individually tailored interventions form the foundation of complementary ACT strategic policy documents. A review of these documents and how they have informed drug and alcohol policies at the AMC follows.

ACT Policy

As described above, the principles underpinning national drug and corrections policies and strategies have been translated and applied to a local ACT context in the following documents, and used to guide drug-related policies and services at the AMC. These documents are reviewed below.

Corrections Management Act

While the *Corrections Management Act 2007* was reviewed by the evaluation team, some of its content (as relevant to this evaluation) is replicated in other ACT policies and strategies reviewed below. As such, this *Act* will be indirectly referred to through other policy documents, rather than outlined directly here.

ACT Alcohol, Tobacco and other Drug Strategy

The *ACT Alcohol, Tobacco and other Drug Strategy 2004-2008* was the relevant publicly available strategy at the time of undertaking this review in mid-2010. A draft copy of the forthcoming strategy (*2010-2014*) was received and reviewed by the project team, and is also discussed below.

The *Strategy (2004-2008)* provides contextual information on the prevalence and complexities of alcohol and other drug issues within the ACT. The parts of the strategy specifically relevant to the prison context will be discussed here.

The *Strategy* has four main aims:

- Improve the health and social well-being of individuals, consumers, families and carers, and the community in the ACT;
- Minimise the harm in our community from alcohol, tobacco and other drugs while recognising the individual needs of all citizens in the ACT;
- Develop evidence-based initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way; and
- Implement the Strategy in a way that respects, protects and promotes human rights.

The *Strategy* also outlines basic human rights principles which guide the strategy. These are:

- Treating people with dignity and respect;
- Empowering people to participate directly in decisions about their health and wellbeing;
- Self-determination in relation to their life choices;
- The right to informed consent and adequate and accurate information to support decision making;
- Adopting strategies to improve self-esteem and self-worth;
- Access to non-judgemental and non-discriminatory services;
- Access to advocacy processes to protect rights in service delivery, basic consumer rights, etc; and
- Respect for the right to privacy.

As would be expected from a strategy of this nature, the document also outlines a commitment to harm minimisation as a guiding principle. Beyond the human rights principles described above, more specific approaches that guide the strategy include:

- Applying evidence-based practice;
- Strengthening partnerships, collaboration and ownership;
- Recognition of social determinants of health and wellbeing;
- Increasing access to services;
- Investing wisely in the future;

- Enhancing health promotion, early intervention and resilience building; and
- Using a quality framework.

Although the *Strategy's* aims, and the human rights and other guiding principles in the *Strategy*, provide a clear context for the development and implementation of drug policies and services at the AMC, the document also contains actions and strategies specific to correctional settings. The *Strategy* provides clear direction on the range and activities of programs to be provided in custodial settings in the ACT via the Department of Justice and Community Safety. Designed to foster behaviour change in relation to alcohol and other drug use, these programs include educational and drug awareness programs, coping skills programs, counselling and case management. These programs are reflective of the tailored interventions described in the *Standard Guidelines for Corrections in Australia* (2004) discussed above.

Particular alcohol and other drug-related actions designated within custodial service delivery are divided into three specific areas. First, the provision of full access to health services and treatments to prisoners, consistent with those available in the community, is described. Second, the development of partnerships and referral pathways between correctional authorities and community-based agencies are recommended to enhance responses to prisoner needs. These partnerships include oversight of case management, compliance with community-based orders and the implementation of throughcare principles. Third, the *Strategy* recommends an increase in the number and accessibility of programs provided to women within the ACT correctional system. In addition, the trial of a prison-based needle and syringe program within ACT corrections receives particular mention in the *Strategy*, however it is noted that the feasibility of a trial needs to be further explored through a cost-benefit analysis and analysis of occupational health and safety issues for staff. It should once again be noted that all of these recommended actions preceded the opening of the AMC. As such, they relate primarily to the context of the Belconnen Remand Centre and Temporary Remand Centre and to throughcare difficulties associated with the return of ACT prisoners to the ACT community from NSW-based prisons.

The *Draft ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014* contains aims almost identical to the earlier *Strategy*. Similarly, the guiding principles also reproduce those of the earlier *Strategy*, with the exceptions of removing "investing wisely in the future" and "using a quality framework" from the draft. This *Draft Strategy* was developed following the implementation of the AMC and therefore makes specific mention of the prison.

It is noted in the *Draft Strategy* that up to 80% of adults in detention are smokers, a rate much higher than in the general community. Adults in detention are therefore described in the *Draft Strategy* as a target population group for interventions related to the reduction of tobacco use. People in detention are also described as requiring a priority focus for interventions relating to alcohol use.

The *Draft Strategy* also notes that of the 164 inmates incarcerated at the AMC at 30 September 2009, two had a drug offence as their most serious offence and 45 people were receiving opioid maintenance treatment. Data on people in police detention presented in the *Draft Strategy* states that around 49% of detainees were dependent on a drug and approximately 40% of detainees reported injecting

drugs. Adults in detention are identified in the *Draft Strategy* as a priority target population for interventions relating to use of illicit drugs.

A number of recommended actions are detailed in the *Draft Strategy*. While some of these are described specifically in relation to correctional settings or services, some other actions are included here that may relate to prisoners and ex-prisoners, particularly those with a history of alcohol and other drug issues. AMC-specific actions are listed first:

- Evaluate the effectiveness of indoor smoking restrictions in the AMC and the uptake of smoking reduction and cessation programs;
- ACT Corrections Health Program to ensure clients admitted to the AMC and Bimberi Youth Justice Centre:
 - Are screened on admission for concurrent mental health and alcohol and other drug problems;
 - Have the opportunity to identify alcohol and other drug and mental health services that they have had contact with in the community that may be advised of the client's admission and offered the opportunity to provide support to these clients whilst in detention;
 - Obtain consultation/liaison support to assist the ACT Corrections Health Program to manage detainees with a suspected moderate mental illness and/or moderate alcohol and other drug problem; and
 - Are referred for joint management of a severe mental illness and/or severe alcohol and other drug problem;
- Ensure prisoners and other detainees, both adult and young people, are able to access the same community-based alcohol and other drug programs and other services where appropriate (e.g., Canberra Rape Crisis Centre) in detention and when they leave detention;
- Strengthen access to health services and support provided for Aboriginal and Torres Strait Islander people who are in detention and after they leave detention;
- Work with ACT Policing, ACT Corrective Services, ACT Corrections Health Program, DHCS and ACT Health to review and expand the investment and effectiveness of diversion programs; and
- Implement a full and comprehensive evaluation of proposed drug policies and services and their subsequent effects on prisoners and staff within the AMC*.

The following are more general actions that have implications for the AMC given the prevalence of drug and alcohol issues among prisoners and their need for access to services within and outside of the AMC:

- Improve access to alcohol and other drug services for vulnerable populations at health care centres and ensuring the culture at these centres is holistic and inclusive of vulnerable populations;

* The subject of this report

- Expand the range of health services authorised to dispense needle and syringe equipment (e.g., mental health services);
- Investigate the feasibility of utilising new service delivery models to overcome some of the barriers for people experiencing difficulties accessing needles and syringes, such as the provision of peer based services to enhance coverage for all people in the ACT who inject drugs (e.g., outreach, foot patrols, peer workers providing NSP services in Community Health Centres and Indigenous specific initiatives);
- Increase the number of subsidised pharmacy places to allow additional clients of the Opiate Replacement Maintenance Program to transfer to community pharmacies;
- Improve access to hepatitis C (HCV) treatment for people who inject drugs;
- Investigate the feasibility of strengthening transition support residential drug treatment programs for people experiencing withdrawal or detoxification including those on opioid maintenance treatment programs; and
- Improve the level and type of information collected in relation to the transmission of blood-borne viruses for priority populations.

ACT Corrective Services Drug, Alcohol and Tobacco Strategy

The *ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008* was also reviewed, although it should be noted that the implementation period for this strategy pre-dates the opening of the AMC and this document is no longer publicly available on the Corrective Services website. It has not been replaced with a more up-to-date strategy.

The *Strategy* provides detailed discussion of the AMC and its proposed policies and services. As would be expected, the *Strategy* discusses the approach of harm minimisation in detail and seeks to align all aims and objectives in the *Strategy* with the pillars of supply, demand and harm reduction.

The *Strategy* describes the operating philosophy of the 'healthy prison' that the AMC will be guided by, but it points out that while the AMC will aim to rehabilitate prisoners, it will still remain a correctional institution which securely houses individuals who have committed crimes against the community or are on remand for suspicion of such. The *Strategy* assumes a meaningful prevalence of co-morbidity relating to mental health and alcohol and other drug issues among the future population of the AMC. Hence service provision will focus on addressing this co-morbidity and "improving the prisoner's ability to function, reduce drug use, and to minimise the health and social consequences of that drug use" (Corrective Services, 2007: 10).

Integration and collaboration between services within the AMC is described as essential for successful drug responses. The possibility of tension and violence impacting negatively on drug policies and services is noted, as is the need to take all reasonable action to reduce the availability of drugs within prisons. The *Strategy* states that a set of differential sanctions for breaches of drug policies by prisoners will be implemented at the AMC. Sanctions and actions to reduce drug supply will be balanced with the need to allow visitors into the AMC.

In recognition of the entrenched nature and complexity of alcohol and other drug use in prisoners' lives, the *Strategy* states that all reasonable efforts will be made to address these issues. This will include the consideration of a therapeutic community as one of multiple responses to alcohol and other drug issues within the AMC. However, the *Strategy* also acknowledges that the prospects of rehabilitation and responding to disadvantage within the prisoner/ex-prisoner population are limited by the nature of custodial settings. As a result, throughcare and aftercare will be particular features of drug policies and services at the AMC.

The *Strategy* states that the operating philosophy of the prison will support an environment where safety, respect, personal improvement and family contact are maintained. While the operating philosophy is described in detail in the *Strategy*, the key points that relate to this evaluation are that:

- An overall emphasis on throughcare will be provided (refer to *Strategy* for full explanation);
- Case management plans will be produced for each prisoner and will include throughcare and aftercare components;
- Programs available will be targeted towards positive change and will be evidence-based;
- Maintenance of family relationships will contribute to successful reintegration and may prevent future reoffending;
- A broad range of programs will be provided which address behaviours, conditions, illnesses and issues in a number of domains;
- A multidisciplinary and collaborative approach will underscore the provision of programs and services;
- Service responses will be specifically developed for those with mental health issues, women and Indigenous people; and
- Specific approaches will be developed for short term prisoners.

The *Strategy* contains principles consistent with the *ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008* (and *Draft Strategy 2010-2014*), but directly applies them to a prison setting. In summary, however, the *Strategy* highlights the importance of viewing time spent in prison as an opportunity to address problematic behaviours.

Reference is made in the *Strategy* to the importance of supporting correctional staff who work in what can be a stressful environment, to ensure overall effective management of the prison and the best possible outcomes for prisoners. Similarly, prisoners themselves are described as a vulnerable group who need support to stabilise their lives and makes steps towards positive changes, particularly in relation to alcohol and other drug issues. However, the *Strategy* emphasises that this support must be provided in an environment that maintains safety and security for staff, prisoners and the broader community at all times.

The *Strategy* lists a range of actions and activities that will be undertaken to support the implementation of harm minimisation policies. These are summarised here under the various headings in which they appear in the

Strategy. Where actions duplicate ones mentioned earlier, they have been omitted.

Table 3 Description of activities outlined in *Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008*.

Supply reduction	Demand reduction	Harm reduction
<ul style="list-style-type: none"> ▪ Use of intelligence ▪ Searching of prisoners, visitors, cells and areas including physical searches, ion scanning and x-ray scanning (prisoners) ▪ Drug testing ▪ Penalties for positive searches and drug tests and penalties for visitors who attempt to introduce drugs into the AMC ▪ Use of drug detection dogs ▪ Monitoring of telephone conversations and correspondence 	<ul style="list-style-type: none"> ▪ Rehabilitation and educational programs (abstinence focused) ▪ Opioid pharmacotherapy programs ▪ Mental health support including access to community-based secure facilities ▪ Referral to community-based agencies ▪ Smokefree areas ▪ Productive and structured day routine ▪ Enforcement of a predator policy ▪ Nicotine replacement therapy ▪ Detoxification ▪ Case management and throughcare ▪ Peer education 	<ul style="list-style-type: none"> ▪ Provision of bleach, condoms and dental dams ▪ Education programs (non-abstinence focused) ▪ Infection control protocols ▪ Effective nutrition ▪ Assessment of prisoners regarding motivation for change ▪ Programs to develop social support, accommodation access and employment prospects post-release ▪ Blood-borne virus testing and vaccination ▪ Cognitive behavioural therapy programs ▪ Provision of hair cutting facilities ▪ Exploration of contracted tattooing services

The *Strategy* includes key performance indicators, but at the time of writing these were being further negotiated and amended by the Evaluation Advisory Group for application to this evaluation so will not be discussed in detail here. The final agreed key performance indicators are noted in the Discussion section (10.0) below.

Human Rights Audit on the Operation of ACT Correctional Facilities under Corrections Legislation

In addition to government policy and strategy documents, two reviews relevant to this evaluation were also included in this desktop review. The first of these is

the *Human Rights Audit on the Operation of ACT Correctional Facilities under Corrections Legislation*, undertaken by the ACT Human Rights Commission during 2006 and 2007. While this audit preceded the implementation of the AMC, it makes recommendations relevant to this evaluation that concern issues identified at the Belconnen Remand Centre and the Symonston Temporary Remand Centre and Periodic Detention Centre. Some of the recommendations were specifically directed towards the future implementation of the AMC, while others were intended to be addressed immediately.

The *Audit* discusses strip searches used for the purposes of locating contraband within correctional facilities and recommends that these be discontinued in order to preserve human dignity. Strip searches may be replaced with electronic scanning methods. Cell searches are also discussed, with the *Audit* emphasising that belongings of prisoners should be left in an orderly manner. In regards to other supply reduction activities that take place in correctional facilities, the *Audit* also refers to drug testing, particularly the provision of urine samples for testing. The *Audit* recommends that these should take place in a room with a camera rather than in the presence of correctional officers.

In relation to general welfare, the *Audit* describes the removal of the position of welfare officer from the staff at Belconnen Remand Centre as potentially leading to deficits in the management of the welfare of detainees. It is recommended that case management processes should be used to ensure that adequate social support is provided to detainees. The *Audit* also explores issues of systemic discrimination against female prisoners and concerns regarding the incidence of racism against both Indigenous and culturally and linguistically diverse (CALD) prisoners. It is recommended in the *Audit* that efforts be made to meet the gender-specific needs of women prisoners and that gender and cultural awareness training is made compulsory for all Corrective Services officers. In addition, translated information should be made available to CALD prisoners and the Indigenous Liaison Officer position should be more adequately resourced.

The *Audit* highlights the importance of providing health services to prisoners that are equivalent with those provided in the community but also equitable in terms of access and outcomes. This is consistent with other policies and strategies described in this review that also emphasise equivalence as a key underpinning principle. Resourcing of health services should be reflective of needs in the prisoner population. Other health-related recommendations highlighted in the *Audit* include the piloting of a needle and syringe program to prevent transmission of blood-borne viruses, the provision of condoms and other safe sex materials and improvement of access to allied health services. The *Audit* recommends that prisoners have full access to Medicare and the Pharmaceutical Benefits Scheme to ensure equivalent access to services and healthcare to that received by the general community.

ACT Health Adult Corrections Health Services Plan

The *ACT Health Adult Corrections Health Services Plan 2008-2012* provides a detailed description of the health services provided within the AMC by ACT Corrections Health Program, a division of ACT Health, and separate and distinct from ACT Corrective Services. Given the focus of this evaluation on drug policies

and services, only alcohol and other drug-related aspects of the plan will be reviewed.

The *Plan* describes the generally poor health of detainees, with particular mention of the high prevalence of HCV and substance use among those incarcerated. The *Plan* states that the ACT Corrections Health Program provided at the AMC will “embrace a best practice evidence based correctional health model that will provide services that are equal to those available in the general community” (ACT Health, 2008:8).

The *Plan* states that most prisoners within the AMC are expected to have alcohol and other drug issues of some kind. As such, the *Plan* recommends that a range of services will be offered to prisoners at the AMC, including those targeted to prevent uptake of harmful drug use and those targeted to reduce drug use among prisoners with alcohol and other drug issues. Effective clinical management of those with substance use issues is recommended to be provided.

The delivery of alcohol and other drug services by ACT Corrections Health Program will recognise that drug use still occurs in prison, that continuity of treatment from community-based services to prison-based services is required, that throughcare for post-sentence care needs to be consistently implemented and that harms associated with drug use are reduced where possible. Services provided to support these aims include counselling, detoxification and pharmacotherapy. The introduction of drug free cottages within the grounds of the AMC is also being explored in the *Plan* as a potential strategy.

The *Plan* asserts that ACT Corrections Health Program are responsible for administering general and mental health assessments on reception to the AMC, including assessments relating to drug and alcohol use. Following these assessments, ACT Corrections Health Program will provide alcohol and other drug services that include (but are not limited to) immunisation (HBV), pathology services (blood-borne virus testing), individual counselling (may be generalist, rather than expressly alcohol and other drug counselling), health promotion and pharmaceutical services (methadone). Other general health services, such as wound care for injecting related abscesses, may also address alcohol and other drug related issues. The *Plan* states that ACT Corrections Health Program will provide prisoners with information on the health services available within the AMC and health promotion information about communicable diseases, safe sex and drug use.

The *Plan* specifies that ACT Corrections Health Program will undertake public health and health promotion activities including disease surveillance, monitoring tobacco use and investigating outbreaks of infections via blood-borne virus testing, vaccination and treatment. In addition, condoms, dental dams, water-based lubricant and bleach will be made available to prisoners to stem the transmission of infectious diseases within the AMC. A trial needle and syringe program will be considered following the completion of this evaluation.

No specific key performance indicators or measures are included in the *Plan*.

Clinical Review of Corrections Health Drug and Alcohol Related Services

A clinical review of alcohol and other drug services provided by ACT Corrections Health Program was conducted by Dr Adam Winstock in October 2008, prior to

the opening of the AMC. A more recent review was conducted by Dr Alun Richards in August 2010, but the outcomes of this review were not available at the time of writing. The subsequent discussion therefore focuses on the Winstock review.

In his review, Dr Winstock expressed concern regarding the drug and alcohol assessment tools used to determine levels of intoxication, dependence and withdrawal (the latter is elaborated below) at entry to correctional facilities, in particular the lack of inclusion of some key observations (for example, pupil size, Glasgow Coma Scale and World Health Organization's Alcohol, Use Disorders Identification Test), and that some fields were completed inconsistently. Incomplete data has implications for effective monitoring of the sedation and drug withdrawal of individuals and the provision of appropriate therapeutic medications. In regards to intoxication and the potential for overdose, it was recommended that a policy be developed for the provision of naloxone in the case of opioid overdose.

The expertise of staff was discussed, with recommendations made that staff with alcohol and other drug experience be present on each shift. The review also highlighted that detailed written information on health and welfare services related to alcohol and other drugs should be provided to all prisoners upon reception and at discharge, possibly in the form of a 'health passport'.

Issues relating to alcohol, benzodiazepine and opioid withdrawal were noted in the review. The use of standardised withdrawal scales and observation of withdrawal were recommended in preference to responding to prisoner self-report. It was reported that the only benzodiazepine provided for withdrawal was diazepam, which was considered efficacious.

Buprenorphine and buprenorphine-naloxone preparations were not recommended for use in either withdrawal or maintenance, given concerns about the potential for diversion (however, it should be noted that this recommendation was specific to the Belconnen Remand Centre). The review also noted that standing orders for nicotine replacement therapy and paracetamol should be considered.

Dr Winstock recommended that induction on to opioid maintenance should be provided in response to prisoner requests, but only where individuals are also separately assessed as being in opioid withdrawal according to the use of clinical withdrawal scales. Dosing should occur the day after a request is made, rather than waiting up to a week while using a detoxification regime. The risk for overdose produced by reduced tolerance after detoxification was noted and monitoring of overdose events post-release was recommended to be enacted. The issue of the admission of patients on opioid maintenance into the therapeutic community was discussed, with a recommendation that a clear policy be developed.

Universal blood-borne virus testing and vaccination on entry to correctional facilities was recommended, indicating that this was not happening at the time of the Winstock review.

The review highlighted the importance of clinical pathways that coordinate services for individuals and plan for discharge, and recommended a key worker oversee health needs for each individual prisoner. As part of discharge planning and throughcare, it was suggested that community service providers with which

prisoners were engaged prior to entering prison should be invited to case conferencing throughout an individual's time in a correctional facility. This case conferencing should occur at key time points to review health progress. Access to methadone prescription and mental health services following release were highlighted as key issues, as was the availability of at least one primary healthcare facility that individuals could access with certainty following release.

It was determined that education about drug use including overdose, dependence treatment and mental health should be consistently provided to all prisoners by relevant community partners. Similarly, information about services provided in the community that may meet prisoner needs during incarceration and following release should be consistently and continuously provided. However, all community providers need to conform to a core set of principles set out by ACT Corrections Health Program around the delivery of such information and education.

With regards to mental health issues, concern was expressed about the potential diversion and over-prescription of atypical antipsychotic drugs and anti-depressants. The review recommended improved communication between ACT Corrections Health Program and Forensic Mental Health regarding these issues, that patients with a psychotic illness enjoy "access to the same range of medications as they would have in the community, and that access to non-pharmacological interventions (e.g., counselling) to be expanded to counter any impacts of a reduction in prescribing of particular medications.

Communication between prisoners and providers and between providers themselves was raised as a key issue. Integrated medical record systems and regular meetings between ACT Corrections Health Program and other providers (particularly Forensic Mental Health) were recommended. It was considered that these measures would improve the quality of services and may be enhanced by the introduction of a clinical governance committee.

Summary

Several common threads exist in the national and local policies and strategies. Harm minimisation clearly informs all of the policies and strategies. Although harm minimisation is generally described in terms of the three separate pillars of supply, demand and harm reduction, as outlined in the *National Drug Strategy 2004-2009*, little guidance is provided on how the three approaches are to be balanced or integrated. This has particular implications for the local application of harm minimisation strategies and for how the AMC balances strategies across these areas. In this regard, the provision of services and the performance of tasks by multiple service providers at the AMC further complicate the application of cohesive drug policy, and have implications for role clarity, governance, and the coordination of activities to fulfil specific objectives. The lack of a current Corrective Services drug-related strategy or policy, particularly where the existing outdated strategy was developed before the implementation of the AMC, is indicative of a need for greater guidance in relation to drug policy within the AMC.

Other significant themes across local and national policy and strategy documents relate to interventions being tailored to address the needs of individuals, in particular the use of case management approaches and the application of

throughcare principles. These principles recognise the holistic nature of effective drug-related services and the idiosyncratic nature of individual experiences and needs. The delivery of effective drug and alcohol services should therefore take account of the complex needs of an individual across multiple domains with clear implications for the aforementioned coordination of services.

The other key theme of the documents reviewed here relates to the equivalence of the types, range and quality of health and welfare services that prisoners are able to access in prison, compared to what would be available to them in the community. This point has a strong foundation in the principles of human rights, another key theme across the policies presented above.

The extent to which the policies and strategies identified in this review that support the provision of drug and alcohol services at the AMC have been implemented and their aims achieved will be assessed in the Findings (9.0) and Discussion (10.0) sections of this report.

7.0 Brief literature review

Introduction

Health and social disadvantage experienced by prisoners is commonly a continuance of pre-existing disadvantage experienced by the same individuals in the general community (Hobbs *et al.*, 2006; Kinner, 2006). Moreover, health problems, social and economic disadvantage, risk of death and risk of reincarceration are worsened by multiple incarcerations (Gendreau *et al.*, 1996; Willis, 2004; Graham, 2003; Kariminia *et al.*, 2007b; Hobbs *et al.*, 2006; Stoové *et al.*, 2008; Coffey *et al.*, 2004).

Given this context, provision of healthcare to prisoners equivalent with that provided in the community may not be sufficient to address the “backlog” of serious health problems commonly experienced by prisoners (Levy, 2005). Rather, planning services with regards to the principle of equity may be more salient, that is to provide services to prisoners that result in an equal outcome to members of the general community, rather than to provide equal services to prisoners and other community members (Levy, 2005).

Accessible and effective pre- and post-release programs and services have been shown to be effective in enabling individuals to overcome disadvantage, reduce morbidities and recidivism and to bring wider community benefits as a result (Cullen & Gendreau, 2000; Willis, 2004; Ward, 2001; Borzycki, 2005).

The prevalence of alcohol and tobacco use (Deloitte Consulting 2003; Kinner 2006b) and illicit and injecting drug use is high among incarcerated populations (Butler & Papanastasiou 2008; Galea 2002; Kanato 2008; Kinner 2006a; Miller, *et al.*, 2009). Given the co-morbidities associated with substance use and the overlap of substance use problems with socio-economic and health disadvantage, quality healthcare and effective pre- and post-release programs cannot be provided without consideration of issues related to substance use in prison populations.

Drug use and incarceration

Approximately half of all prisoners in Australia attribute their offending to drug use, with property and other acquisitive crimes (e.g., dealing and possession offences) adding to crimes related directly to drug use (Johnson, 2004; Makkai & Payne, 2003). Lifetime and current prevalence of illicit and injecting drug use is substantially higher among the prison population than the general population (Deloitte Consulting, 2003; Kinner, 2006; Butler & Papanastasiou, 2008; Kanato, 2008; Galea & Vlahov, 2002; Hellard *et al.*, 2004). Australian studies have shown up to 92% prevalence of lifetime illicit drug use among prisoners (Kinner, 2006) and 44-64% prevalence of injecting drug use (Kinner, 2006; Butler & Papanastasiou, 2008; Butler *et al.*, 2003). Lifetime heroin use is up to 10 times higher in the prison population and prisoners are 20 times more likely to inject drugs than the general population (Kanato, 2008; Galea & Vlahov, 2002). Butler *et al.* (2003) found 43% of a NSW sample of 789 prisoners reported using drugs

in prison, such that “the demand for illegal drugs in prison limits the prospect of eradicating them from prison”.

There is a common perception among prisoners that staying drug-free after release will be challenging (Ross *et al.*, 2003; Ogilvie, 2001). A recent study of Queensland prisoners found that 55% of participants returned to illicit drug use (29% injecting) by one month post-release. By just under one year post-release, 19% were re-incarcerated; significant predictors of re-incarceration included injecting drug use history and an expectation of illicit drug use post-release (Kinner, 2006). A recent study of ex-prisoners in Melbourne with a history of injecting drug use found that 85% of participants had returned to injecting drug use within the first month following release from prison, and were injecting a median of three times per week (Stoové *et al.*, 2010). In this study and others (e.g., Ross *et al.*, 2003) continued drug use was associated with reoffending. Dolan *et al.* (2010) found that 11-53% of prisoners reported injecting while in prison and the aforementioned study of ex-prisoners estimated that 29% of participants had injected drugs during their most recent incarceration (Stoové *et al.*, 2010).

High prevalence of drug use histories among prisoners is indicative of a need for comprehensive drug-specific services and programs during prison sentences and following release (Graham, 2003; Kariminia *et al.*, 2007c; Farrell & Marsden, 2007; Bird & Hutchinson 2003; Stewart *et al.*, 2004; Dolan *et al.*, 2005).

Drug use and other co-morbidities

The prevalence of both chronic illness and drug use in prison populations are closely related (Galea & Vlahov, 2002). Further, incarceration itself can contribute to ill health and death: multiple incarcerations are an independent risk factor for infection with HCV and increased mortality (Galea & Vlahov, 2002; Graham, 2003; Kariminia *et al.*, 2007b; Hobbs *et al.*, 2006; Dolan, 2000). Drug use and incarceration also contributes to increased health needs, including in the post-release period; however, discrimination experienced by drug users and ex-prisoners in mainstream health services may lead to unmet health needs and poor access to services (Galea & Vlahov, 2002; Narevic *et al.*, 2006; Anti-Discrimination Board of New South Wales, 2001; Stoové *et al.*, 2005).

Blood-borne viruses

Incidence

HCV is the predominant blood-borne virus affecting people who inject drugs (PWID) and prison populations in Australia (see Table 4). Given that prisoners cycle in and out of incarceration and prisons in Australia do not have systematic and effective blood-borne virus testing strategies, it is difficult to determine where or when viral transmissions have occurred and provide definitive HCV incidence rates in prison. A further complicating factor is that people exposed to HCV can clear the virus and potentially be subsequently re-infected. Although blood-borne virus transmission has been reported in Australian prisons, both via injecting and tattooing routes (Post *et al.*, 2001; Butler *et al.*, 2004; Ministerial Advisory Committee on AIDS Sexual Health and Hepatitis - Hepatitis C Sub-

Committee (MACASHH) 2006; Miller *et al.*, 2009), few researchers have attempted to estimate HCV incident infections in prison environments.

Dolan *et al.* (2010) recently reported HCV incidence of 34.2 per 100 person years among a population of 120 continuously imprisoned individuals in New South Wales. Crofts (2001) found an incidence rate of 38 per 100 person years among male prisoners with a history of injecting. Recent data emerging from the aforementioned study of prisoners in New South Wales indicate even higher rates of HCV re-infection among the cohort (40 per 100 person years) (Pham *et al.*, 2010), consistent with results from an Australian-based community cohort of people who inject drugs (PWID) that indicated higher re-infection rates compared with naïve infection (Aitken *et al.*, 2008). Despite more limited access in prisons to the illicit injection of drugs, these incidence rate estimates exceed HCV incidence rates reported among Australian community-based cohorts of PWID (e.g., Crofts *et al.* 1997; Selvey *et al.* 1997; Aitken *et al.* 2004; Maher *et al.*, 2006) and are likely to reflect the substantial risk environments for blood-borne virus transmission that prisons represent.

The accuracy and utility of in-prison HCV incidence rates are impacted by the frequency of testing, prisoners leaving and returning to prison some time later and the fact that clearance and re-infection can occur.

Prevalence

Prevalence results from Australian literature reviewed are summarised here:

Table 4 Reported blood-borne virus prevalence in Australian prisons

Study	HIV* (%)	HCV (%)	HBV (%)
Crofts <i>et al.</i> , 1995	0.28	39	2.5
Hellard <i>et al.</i> , 2004	N/A	57.5	N/A
MACASHH, 2006	N/A	40-60	N/A
Butler <i>et al.</i> , 2007	1	34	20
Butler and Papanastasiou, 2008	<1	35	N/A
Watkins <i>et al.</i> , 2009	0.6	24.8	4.5

* human immunodeficiency virus

The above prevalence figures represent results among total prison populations. When Butler and Papanastasiou (2008) examined only prisoners with a history of injecting drug use, they found an HCV prevalence of 60%.

The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis - Hepatitis C Subcommittee (2008) posited that “the period of incarceration should be viewed as a public health window of opportunity”. Given low rates of treatment for HCV in the community (1% of overall infections), and the high prevalence of HCV within prison settings, treatment should be offered to all eligible prisoners and arrangements made for appropriate post-release care to

ensure treatment continuity (Ministerial Advisory Committee on AIDS Sexual Health and Hepatitis (Hepatitis C Sub-Committee) 2008).

Sexually transmitted infections (STIs)

Much less literature exists on STIs among Australian prisoners, with most coming from overseas. The low prevalence of HIV among PWID in Australia and within Australian prison populations may partly explain the paucity of local literature. The Victorian Prisoner Health Study (Deloitte Consulting, 2003) found a lower prevalence of chlamydia among prisoners than that found in the general population and similarly low rates of gonorrhea and syphilis. A study of syphilis infection among NSW prisoners found low rates of untreated syphilis (2% of male and 1% of female inmates) similar to those in the general population (Butler *et al.*, 2001). Another study of NSW prisoners found rates of herpes simplex virus among inmates higher than community estimates, with higher rates among women (58%) than men (21%) and among Indigenous (34%) than non-Indigenous (24%) populations (Butler *et al.*, 2000). US Studies have found between 33% and 95% of incarcerated individuals are engaging in 'risky' sexual behaviours (i.e., unprotected sex with other PWIDs or sex workers) prior to and following incarceration (MacGowan *et al.*, 2003; Grinstead *et al.*, 2005; Teplin *et al.*, 2003).

Risk behaviours and transmission

Behaviours that carry risk of transmission of blood-borne viruses and STIs include sharing of injecting equipment, sharing of tattooing equipment and unprotected sex. While the transmission risks posed by some of these behaviours are much higher in the prison environment (e.g., tattooing), the rates of these behaviours in prison or in the community may be influenced by the relative access to sterile injecting equipment or condoms in different environments (Gaughwin 1992; Jurgens 2009). As reported above, recent Australian data show that, despite more limited access to injecting drugs, HCV incidence estimates in prisons are higher than those reported in the community (Dolan, 2010; Pham *et al.*, 2010). Sharing of injecting equipment has been reported to be lower in community settings compared with prison settings and prisoners report more frequent changes in injecting partners and higher numbers of injecting partners than PWIDs in the community (Darke *et al.*, 1998; Dolan, 2000).

Incarceration has also been identified as an independent risk factor for exposure to HCV (Dolan, 2000; Kendall, 2005; Levy, 2007), HIV (Tyndall *et al.*, 2006; Werb *et al.*, 2008), and HBV (Backmund *et al.*, 2006; Winter *et al.*, under review). The high rates of HCV incidence in prisons reported above, alongside high rates of post-release risk behaviours (Hellard *et al.*, 2004), highlight the potential role in-prison HCV transmission plays in sustaining the epidemic. Measures currently available in prisons to reduce transmission include opioid pharmacotherapy, condoms, bleach, and education and prevention programs, but access to these programs is not consistent across jurisdictions (Black *et al.*, 2004).

Mental health

Poor mental health is common among prison populations and is associated with other problems, including impaired physical health (Allnut *et al.*, 2007; Butler *et al.*, 2007). Twenty-eight per cent of prisoners participating in the *Victorian*

Prisoner Health Study reported a diagnosis of a mental illness at some time, the most common condition being depression. Around a quarter of study participants met diagnostic criteria for a mental illness at the time of the study. Just under half of the cohort reported ever experiencing suicidal thoughts and of those, 60% had ever attempted suicide (Deloitte Consulting, 2003). Ogloff *et al.* (2007) found that the prevalence of particular mental health conditions was three to five times higher in the prisoner population than the general community. A history of injecting drug use is also known to elevate risks of mental health disorders among prison populations (Ogloff *et al.*, 2004).

NSW research reported an 80% 12-month prevalence of 'any psychiatric disorder' (vs. 22% in the community) and a prevalence of psychosis 30 times higher than in the community (Butler *et al.*, 2006). A study of Queensland prisoners found that 28% reported high to very high levels of psychiatric distress prior to entering prison (Kinner, 2006). A study of recently released prisoners with a history of injecting drug use reported that more than one third of participants were being prescribed at least one medication for mental health problems (Stoové *et al.*, 2010).

These levels of mental health morbidity contribute to ongoing recidivism. Offenders with mental illness and those with mental illness and substance use issues have been shown to be at high risk for re-offending, violence, inpatient/in-prison violence, and social disturbances (Ogloff, 2002; Ogloff *et al.*, 2004; Ogloff *et al.*, 2007).

Prison health and support services

Imprisonment provides an opportunity for education, prevention, assessment and treatment of a range of health issues (Butler *et al.*, 2007; MacGowan *et al.*, 2003; Butler & Papanastasiou, 2008; Skipper *et al.*, 2003). Because correctional services are individually managed by states and territories in Australia, the services provided within prisons can vary across jurisdictions. This can produce differential health outcomes for prisoners, despite national policies which frame requirements for health service provision in prisons (Khaw, 2007; Levy, 2007; Watkins *et al.*, 2009).

The provision of blood-borne virus and sexually transmitted infection testing and vaccination, drug treatment (particularly pharmacotherapies), mental health assessment and welfare services in prison have been described as essential (Anti Discrimination Board of New South Wales, 2001; Deloitte Consulting, 2003; Skipper, 2003; Hellard *et al.*, 2004; Butler & Papanastasiou, 2008). However, availability of some of these services may be outstripped by demand. Where services are unavailable or inaccessible, coordination between in-prison and community-based services to ensure support for prisoners post-release may be compromised (Ashford & Cox, 2000).

Dialogue in Australia regarding the need for a consistent national approach to prisoner healthcare has resulted in the initiation of the National Minimum Dataset for Prisoner Health (Australian Institute of Health and Welfare, 2010). It has been argued that this unified national approach should be extended to consistent reporting of prison separations to allow for appropriate planning for transition of individuals back into the community (Martire & Larney, 2010).

Throughcare

Effective throughcare ensures that services in prisons are consistent with types of services in the community, both in standard and availability. This principle (known as equivalence) is outlined in United Nations and World Health Organization covenants and treaties that relate to the human rights of prisoners (Lines, 2008). Throughcare also describes how custodial and community service systems must work together to ensure that continuity of care is preserved for prisoners during their time in prison and post-release (Borzycki, 2005; Burrows *et al.*, 2000). An important part of effective throughcare involves prisoners being provided with appropriate referral pathways to ensure they receive a continuation of support after they are released.

Communication between clients and community-based workers should be facilitated to continue or be initiated during sentences and after release (Borzycki, 2005; Burrows *et al.*, 2000; VAADA, 2003; Ward, 2001). Throughcare is also the principle by which treatments or services (e.g., pharmacotherapy, HCV treatment) commenced in prison can be continued throughout the prison sentence as prisoners move between facilities and following release (Burrows *et al.* 2000; Anti Discrimination Board of New South Wales, 2001; Borzycki & Baldry, 2003; Borzycki, 2005). Throughcare should be a key approach in the planning and implementation of in-prison and post-release services.

Confidentiality

Confidentiality concerns may compromise care and support of both prisoners and ex-prisoners. Prisoners may have concerns about accessing prison-based health services due to fear of retribution or victimisation by prison officers (e.g., targeted drug testing, additional cell searching, isolation in cells designed to prevent self harm) (Burrows *et al.*, 2000; Flat Out, 2007). Community-based workers may also be reluctant to contribute to prison-based health and welfare assessments as they may be disclosing sensitive information about prisoners to prison authorities (Burrows *et al.*, 2000). Similar issues can occur post-release, where prisoners may be reluctant to disclose problems to community corrections workers (and others), despite needing assistance, as they may be in breach of non-custodial orders (Burrows *et al.* 2000).

Pre-release planning

The process of providing post-release support should ideally commence while a person is still in prison. As discussed earlier, pre-release planning forms part of a throughcare approach. Pre-release programs offered within prisons need to be highly visible and easy to access prior to release if they are to be effective (Ward, 2001; Rich *et al.*, 2001); however, it has been recommended that skill development programs should be offered close to the time of release so that skills learned can be positively reinforced by being applied in the community as soon as possible (Borzycki, 2005).

Prisoners on short sentences can experience difficulty in accessing programs pre-release due to a lack of time and eligibility (Hinton, 2004); this may be exacerbated when people spend extended periods on remand. Similarly, uncertainty around release dates contributes to poor pre-release planning in many instances (Rich *et al.*, 2001; Ogilvie, 2001; Willis, 2004; VHS Focus Group, 2001).

Drug-related services and policies in prisons

Supply reduction

Black *et al.* (2004) note that supply reduction activities in prison generally include searching (e.g., with drug detection dogs) and drug testing by urinalysis. Despite the cost of these programs, they are generally not well documented and little evaluation of activities takes place (Black *et al.*, 2004). Jurgens, Ball and Vertster (2009) argue that prison drug testing has been found to reduce cannabis use but has little effect on opioid use, which is less likely to be detected in testing due to the short half life of opioid drugs.

Demand reduction

Opioid substitution therapies play an important role during incarceration and post-release as a potential strategy to reduce mortality risk and drug use. Capelhorn *et al.* (1996) found that PWID not in opioid pharmacotherapy in the community were three times more likely to die than those in treatment. Higher doses of methadone were associated with greater retention in the program and being in the program was associated with reduced risk of death from heroin overdose (Capelhorn *et al.*, 1996a; Capelhorn *et al.*, 1996b). Not being in methadone maintenance treatment (MMT) was found by Dolan *et al.* (2005) to be associated with a greater risk of death (untreated mortality rate of 2.1 per 100 person-years), both in prison and post-release. Ideally, induction onto the program and dose stabilisation should occur prior to release, as this is a particularly risky time for fatal accidental drug toxicity (Capelhorn & Drummer, 1999).

Jurgens *et al.* (2009) found that prison based opioid substitution therapies resulted in decreased frequency of injection among service users, however a dose above 60mg was generally associated with this reduction. Similarly, Warren *et al.* (2006) reported that prison-delivered opioid pharmacotherapy significantly reduced heroin use, resulting in a six-fold increase in the number of heroin free days per month. A recent study of post-release prisoners with a history of injecting drug use in Melbourne found that participation in prison-based opioid pharmacotherapy was protective of self-reported in-prison injecting drug use and that being released into a facilitated community-based opioid pharmacotherapy program was protective of daily injecting post-release (Stoové *et al.*, 2010). Longer term (i.e., more than six months) and higher dose opioid pharmacotherapy has also been associated with reduced HCV infection and reduced mortality (Jurgens *et al.*, 2009).

Warren *et al.* (2006) wrote that cessation of opioid pharmacotherapy at entry to prison negatively impacts the potential benefits of opioid pharmacotherapy overall, as benefits accrue the longer and more consistently someone is in treatment, both in prison and in the community. These benefits include reduced recidivism and reincarceration, reduction in injecting and sharing of injecting equipment, reduction in blood-borne virus transmission, reduction in mortality and greater uptake of treatment in the community (Warren *et al.*, 2006).

Therapeutic communities, operating from within prisons and as a transitional facility at the end of a prison sentence, have been suggested as a useful model

for preventing or reducing post-release drug use and subsequent re-offending (Hiller *et al.*, 1999). Although the focus of these therapeutic communities is on reducing drug use, the additional programs they provide for gaining employment and accommodation following release also offer mechanisms to prevent relapse and re-arrest (Hiller *et al.*, 1999). Others emphasise that a harm reduction philosophy may be an appropriate approach for drug treatment for post-release prisoners, given the likelihood of relapse (Borzycki, 2005).

Black *et al.* (2004) found that, despite counselling programs being widely implemented in Australian prisons, little has been done to evaluate them. Programs tend to be based on cognitive behavioural therapy ⁵(CBT) and motivational interviewing techniques and conducted in group rather than individual formats (Black *et al.*, 2004). A combination of both group and individual approaches is indicated as being the most effective method of addressing drug related issues (Forensic Psychology Research Group, 2003)

Harm reduction

Measures currently available in Australian prisons to prevent disease transmission include opioid pharmacotherapy, condoms, bleach and education and prevention programs, but access to these programs is not consistent across jurisdictions (Black *et al.*, 2004).

No Australian jurisdiction currently provides a needle and syringe program (NSP) in prison, despite the World Health Organization (WHO), in its *Guidelines on HIV Infection and AIDS in Prisons* (1993), stating that “preventive measures for HIV/AIDS in prison should be complementary to and compatible with those in the community. Preventive measures should also be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users”.

Transferability of the concept and aims of NSP from the community to an institutional setting has been clearly demonstrated in 11 countries. Lines *et al.* (2006) provide examples of prison NSPs from countries as diverse as Switzerland, Germany, Spain, Moldova, Kyrgyzstan and Belarus as evidence of the success of the programs in reducing blood-borne virus transmission and providing other benefits to health and wellbeing. Given the overwhelming international evidence, the Australian National Council on Drugs (2002) recommended that Australian prisons should introduce a trial NSP to address blood-borne virus transmission and related health issues. In addition the most recent *National HIV and Hepatitis C Strategies (2010-2013)*, which has been signed off on by Commonwealth and all jurisdictional governments, contains recommendations to trial NSPs in custodial settings.

Jurgens *et al.* (2009) found that prison-based NSPs have contributed to reductions and in some cases cessations in sharing of injecting equipment. No new cases of HIV or HBV have been reported in any prison where an NSP has been implemented (Jurgens *et al.*, 2009). Prison NSPs are also associated with a reduction in overdose numbers and severity, greater engagement with drug treatment, reduction in abscesses, improved relationships between prisoners and

⁵ Cognitive behavioural therapy is a form of counselling therapy that aims to solve problems concerning dysfunctional emotions, behaviours and cognitions through a goal-oriented, systematic procedure.

staff, increased awareness of blood-borne virus transmission risks and increased staff safety (Jurgens *et al.*, 2009). No incidents of needles being used as weapons have been reported, and prison NSPs have not resulted in an “increased number of prisoners injecting drugs, an increase in overall drug use, or an increase in the amount of drugs in prisons” (Jurgens *et al.*, 2009). However, prison NSPs must be easily accessible, without fear of negative consequences, in order to be effective. Bleach programs, on the other hand, have been found to be somewhat ineffective, as prisoners lack the time to effectively clean used syringes (Jurgens *et al.*, 2009).

Several studies highlight the importance of harm reduction programs (e.g., overdose prevention education, distribution of naloxone) prior to release, with new programs needing to be initiated (particularly naloxone distribution, which doesn’t currently occur in Australia) and existing programs expanded and targeted towards specific sub-populations (e.g., individuals who have been incarcerated previously or those with overdose histories) and thoroughly evaluated (Graham, 2003; Kariminia *et al.*, 2007c; Farrell & Marsden, 2007; Bird & Hutchinson 2003). Offering these programs in conjunction with accessible pharmacotherapy and drug rehabilitation programs in prison, with well coordinated transfer to community-based treatment (particularly in relation to appropriate dosing pre- and post-release and adequate monitoring), may also diminish overdose risk post-release (Kariminia *et al.*, 2007c; Farrell & Marsden, 2007; Stewart *et al.*, 2004; Dolan *et al.*, 2005).

Post-release mortality

Ex-prisoners face elevated risk of death following release from prison. This has been demonstrated in some key Australian studies as well as studies from the US and UK. In addition, research findings suggest a cumulative effect of incarceration on mortality risk. Five Australian studies have reported cumulative incarcerations as being associated with a greater risk of death among post-release prisoners (Graham, 2003; Kariminia *et al.*, 2007b; Hobbs *et al.*, 2006; Stoové *et al.*, 2008; Coffey *et al.*, 2004).

Mortality comparisons have also been conducted in relation to non-custodial settings. Individuals serving community-based correctional orders in all Australian jurisdictions have been found to have a higher risk of death than the general population (Fleming *et al.*, 1992; Biles *et al.*, 1999). While rates of mortality were higher for people on community-based correctional orders compared with those serving custodial sentences, being on parole from a custodial sentence (15.1 deaths per 1000 per year) was found to be associated with a greater risk of death than serving an entirely non-custodial sentence (5.6 deaths per 1000 per year) (Fleming *et al.*, 1992). Petschel (2000) reported 21 deaths occurring among those serving non-custodial sentences in Victoria between 1991 and 1996. In these studies, the most common causes of mortality were related to alcohol and other drug use and mortality rates were higher among younger age groups on parole (Fleming *et al.*, 1992; Biles *et al.*, 1999; Petschel, 2000).

Causes of death have been speculated upon, for example lowered drug tolerance leading to overdose following release. However, the lower socio-economic status

of the prisoner/ex-prisoner population, alongside adverse social conditions post-release, such as lack of accommodation, difficulties in rebuilding family and social relationships and involvement in criminal activities have all been cited as potential contributors to the elevated risk of death. The attribution of post-release mortality beyond the typical drug-related causes is supported by a recent analysis of Australian prisoner discharge data (Kinner *et al.*, under review). These data were combined with data from post-release mortality studies in Western Australia (Stewart, 2004) and New South Wales (Kariminia, 2007a) to indirectly estimate post-release mortality. This analysis estimated between 449 and 472 deaths among ex-prisoners nationally in 2007/08, with between 68 and 138 deaths estimated to have occurred in the first four weeks of release. Although the most common causes of death were identified as drug-related, most deaths in the first year and first four weeks post-release were not drug-related.

All-cause mortality following release

In a Victorian study linking data on prison releases and deaths among ex-prisoners between 1990 and 1999, ex-prisoners were found to be at 10 times greater risk of unnatural death than the general population in the period following release (up to nine years). This risk was not evenly distributed among men and women; women were 27 times more likely to die and men seven times more likely to die (Graham, 2003). Stewart *et al.* (2004) described ex-prisoners in Western Australia released between 1994-1999 as experiencing between 5.9 and 69.1 times greater risk of all-cause mortality (dependent upon gender and Aboriginality) in the six months following release when compared to the general population. Aboriginality and gender also affected mortality outcomes in a later Western Australian study covering the period between 1995 and 2003, with highest relative mortality risk for female non-Indigenous ex-prisoners (11 times the risk) and Indigenous females (9 times the risk) in the period following release (up to eight years) (Hobbs *et al.*, 2006). A New South Wales study examining mortality up to 14 years post-release found that released men and women were respectively 3.7 and 7.8 times more likely to die than the general population (Kariminia *et al.*, 2007a).

International research findings of post-release mortality largely reflect findings from Australian research. A recently published meta-analysis of research findings on mortality in the immediate post-prison release period found that mortality risk was significantly higher in weeks one and two post-release compared to weeks three to 12 (the risk was determined to be four times higher in this period for Australian studies and between three and eight times greater internationally) (Merrall *et al.*, 2010). Farrell and Marsden (2007) reported that, in England and Wales, male prisoners were 29 times more likely and women 69 times more likely than their counterparts in the general population to die from any cause in the week following release. In Scotland, the risk of death among 15-35 year old male prisoners following release was found to be five times that experienced in the general population (Bird & Hutchinson, 2003). In the US, ex-prisoners in Washington State experienced 3.5 times the risk of mortality in the first four years post-release compared with the general population, with the first two weeks being the riskiest time at 12.7 times the risk of death (Binswanger *et al.*, 2007).

Drug related deaths

Regardless of incarceration history, PWID are at substantially greater risk of mortality (estimated at between six and 20 times) compared with their non-injecting peers (Darke & Zador, 1996; Hickman, 2003). Opioid use constitutes the largest contributor to illicit drug deaths, driven substantially by the injection of heroin (Preti *et al.*, 2002; Darke *et al.*, 2006). Mortality among PWID is dependent upon a complex interaction of associated precursors and sequelae, including psychosocial and environmental factors such as homelessness (Engstrom, 1991; Gossop, 2002), medical complications (Sanchez-Carbonell, 2000; Vlahov, 2004); and opioid pharmacotherapies (primarily during initial treatment periods) (Capelhorn, 1998; Capelhorn, 1999). As mentioned earlier, incarceration history and being released from prison also interact with the aforementioned correlates of mortality among PWID.

There are few Australian data on drug-related mortality risk in the immediate post-release period. Risk of death in the weeks following release is particularly high and decreases over time, especially for drug related causes (Graham, 2003; Stewart, 2004; Kariminia, 2007a; Kinner *et al.*, in review). Kariminia (2007c) and Stewart *et al.* (2004) reported that 13% and 24% respectively of deaths within one year of release occurred within the first 28 days. International research has consistently demonstrated substantially higher risk of drug-related death in the first two weeks following release (Seaman, 1998; Bird & Hutchinson, 2003; Binswanger *et al.*, 2007).

A substantial proportion of deaths among post-release prisoners in Australia are related to drug use, primarily heroin – estimated at between 30% and 60% (Graham, 2003; Kariminia, 2007a). Findings from a study of Western Australian ex-prisoners showed an 11 times elevated risk of drug-related mortality compared with the general population (Hobbs, 2006). Davies and Cook (2000) noted that mixed drug toxicity is evident in the deaths of most women ex-prisoners, most commonly heroin and benzodiazepines.

In studies conducted overseas, between 25% and 86% of post-release deaths were identified as drug related (Seaman, 1998; Farrell & Marsden, 2005; Binswanger *et al.*, 2007). Drugs commonly implicated in deaths included opioids, cocaine and methamphetamine (Farrell & Marsden 2005; Binswanger *et al.*, 2007). In one study, all causes of excess mortality in women in the first month following release were found to be drug-related (Farrell & Marsden, 2005).

Capelhorn *et al.* (1996) found that PWID not in MMT were three times more likely to die than those in MMT. Higher doses of methadone were associated with greater retention in the program and being in the program was associated with reduced risk of death from heroin overdose (Capelhorn *et al.*, 1996). Similarly, Dolan *et al.* (2005) reported that not being in MMT was associated with a greater risk of death both in prison and post-release.

The results highlight the important role of pharmacotherapies during incarceration and post-release in reducing mortality risk. Patterns of mortality risk among MMT clients, however, suggests that induction into MMT and dose stabilisation should occur prior to release, as the first few weeks following commencement of MMT is a particularly risky time for fatal accidental drug toxicity (Capelhorn, 1999).

8.0 AMC Background Data

The evaluation team was provided with data that assisted in describing the characteristics of the prison population at the AMC. These data provided a context for the evaluation by helping to identify the potential needs of prisoners and the extent of particular issues and behaviours. This short description of the AMC prisoner population informs the discussion of findings later in the report.

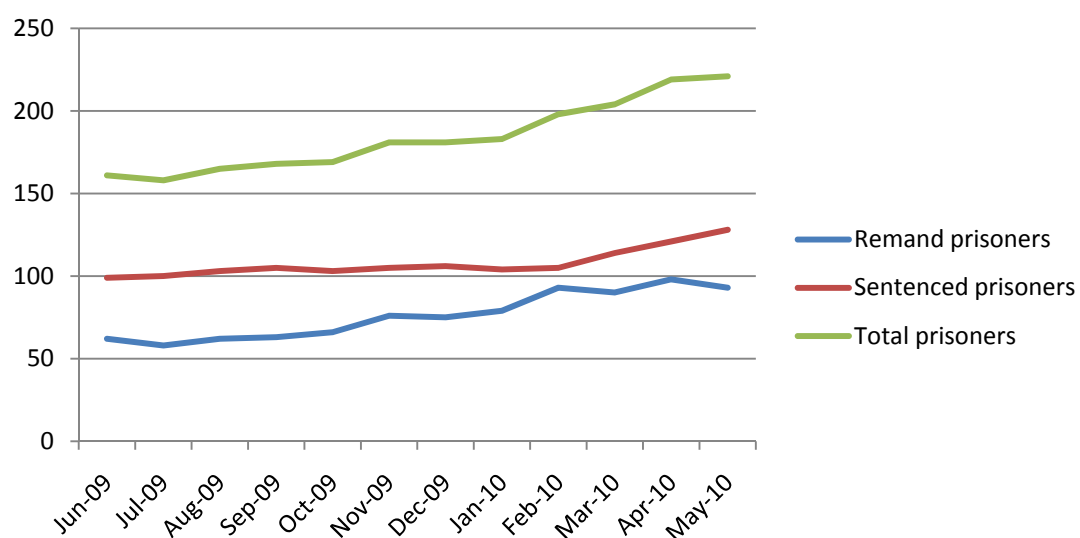
8.1 Prison population

The total population of the AMC (daily average for each month) increased steadily between June 2009 and May 2010, with an average monthly prison population of 184 (76 remand and 108 sentenced) over this time (Table 5; Figure 1). The proportion of remandees incarcerated at the AMC increased from 39% in June 2009 to 47% in February 2010, thereafter declining to 42% (Table 5). At any point in time, about 25% of the AMC prison population is aged less than 25 years (sourced from Corrective Services data).

Table 5 Monthly average number of prisoners incarcerated at the AMC by remand and sentenced, June 2009-May 2010

	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	12-month Average
Remand	62	58	62	63	66	76	75	79	93	90	98	93	76.25
Sentenced	99	100	103	105	103	105	106	104	105	114	121	128	107.75
Total prisoners	161	158	165	168	169	181	181	183	198	204	219	221	184
% on remand	39	37	38	38	39	42	41	43	47	44	45	42	41

Figure 1 Monthly average number of prisoners incarcerated at the AMC by remand and sentenced, June 2009-May 2010



Between June 2009 and May 2010, the average monthly Indigenous population at the AMC ranged between 23 and 37, representing an average of 15% of the overall monthly population. The average monthly female population of the AMC ranged between 12 and 20 over this time, representing 7-10% of the average monthly prison population and 6-13% of the average monthly remand population.

Between June 2009 and May 2010, an average of 50 receptions (minimum 39, maximum 62) and 46 discharges (minimum 28, maximum 58) occurred per month at the AMC.

8.2 Characteristics of the prison population

The Inmate Health Survey (conducted in May 2010 with AMC prisoners N=135) generated more detail about the demographics of the AMC population. Most of the survey respondents were male (92%), born in Australia (84%) and reported English as the language spoken at home when growing up (84%). The average age of respondents was 33 years, and 17% identified as Aboriginal or Torres Strait Islander. More than half (53%) of respondents reported currently serving sentences of less than six months at the AMC (unpublished data, analysis by the Burnet).

Respondents were generally educationally disadvantaged, with 38% having completed Year 9 or less and 11% achieving their Higher School Certificate (year 12 equivalent). Participants had on average left education at the age of 16 years and 69% reported having ever been involuntarily excluded from school.

Prior to entering prison, 24% of respondents were living in public housing, 61% with their family in private rental or in a privately owned home, and 9% lived in other types of accommodation like shelters, temporary accommodation, boarding houses and hotels. Six percent reported being homeless upon entering the AMC.

Nearly half of respondents (47%) reported some kind of employment in the six months prior to entering the AMC, six percent had never been employed and 39% had been employed for a total of less than two years in their lifetime. About two-thirds of respondents (65%) completed any educational programs during their current sentence.

Average age of first incarceration among respondents was 24 years and 42% reported spending time in a juvenile detention centre (average age of first admission to juvenile detention was 14 years). Remand and sentenced prisoners each accounted for 47% of respondents.

With regards to family and other relationships, 62% of respondents identified as single, divorced or separated and 38% as being married, in a de facto relationship or having a regular partner. Forty-two percent of respondents had not received any visits in the fortnight prior to completing the survey and 15% had not made any phone calls in that time. Nearly half of all respondents (47%) reported having children and 18% of women (2 of 11 female respondents) were currently pregnant. More than two-thirds of respondents (38%) had been placed in state care before the age of 16 years. About one in five respondents (20%) reported that one or both of their parents had been sent to prison when they were a child.

These survey responses indicate significant levels of disadvantage among the prison population at the AMC, including low levels of education, limited employment histories, unstable housing and high levels of childhood disadvantage. Many had incarceration histories, with juvenile detention common. Shorter sentences were also common, with more than half of the prisoners surveyed likely to be in prison for less than six months. Many of the survey respondents had limited family and social support, with most not currently being in an intimate relationship. This was also reflected in data on visits, with more than two thirds of the sample having not received any visits in the past fortnight.

Consistent with other Australian jurisdictions, women were under-represented in the AMC prison population and Indigenous prisoners were over-represented. In 2009/2010, Indigenous prisoners represented about 15% of the AMC population, compared to 1.5% of the population of the ACT (ABS, 2009). Both women and Indigenous people represent significant sub-populations within the broader prison population with specific needs, particularly in relation to health and wellbeing.

8.3 Drug use

According to responses to the Inmate Health Survey, a history of illicit drug use is common among prisoners at the AMC. A large majority of respondents (91%; n=122) reported lifetime use of illicit drugs, most commonly cannabis (99%), amphetamines (82%) and heroin (65%). More than half of the lifetime users of heroin (65%), cannabis (61%) and amphetamines (55%) had used these drugs in the 12 months prior to their most recent incarceration. Nearly three quarters of respondents (74%) reported that the crimes related to their current prison sentence were related to drugs and 79% reported that they were affected by drugs and/or alcohol when they committed the relevant offence.

Of the 122 individuals who had ever used illicit drugs, 81 (66% of illicit drug users and 60% of all respondents) had ever injected drugs. Median age of first injection was 17 years, with a minimum age of initiation of 12 years. Thirty-two percent of respondents (24 of 72)⁶ reported ever injecting drugs at the AMC and 27% (21 of 79) reported that the last time they injected drugs was in a prison.

Nearly half of all respondents (44%) reported that they drank more than 10 standard alcoholic drinks in a typical day on which alcohol was consumed, with 33% reporting consuming six or more standard drinks on one occasion daily or almost daily prior to their incarceration. An overwhelming majority of respondents (85%) reported currently smoking cigarettes and 80% reported that they would like to quit smoking.

Forty-two percent of respondents (51 of 122) reported needing help with quitting drugs, with 52% (49 of 94) ever having been told by a doctor that they were drug dependent and 26% (24 of 94) having been told they were alcohol dependent.

⁶ These notations indicate that the percentages reported refer to a sub-group of the total respondents. This is due to the applicability of questions to some participants (eg those reporting a history of drug use) and to participants opting out of answering particular questions.

These results overwhelmingly indicate that drug use is a problem among the prisoner population at the AMC. Appropriate demand and harm reduction programs have the potential to increase the wellbeing of prisoners at the AMC and reduce the mortality and morbidity associated with drugs post-release.

9.0 Findings

Findings of this project were grouped according to themes established during the development of the project methodology and those that emerged as qualitative data were collected. Both quantitative and qualitative data are discussed under individual theme headings. The consistency or otherwise of qualitative and quantitative data is highlighted within thematic headings where appropriate. Further triangulation and discussion of findings are provided in the Discussion section (10.0).

Themes have been ordered according to broad groupings as follows, which relate to both approaches and providers of services:

- Policy and governance
- Non-medical therapeutic interventions
 - Case management
 - Counselling
 - Programs – educational
 - Programs – recreational
 - Programs – therapeutic
 - Therapeutic community and external residential rehabilitation
- Medical therapeutic interventions
 - Primary healthcare
 - Mental health
 - Detoxification
 - Opioid pharmacotherapy
- Interdiction and supply reduction
 - Searches and seizures
 - Urinalysis
- Drug use and harm reduction
 - Drug use in prison
 - Blood-borne viruses
 - Overdose
 - Bleach provision
 - NSP

9.1 Policy and governance issues

A common concern among interviewees was that drug and alcohol-related policies at the AMC are developed without sufficient consultation with frontline staff. This includes both higher level policies and strategies (for example ACT Drug, Alcohol and Tobacco Strategy) as well as those focused on operational issues (for example Corrective Services policies and procedures for the AMC). Decision making regarding direction and content of these policies and strategies was perceived as occurring at executive levels of the relevant government departments (Department of Justice and Community Safety and ACT Health). This lack of consultation and transparency in policy-making was seen to impact on the effectiveness of policies that then required further refinement and adaptation to adequately guide practice.

'There are two things you can do with policy. You can introduce policy or you can inflict the policy on someone. They tend to inflict rather than introduce.' (key informant)

'I think all of our policies need to be adapted to the environment.' (key informant)

'There is the usual feeling amongst the troops in there that the policies and procedures are developed by academics in town who haven't actually walked into the jail.' (key informant)

Although prison staff interviewees considered that they had ample opportunity to feed into quality improvement and policy redevelopment where policies did need to be adapted, this was not the sentiment expressed by community-based service providers. These service providers felt that they had little opportunity to contribute to policy-making processes.

'The main thing I think that gets to me about a lot of the policies is they don't marry up with the outcomes.' (key informant)

'And the thing is they really want to be involved and they really want, they've got so much to offer to policy development it's just about facilitating it.' (key informant)

'They were very tied to those policies and they didn't want anyone to see [them].' (key informant)

'The only time when we had consultation was kind of under the table, just hiding.' (key informant)

One particular area in which community-based service providers felt they received limited opportunity to influence policy was in relation to gender issues caused by the co-location of male and females in the prison. This was seen as resulting in a particularly combative advocacy environment that was perceived as counter-productive. A recent case of a pregnant prisoner highlighted many policy inadequacies where female prisoners were concerned.

'All the resources go mostly to men so the invisible women, they become invisible over there.' (key informant)

'So we advocate for the women also, if there is issues with the women like... they don't have... access to medication or to clothes.' (key informant)

'Like when they did the women and children's program you know it took advocacy, it took playing political football and using media to advocate... to get that policy down. That policy was finalised on Christmas day then we had to advocate for the application form. This woman is sitting in prison now ready to give birth in about six weeks [and arrangements are yet to be finalised].' (key informant)

The human rights framework under which the prison was commissioned was considered by key informants to have both positive and negative consequences. While it was agreed that prison authorities should be held accountable for human rights issues and that this would lead to better practice, there was some unease that the framework had engendered a culture in which prisoners had become overly focused on rights, to the detriment of what might be considered their perceived personal responsibilities. This was seen by Corrective Services staff and community service providers as impacting on the rehabilitation prospects of prisoners in terms of abrogating responsibility for their offences.

'They actually forget somewhere in there that they've offended against the community which is a real concern.' (key informant)

'It's too much that way to the extent that it's all about prisoners rights and not about any of their responsibilities and it's all about, and for staff, staff don't have any rights. They simply have responsibilities.' (key informant)

Disciplinary boundaries were seen as impacting on the development of policy. Given the context of the AMC as a prison where multiple service providers are responsible for various roles, policies were believed to be impacting on the practice of a wide range of individuals but not necessarily recognising the subtleties of the different roles played by those individuals and organisations. For example, some interviewees reported that the ways that supply, demand and harm reduction activities are operationalised could conflict, despite aiming to service the same overarching harm minimisation objectives. This conflict was seen as disadvantaging prisoners through poor coordination of harm minimisation interventions. In particular, conflict between Corrections Health and Corrective Services staff on drug policy was discussed.

'If it's solely in relation to drugs or drug use there's... a lot of fingers in the pie. Is it a health issue? Is it a corrections issue? And we work quite independently in some ways of each other.' (key informant)

'So if you look at something like the policy on corrections, you know I'm on that email list and that email goes to something like 70 people. Well, that's huge and some of its policy stuff, some of its general interest stuff and some of it's about service provision within the prison. It kind of highlights how many fingers are in the pie and how people aren't clear about what their roles are and who is doing what and how advocacies might be different for looking at the specific service provision needs of prisoners.' (key informant)

The evaluation team believes that the disciplinary conflicts described above are a major impediment to the provision of drug policy and services that meet harm minimisation objectives. The current governance structure and the lack of coordinated leadership in relation to drug policy and services at the AMC appears to be a major barrier to coordinated and complementary harm minimisation

practice. These points are discussed in more detail in the Discussion section (10.0) of the report.

Summary

- Lack of consultation with frontline staff during policy development
- Inadequate implementation of policies that address gender issues
- Human rights approach has emphasised rights more than responsibilities
- Accountability contributes to good practice
- Disciplinary conflicts have been occurring
- Policy not adequately guiding how to balance harm minimisation interventions
- Lack of leadership and coordination of drug-related activities

9.2 Case management

Case management was a subject that came up often in qualitative interviews. In the context of this report, case management is defined as the provision and coordination of support that ensures the needs of individual prisoners are identified and plans put in place to meet those needs. The principal aims of case management are to improve the health and wellbeing of prisoners and reduce recidivism. Rather than support from one type of service within a particular service domain, coordinated case management is routinely provided from multiple sources and be both generalist (e.g., AMC Case Managers) and specialist in nature (e.g., drug related services).

Both prisoners and service providers viewed effective case management as essential to addressing drug-related issues. The importance of holistic and integrated approaches that respond to the range of needs of prisoners (including psycho-social and drug dependence needs) rather than a siloed approach to their various 'issues' was highlighted often. Some quantitative data on case management services provided by external NGOs were provided to the evaluation team (see Table 6 below), but no equivalent data was received from Corrective Services. The quantitative data were not originally requested by the evaluation team, as they were not considered drug-specific, however, throughout the evaluation, it became clear that case management is vital to addressing drug-related issues among prisoners at the AMC.

Multiple case management roles

Several organisations provide case management services (broadly defined) for prisoners at the AMC. The primary provider of case management is ACT Corrective Services, with the AMC Case Managers working with all prisoners at the AMC, not just those with drug and alcohol dependence concerns. These AMC case management roles are centrally coordinated under the Offender Services Unit with a team leader and a manager overseeing the delivery of case management services. The role of the AMC Case Managers includes offender classification, case management, programs, chaplaincy, and coordinating education and library services. Corrective Services workers that also contribute to case management, although to a more limited extent, include AOD Team workers who provide some assistance with organising access to rehabilitation facilities and custodial officers who monitor prisoners and document significant events and behaviours (or changes in behaviour) over time. To the evaluation team, these various Corrective Services case management roles did not appear to be centrally coordinated.

The structure of Corrective Services case management arrangements has changed over time. Case managers were formerly sourced from ACT Community Corrections and underwent six month placements at the AMC. This practice has since ceased and case managers are now permanently employed at the AMC. In the early operating stages of the AMC, case managers were allocated prisoners for whom they were responsible throughout their sentences. The system was modified recently, to give prisoners separate case managers for reception, during incarceration and at discharge. The current system was reportedly implemented to improve the quality of case management processes and practices so that sentence planning and pre-release preparations would be more consistent.

Several community-based NGOs (for example Directions ACT, Toora WIREDD, Inanna, ACT Women and Prisons, Prisoners Aid, Gudan Gulwan, Canberra Recovery Services) also provide case management assistance to prisoners, with workers visiting the AMC regularly to provide information, assessment, case work and general support services. Some of these services are focused on making arrangements for prisoners post-release, for example supporting prisoners to obtain accommodation. These services are not mandated and it is generally up to prisoners to initiate access to these services. Corrective Services informed the evaluation team that this approach was intended to empower prisoners to take responsibility for their rehabilitation by self-referring to services on the free phone list. Case managers assist with service coordination in addition to self-referral and often instigate the process. Although most of these organisations are not specifically funded to provide services to prisoners at the AMC, they do appear to currently provide substantial case management assistance to prisoners at the AMC (see Table 6).

Table 6 describes the case management-related sessions provided by NGOs at the AMC between 1st July 2009 and the 30 June 2010 and the number of AMC prisoners to whom they were delivered. While community service providers were aware of the roles that each played in the provision of services, they were generally not aware of other services that individual prisoners accessed or what kind of assistance they received from Corrective Services workers. Because of this unsystematic approach to case management services provided by NGOs, individual prisoners may have accessed multiple case management episodes from multiple providers over this time. As such, it is not possible to determine the proportion of prisoners at the AMC that have accessed case management sessions during their time at the AMC. To provide some context to the numbers shown in Table 6, an average of 184 prisoners were incarcerated at the AMC at any one time and there were approximately 600 receptions over this period.

Table 6 Case management service provided by NGOs at the AMC, 1 July 2009 to 30 June 2010

Type of case management episode	Service Provider	Time period	Number of episodes
Information & assessment sessions	Directions ACT	1 Jul 2009 – 30 Jun 2010	101 sessions to 101 individuals
Information & assessment sessions	Toora WIREDD	1 Jul 2009 – 31 Dec 2009	58 episodes to 21 individuals
Information & assessment sessions	Toora WIREDD	1 Jan 2010 – 30 Jun 2010	12 individuals
Information & assessment sessions	Gudan Gulwan	1 Jul 2009 – 30 Jun 2010	17 sessions

Information & assessment sessions	Canberra Recovery Services	1 Jul 2009 – 30 Jun 2010	55 assessments & 40 orientation sessions to remandees
Consultation Liaison	ADP	1 Jun 2009 – 31 May 2010	26 individuals
Housing services	Toora	1 Jul 2009 – 30 Jun 2010	7 individuals
Housing services	Inanna	1 Jul 2009 – 31 May 2010	Housed 12 women (& families) post release
Housing services	Samaritan House	1 Jul 2009 – 31 May 2010	Regularly receiving post release male prisoners
Case management	ACT Women & Prisons	1 Jul 2009 – 31 May 2010	47 group visits (average 12 women per visit, 1/3 of whom are ATSI) 12 individual visits 68-78% of clients maintain contact with service up to 3 months post release
Case management	ADP	1 Jun 2009 – 31 May 2010	83 appointments
Case management	Inanna	1 Jun 2009 – 31 May 2010	20 visits (plus 6 occasions of being unable access due to lockdowns) Average of 3-10 calls/week seeking assistance & support

ACT Corrections Health Program has responsibility for health services for prisoners. Forensic Mental Health also provide some oversight of prisoners from a mental health perspective; in particular, the Forensic Mental Health team develops recovery plans to guide prisoners through mental health treatment via a team-based care model, which is also a form of case management. It is intended that ACT Corrections Health Program develop care and discharge plans for prisoners (these plans are identified as key performance indicators in this evaluation). Prison-based health staff highlighted concerns with a lack of awareness of other case management that was being provided to prisoners, both by Corrective Services and external community-based service providers.

These varied case management providers and arrangements indicate a high degree of fragmentation in the provision of case management and the potential for duplication and poor coordination of services.

Awareness and access

Qualitative interviews revealed several difficulties with the current case management system. Many prisoners were not aware of the case management services provided by Corrective Services AMC Case Managers and did not know their individual case manager. This sometimes resulted in prisoners utilising community-based service providers to undertake an un-funded case management role.

'Well they say that this place is supposed to be for rehabilitation and releasing you back in the community. There is supposed to be a case worker that works with you and so forth and helps you do things. I was here six months before I knew who my case worker even was. I don't even, my case worker had done nothing for me. I didn't even know I had a case worker.' (key informant)

'Yeah you need to hit the ground running. It's the biggest thing I reckon, they need to give you a case manager.' (key informant)

'When I have people saying to me every week can you help me fill out this housing for or this or this or this, the case manager should be the person who is supporting them with their pre-release transition planning. They should be supporting them in the lead up to a parole hearing so this is your argument, this is what you're going to come up against. There is no support to prepare for those events and obviously there are implications of that on health.' (key informant)

Prisoners who were aware of the AMC case management services described experiencing very little or no communication with their case manager and feelings that their case manager wasn't meeting their needs. This was also reflected in some staff feedback.

'These case managers, put it this way I've been here for five months and they've never come down and spoken to me about housing, how about your housing, how about this and how about that. They don't go out of their way to come down and make sure.' (key informant)

'When you read the handbook to the jail it says your case manager will come down and see you and speak about what you need. So you'll see him and he'll say do you have a drug problem and you go yeah and he'll enrol you into this drug and alcohol class. What about a problem with your anger – yeah sometimes, alright I'll enrol you in that. If you get in trouble for losing your temper or something they come down and see you and say look I heard you lost your temper. We're going to get you into anger management class if you want to do it but it's not like that... Well I end up doing it all myself. They don't come down.' (key informant)

'You've got your case managers, they don't do anything, they don't do jack shit you know what I mean. You ask them, like the only thing they will do is maybe fax your paperwork over to housing or something but you're better off just doing that yourself too because then you know it gets done. But

otherwise yeah you just, it's all just self help in there. No one to help you, no one to guide you, no one.' (key informant)

'I'd had nothing to do with any case manager until my application for TRC [transitional release centre] and you know they gave me a copy of a report they'd done apparently in conjunction with me.' (key informant)

'They don't do that well here either, they don't case plan well.' (key informant)

Interviewees talked about more restricted access to case managers by remand compared to sentenced prisoners. Given the large proportion of remand prisoners at the AMC, this reported differential access is a concern. Corrective Services informed the evaluation team that all remand prisoners are allocated a case manager.

'I know remand you don't get as much assistance 'cause the case managers and stuff, they're the ones who are meant to help with ID and Centrelink and they don't have to work down here, it's not in the legislation that they have to work with remand prisoners.' (key informant)

Key informants considered that the system of rotating case managers through the AMC on six month placements was hampering the development of effective relationships between case managers and prisoners and reducing continuity of care. This practice has since been revised.

Role clarity

Prisoners and staff expressed significant confusion about the roles of case officers (regular prisoner monitoring by custodial staff) and case managers (sentence and pre-release planning by community corrections staff) and difficulty in determining which person to go to for particular types of assistance.

'When I first got here I think I got introduced to somebody but I didn't even know the difference who is one of these people who write things about you on the computer and a case manager. I found out who my case manager was finally and she's helped me with housing and a few things but its hard you don't know who actually to talk to because like you're introduced to bang bang bang bang people when you get here and you don't really know what any of these people are there for.' (key informant)

'And it's just, it would be good if you were given a list of who is your case officer, who is your case manager, who is your probation officer you know things like that. But you're not and it took me a while to work out.' (key informant)

'Probably not have one of the officers as your case worker? Probably have a drug and alcohol worker as your case worker instead of an officer set as your case worker cause that's how it works here.' (key informant)

'Us calling one case officers and one case managers is confusing.' (key informant)

'Yeah it's not been defined very clearly to custodial staff but prisoners themselves get confused especially when you introduce yourself as a case officer and they go but somebody else is my case manager and they're a parole officer, what are you.' (key informant)

Quality and communication

There were some positive reports about experiences with case managers and case officers, though they were in the minority.

'I'm satisfied with the help they've given me to be released and feel secure within my release and within the community so I won't sort of reoffend.' (key informant)

'Yeah, the longer it's open the more that they get established, like the case officers and stuff are pretty helpful yeah.' (key informant)

'Yeah. My case officers were really good. My two case officers; they were really good. They always got stuff done for me. Like to be quite honest my case officers sometimes got more done than my case managers while they were trying to do their jobs you know what I mean.' (key informant)

'That works really well. Like we share information, we work together with the clients ... that communication with the case managers is excellent... it's wonderful.' (key informant)

There was a sense that case management processes were slowly improving, but there are still significant gaps in communication and coordination, both between service providers and with prisoners.

'I think there's not enough communication between the case managers and the case officers. No, not at all. That's because of a raft of reasons I think really. I think some of those reasons are that some of the case managers aren't interested in assisting a prisoner at all and that's got to do with their attitude and their beliefs and that's something we as an organisation need to work on.' (key informant)

'I think we need a more coordinated approach to what everyone else is doing and that's having an idea of actually what everyone else is doing.' (key informant)

'Currently we don't liaise at all. They're going about their business and we don't know.' (key informant)

'I know that there are drug and alcohol services or people that do those roles but what they do, I don't know.' (key informant)

'I think staff are still struggling on both sides to navigate well how do you get in contact with a case manager from Corrective Services and if you did know their name where do they sit, what would be their phone number, what's the best way to pass information because initially there was these great plans that everyone would have a rehabilitation plan and the case manager would go around and say you know, have you got any information that you want to share on blah, blah but the reality is everyone is too busy.' (key informant)

There was concern that the current case management system was under-resourced and this was the cause of many of the problems experienced by prisoners and service providers.

'Anyway yeah case managers, some of them are very good and some are just worked off their tails.' (key informant)

'We do three quarters of the work that case officers or managers don't have the time.' (key informant)

'I see in the AMC that the case managers do an enormous amount of work but for that, they've got to have a welfare officer, that is going to do phone calls, the welfare type, the family welfare issues.' (key informant)

In addition to under-resourcing, prison staff were also concerned that the training of staff was inadequate for effective case management.

'No one really knows how to do case notes here as case officers. They are slowly getting there through word of mouth but they've been copying officers that have come from other jurisdictions.' (key informant)

The quality of case management provided by community service providers was described as consistently good, with many prisoners and ex-prisoners speaking positively about their relationships with workers from NGOs.

'Yeah it's one you can organise yourself off like the phones. [NGO] is on the list of phone numbers, free calls so you're just dialling [NGO] and ring up and say can a counsellor come out and see me please. I've found that more beneficial than working with any of [the Corrective Services] workers.' (key informant)

'Housing, I asked the, like because you get case managers, I asked for four months who my case manager was and I didn't find out until the last week who it was to chase up my housing and that. If it wasn't for [NGO worker] and that I would have got out to nothing, nowhere to go, nothing.' (key informant)

Community service providers raised concerns about their ability to provide services effectively when physical space was limited. Some workers had been shifted out of the Programs and Health buildings due to space restrictions. Services were often being provided in the visits area, which meant workers had no access to phones or computers which would assist them in providing effective support to prisoners.

'Basically what happened with her was she's been going there for 12 months up until about two or three weeks ago. She went to her office where she'd been based out there and was notified that she wasn't going to there no more because of the diabetes clinic. That's thrown that structure that they had in there at that point and they said why don't you just get your clients and go and have a cup of coffee in the tea room. She said no... I'm not going to go and sit in a common area for people to listen in.' (key informant)

Service coordination

Key informants agreed that some kind of service mapping or centralised care plan for individual prisoners would ensure that providers were aware of what others were doing so that duplication would be reduced and integrated care to meet individual needs increased.

'Yeah like it would be lovely wouldn't it to be able to have like a structure in the AMC, like a treatment structure so you could see what service is coming up, I've got no idea really of what services go in.' (key informant)

'From a drug service sector perspective one of the challenges is that what we haven't progressed is who is responsible for what.' (key informant)

'I think in our case it's about going what can we do to bring together the stakeholders to say who is doing what. That would be really helpful and a useful type of thing.' (key informant)

'I think it would be worth looking at finding our key areas of responsibility, the key markers of people who are responsible for certain things for people to have channels to link into and it be whatever it is.' (key informant)

Some stakeholders suggested that service quality may not be the principal issue in relation to meeting the needs of prisoners. Rather, that better service coordination would improve services, particularly in an environment where complex clients are being serviced.

Holistic approaches

Interviewees made various suggestions for a more holistic approach for individual prisoners, but others believed existing problems could be solved by having more specialist case managers in different areas.

'We need to start at the beginning. The first time, as soon as we engage an offender we need to very clearly define a plan for them. These are not structured people but they do respond to that structure.' (key informant)

'I think we could make changes in what's offered. I think we can look at that and I think going out and talking to the other agencies and doing a holistic approach rather than us all doing our own approach.' (key informant)

'We need a case manager employed by ACT Health specifically for people with drug and alcohol issues. I think one is not going to be enough really but one to start with would be good.' (key informant)

'So if we had a case manager and they knew they were going to see a case manager or key worker or whatever they can identify all that risky stuff that's going on.' (key informant)

'I don't know how many more case managers they need but they need to case manage it better and those case managers should be if possible holistic case managers as opposed to discreet... if the case managers were able to deal with all the issues as opposed to just one that would be terrific but I don't know where you find those. You probably don't find them.' (key informant)

'As I said if staff were more focused on managing people from a psychological perspective then addressing them as individuals with problems that need to be addressed rather than just imagining that the longer you lock them up their problems will be fixed.' (key informant)

'I think that it needs to be a more, I guess holistic approach.' (key informant)

Throughcare

Prisoner and ex-prisoner interviewees repeatedly described past experiences of having got out of prison with 'nothing'. This referred to not having any pre-release preparations for transport, accommodation, identification documents and Centrelink payments, among other services. This was considered by these participants to be counter-productive and likely to lead to reoffending and return

to the AMC. The evaluation team were informed by Corrective Services that no prisoners have been released without transport and accommodation arrangements since the appointment of a Pre-Release Officer.

'When I got out? Last time I didn't have much but I know they've got more now. I had to go to Centrelink myself everything but now they've organised that everything is done for you before you get out.' (key informant)

'A lot of people get out with pretty much nothing.' (key informant)

'They give you parole and you get out and they say good luck to you and that's it and they just leave you with it, no support or accommodation or nothing so it doesn't take you long to slip back into your old ways of what you were doing before and then you're back again.' (key informant)

'I was left standing out the front of the jail. What was I supposed to do then - walk? Where to?' (key informant)

'The jail doesn't really do anything. Most people just walk out the roller doors, released and here's your half a dole cheque and on your way you know and then they're back in a week.' (key informant)

'I've had to organise it all myself. I rang up and hooked in with Directions ACT, a program called the Inside Out program. I hooked up with them, Canberra Men's Centre, like I've done all this stuff, like off my own bat ringing and getting this stuff but otherwise no one will help you do this stuff, you just, you walk out the door and you have nothing.' (key informant)

Communication about pending releases was reported by many interview participants as inadequate and severely impacting on throughcare, with implications for both prisoners and service providers. It was not clear where information about releases would be coming from and who would be responsible for informing various parties. Given that a specific case manager is responsible for release preparations, it would seem logical that this case manager would have a role in informing relevant parties about pending releases, but the data indicated this was not happening in many instances.

'Yeah he, I was waiting for him to come over for the last week and he just happened to drop by to see someone else and I said to him, I'm getting out in two days and he didn't know and that blew me out you know, how are you supposed to be providing me support if you know, less than 48 hours before release you don't know I'm going?' (key informant)

'There must be some form of print out or something that can, you know in the next month, I know remand is a lot harder because they're going to court and they might be released and they might not, but the people who have served their time in sentenced, there should be something that these are the people who are due for release in August.' (key informant)

'The women also call us saying you know we're going to be released and my application is not there.' (key informant)

Poor communication about release dates is particularly concerning where arrangements for continuation of medications would need to take place.

'Another massive gap is the accountability of ensuring that every prisoner is set up with supports and a doctor and everything coming out.' (key informant)

Interviewees, in particular community service providers, believed that throughcare for prisoners is currently inadequate and further work is needed to implement the throughcare model effectively.

'At this stage I think the throughcare stuff is all a model. It's not getting implemented properly.' (key informant)

'Especially with throughcare. I mean no one is going to put their hand up to go through with the throughcare stuff unless they are funded appropriately and right now it's an expectation that people are going to pick that up as part of their prior funding arrangements. Unless the government says we're going to fund you two positions to do the throughcare we are going to keep going how we are now.' (key informant)

'That somebody calls for me is an indication that the whole system has failed. Or even that if somebody calls us you know, anybody who's sentenced and he knows he's coming out in six months time, why does he call a crisis accommodation service? Why aren't there other services that are medium term, longer term that he can transition into?' (key informant)

'I wasn't surprised by the lack of coherence of the throughcare, after care program. I've been invited to one of those, in the centre of that huge diagram there's a conference with all the supporters prior to release, you know well prior to release where you plan it and you get it all sorted out. I've been to one and the bloke said you can go now, thank you very much, we don't need you.' (key informant)

Case conferencing was described by community service providers as forming an important part of throughcare. Where case conferencing occurred prior to release, which was deemed to be happening inconsistently (i.e., not with all prisoners), it was considered a valuable contribution to pre-release planning. The importance of engagement with all relevant parties during case conferencing was discussed, as it was suggested that the range of agencies involved was too narrow. Corrective Services advised the evaluation team that case conferencing is offered to all prisoners prior to release and relevant support services are invited. Corrective Services advised that where case conferencing occurs, prisoners attend.

Addressing needs of Indigenous prisoners

The multiple service provider structure has fragmented case management arrangements and obscured specific roles and this appears to particularly affect individuals with specific or complex needs. Case management arrangements for Aboriginal people were being dealt with by a specific worker, but this model was not adequately resourced to respond to the needs of the individuals concerned.

'Corrective Services were quite adamant that they see people with alcohol and drug issues as far as case management is concerned. They didn't want anybody else to do that but they were allowing the Aboriginal Liaison Officer to continue to work with her own clients.' (key informant)

'Better throughcare for aboriginal people. We're looking at identifying a throughcare model specifically for aboriginal people. That's part of the project we're working on.' (key informant)

'If there is some evaluation about all this there needs to be, if they're looking at the throughcare that is going to happen in this prison pretty soon, then we need more aboriginal people in that, involved in that process to be able to work with our people inside the prison and as we said we've got two or three organisations on the outside the prison that would have better access to them.' (key informant)

Summary

- Fragmentation of case management service system
- Change in case management structure intended to improve quality
- Lack of awareness of AMC Case Managers among prisoners
- Poor relationships between AMC Case Managers and prisoners
- Good relationships between prisoners and community service providers
- Confusion between case manager and case officer roles
- Differential access to case management for remand and sentenced prisoners
- Case management slowly improving
- Lack of coordination of services provided to prisoners by Corrective Services, ACT Corrections Health Program and NGOs
- Lack of role clarity among service providers
- Poor communication between service providers
- Implementation of throughcare has been inadequate
- Case conferencing working well but needs to be consistently applied
- Specific issues experienced by Indigenous prisoners in relation to quality of care

9.3 Individual counselling

Quantitative data presented in Table 7 regarding drug dependence counselling provided to prisoners at the AMC refers to sessions provided by external organisations working on an in-reach basis or for ex-prisoners post-release. No quantitative data regarding counselling provided at the AMC by Forensic Mental Health were provided to the evaluation team. Directions ACT is by far the largest provider of counselling services, according to the data, but the evaluation team was advised that not all sessions counted in these data relate to formal counselling. Much of the activity could more accurately be referred to as case management, involving the coordination of services, advocacy and general support.

Table 7 Drug dependence counselling services provided by NGOs at the AMC, 1 July 2009 to 30 June 2010

Type of counselling	Service Provider	Time period	Number of sessions /individuals
Drug counselling at AMC	Directions ACT	1 Jul 2009 – 30 Jun 2010	198 sessions to 95 individuals
Drug counselling at AMC	Toora WIREDD	1 Jul 2009 – 30 Jun 2010	18 individuals
Drug counselling at AMC	Gugan Gulwan	1 Jul 2009 – 30 Jun 2010	6 individuals
Drug counselling post-release	Directions ACT	1 Jul 2009 – 30 Jun 2010	30 individuals
Drug counselling post-release	Gugan Gulwan	1 Jul 2009 – 30 Jun 2010	9 individuals
Drug counselling post-release	ADP	1 Jun 2009 – 31 May 2010	4 individuals

Limitations in the data make it difficult to determine the extent to which the services described in Table 7 meet the demand for drug and alcohol counselling. Over this reporting period, there were approximately 600 receptions to the AMC. Based on Inmate Health Survey data (e.g., 42% self-identifying need for help quitting drugs, 42% used heroin in past 12 months, 40% ever been told by a doctor they were drug dependent) we might expect that at least 240 prisoners passing through the AMC in this time would likely benefit from drug and alcohol counselling.

There was strong consensus among the range of stakeholders interviewed for this evaluation that there were too few counselling opportunities available to prisoners at the AMC. The options mainly described by prisoners, ex-prisoners, prison staff and community service providers were counselling provided by Forensic Mental Health (data not available) and by Directions ACT (see Table 7). While prisoners and ex-prisoners were aware of counselling provided by Forensic Mental Health,

they were not always able to access it. Prisoner and ex-prisoner participants noted that they needed to have serious mental health problems to access this support. Those that were accessing this counselling found it incredibly helpful and supportive, and talked about the positive changes they were making to their lives as a result.

The few prisoner and ex-prisoner participants who received counselling from Directions ACT through the Inside Out Program described needing to organise the counselling themselves, rather than it being offered as a part of their sentence plan. Workers from the Inside Out program confirmed that capacity to provide services to prisoners was limited by only having one full time worker going into the AMC to provide services to prisoners. Despite these access issues, those that did use Directions ACT counselling spoke highly of the services provided and the way counselling had enabled them to turn their lives around; this was particularly true of ex-prisoner participants who had continued to access the services post-release. This highlighted the importance of the throughcare approach of the Inside Out Program, where the same provider was able to follow an individual prisoner through their incarceration and into the community.

Prisoners who weren't accessing counselling generally believed that it wasn't available. This finding is consistent with the comments reported above about prisoners needing to proactively seek counselling services as opposed to being offered them. All key informants consistently stated that they thought counselling should be offered to all prisoners as a matter of course. Prisoner and ex-prisoner participants' descriptions of counselling services as under-resourced was also supported by responses from Corrective Services, ACT Corrections Health Program staff and community service providers. These stakeholders also believed that counselling was generally unavailable.

'Nah, I don't think there is really much counselling.' (key informant)

'We don't actually have counsellors for the prisoners. I have brought this up with the principal psychologist. I've never worked in a prison where there's not been counsellors.' (key informant)

'I'm not sure if regular counselling is available, like weekly counselling.' (key informant)

'The jail offered no counselling, not much support.' (key informant)

'Well the only type of counselling I could get was with the mental health people and they didn't specialise in drug and alcohol which is what I wanted to talk about. They just wanted to know if I was, had any mental health problems and that was with the psychiatrist and what medications they could prescribe me you know. But I couldn't get just regular counselling.' (key informant)

'There are no counsellors at the AMC.' (key informant)

While group programs may offer a therapeutic environment where counselling could take place, both service providers (Corrective Services and community service providers), prisoners and ex-prisoners believed that this wasn't appropriate for all prisoners. There was significant consensus among stakeholder groups that regular one-on-one counselling with a qualified practitioner was the best intervention for the prison context and the challenges experienced by the prison population. Prisoners, ex-prisoners, Corrective Services staff and

community service providers talked about 'jail politics' and how it could constrain interactions in group therapeutic programs (for example First Steps and Back in Control, discussed in greater detail elsewhere). The histories of individual prisoners, which often included violence, abuse and trauma, were described as sensitive and requiring tailored, individual interventions. In addition to these concerns, group facilitators believed that issues raised in groups may need individual follow-up which they were not resourced to provide. This limited the efficacy of group programs from a counselling point of view.

'Even if you just see someone for 20 minutes a week and they're talking to you properly and you're getting something out of it... Yeah and I would find that 10 times more helpful than one of those group deals where they're getting you to pick which animal you want to be or something like that.' (key informant)

'We could actually open up some stuff in the group setting too that articulates a little more what is needed but we can't or are reluctant to and won't do that because there isn't anyone to support after.' (key informant)

'One on one counselling. There are some guys who just can't handle the group process.' (key informant)

'Some people aren't able to do group work, some people find it very difficult to do group work.' (key informant)

Prisoners and ex-prisoners were certainly receptive to the notion of counselling and, in many cases, had a strong understanding of the benefits that counselling could provide.

'They'd like counselling which is something, foremost, you know that should be [a] regular thing for people here because they've got problems. They sit and stew on their problems and they can't brainstorm with somebody. It's always good to have someone else's opinion on a problem. You start thinking down one line and then you get stuck on that line of thinking where you'd like to have a couple of inputs from someone else, some other options you could take that won't be as effective as what you're thinking about, but will be more beneficial for yourself.' (key informant)

'There are plenty of guys here who talk about their situations and so forth and get other inputs from other inmates and so forth but they're all the same mentality and thinking of the jail lifestyle and inmates whereas outside thinkers are a lot more open minded about things and have dealt with issues not to do with drugs which are probably issues the boys in here don't have much emphasis on dealing with because they've always been in a drug situation and that's what causes all the dramas. To get away from the drugs you've got to deal with the problem that starts, manifests before the drugs.' (key informant)

Without exception, interviewees agreed that counselling services for prisoners are greatly needed at the AMC and that they could make a real difference to coping with drug and other personal issues.

'All cohorts need to have individual counselling.' (key informant)

'I think some girls in here really need regular counselling like at least once weekly and I'm not sure if that is available but if it isn't it's something that needs to be.' (key informant)

'The other thing is that yes we do need far more access to counselling for our clientele so I agree with that whole-heartedly.' (key informant)

'We had conversations about the access to one on one counselling which people definitely want.' (key informant)

Individuals discussed the best way to provide counselling services. Increased availability of services was most frequently mentioned, with opportunities for weekly counselling deemed a minimum.

'I don't know, I think there should be a counsellor that you can go to at all times. Like you don't have to put a 'bluey' [request form] in, wait six months and explain why. The officers like have people in and out all day but no one can go to them. There should be someone down here at all times that just wants to talk. People could just go and talk to them.' (key informant)

'As far as, like we've seen they've got an outside provider coming in and that's not working, well it's not adequate. I'm not saying that it's not working with the inmates that they're working with, it's just not adequate for all the inmates here.' (key informant)

Several external providers are equipped to provide the counselling required, but resourcing them appropriately would be essential.

'And I'd have to say that the Alcohol and Drug Program team that they're very keen to actually come out here and do counselling.' (key informant)

'Certainly if we could provide a counselling service, whether that, you know that could be through brokerage if Corrective Services were, we could send in counsellors but they'd have to pay for that time or you know funding for another person to do it within this program.' (key informant)

Summary

- Insufficient counselling opportunities available to prisoners
- Insufficient awareness among prisoners of counselling
- Belief among prisoners and service providers that individual counselling would be more effective than group counselling
- Strong understanding of benefits offered by counselling
- High need among prisoners for regular individual counselling
- Insufficient resources to offer counselling to all prisoners

9.4 Programs – educational and employment

The evaluation team did not receive any quantitative data about education and employment programs at the AMC, but key informants did raise these programs as part of discussion on drug policy and services. It was considered that a holistic approach to drug related issues would include building the skills of individuals to enable them to lead more productive lives in the community.

There was consensus among those interviewed that education and employment programs at the AMC are inferior to those offered at prisons in NSW. It was felt that the area allocated to industries within the AMC is currently under-utilised and many more courses could be offered⁷. Other program changes, including more employment opportunities in the prison and arrangements for jobs following release, were also supported.

'So I think the education side is getting better but I mean a lot of people got dragged from [NSW prisons] where they could get a forklift license, they could get a certificate for building, they could get, they could do apprenticeships and all kinds of stuff whereas in the AMC it looks all pretty and it's all very nice... but there's just nothing to do.' (key informant)

'There should have apprenticeships or something maybe for the young fellas. The older blokes like myself we don't care about that stuff you know, I would have if I was young. Like baking, making bread.' (key informant)

'Then there is the activities and then there is the accredited courses, accredited programs run through AusWide. There are some big issues there as well because accessing those programs I mean I understand that there is some discussion not being viable for them economically because they're just not getting the numbers through as a result of staff shortages, as a result of nobody feeding the information to the prisoners about those courses, nobody supporting them to be there. The way they are run is a very traditional, there is no innovation in the facilitation of the courses and then engaging the prisoners becomes really limited.' (key informant)

Educational programs focused upon life skills – topics like cooking and parenting – were suggested. Similar programs had been run in the past, but were discontinued. Community service providers and ex-prisoners discussed how the grounds of the AMC could be utilised to run practical education and employment programs like agriculture (e.g., keeping livestock or maintaining a vegetable garden). Corrective Services informed the evaluation team that horticulture programs are currently occurring at the AMC.

'Also what it does is it explains away your time. When I come out of the AMC what was I doing? I was doing my Cert III in horticulture for that year and you were. You can put something on your resume that explains away the time.' (key informant)

The wider benefits of adequate education and employment programs were noted by many, as were education and employment programs serving a rehabilitation function at the AMC. Education and employment programs were also seen as

⁷ It is understood this area is now to be utilised for a gymnasium and that large scale industries are not possible or sustainable in a prison the size of the AMC

contributing to the security and good order of the prison, relieving boredom, instilling prisoners with a good work ethic and creating a basis for potential future employment. Employment programs during transition back into the community were also mentioned as likely to have benefits.

'If you get them into that routine they quite enjoy it and it keeps them busy and it keeps them entertained and they don't get into trouble.' (key informant)

'We would very much like to see some program for the first three to six months following release where they would get skills and we've actually had a conversation with government about this. We would like to see, we would like to establish a market garden, a self sustaining market garden where they could work, access some sort of support group in therapy during that self sustaining horticultural program and a coffee shop.' (key informant)

Summary

- Employment related programs needed – pre-release arrangements for jobs would be beneficial
- Poorer access to education and employment programs than in NSW prisons
- Greater variety of courses needed
- Industries area currently under-utilised
- Practical life skills focus for programs would be beneficial
- Courses are being started and discontinued

9.5 Programs – recreational

Similar to educational and employment programs, all stakeholder groups consulted saw the benefit of recreational programs at the prison. The main type of program mentioned was a gymnasium. Current facilities for physical activity at the AMC are inadequate or non-existent for most prisoners. The evaluation team is aware that women prisoners have gym facilities, but these were seen by the women as inadequate and were under-utilised as a result. Corrective Services informed the evaluation team that there are gym facilities currently available, however these are temporary.

Recreational programs were perceived by key informants as having a potentially significant impact on the wellbeing of prisoners. Recreational programs may also limit boredom, which could improve the security and good order of the prison.

'Part of that also is they are bored; they are absolutely bored shitless... and that is something that we've heard the whole time. You go there in the afternoon and they'll be in bed still because they're just bored and cold. It's a huge issue, huge issue.' (key informant)

'They've got nothing to do.' (key informant)

'I believe in healthy body and healthy mind and if there is one thing that's missing in this jail it's a gym, which every other jail has. For me, that's the first step... I was fat, 115kg, overweight and depressed and down and I was on all kinds of medication and things and then I started getting healthy and starting to get a little bit of confidence and self esteem back. This ultimately led me to making the right decision to go into rehab.' (key informant)

'Gym, there's no gym, nothing. It's just so boring, which leads to trouble.' (key informant)

When writing this report, the evaluation team was advised that funding for a permanent gym was being sought.

Summary

- Gym should be available
- Opportunities for recreation can improve wellbeing
- Recreational opportunities can improve order within the prison

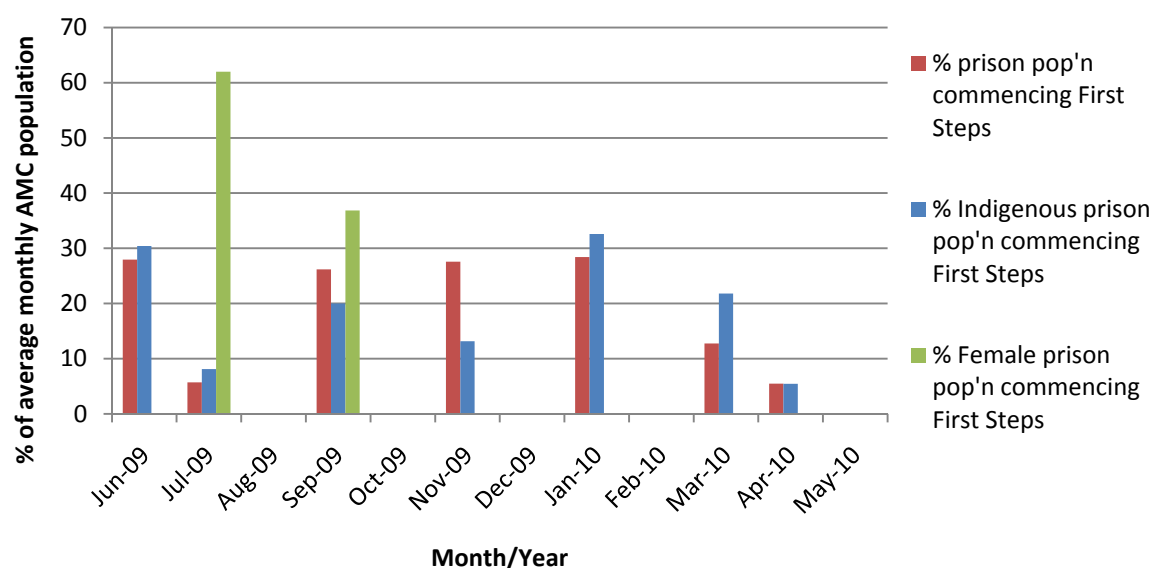
9.6 Programs – therapeutic

A large amount of data was collected on therapeutic programs during the evaluation and the topic was raised often and in detail by all the groups consulted.

This section refers predominantly to therapeutic programs delivered by the AOD Team of Corrective Services. This team of civilian workers runs group therapy sessions focused on drug issues. The three programs being run by this team at the time of this evaluation were 'First Steps', 'Back in Control' and the Health and Wellbeing program. These are structured weekly programs delivered to small groups of volunteers by two facilitators. 'First Steps' runs over approximately six weeks and aims to support participants with the challenges faced when ceasing or reducing substance use by facilitating the group to explore alcohol and other drug awareness, education and relapse prevention. 'Back in Control' runs over approximately 20 weeks and expands upon and consolidates skills learnt in First Steps. The Health and Wellbeing program is run over six weeks. Intake data for First Steps was available from May 2009 and the Back in Control program enrolled prisoners in June and September 2010. Both programs were in review at the time of writing.

For the period May 2009 to June 2010, 25 First Steps Program intakes were offered for sentenced and remand prisoners - 22 for males and three for women. Over this period, 286 prisoners commenced the First Steps program. Intakes were irregular and monthly intake numbers varied greatly, from five in June 2010 to 52 in January 2010 (in some months no programs were commenced). Figure 2 shows the large variation in monthly prisoner intakes into the First Step program as a percentage of the average monthly AMC prisoner population. These data suggest potentially excellent program coverage in some months but limited (or no) coverage in others. Although relative monthly coverage of the First Steps program varies for Indigenous prisoners at the AMC, coverage here is largely similar to the overall population. The coverage is largely poor for female prisoners at the AMC. There were only two intakes of female prisoners (July and September 2009) over this reporting period involving 14 women (in addition to one intake in May 2009 involving nine women; no AMC prison population data were available pre-June 2009). Corrective Services advised the evaluation team that poor female participation was due to women declining to participate, despite repeated attempts by staff to engage women prisoners. Limited program participation among female prisoners is problematic and requires further exploration to determine the cause of poor participation levels and lack of engagement.

Figure 2 Monthly intakes into the First Steps program as a percentage of the average monthly total, Indigenous and female prisoner population at the AMC, June 2009 to May 2010



A large minority of prisoners commencing First Steps did not complete the six-week program. Of the 286 prisoners that commenced the program over the reporting period, 126 (44%) completed the program. The 160 prisoners who did not complete the program withdrew voluntarily (54%), were bailed and released from the AMC (30%) or underwent change in classification that prevented them from participating further (16%). Completion rates were lowest among younger inmates (<25 years; 33%) and Indigenous inmates (37%) and highest among older inmates (≥25 years; 49%).

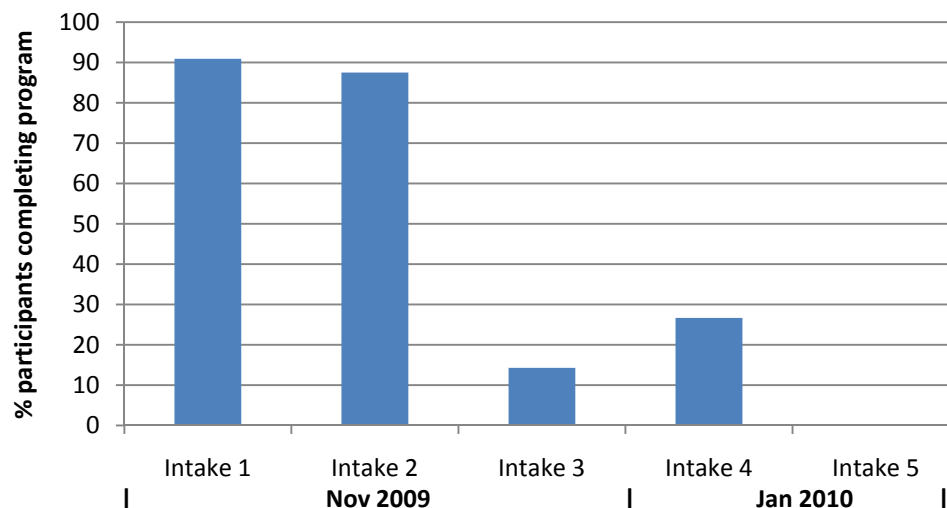
Twenty prisoners commenced the Back in Control program in the two intakes in April 2010, but only six participants completed it. Reasons for not completing Back in Control were largely voluntary; eight were due to 'disciplinary action' and five due to 'lack of participation/dismissal.'

Few data were available regarding completion rates for prison-based drug dependence therapeutic programs; however, the completion rates reported above are lower than those reported for comparable programs in NSW. *The Drug and Alcohol Addiction Program* and the *Relapse Prevention Program*, both targeting offenders with a higher risk of recidivism, reported combined completion rates of 58% in 2008/09 (297 prisoners participating in 21 programs) and 59% in 2007/08 (Corrective Services NSW, 2009).

Other programs have been developed and delivered by the AOD Team, but to a more limited extent. The 'Health and Wellbeing' program, mentioned above, is based on cognitive behavioural therapy principles and runs over six weeks. Specific topics covered in the Health and Wellbeing program include budgeting and financial management, stress management, conflict resolution, goal setting, self esteem and parenting skills. Fifty AMC prisoners commenced the five Health and Wellbeing program intakes in November 2009 and January 2010; only 22 prisoners (44%) completed this program. There was an increasing trend for non-completion of this program over time (Figure 3). Of the 29 prisoners who did not

complete the program, 28 dropped out due to 'lack of participation/dismissal' (one was released from custody). All nine prisoners that commenced the final program intake in January 2010 did not complete the program for this reason. Corrective Services informed the evaluation team that this program is still offered to prisoners.

Figure 3 Percent of AMC prisoners completing 'Health and Wellbeing' program, November 2009 and January 2010



The 'Personal Effectiveness Program' was a structured personal development program, also based on cognitive behavioural therapy principles, that is no longer offered to prisoners. The program presented four modules of ten sessions each, covering 1) communication, 2) mental fitness, 3) working in groups and 4) self and others. The 'Personal Effectiveness Program' was considered a readiness program for further therapeutic interventions. Forty-seven participants commenced the program in November and December 2009 but no-one completed it, primarily due to voluntary withdrawal (80%). Corrective Services advised the evaluation team that this program was commenced at the request of prisoners. However the program was discontinued when prisoners appeared to 'lose interest' and Corrective Services was comfortable discontinuing it as it was not a criminogenic program.

Access and awareness

Prison staff described the sign-up processes for accessing the courses.

'At the end of a group cycle when we're ready to start a new group cycle we'll go into the blocks and we'll say here's the waitlist if your name's not on it last chance. They get that opportunity to do it then.' (key informant)

'In terms of waitlist not big and just about everybody accesses alcohol and drug more than anything else. We have developed systems where we have a lot of people through.' (key informant)

'From our point of view we consistently run the programs and we consistently call for volunteers.' (key informant)

Prisoners and ex-prisoners reported difficulty in accessing the programs; they weren't always aware when programs were being offered or how to sign up for them. Other service providers also highlighted this difficulty. These qualitative data were consistent with quantitative data, confirming significant variability in intake numbers over time.

'Yeah I have, I have [tried to access courses] and it's difficult.' (key informant)

'I think there are drug and alcohol workers here but they're hard to see and there are very few around to get a hold of.' (key informant)

'People have been in for four, five, six weeks and more before they hear anything about programs, before anyone talks to them about programs.' (key informant)

Sign-up processes appeared to be passive, rather than actively responding to the sentence plans of individual prisoners. Qualitative data indicated that the AMC does not systematically promote programs to prisoners across security classifications or to prisoners with particular relevant needs. Corrective Services informed the evaluation team that sentenced prisoners were generally referred to attend programs by case managers, however this was not happening for remand prisoners.

'It was just a piece of paper put on a table in the middle of the remand unit and if you want to do a course put your name on it.' (key informant)

'Oh it's just passed throughout the jail, your name gets put on a list and they sort of pick you out amongst themselves. They sort of like to think they know what's going on and they pick you out with other people for the course I guess. Not everyone gets the treatment they need.' (key informant)

'They need to like do pamphlets or something like that. People don't hear the calls and you don't hear officers yelling it out because you might not be in here.' (key informant)

Prisoners and ex-prisoners interviewees also reported waiting for long periods to begin courses after they had signed up.

'We had to wait a little bit but we got on to it.' (key informant)

'It takes 'em months between like that will finish and it'll take another few months for another one to start so that's why I had to really fight hard to get into this First Steps because I might be getting parole soon, I can't afford to have it put off for months because Parole will say we're knocking you back for three months so you can do First Steps.' (key informant)

Difficulty in accessing programs and irregular scheduling (as demonstrated by the program quantitative data presented earlier) was seen as negatively impacting on sentencing, parole and bail applications.

'Yeah well I've tried to do a drug and alcohol course but I got told that I've got to wait for the next intake and that was another five to six weeks and I needed to do a drug and alcohol course ASAP for a pre-sentence report and all that.' (key informant)

'I got resentenced on a suspended sentence and because they couldn't provide me with drug and alcohol course and things like that the judge looked at it as if I'm not trying. So they turn around and gave me time instead and they pulled my suspended sentence.' (key informant)

'Well I had, I was due for parole in October last year but they knocked me back because I didn't do the Violent Offenders Program. I didn't do it because it wasn't available. So how could I do it?' (key informant)

'Yeah and we've had several clients that have had parole denied because they have meant to have done certain programs and they can't get access to those programs and, but its also given us a point to argue at a parole hearing, to say you know, release them into the community and we'll get it done for them in the community.' (key informant)

Interviewees reported that access to programs seemed to depend on classification. It was perceived that male remand and female prisoners fared worse than male sentenced prisoners in accessing programs. Quantitative data regarding the First Steps program presented earlier support the contention that females had relatively limited access. In addition, no women had enrolled in the Personal Effectiveness Program and only one of seven women commencing the Health and Wellbeing program completed this program. The evaluation team was unable to obtain quantitative information on program participation by sentenced or remand prisoners; however, given the high numbers of remandees in the ACT, this inequitable access reported by interview participants is a concern.

'Over in sentenced they make out there is more happening down there but it's not. A little bit more is but not much more. It's like you're on remand you can't do nothing until you get sentenced and you go down to sentenced and bugger all is happening there as well to be honest with you.' (key informant)

'Well here, remand's got no drug and alcohol. We've got one course 'Relapse Prevention' and that's all we can do.' (key informant)

'That relapse prevention course, that would have been really good, like it seemed really good on that first thing, but they just never come back and yeah I think just because there's more males than females.' (key informant)

'My name was down for it but never got to it. Especially in remand, they mainly concentrate on the sentenced people.' (key informant)

'Because like we were in protection remand too that, you know like, we were the last for everything basically.' (key informant)

'I think remand get a little less. They don't seem to have as many programs as sentenced. Whether that's right or wrong I don't know.' (key informant)

'Yeah, OK, now go back to the remandees and they get nothing. Now if [a prisoner] is innocent, he's been there for a year and a half already, you know they've all been there for a year plus, nothing, absolutely nothing to do. So why are the programs and particularly the drug and alcohol programs, why are they not permitted to be given to remandees? Surely there's not a human rights thing that says you know you can't.' (key informant)

'And that's certainly the feedback that we have had from the inmates for the last seven months. That there are programs available but they're not available

to everyone all the time. They're available to certain classifications. The women certainly don't have as much access to programs as what the males do.' (key informant)

Quality of programs

There were several positive reports about the drug programs on offer at the AMC. Many individuals found the content helpful and believed it would help them make positive changes to their lives post-release.

'It's helped me a lot already, just my way of thinking and so forth.' (key informant)

'I wouldn't have a plan if I didn't do Relapse Prevention.' (key informant)

'I've got to do this cognitive behavioural therapy it's called 'Cogs' and I've found it very helpful because you kind of work things out before you go off at people kind of thing.' (key informant)

'Yeah I reckon there are a lot of things there that will help me.' (key informant)

'They put a lot of work into it, I'll give them that. Yeah, they done well.' (key informant)

Prison staff and community service providers saw some positive aspects to the therapeutic programs, but believed they were not working to their full potential.

'They do run some groups which are pretty good and the facilitators seem to be very good and they seem, from what I can see, to have a good relationship with the people that we see. They probably could do more.' (key informant)

There was some negative feedback about the content and facilitation of programs. Participants were concerned that programs were too closely based on textbooks or only loosely relevant or specific to drug and alcohol management and that facilitators perhaps didn't have sufficient specialist expertise. These issues may relate to the relatively high proportion of voluntary program withdrawal reported earlier.

'I'm not saying they're incompetent or not very good at their job but they're not interested or I don't know they don't seem to do it right.' (key informant)

'The way it was run was pretty sketchy. The coordinators don't have drug issues so they're like a text book counsellor who wouldn't understand the ways of an addict.' (key informant)

'Honestly the most help I got around drugs and alcohol I got in cognitive self change. ... But that's not even a drug and alcohol course and that's like the most help I got with my drug and alcohol issues which is pretty bad.' (key informant)

'She was reading out of a book all the time not from her own experience. I get more from people who have been in addiction.' (key informant)

'It's like we ended up teaching them you know what I mean. Like some of the girls did the hep C program and they ended up teaching the facilitators more than what they could give the information to the girls.' (key informant)

'Just in our staff that run our programs there are none of them that have a background in alcohol and drugs.' (key informant)

Evaluations of therapeutic programs were occurring and being used to improve the content of programs via a continuous quality improvement process. This was leading to greater tailoring of programs to meet AMC prisoner needs, but the ability to tailor to the needs of individuals is severely limited by the group context in which programs are delivered. This is mentioned in the Individual counselling section of this report (9.3) as being a particular issue for the effectiveness of programs delivered at the AMC.

'Over here in terms of evaluation of programs we do that through client self report, through their evaluation forms, through the focus group and also through our own personal research around current better practice.' (key informant)

Frequency and regularity of programs

Where programs were commenced, they often ran irregularly (as reflected in the earlier quantitative data) or ceased without prisoners understanding why. Program schedules also reportedly clashed with other activities happening in the prison, like specific health clinics, visits, NGOs attending the prison and educational programs; it is unclear if these factors may relate to the relatively high proportion of non-completions relating to 'lack of participation/dismissal' reported earlier for some programs. Some prisoner and ex-prisoner interviewees believed the programs needed to be run more frequently and some questioned the quality of the programs and the way in which they were delivered.

'Only now and again they run the drug and alcohol program up there.' (key informant)

'Yeah it was pretty hard to get into. It's run irregularly.' (key informant)

'I started a course, it's been going for about seven weeks probably. I just got to the third week this week, maybe eight weeks ago maybe.' (key informant)

'While I'm in here I'm doing a cognitive skills program and a 'First Steps' workshop which I haven't really done yet because every time they seem to come on a Monday we seem to have other things going.' (key informant)

'There's a drug and alcohol course I'm supposed to do called 'First Steps' to be released but they keep coming on the wrong day and shit and it's been a fuck around.' (key informant)

'When I went into the AMC I asked to do relapse prevention and that and I didn't get offered any. They had none running the whole six months I was there and then they started to do a drug and alcohol course just before I left. So I couldn't start it anyway.' (key informant)

'There was drug and alcohol programs on Thursdays but they either wouldn't turn up most of the time or you'd be sitting in a class and they'd be like reading off a piece of paper and just not knowing what they're talking about.' (key informant)

'Towards the end of my sentence they just weren't coming at all. Like you'd be expecting them to turn up on Thursday afternoon and they just wouldn't come.' (key informant)

Diversity of programs

All groups of key informants were critical of the range of programs that were on offer. Program choice was considered somewhat narrow and very similar to what is offered in other prisons and completed by individuals in the past. Once prisoners had completed the programs on offer, they found there were no other programs for them to progress to.

'They've got a lot of people to deal with but they've got a fair few drug and alcohol workers and they don't seem to have much programs or the only program they ever seem to have running is 'Relapse Prevention' which I've done 50 times in the past.' (key informant)

'Very very limited. In the 10 months that I've been here it took me not even 4 or 5 months to do all the courses that I could do in this centre and now I'm stuck and there are no courses that I can do.' (key informant)

'I'm stuck and asking for more things to do but there is nothing else I can do. Very limited so they're trying to re-write the program again so that people who have done it already can do it again.' (key informant)

'As far as I'm concerned they need more stuff to do.... Get things done, give you something to do, something to look forward to and work on your issues at the same time.' (key informant)

'I swear with those programs you've done one you've done them all. I think more one on one counselling is better which I'm trying to organise.' (key informant)

'NSW there's heaps to do, heaps of courses, heaps of, especially things to do once all the programs are finished and that. There was nothing to do out there.' (key informant)

'But just towards the end I just found it really boring because it was just very repetitive and it's like they ran out of things to do with us.' (key informant)

'It would be beneficial for all if we could... increase the amount of courses.' (key informant)

'The suite of programs is very limited and it's based pretty much entirely around clinical based therapeutic programs including alcohol and drugs, violent offenders program, sexual offenders programs, family violence program. It's about four or five and they haven't all been running consistently.' (key informant)

By comparison, Corrective Services NSW offers a greater range of programs with varying levels of program intensity. Corrective Services NSW provide 10 AOD-specific programs, including AA/NA programs, readiness programs and criminal conduct and substance use treatment programs. In addition, a range of related but non-AOD-specific programs are offered including general readiness programs, cognitive skills programs, and community engagement programs (Corrective Services NSW, 2009).

Interviewees made suggestions about other types of programs that could be run or changes to existing programs.

'There is no AA, there is no NA which would be, it would be good because there are a lot of alcoholics and narcotics people, people that use narcotics and that.' (key informant)

'They should have people visit from Directions, I think they have one lady from Directions come about the Inside Out Program but they should have it more.' (key informant)

'I'd say if they let inmates build their own drug and alcohol meeting, NA meetings and that like I've seen other jails do it and it works like some blokes might turn up so they can catch up with mates and that but some blokes that really really want it, it works for them if they really want it.' (key informant)

'I don't think there is a lot of anger management is done. That's important in my opinion. Even that can flow through to drugs too. I don't believe there is enough of that. It's probably one course I would be aware of that needs to be increased dramatically.' (key informant)

'A lot of the programs and therapies and things are based on CBT [cognitive behavioural therapy], they need to start looking at some DBT [dialectical behaviour therapy⁸] because they won't learn those things without doing DBT because it's been bypassed.' (key informant)

One participant gave a detailed account of how he believed AOD support like therapeutic programs should be run and his experiences trying to access them at the AMC:

'In an ideal world I've landed myself in prison for something stupid. I'd have drug and alcohol staff, medical staff ready to go. They'd be seeing the person as soon as they walked in the door... At reception and they'd get taken down and getting everything like what's your drug history and then a plan would be made and then two or three days later them same drug and alcohol people would be following up, seeing how interested the prisoner is to get some ideas about how to try and fix his drug problem that he's said.... Yeah and they just continue, while the prisoner's motivated, ready to go and he wants to change his life. He wants the drug and alcohol [support], he wants help from them people and they just attack it full on from there. But here, you're lucky to fuckin' see them within six weeks. Like you've got to put in forms to see them. They won't come and see you unless you put in a form to see them and once you have done that they will come down and say we have this available or that available and we'll put your name down for it and you'll be right. That's what happened with me the other day and now this course was meant to be going Friday and I haven't heard boo from the bloke.' (key informant)

⁸ Dialectical behaviour therapy is a counselling therapy approach that combines standard cognitive-behavioural techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice.

Summary

- Poor access to programs, passive sign-up processes, under-promotion
- High non-completion rates of programs
- Poor or no program access negatively impacting on release or bail
- Differential access to programs depending on security classification and gender
- Quality of program content and facilitation inadequate
- Continuous quality improvement occurring
- Irregular frequency of programs being delivered
- Not enough types of programs are offered

9.7 Therapeutic community and external residential rehabilitation

The Solaris Therapeutic Community (TC), a joint venture between ACT Corrective Services and community-based service provider ADFACT, is one of the AMC's drug rehabilitation services. While the AMC provides other drug rehabilitation programs, this section focuses specifically on Solaris TC and will provide some discussion on access to external residential rehabilitation programs.

Solaris is situated within the male sentenced area of the prison. It is located within one of the cottages, and is classified as minimum security. Attendees of the program are not physically segregated from other prisoners and have access to other populations and the same areas of the prison as any other minimum security sentenced male prisoner. In the first twelve months of operation (July 2009 to June 2010), Solaris hosted 20 prisoners, 15 of whom completed the program and three who were involuntarily discharged.

Although the Solaris TC was perceived as offering an effective service (see later), interviewees expressed significant concern that drug rehabilitation programs were not available to all prison populations. Both remand and women prisoners are unable to access Solaris and this was seen by many as grossly inequitable.

'Yeah like it's supposed to be like a jail for rehabilitation but all the rehabilitation is getting done for the men, you know what I mean? Like I said because they're a bigger group but still the women shouldn't just be like falling through the gaps.' (key informant)

'We can't mix prisoners. We can't mix remand with sentenced prisoners so if there were more staff and more resources we could run a TC in different environments. But there is no capacity to do that at the moment so therefore people are excluded.' (key informant)

'I think from the men's side having the therapeutic centre there has worked well for them. In saying that a lot of the men say that it's not fair because they want to access it but there's only a small amount of people that can actually access that. For the women not to have that, that's a big gap.' (key informant)

'One question though is why aren't females given an opportunity to go through something like that?' (key informant)

Solaris TC program providers clarified that being on opioid pharmacotherapy was not considered a barrier or impediment to program participation; however, concerns were expressed about remandees accessing external TC services, with health staff describing prisoners reducing quickly off opioid pharmacotherapy to enter external rehabilitation programs because only abstinence-based programs were available in the Canberra area. The benefits from opioid pharmacotherapy accrue the longer an individual stays on the program, so these rapid withdrawals may negatively impact on the individuals concerned.

The evaluation team received numerous positive comments about the Solaris TC, which was seen as effective for the participants.

'It's a good program if you really want to change your life and stuff. I'd recommend it to anybody.' (key informant)

'I've got heaps of stuff. I can't wait to get out there and test all this stuff out you know. I feel really confident that I'm going to get my life together. I've got a job out there, I've got plenty of plans and stuff.' (key informant)

'Then I just started feeling good within myself you know, I was training, I was working on my body as well and working on my mental and emotional side of things and I don't know I guess I just started feeling a lot more alive.' (key informant)

'The ones I've seen come out of that have been nothing short of amazing personally.' (key informant)

The content of the TC program was discussed by several interviewees. There was concern that the approach was being altered over time and this was confusing to the participants.

'The program changed even while I was there. The rules changed all the time. The format, the big book that they went through, they've scrapped that now... they're just not sure what they're doing.' (key informant)

There was also concern that the program may not adequately cater to those with low literacy levels. Corrective Services informed the evaluation team that literacy issues in any AMC programs are addressed through education and other staff providing additional support as required. The reported availability of this support indicates a need for improving awareness among prisoners that this kind of support is available to ensure that potential participants are not opting out on the basis of a perception that their low literacy will be an impediment.

'There is a lot of writing and a lot of text-book stuff and I'm not a text-book person. I got kicked out of school and I don't like concentrating too much on text-books.' (key informant)

How well the TC environment was preparing participants for life in the real world was also discussed.

'I'm worried when I leave there I'm not going to be around positive people and I'll just relapse back into it. That's what worries me.' (key informant)

'Yeah I'm confident but I still feel like you know, I don't know, I feel like I'm wrapped in cotton wool at the moment in this safe environment. It's easy, you're around positive people and there is no one trying to bring you down because we're all on the same page.' (key informant)

The location of the TC within the male sentenced area of the AMC was a common concern. There was consensus that the TC would operate better from a more secure location within the AMC. It was believed that the current location was having a significant negative impact on participant outcomes through ongoing exposure to the mainstream prison environment which entails the risk of coercion to act inappropriately and continued association with drug using peers.

'I think it's a great idea in theory but it's in the wrong place, I don't think it can work under those conditions. The guys are in programs for a few hours a day and then they're in the normal population for the rest.' (key informant)

'I certainly think that it should be in a different setting. It should be outside the wall or at least inaccessible.' (key informant)

'The therapeutic community working in a prison environment is difficult because of influence from others. You only need one aggrieved prisoner who got kicked out or didn't get in and they want to influence those who are there.'
(key informant)

Throughcare issues in linking prisoners with post-release community residential rehabilitation programs were identified. Those unable to access the TC suggested that there wasn't enough assistance to access external residential rehabilitation programs. Prisoners have access to a list of telephone numbers of rehabilitation facilities, but are largely required to contact the services themselves.

'A lot of people come in here or are on remand and they're trying to get to a rehab you know what I mean, they have to sit on that phone out there all day and ring rehabs. There should be somebody that does that with them.' (key informant)

Some external rehabilitation programs regularly provide information and assessment sessions at the AMC and these have resulted in admission to residential rehabilitation programs for prisoners on remand. Where this was facilitated, prisoners were highly appreciative of the support. Canberra Recovery Services facilitated 15 such admissions during the first twelve months' operation of the AMC.

The evaluation team is aware that the Corrective Services AOD Team previously provided some support for referrals to rehabilitation programs, but this function has recently (during the course of this evaluation) been shifted to the AMC Case Managers. It has been reported to the evaluation team that the recent shift of the case management function has negatively affected both the provision of rehabilitation-related support and external providers' ability being able to access the AMC to provide information and assessment services.

Summary

- Access to residential rehabilitation for all populations is needed
- Individuals on opioid pharmacotherapy experiencing access issues with external residential rehabilitation
- TC program viewed as being high quality
- Content of the TC program is changing over time, which program participants find confusing
- Support for program participants with low literacy requires greater promotion to ensure potential participants are aware of it
- TC approach may not adequately prepare participants for a return to the community
- Location of the TC needs to be moved outside of the male sentenced area
- Improved support needed for AMC prisoners not eligible for Solaris TC wanting to access external rehabilitation programs

9.8 Primary healthcare

The evaluation team collected quantitative and qualitative data about primary healthcare services provided at the AMC. This section of the report focuses on general aspects of the care provided to prisoners by ACT Corrections Health Program, such as medications, access to services and quality of services. Specific drug-related services like detoxification (9.10) and opioid pharmacotherapy (9.11) are addressed elsewhere.

Access to services

Concern was expressed by interviewees regarding delays in accessing health staff for consultations. While nursing staff attend the various areas of the prison on a daily or twice-daily basis, prisoners must attend the health centre to see doctors and other practitioners. Unacceptable delays were reported by both prisoners and staff. Staff described the delays as primarily relating to staffing issues, whereas prisoners were more likely to consider the cause of delays to be inaction or a lack of care or attention by staff. These delays are indicative of a lack of equivalence with the accessibility of primary healthcare services such as GP clinics in the community. It is noted that prisoners are not eligible for Medicare benefits, however equivalence is a key principle guiding in-prison health services, as stated in relevant policy in the Desktop policy review section (6.0).

'The only, the biggest problem, is the wait to get in to see a doctor; if you've got something wrong and you want to see a doctor there is sometimes up to a four week wait.' (key informant)

'Well it took three weeks and then... I finally saw the doctor and she said why didn't you fill out this paperwork and this paperwork, we could have seen you and I said because every day I didn't fill it out because the nurse told me every day I'll get you up there today, we promise you. The next day, we've been real busy, we'll get you up there to the clinic tomorrow you know and it just never happened and then finally when I did see the doctor she said yeah it looks like it's probably broken but there's nothing we can do about it now... they wouldn't give me crutches because crutches could be used as weapons so I had to hobble around... it took about six weeks before I could walk even half decently on it.' (key informant)

'But sometimes the list is long I mean I broke my hand two months ago and it took 'em like a month and a half to get me to the doctor and by the time I saw the doctor like they just said we can't do nothing about it. You're just going to have to let it heal itself.' (key informant)

'Like we have a health [based custodial] officer and that post never gets moved so it doesn't matter how under resourced they are we always have a health officer. The health officers will continually tell you time and time again that we need our own health rover [to specifically escort prisoners to attend the Health Centre].' (key informant)

'It might be another two months before they come to the top of the queue; by then they maybe have gone so you know there is that sort of whole systemic thing that's not working.' (key informant)

Although 90% of respondents to the Inmate Health Survey reported that they had visited the AMC Health Centre, no quantitative data were available to determine the frequency of visits, barriers to access, or whether these indicators might vary according to perceived need.

Quality of care

Despite some of the access issues described above, prisoners and ex-prisoners were generally positive about the quality of health staff and services. This was supported by Inmate Health Survey data where 76.3% of respondents rated care provided by ACT Corrections Health Program as 'good' or 'very good'.

'The nurses are good, the doctors are good, the mental health workers are good. I don't have any problem with them and talking about anything with them like I feel pretty open with them.' (key informant)

'Yeah like the dentist is really good.' (key informant)

'Yeah the nurses are excellent.' (key informant)

'Yeah the health staff were good. They were probably the best [staff] there.' (key informant)

Data from the Inmate Health Survey showed that only 59% of prisoners reported being given any information about health services at reception to the AMC. Sometimes prisoners found the health system difficult to navigate.

'Half the time you don't know who to talk to about your medication. Like the nurse, they don't really give you specific answers about anything. A lot of things could be better explained to you when you get here but you do get to see a nurse and stuff but you don't really know how much to tell them.' (key informant)

Consistency of care

Prisoners and staff expressed concern regarding the consistency of care provided. Care was seen as being dependent upon the person providing it, varying attitudes among health staff to specific health problems and different levels of experience with drug and alcohol issues.

'Yeah except for sometimes different nurses, different things.' (key informant)

'They're very inconsistent. One nurse will give you something and the other nurse won't.' (key informant)

'The nurses change day to day. It would be good if they just had a couple of nurses that just done the morning shift so you can get familiarity with them. You could tell them like how about that nicotine patch and not have to wait a whole week for that nurse to be on again just ask them if they remembered. I really think familiarity is really important with services like that.' (key informant)

Systemic problems with communication also impacted on consistency of care.

'By the time you've asked the question on one fortnight you're forgotten what it was, by the time you're come back next fortnight you're busy or someone says we're working on it. We have a doctors' meeting every couple of months

and we can't always get to it. There isn't a good systematic way of informing us what happened.' (key informant)

'From the medical officers' point of view I think it's pretty sketchy. I've seen colleagues try to bring things up to try and make things more coherent and it just basically staggers along and not go anywhere at all.' (key informant)

'Currently we have a range of GPs that come in for sessions, two hour sessions, and they might just come in once a fortnight. What I'm seeing is very frustrating because I end up having to fill in those gaps and provide that continuity, is lack of continuity because the clients are seeing different doctors.' (key informant)

Services like medications were often provided at different times, despite the importance of dosing regularity with dispensing particular types of medications.

'There is no consistency exactly. Like on the weekend you can expect it sometime near lunch time it will show up. During the week sometimes it comes around 10am, sometimes its 10.30.' (key informant)

Some prisoners cited different practices in different parts of the prison.

'Well they give your night time meds they give them to you over here in the mornings and you can hold on to it until whenever you want to take it. Over there your night time meds they give it to you at night times and they don't give it to you in a package and you've got to take it in front of the officer. It's totally different from remand.' (key informant)

'In the cottage they mix protections and mains. Like they get meds together and that. Like I don't see how they can run it that way when protection, that's why people are in protection.' (key informant)

Health staff described how medication rounds provided an opportunity to monitor patients on a daily basis.

'There's no block in terms of accessing GPs and there's no block in seeing nurses... it's quality time but the nurses are out there twice a day.' (key informant)

'The nurses there, medications and all that are attended to and then other clients have the opportunity to come up and put in health requests and to speak to you about something or other.' (key informant)

However, prisoners did not necessarily agree that this practice resulted in their needs being met. They raised issues with inconsistency in how health issues are notified to health staff and then actioned.

'Sometimes you have a nurse work that morning and then she'll bring the medication that night but then you won't see her for a week and then she's like 'oh that's right you wanted that'. It's not fast enough, it would be good if they had some kind of diary that they could write in what people wanted, what that person needs to know about today. You know just list....yeah case notes, not just writing it down on a scrap of paper and if they remember to do something with it you know.' (key informant)

Equivalence with community-based services

There was concern among some prisoners that they were unable to access the same medications in prison that they were prescribed in the community. These concerns are clearly supported by current clinical practice at the AMC that exclude the provision of medications such as buprenorphine, delays in inducting people onto opioid pharmacotherapy and restrictions in the prescribing of some medications for conditions such as anxiety and sleep disorders. These practices conflict with the principle of 'equivalence', which is a key policy basis for service provision at the AMC.

'I think there should be more services for people who are on medications on the outside to have them continued in here.' (key informant)

'They should look at people more and the medications they were on before they came in and sort of help them with that.' (key informant)

In a broader sense, equivalence with community based services was lacking in regards to the accessibility of services in that there were significant delays in getting to see a doctor. Medical issues like chest pains and broken bones were not being responded to in a timely fashion, despite requiring relatively urgent care.

Service improvements

Staff suggested ways in which healthcare at the AMC could be improved. It was considered that assessment at entry was working well, in that all prisoners received assessments, but health staff considered that one assessment instead of two could be conducted to improve efficiency (i.e., general and mental health are currently conducted separately).

Despite the notion of care plans being supported by practitioners, their use was found to be non-existent in the medical records audit conducted by ACT Health (although Forensic Mental Health advised that they had developed recovery plans). The absence of coordinated care plans, in part stemming from the lack of overarching governance and leadership and limited communication and case management coordination between service providers, is a major impediment to effective service provision and throughcare to those with drug dependence problems.

Health staff reported that record keeping in general was poor, as was access to information about individual prisoner histories and other services being received by individuals from different providers. Interviewees suggested that better systems for record keeping needed to be developed to enhance quality care and appropriate clinical governance. In relation to clinical records, the evaluation team was frustrated by the lack of systematic record keeping that hampered a thorough evaluation of clinical and other service provision at the AMC.

Drug and alcohol expertise among health staff was considered to be inadequate. A solution currently being used to address this is for health staff to undertake a four-week placement with the Alcohol and Drug Program of ACT Health. Feedback suggests this has been only partially successful and has not resulted in a desired level of up-skilling of staff, meaning specialist expertise is still lacking.

'I think having some specialist AOD nurses would be helpful considering the amount of alcohol and drug issues there are.' (community service provider)

Summary

- Delays experienced by prisoners in accessing health staff
- Quality of care generally good
- Some concerns with consistency of care
- Systemic problems with prisoners reporting health issues and requests to nursing staff on medication rounds and experiencing a lack of action or response
- Lack of care and discharge planning
- Problems with clinical record keeping
- Equivalence with community-based services lacking in some areas

9.9 Mental health

Key informants often raised concerns relating to mental health in the context of the evaluation of drug policy and services. It was recognised by key informants that adequate mental healthcare is integral to the delivery of effective services that address drug issues, given the high rates of co-morbidity among prisoners. Results from the Inmate Health Survey clearly indicate a high prevalence of mental health morbidities among prisoners at the AMC (see Table 8). This is consistent with mental health morbidity in prisoner populations, often co-occurring with drug use issues, described in the Brief literature review (section 7.0). More than three quarters of prisoners who responded to survey questions on mental health reported having ever received a mental health diagnosis from a doctor, most commonly depression and anxiety. Current psychological distress, as measured by the Kessler Psychological Distress Scale (K10), was also considerably higher than Australian population norms. The prevalence of lifetime suicidal ideation was high, with more than 40% of all respondents reporting having ever contemplated suicide and more than two-thirds of these respondents reporting having actually attempted suicide. Approximately half of these participants reported that their suicidal ideation had decreased since entering prison. These data indicate very high levels of mental health morbidity typical of incarcerated populations and a high level of need for mental healthcare services among prisoners at the AMC, much of which was reported as being unmet.

'So we don't reach in, we don't cover half of what we would need to. There's what 220 prisoners and I think we have about maybe 50 in our intervention team and maybe another 30 waiting or on the assessment list.' (key informant)

Table 8 Mental health morbidity, Inmate Health Survey, May 2010

Diagnosis of mental health	Percentage (n)
Ever told by doctor you have depression	78.7% (74/94)
Ever told by doctor you have schizophrenia	20.2% (19/94)
Ever told by doctor you are manic depressive/psychosis	14.9% (14/94)
Ever told by doctor you have anxiety	63.8% (60/94)
Ever told by doctor you have personality disorder	23.4% (22/94)
Psychological distress (K10)	
No or low distress (score 10-15)	14.1% (9/64)
Moderate distress (score 16-21)	43.8% (28/64)
High distress (score 22-29)	34.4% (22/64)
Very high distress (score 30-50)	7.8% (5/64)
Ever thought about suicide	40.6% (54/133)
If yes to above, thoughts about suicide since coming into prison have these thoughts ...	
Increased	20.8% (11/53)
Decreased	47.2% (25/53)
Remained about the same	32.1% (17/53)
Ever attempted suicide	68.5% (37/54)
Ever deliberately harmed/injured yourself	52.9% (27/51)

The coverage of mental health assessments at the AMC appears reasonable with 70% of respondents to the Inmate Health Survey reporting that they had received treatment or been assessed by a psychiatrist or doctor for mental health problems while at the AMC. Nevertheless, the comprehensiveness, responsiveness and quality of mental health services was questioned by many key informants.

Prisoners and ex-prisoners reported difficulties in accessing mental health staff for counselling and for medications. It was acknowledged that the Forensic Mental Health program at the AMC is under-resourced and much need remains unmet. Prisoners experienced delays in seeing mental health staff, despite making repeated requests to do so. Individuals reported withdrawing from mental health medications following admission to the AMC, then being re-commenced on the same medications after seeing staff. Corrective Services informed the evaluation team that delays in continuing medications may be due to health staff needing to confirm medications with prescribers in the community.

'When I got here I had to wait four days for my anti-depressants... and I've put in to see Mental Health three times now, three notes and a fourth one this morning.' (key informant)

'And just with the psych medication I think, like out there you get locked up, you might have to wait a week or two to get on your psych [medication]...

Yeah and I think that's wrong, yeah because a lot of the medication you can't just jump off.' (key informant)

'So I think they need to, Mental Health need to interact with the girls a bit more. Especially if they're asking for help and not getting it.' (key informant)

Dual diagnosis⁹ among prisoners was seen as a complex issue that was not being managed well. Many key informants highlighted that drug and alcohol issues could not be managed in isolation from co-occurring mental health problems. These concerns amplify the challenges associated with effective case management and complementary and coordinated health services when different treatment and support programs are offered by different teams. Interviewees reported problems with communication between programs.

'The other thing is about the management of people with complex dual diagnosis. Virtually dual diagnosis is the norm inside; it's not the 5% or 10% that it might be in the general community. Virtually everyone who has a significant mental health in there has a significant substance use problem as well. The extent of them is obviously going to vary but I'm not sure they're actually being managed as dual diagnosis patients.' (key informant)

'We've got a mental health side who are not liaising with us, not case conferencing with us, not care planning with us and prescribing all kinds of psychotropic medication that is traded. They're on a completely different arm of the service. They're physically located in the same, in the Hume Health Centre, but it's like this grand canyon down the middle.' (key informant)

Where access to services is delayed (a frequent occurrence as reported above), it was felt that custodial officers were not adequately resourced to support or respond to unwell individuals in the interim.

'The biggest concern at the moment is that corrections officers don't seem to be routinely trained in the proper [responses] or how to recognise people with mental health issues, how to manage people with mental health issues. How they should deal with people with mental health issues and there also seems to be a feeling that oh well privacy legislation means you're not allowed to tell people's medical history. We can't do that. So they've built this wall that we can't tell the corrections officers this person is in fact has a clinical diagnosed mental illness or any other medication condition for that matter. A consequence of this is we think there are people with mental illness who are not being managed appropriately and the corrections officers haven't received the training and don't have the understanding they need to manage those people.' (key informant)

'They're waiting over a week and a half to speak to mental health... It's a very long time and you get these girls saying well if you don't get me there I'm going to slash up and hurt myself. Then they get thrown in CSU in these smocks and things and they still don't get talked to.' (key informant)

Prisoners, ex-prisoners and prison health staff reported insufficient access to prescribed benzodiazepines at the AMC. Interviewees were concerned that this meant little support was provided for anxiety or sleep problems. Mental health

⁹ The presence of co-occurring drug use issues and mental health issues

staff reported that resources were not adequate to respond to 'high prevalence' mental health issues like depression, anxiety and sleep disorders. Instead, resources were focused on psychotic illnesses, as these were considered more serious. This concurs with reports presented earlier of prisoners perceived as having less acute or serious problems experiencing poor access to mental health counselling (see section 9.3). The evaluation team observed that prisoners may need to become acutely unwell to get mental health support, when early intervention could potentially have prevented this escalation.

Furthermore, the evaluators observed that prisoners lacked access to medications and treatments (e.g., for anxiety or sleep) equivalent to that available in the community. Many prisoners were involuntarily detoxed off medications and these were not replaced with behavioural interventions. Furthermore, prisoners, ex-prisoners, prison health staff and community service providers interviewed were concerned that anti-psychotic medications were being prescribed to prisoners instead of appropriate counselling or behavioural interventions to assist with sleep and anxiety disorders. Some community service providers believed this was designed to make prisoners 'easier to manage' from a behavioural point of view, but did nothing to treat underlying problems.

'I just have a hard time sleeping at the moment and I don't know why that is. They don't like giving any kind of sleeping pills here. I would like something to help me relax so I could sleep. I suffer from anxiety where I hop into bed and I'm really tired but I can't stop thinking which is what I think anxiety is.' (key informant)

'That is one of the areas again where prisoners' health, where they are excluded from something that the community can get. I mean in terms of in the community they can get sessions of psychology prescribed by a GP or as referred for four to six sessions in any 12 months.' (key informant)

It was clear from the consultations that there was conflict between ACT Corrections Health Program and Forensic Mental Health. While some measures were in place to ensure communication to facilitate quality care for prisoners, these measures were not consistently implemented or were not working optimally. In particular, disagreements around the prescription of mental health medications appeared to be hampering collaboration and impacting on patient care. Joint meetings were described as poorly attended and sometimes hostile, but it was noted that some communication and information sharing was occurring.

'If you were running it in the best possible world you'd have you know the health care plan but at the moment we can't see the mental health plans.' (key informant)

'There is sharing between the two. We don't as a matter of course get information from them, so we don't always get their induction forms however they always get a copy of ours and ours includes the mental health history as well.' (key informant)

'Probably the doctors would say there's tension with Corrections Health around prescribing, but really we are the tertiary mental health people and the psychiatrists are not juniors, they're actually very senior and so they shouldn't

have to be constantly justifying why they're providing treatment and care to someone.' (key informant)

There was particular concern expressed by community service providers and prisoners about the Crisis Support Unit at the AMC, which houses individuals in acute psychological distress or at risk of self-harm.

'We've been looking into the crisis support unit and I've got some real concerns there about that area being probably worse for people's mental health than looking after people's mental health. They're locked up for so many hours a day and then not having access to programs there is not even televisions in there. There is only one television. It's just basically not been set up as the most conducive way of looking after people's health. If they were in the psychiatric unit at Canberra Hospital they'd be monitored by health professionals and they'd be given treatment by health professionals. Because they're in the CSU mental health goes in once a day I think but they're not being monitored by health professionals.' (key informant)

It is a policy direction (ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008) that prisoners should have access to secure community-based mental health facilities. It is understood by the evaluation team that the Crisis Support Unit is the sole facility in the ACT which is currently able to house prisoners with mental health issues.

Summary

- High prevalence of mental health problems among prisoners
- Prisoners experiencing difficulties in gaining access to mental health staff
- Delays in continuing prescription mental health medications after admission
- Little support available for prisoners with sleep problems and anxiety disorders
- Prisoners report being unable to access non-medication support such as counselling
- Conflict between Forensic Mental Health and ACT Corrections Health Program
- Issues with Crisis Support Unit

9.10 Detoxification

Prisoner, ex-prisoner and health staff key informants described the detoxification 'packs' that are available to prisoners at reception to the AMC (if they are assessed as being in withdrawal during their general health assessment and induction, which includes a drug and alcohol component). This assessment and the subsequent provision of detoxification packs does not rely on the observation of physical signs of withdrawal alone, and may occur in response to prisoner self-report of drug use prior to admission to the AMC. No quantitative data on the administration of detoxification regimes were provided to the evaluation team.

Different packs are available for opioid, benzodiazepine and alcohol withdrawal. These are medicated withdrawal regimes that include standardised doses of medications that gradually taper off over several days. Those using the packs are monitored throughout their detoxification to check whether the dosing levels are appropriate. Prisoner and ex-prisoner participants noted that there were sometimes delays in having their dose increased to reduce the symptoms of withdrawal, after standard doses proved inadequate.

'One of the other inmates helped me to speak with the nurse and that and tell the nurse that the Valium and the Doloxene just weren't holding me, wasn't enough. They got me up to see the doctor on the Monday and I came in on the Friday.' (key informant)

Prisoners and ex-prisoners cited examples of detoxing off medications such as methadone or oxycodone and receiving no medicated withdrawal. There was also concern that amphetamine users received no detoxification support, medicated or otherwise.

'One thing I found weird since I got here is that I actually got off the methadone in here.... they couldn't help me with anything as far as withdrawal. I've seen the doctor twice. If I came in off the street and I was withdrawing from heroin they would have given me something to help me sleep but when I got off the methadone, they you know, methadone's just as hard as the heroin to get off, it's probably harder but they couldn't help me.' (key informant)

'Here's your valium for a couple of days and on your bike sort of thing.' (key informant)

'I reckon the opiate users got a lot more. Like with their methadone, they can get on drugs to come down off it, whereas the amphetamine users are just, yeah.' (key informant)

Others highlighted that medicated withdrawal alone was inadequate and other support such as counselling could have assisted them through their detoxification.

'One thing when I did come in was I was on Xanax for real bad anxiety attacks and stuff like that and they just cut me straight off it which is understandable but they didn't medicate me with anything else and I had an anxiety attack, panic attack in my cell. I was just left there to deal with it myself... They wouldn't help.' (key informant)

The question of when to use detoxification packs and when to induct prisoners on to treatments like methadone was discussed. Health staff believed that fully

detoxing individuals before putting them on opioid pharmacotherapy was safer, given prisoners' varying levels of dependence.

'We don't know, objectively we don't know you know where they are in their detox program so it's much safer in inducting them in the therapeutic program from zero again.' (key informant)

'It's our safety and it's not unkind.' (key informant)

The clinical review conducted by Dr Adam Winstock in October 2008 suggested that delays in inducting individuals on to opioid pharmacotherapy, were unacceptable and unnecessary, yet at the time of this evaluation it appeared that little had changed. The Winstock review also suggested that medicated withdrawal should not commence until signs of withdrawal are observed; this was considered safer and better practice. This advice conflicts with practices reported at the AMC in this evaluation. The lack of 24 hour nursing care at the AMC was seen by key informants as contributing to the practice of dosing prior to the observation of withdrawal symptoms. Scoring dependence levels during assessment was suggested as a way to counter this difficulty.

'A sad thing is a lot of the nurses can get upset is when they come in the next day and find out that they've been hanging out all night and been sick during the night. Not sick enough to call a doctor but you know and you see them the next morning and you think gosh if they'd just got one dose into them before the nurses went off duty you could have prevented that. So we don't wait for withdrawal signs.' (key informant)

Summary

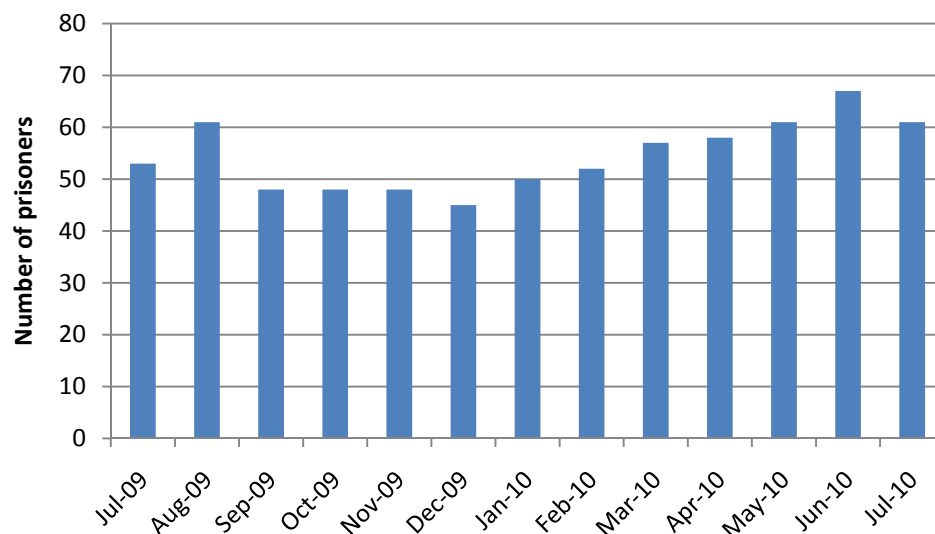
- Standard detoxification 'packs' are provided at admission for dependence on illicit opioids, benzodiazepines and alcohol
- Delays experienced by prisoners in seeing medical officers for review of detoxification regimes
- No assistance for prisoners withdrawing from prescription medications
- Lack of non-medication support (for example counselling) for detoxification
- No medication provided for amphetamine withdrawal
- Safety issues reported by staff with initiating prisoners on to withdrawal regimes
- Contrary to previous advice, prisoners are being detoxified before being inducted on to opioid pharmacotherapy
- Responding to signs of withdrawal to initiate detoxification regimes recommended instead of responding to self-reported drug use

9.11 Opioid pharmacotherapy

Opioid pharmacotherapy was one of the topics raised most often in interviews. Figure 4 shows the monthly aggregated numbers of prisoners receiving opioid pharmacotherapy at the AMC between 1 July 2009 and July 2010. These data represent the total number of individuals that received at least one dose in a given month, but it is difficult to determine the proportion of the AMC prison population receiving opioid pharmacotherapy over time. No data are collected on length of stay in the program or dosing levels (i.e., average dose across all participants) hindering analysis of the adequacy of the program.

There is some recording of the rates at which people continue to receive opioid pharmacotherapy post-release. Interviewee responses suggest that many prisoners do not continue opioid pharmacotherapy after release, and this is supported by the quantitative data, which indicated that from June 2009 to May 2010, only 15 individuals continued opioid pharmacotherapy for at least three months post-release. It is not clear if this high dropout rate is due to voluntary cessation of the program, lack of coordination of treatment at release or a lack of access to treatment once prisoners return to the community.

Figure 4 Monthly aggregated numbers of prisoners receiving opioid pharmacotherapy, July 2009 to July 2010



Access to opioid pharmacotherapy

While most key informants agreed that prisoners could start opioid pharmacotherapy fairly quickly, this occurred only if they were already on a program in the community. In this case, health staff obtain a dosing history from the community-based opioid pharmacotherapy provider and continue dosing on the existing regime.

'To get on the methadone program it's pretty easy here. They do it pretty quickly and that.' (key informant)

'It was the same day.' (key informant)

'No, no delay at all. You just got on it the next day, I got on it the same day.'
(key informant)

Prisoners that not receiving opioid pharmacotherapy at prison entry often experience significant delays in receiving opioid pharmacotherapy in the AMC. These delays meant that often individuals were withdrawn from opiates to such an extent that they could be considered as having undergone full detoxification. Consensus on this point was received from prisoners, ex-prisoners, health staff and community service providers.

'You have to wait a week which kind of sucks because you've finished withdrawals. It's stupid.' (key informant)

'We get women that get locked up in there and its four days, five days before they've seen a doctor, then they're put on methadone. Well they've already withdrawn.' (key informant)

'I can't see any point on detoxing someone and then putting them on methadone.' (key informant)

'It took them a while just to get me on the methadone and by the time I did get on it I was already clean already. Do you know what I mean? The time when I needed it the most it took them a week and a half to get me on it.'
(key informant)

Prisoner and ex-prisoner key informants raised concern with the delays and often questioned why delays needed to happen. Many service providers also disagreed with delays and did not believe that there was a clinical need to delay dosing individuals, particularly when they were in severe withdrawal. These key informants believed that the current scenario was unnecessarily cruel.

'I come in and it took me like a week maybe more to get onto it.' (key informant)

'I hung out for five days up on the remand unit and then after five days they put me on methadone.' (key informant)

'It took me about three days to get on it. I came in here in severe withdrawal, pretty bad.' (key informant)

'Yep. I was crook for about three weeks when I come in here... I had to wait a week to get on the methadone so that just took an extra week of me hanging out.' (key informant)

'Yeah you've got to hang out for a few weeks and then you can jump onto the methadone. So it's just stupid to me. I don't know how that works.' (key informant)

'Yeah like some of the girls like when you get here if you don't get here on the day that methadone is ordered then you have to go on the doloxene withdrawal pack and some of these girls are on 100 and whatever and they won't give them methadone, they've got no back up so they put them on the doloxene pack and that doesn't hold them. So it's not right.' (key informant)

'Yeah, normally they make you wait a week but because I was really sick they put me on it straight away and brought me up by 10mls every day but that was only because I was pregnant too.' (key informant)

Others were concerned that informed consent couldn't be given if an individual was experiencing withdrawal symptoms.

'My belief is people will ask for methadone out of desperation because they don't like the withdrawal and that's the best thing they know of. In fact they don't actually want to be on methadone but they're not really in a position to make an informed decision about whether they want to be on methadone long term in the first few days of their withdrawal.' (key informant)

Some prisoners, ex-prisoners, community service providers and Corrective Services staff were concerned that prisoners experienced undue influence from health staff to commence methadone, especially after they had detoxed from other drugs.

'I found myself that they try and push methadone on a lot of people.' (key informant)

'I don't like it but they do push it on a lot of people which they should be able to make up their own mind about that.' (key informant)

'They push push push the methadone [after people have withdrawn].' (key informant)

'They sort of push it on you.' (key informant)

'I had one woman who was very much a child, just made it in there, was breached for parole. Her parole stated that she must be on the methadone program. Now every time she would go to the methadone clinic she'd run into the old people and that situation and within three weeks of being back on that, she couldn't, she was dealing, she was using other drugs, so she decided she wasn't going to do it so she just didn't go to get her methadone. She actually dried out, cleaned herself out, hadn't used anything in three months, they breached her for her parole, put her back into prison and put her back on methadone and refused to bail her unless she kept taking the methadone.' (key informant)

'I have had clients that you know have told me that they've been coerced into going onto the methadone program when they've not wanted to.' (key informant)

Buprenorphine

All stakeholder groups discussed the lack of availability of buprenorphine. Many believed that a buprenorphine preparation should be available (as it is in prisons in some other jurisdictions) in the same way that methadone is available. Corrective Services staff, community service providers, prisoners and ex-prisoners considered that were buprenorphine to be offered by ACT Corrections Health Program improved equivalence with community-based services would be achieved.

'They do make it hard for a few people on the bupe program.' (key informant)

'If someone wants to get on the bupe they should be encouraged like out there to get on the bupe.' (key informant)

'I don't think the rationale for methadone as the only pharmacotherapy being provided is sound. I think it's about personal agendas and I would like to see buprenorphine.' (key informant)

'Pharmacotherapy, replacement therapy, it might be useful to actually have more than methadone.' (key informant)

'Here if you go to the doctor and say look there are reasons behind why I want to get on the bupe he won't put you on the bupe... If you come in off the street on bupe they will switch you straight over to methadone. They don't even bring you down they just swap you straight over to methadone and say that's it.' (key informant)

'It seems eminently sensible for somebody who hasn't been on methadone [to go on buprenorphine] you know, why is prison the place where they can't manage their medication adequately so that bupe is such a threat to them, the trading of bupe?' (key informant)

'I probably find a bit disturbing is that they can't have bupe while they're in there, they've got to have methadone and you know, we know that methadone is different to bupe and some people go up so high on their methadone not realising that its going to be so difficult to come off, to come down off and some people don't want to be on methadone but they can't, they haven't got that choice. I've had a few clients in that situation, they've been devastated.' (key informant)

Some key informants expressed concerns about the introduction of some buprenorphine preparations and their potential for diversion. While the introduction of buprenorphine preparations at the AMC may help limit the trafficking of buprenorphine into the prison and offer greater equivalence, consideration should be given to the potential for buprenorphine diversion at the AMC prior to changes to the pharmacotherapy program being considered.

Diversion

Diversion of a range of medications was reported to the evaluation team, including opioid pharmacotherapy; however, diversion was not observed by the evaluation team to be a common practice, and a relatively minor concern compared with the trafficking and use of illicit drugs brought into the prison from the community.

'I've actually been on it for a while because I get other peoples' doses and that but it was just a fuck around for me to try and get on it myself and while I'm waiting I have to get other people's half dose and it's just a hassle. It took me a whole week and a half to try and get on it but I find it does help me.' (key informant)

'They say the reason is because of the diversion of bupe, but they talk about the diversion of bupe in the jail when in actual fact it's not necessarily the diversion in jail it's because bupe is coming in.' (key informant)

Dispensing arrangements

ACT Corrections Health Program staff and community service providers described the current pharmacy opioid pharmacotherapy dispensing arrangements, in which a commercial pharmacist prepares measured doses off-site in what were described to the evaluation team as 'take away dose' bottles. Health staff and community service providers believed that the ACT hospital pharmacist should be providing the methadone on-site rather than the external commercial pharmacy. It was felt that on-site measurement of doses would be more efficient and result in fewer delays in commencing on methadone (and in having doses adjusted), as access to methadone for new prisoners wouldn't be reliant on the weekly ordering of methadone from the external pharmacy. The evaluation team was advised that additional doses are stored on-site for the purposes of induction and dose adjustment, which suggests that delays are the result of a specific intention to detox individuals or enforce a once-weekly opportunity to alter doses, rather than systemic supply-related issues.

The times at which methadone is dispensed at the AMC were also of concern to both staff and prisoners. Some staff felt that prisoners should not be dosed if they didn't present at the specified dosing time, whereas others felt that doses should not be denied as a matter of principle. Some considered that refusing to dose when prisoners did not present instilled a sense of discipline and maintained a workable schedule of dosing so that individuals in other areas of the prison did not have to wait. Changes in the time of dosing were raised by interviewees.

'When they come and dose me a number of times they're running late or...something like that.' (key informant)

'On a Sunday it doesn't come until about 11am sometimes.' (key informant)

'One guy will be educated in a minute if some other guys finds another way around the loop so you can stay in bed, get dosed at 12 o'clock, all of a sudden they all want it which is a fairly natural process but its unworkable.' (key informant)

'For us certainly less now but certainly in the initial stages methadone dosing was a big issue. People either having not got the message that they need to get themselves to a certain place at a certain time otherwise they were to miss out.' (key informant)

Dose adjustments

Interviewees described processes for adjustments to doses (increases and reductions) at the AMC as inadequate. Currently, prisoners need to notify health staff on a weekly basis of desired reductions or increases to doses. Doses can be changed by 5-10mgs at a time and these changes are then implemented the following week. This restricted frequency and volume of dose changes is not consistent with the flexibility available in community-based services. In addition, conversations about dose adjustment at the AMC take place during medication rounds, which offers limited privacy and confidentiality to prisoners and limited time in which to have the conversation, as others are generally waiting to be dosed. The quality of this interaction was questioned by prisoners and prison staff.

'They keep telling me I've got to jump off 5ml [milligrams] or receive it every second day or maybe every third day.... On the outside at the clinic you get to go down to 2.5ml [milligrams] and I've asked them if I can just have half of it, can they measure up half in the cup.' (key informant)

'If she got here on the Monday she had to then wait until Sunday [for dose adjustments].' (key informant)

'You have to wait a week to move up or down.' (key informant)

'In the community they can adjust their doses twice a week; here they can only adjust it once a week. It's a discipline. It has no clinical relevance.' (key informant)

'You've got nurses on rotating rosters and what have you so they're conducting their methadone medication round and the orders are taken on a Sunday so you know you come up and get your methadone from me Sunday morning and I also ask you what do you want to do next week basically. There is no opportunity because you're doing it through a little, you've seen the little glass hatch we operate. There is no opportunity to have any conversation about that.' (key informant)

'Some of the nurses are really good, you can have a good chat to them and they could advise you, you know like, but other nurses would be like what are you doing on the methadone, you should get off it, you know some of them didn't have a clue you know.' (key informant)

'To me I was more concerned that about the way their doses go up or down that they're seemingly determining what dose they want to be on for the next week by telling the nurse at the end of the queue in a big block of people. That's not the way, that's not case management.' (key informant)

All individuals that were inducted on to opioid pharmacotherapy at the AMC, without having transferred from a community-based program, received a starting dose of 30mg. Many health staff felt that some prisoners were on sub-therapeutic doses of opioid pharmacotherapy in the absence of a specific intention to reduce and cease opioid pharmacotherapy completely; this was perceived as clinically inappropriate. Some key informants spoke of low-dose pharmacotherapy as being ineffective in reducing overdose risk, preferring complete withdrawal; however, stakeholders expressed concerns in relation to complete withdrawal as being equally ineffective for reducing overdose, and that maintenance at therapeutic doses would be more appropriate for lowering overdose risk.

'A starting dose is 30mgs therefore I can't maintain a person on anything less than 30mgs. I simply cannot.' (key informant)

'A dose at 5mgs, 10mgs, 15mgs is not going to protect them from an overdose so quite frankly its not sustainable, not as a clinician. So at 45mgs we, the conversation gets a little sharper, at 10mgs, 15mgs they've got to have a plan to come off.' (key informant)

Where prisoners do reduce their dose and come off the program, it was perceived by prisoners and community service providers that there was little support for them to do so. Prisoners, ex-prisoners and community service providers felt this

was in stark contrast to the detoxification support provided at entry and encouragement by health staff to get on to methadone during incarceration.

'One thing, if someone wants to jump off it I think they should have like wean 'em down, get 'em on the bupe for 7-10 days or whatever and then after that's finished put them on a withdrawal pack or something.' (key informant)

'A few people have got off the methadone and they haven't helped them which I think it should be a big thing.' (key informant)

Throughcare

Many interviewees raised throughcare as an issue for opioid pharmacotherapy. While arrangements may be made to continue opioid pharmacotherapy after release, it was considered by some prisoners and ex-prisoners that attending community clinics was undesirable after release as this would result in unwanted contact with peers. This desire to avoid peers post-release was reported as contributing to some individuals undergoing fairly rapid reduction schedules so that they could be off methadone by release.

'I'm not going out to the Woden Clinic there because there are a lot of dropkicks who go out there and hang around out there. Just don't want to go out there and see them. It just leads back into the same old crowd and same old people.' (key informant)

The limitations of the quantitative data on opioid pharmacotherapy mean it is difficult to determine if throughcare is the only reason for poor retention in opioid pharmacotherapy following release. Further exploration of reasons for program cessation, including how the acceptability of the public clinic could be improved or how other dispensing arrangements could be accessed, is warranted.

Summary

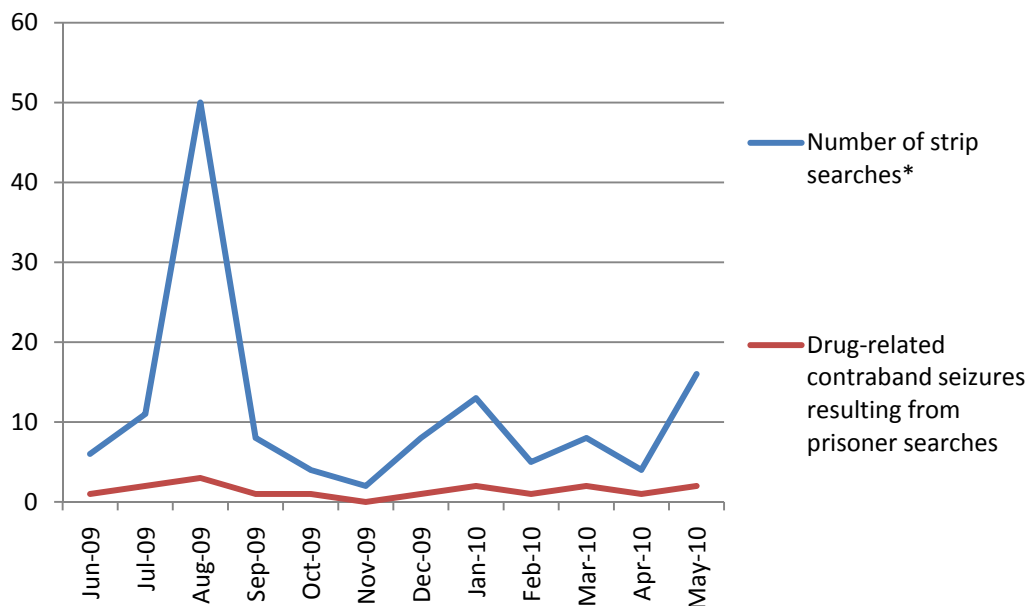
- No waiting list to access opioid pharmacotherapy if already on a program prior to entering prison
- Delays in getting on to opioid pharmacotherapy if not on a program in the community
- No access to buprenorphine
- Some diversion of opioid pharmacotherapy and other medications occurring
- Perceived pressure to go on methadone for those not currently on a program
- Irregular dosing times experienced by prisoners
- Lack of advice and consultation for prisoners regarding reduction schedules
- Importance of maintaining therapeutic doses of opioid pharmacotherapy highlighted by staff and other stakeholders
- Lack of support experienced by prisoners wanting to cease opioid pharmacotherapy following a reduction schedule
- Throughcare may be inadequate to ensure program retention post-release
- Further exploration of reasons for program cessation post-release is needed

9.12 Searches and seizures

Data received by the evaluation team from Corrective Services demonstrate that different types of searches are routinely conducted, though sometimes with inconsistent frequency. It should be noted that searches are not only for the purpose of locating drugs and other contraband items are also being searched for during these procedures.

Figure 5 shows the monthly number of prisoner strip searches at the AMC and the seizures of drug-related contraband as a result of these searches. From June 2009 to May 2010, 135 strip searches were conducted, resulting in 17 drug-related contraband seizures. The number of monthly searches ranged from two (November 2009) to 50 (August 2009), with monthly seizures remaining relatively consistent at between zero and three. Contraband seized included green vegetable matter (n=8), syringes (n=8), tablets (n=3), white powder (n=2) and excess medication (n=1). Although the number of seizures made up a small proportion of strip searches within a given month, there was a strong correlation ($r = .80$, $p = .002$) between number of strip searches conducted and the number of seizures in a particular month.

Figure 5 Number of strip searches and drug-related contraband seizures resulting from these searches, June 2009 to May 2010



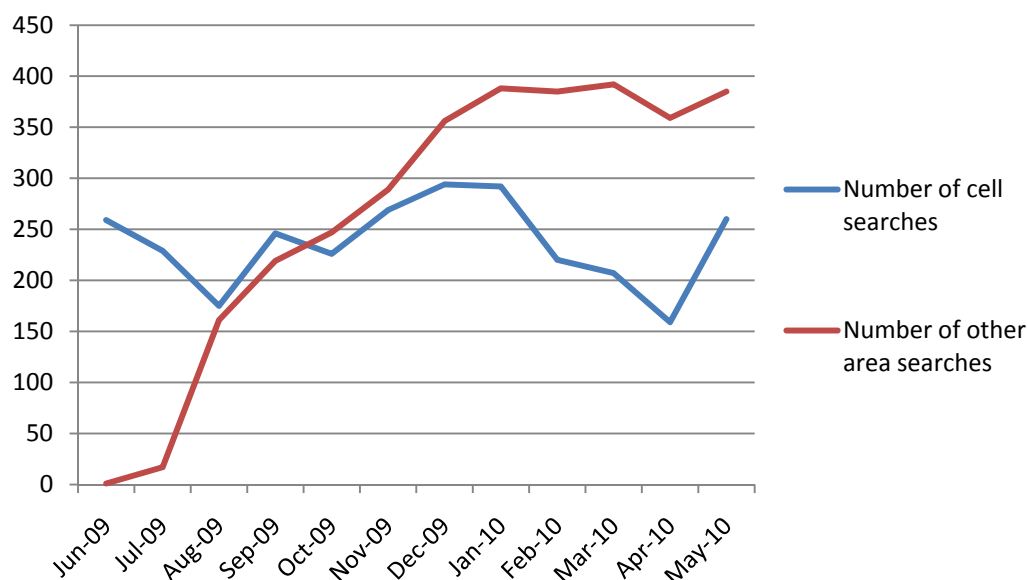
* Includes instances where prisoners were searched more than once in a particular month.

Strip searches were eventually supplemented with SOTER (body scanning machine) searches. Since the SOTER machine was introduced at the AMC in February 2010, 236 SOTER searches have occurred among 143 prisoners up to May 2010, with the number of monthly searches ranging from 27 (February 2010) to 82 (May 2010). These SOTER searches have resulted in one seizure of green vegetable matter.

Searches conducted with drug detection dogs on prisoners were not recorded before March 2010. Between March and May 2010, searches with drug detection dogs on prisoners ranged between 50 and 123 per month. Drug detection dog searches over this period resulted in seizures on two occasions; a syringe, a white substance and white powder were seized.

Figure 6 shows the monthly number of cell and area (e.g., common areas such as yards or cell block kitchens) searches conducted between June 2009 and May 2010. Over this time, 2,836 cell searches and 3,199 area searches were conducted. Whereas the number of monthly cell searches has fluctuated over time, from 294 in December 2009 to 159 in April 2010, the number of area searches has increased consistently over time, from 1 in to June 2009 to 392 in March 2010; these cell and area searches produced 20 and 17 searches respectively. There was a weak relationship between monthly numbers of cell or area searches and monthly seizures of drug-related contraband ($r = .18$, $p = .57$), with cell and area searches resulting in the seizure of drug-related contraband on less than one percent of occasions. It should be noted again that not all searching has the express purpose of locating drug-related contraband. The most common contraband seized in cell searches were tablets ($n=8$), smoking implements ($n=7$) and syringes ($n=3$). The most common contraband seized in area searches were syringes ($n=6$), smoking implements ($n=5$) and green vegetable matter ($n=5$). Between February and May 2010 there were 72 drug detection dog area searches resulting in no seizures.

Figure 6 Number of cell and area searches, June 2009 to May 2010



Visitors to the AMC are also searched using several methods. Between June 2009 and May 2010, there were 5,613 random and targeted searches of visitors to the AMC using drug detection dogs, resulting in 16 seizures of drug-related contraband. Over this time there were 11,884 visitors to the AMC, with all being screened by metal detector. No data were available on seizures resulting from

metal detector searches at the AMC. Monthly searches of visitors using drug detection dogs ranged from a low of 291 (29% of visitors in October 2009) to a high of 906 (102% of recorded visitors in September 2009; this percentage is greater than 100 because the number of searches includes searches of persons who have not registered to enter the AMC, for example searches conducted in the AMC car park or at the entrance of the AMC). Dog searches on visitors over this time resulted in 16 seizures and seized items were consistent with those reported above. Again, there was no relationship between monthly seizures and the coverage of searches as a proportion of all visits, however not all visitors are subjected to dog searches (i.e., these are targeted), whereas all visitors are subject to metal detector searches (i.e., these are untargeted).

Members of the evaluation team were searched at entry and exit from the prison. Team members observed that searching practices were inconsistently applied, as they completed several visits with items (handbags and satchels) in plain view that were later identified as contraband and could not be taken into the AMC. In addition, the evaluation team was later made aware that all belongings brought into the AMC should have been stored in clear plastic valises. This requirement was not raised with evaluation team members during early visits. Team members complied with this requirement once they had been made aware of it.

As with cell and area searches described above and urinalysis tests described later, there is little relationship between the coverage of visitor searches and contraband seized.

Figure 7 Number of drug detection dog and metal detector* visitor searches, June 2009 to May 2010



* All visitors to the AMC are screened via a metal detector. Metal detector searches are therefore a proxy for numbers of visitors to the AMC.

Thirty-seven positive visitor drug indications were detected using an ioniser between June 2009 and February 2010. The numbers of visitors scanned through the ioniser and the number of positive indications that resulted in a seizure were

not recorded. This is due to some positive indications not necessarily indicating that a person is attempting to bring contraband into the AMC. The ioniser is capable of very sensitive detection of drug particles that may be present on a person through normal day to day activities such as handling money.

No quantitative data were provided on the searches conducted on AMC staff, but records showed that no seizures had occurred as a result of either x-ray baggage scanning or metal detector searches. Two positive staff indications occurred in the ioniser, but neither was linked to a seizure.

No needle stick injuries were sustained by staff during searching conducted at the AMC between June 2009 and May 2010.

Interviews generated qualitative data about searching practices. There were varying views among prisoners and ex-prisoners on the effectiveness of searches conducted.

'We should be able to be stripped searched so they can find that kind of paraphernalia. I know I'm supporting the screws but I'm supporting everyone for safety, for everything. There is yard knives, everything is still here.' (key informant)

'They're doing a good job of it really. Drugs are always going to get in. Always. But pretty limited compared to a lot of jails you know for sure.' (key informant)

'They're never going to stop it fully are they but they are trying to do as much as they can to stop it.' (key informant)

'They need to be taught how and where to look for drugs... Even when they raid your room they've got no idea.' (key informant)

'On the visits it's pretty easy to sort of get any sort of drug in that you want through visits or through a ball over the fence.' (key informant)

'Their searching is half arsed, they miss everything, they don't know how to search properly and the boys in there, they're so creative you know, you wouldn't find anything that was hidden you know, it could be anywhere.' (key informant)

'But they miss everything. The screws don't, they're not, you know they just want to get in and out, they're not interested, they don't take everything apart, they don't you know, and there's 110 places to hide things so you know. But yeah, but even, other people just didn't get searched much and the officers couldn't be bothered doing it.' (key informant)

Staff tended to have a positive view of the effectiveness of searches, though some were concerned that not enough resources were devoted to it.

'In fact the drug supply has dried up a little bit of late because of strategies put in place. That will only get better.' (key informant)

'I suppose if I was to be cynical I'd say the biggest success we had was recently when we conducted a search and found half a dozen syringes and withdrew them from use. To me that's a great success because we've improved the health potential of prisoners and the safety of staff and prisoners.' (key informant)

'Searching is not happening I guess as much as I thought it would. That's around resource limitations, they need to be doing more ramps on a regular, random basis. Not just as a result of something happening. We need to be getting more urinalysis screenings happening randomly.' (key informant)

Some interviewees were concerned that searches were used to victimise particular individuals rather than to locate contraband. It was questioned whether searching practices aligned with Corrective Services policy regarding leaving cells in an orderly manner after searches.

'Yeah if you're giving them the shits or something they'll come in three days in a row and turn your room upside down, walk out and they've found nothing and they never had a suspicion.' (key informant)

'They come in and you get strip searched and everything gets searched and they rip your room apart, they search around and they didn't find anything you know and then they'll just leave it upside down and fuck off.' (key informant)

'They search everything and he called me a mole and a slut.' (key informant)

'Like if the screw had a grudge on you or something or didn't like you, yeah you'd cop a lot more than the other boys would.' (key informant)

'Yeah some would be good and leave it pretty tidy or fold your clothes back up, others would just leave a complete mess. Deliberately piss you off to get a reaction and if you do anything, you're in more trouble.' (key informant)

The weak relationship between the coverage of cell and area searches and seizures, alongside self-report and urinalysis data related to drug use in the AMC raises questions regarding the effectiveness of these search strategies. These issues are explored further in the Discussion (10.0) section.

There was some anxiety expressed by prisoners over the use of the SOTER machine and the potential for accompanying risks. Prisoners did not feel they had been adequately informed about potential risks or that risks were very well understood. The evaluation team is aware of a memorandum provided to prisoners on the SOTER machine in March 2010, however further evidence regarding the nature of risk may need to be provided to assuage health concerns.

'Well with their x-ray machine they won't give us no information about the x-ray machine, how much radiation it causes or whatever. I've been waiting for that ever since they brought it up and they still haven't given me no information about it. They've given me a sheet that they've written down themselves that they've made up themselves.' (key informant)

'If they think it's not that much radiation like why do they stand behind the mirror.' (key informant)

'I told them I'm willing to be strip searched but I don't want to go on there and I find a strip search less invasive than going through the x-ray machine and if it's that safe why is there a sign saying 'Caution Radiation'? But yet they won't give me the information about it.' (key informant)

Prison staff were in favour of the use of the SOTER machine as a less invasive form of searching, but didn't consider it to be as effective as strip searching. These concerns regarding the relative effectiveness of the SOTER machine appear

to be borne out in the quantitative data on the proportion of searches (strip versus SOTER searches) resulting in seizures of drug-related material presented earlier.

'Technology will continue to assist us I would say. I would say we're only at the first steps of what we can do with it.' (key informant)

'Strip searching again is very much obviously against human rights but by crikey it used to stop a lot. The amount of stuff we found through strip searches coming out of a visit was just amazing.' (key informant)

Summary

- Inconsistent rates of searching over time
- Drug-related contraband is being seized following searches of prisoners, areas and visitors
- Lack of any meaningful relationship between cell and area search and seizure rates of drug-related contraband over time, however not all searching is intended to locate drug-related contraband
- Concerns about effectiveness of searches and resources required to undertake searches
- Searches allegedly used to victimise individuals
- Safety concerns of prisoners regarding the SOTER machine need to be more effectively addressed

9.13 Urinalysis

Figure 8 shows the monthly untargeted urinalysis tests among new entrants to the AMC as a percentage of monthly entrants (this percentage will slightly over-estimate the proportion of new entrants tested as the data includes a few prisoners who entered the AMC more than once in a single month; see Figure 8 footnote). Between June 2009 and May 2010, 73 tests were conducted on new entrants ('untargeted') to the AMC. Frequency ranged from a low of zero (September and October 2009) to a high of 24 (November 2010) tests per month. As indicated in Figure 8, the proportion of monthly new receptions receiving urinalysis testing varies considerably. To obtain reliable data on trends over time, a systematic and consistent approach to urinalysis should be adopted. Unlike with prisoner searches, urinalysis results report unique individuals, providing greater scope to analyse the effectiveness of testing practices and the coverage of testing within the AMC population.

Figure 8 Untargeted drug urinalysis tests at reception and positive drug indications as a percentage of total prison receptions, June 2009 to May 2010

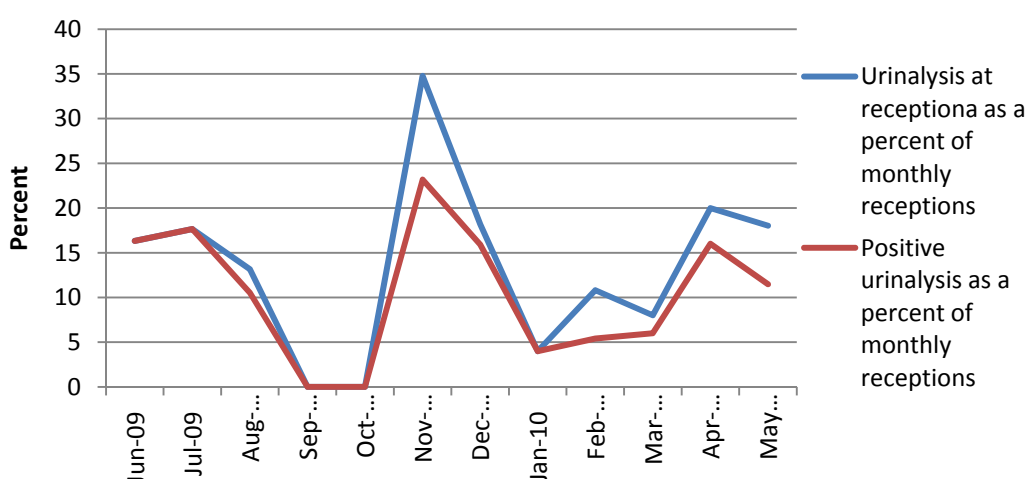


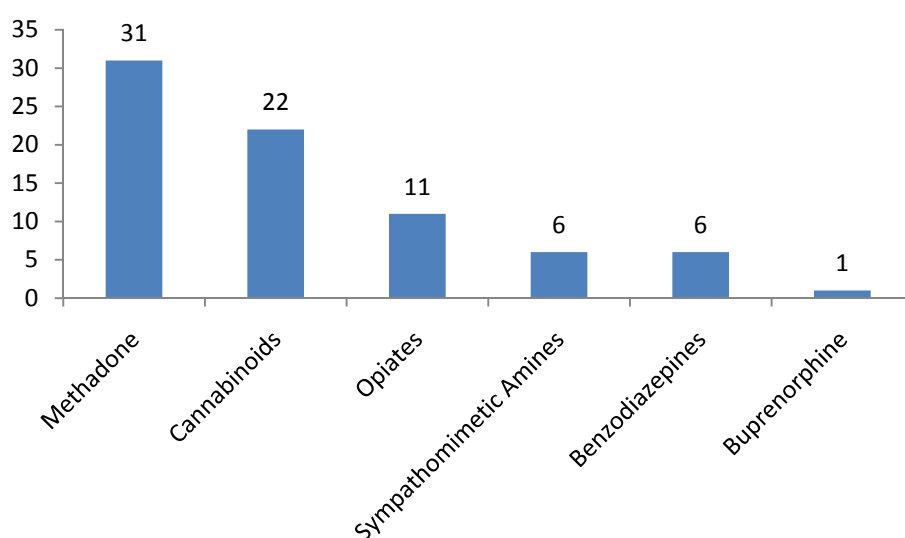
Figure 8 also shows the proportion of total prison entrants that returned positive urinalysis results. Over the reporting period, 55 positive tests on discrete prisoners (11% of all receptions and 75% of reception tests) were recorded. Although the proportion of positive tests generally followed trends in testing, there were some notable exceptions, with 50% of urinalysis tests returning positive results in February 2010 and 100% returning positive results in June and July 2009 and January 2010. It is important to note that these discrepant percentages refer to months where the numbers of tests for 'new receptions' were low (June 2009 – 8; July 2009 – 3; January 2010 – 1; and February 2010 – 4). Monitoring trends in urinalysis results at reception over time will provide the AMC with useful data on demand for drug dependence programs.

Additional random (untargeted) urinalysis testing was conducted in December 2009 when the entire prison population was screened. Of the 169 tests, 13

(7.7%) were positive for at least one drug (18 positive drug indications) that resulted in disciplinary action (thus excluding positive tests associated with licitly prescribed medications). Of the 18 positive drug indications, nine detected cannabis, two detected opiates (other than methadone) and seven detected methadone metabolites.

In addition to these results, between June 2009 and May 2010 there were six positive benzodiazepine detections and one positive buprenorphine detection resulting in sanctions (from 501 targeted tests and 169 random tests (whole of prison tested in December 2009)). Figure 9 shows the number and types of drugs and drug metabolites detected during targeted urinalysis screening between June 2009 and May 2010. The drug types most commonly detected through targeted urinalysis over this period were cannabinoids and methadone (non-prescribed), opiates, sympathomimetic amines (speed or ice) and benzodiazepines. It should be noted that these metabolites may be present as a result of prescribed medication, so are not indicative of positive tests resulting in disciplinary action.

Figure 9 Number and types of drugs and drug metabolites detected during targeted testing resulting in disciplinary action, June 2009 and May 2010*

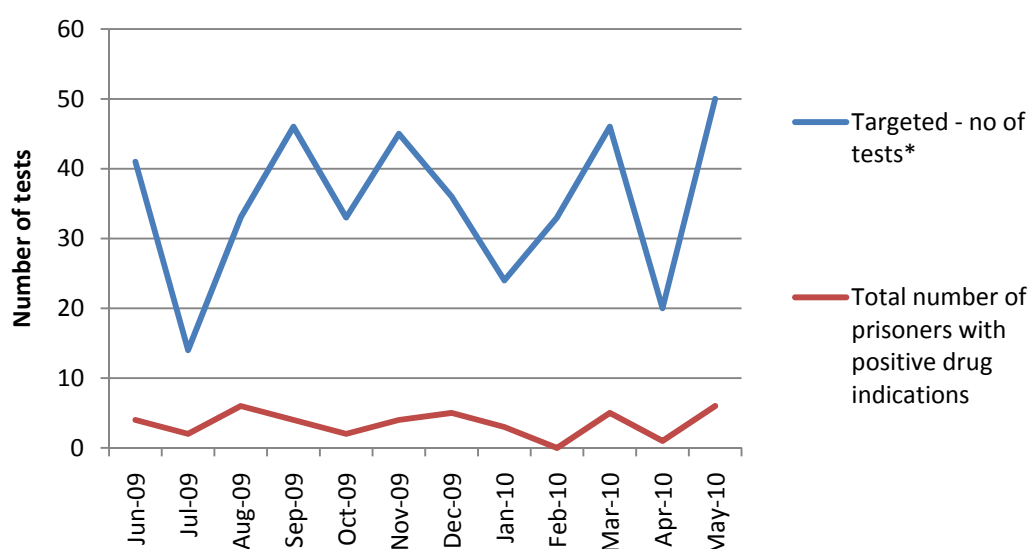


* No detections of cocaine, ketamine or barbituates occurred over this reporting period.

Figure 10 shows the monthly number of prisoners undergoing targeted urinalysis tests and the number returning positive results after admission that resulted in disciplinary action (thus indicating illicit use) between June 2009 and May 2010. Targeted urinalysis after reception was conducted with 421 prisoners between June 2009 and May 2010, ranging from a low of 14 prisoners in a given month (July 2009) to a high of 50 (May 2010). Forty-two prisoners returned positive results (77 drug indications accounting for multiple drug use) over this period. Figure 10 indicates that there was not a strong relationship between the number of targeted tests performed in a given month and the number of positive drug detections across the reporting period. However, from February 2010 to May

2010 a stronger relationship between number of tests and positive detections resulting in disciplinary action was found. Overall, approximately 10% of targeted urinalysis tests resulted in positive drug detections and disciplinary action. The lack of a meaningful relationship between targeted testing and positive tests results suggests that the AMC should review the process by which prisoners are selected for targeted urinalysis (whether based on intelligence or other reasons).

Figure 10 Number of prisoners undergoing targeted drug urinalysis tests after reception and the number returning positive drug indications as a percentage of total prison receptions, June 2009 to May 2010



*tests performed on unique individuals

Qualitative data from prisoner and ex-prisoner interviewees indicated that urinalysis processes were open to manipulation. Corrective Services informed the evaluation team that targeted testing was based on a combination of intelligence and observed behaviour of prisoners.

'It's supposed to be random but it's not. Its targeted, it's always targeted at the same bunch of boys.' (key informant)

'Some got urined more than others if they were under suspicion but they don't stand there and watch you so people just put in a dodgy urine.' (key informant)

'They have guys peeing in a glove and wrapping it on their person so it stays warm and basically they go and do a urine test and they put them in a room with a camera, no supervision and these guys are dodging the urine.' (key informant)

Some of the problems with urinalysis identified by AMC staff related to resourcing.

'In terms of supply reduction there's been major problems there around getting prisoners up to the correct areas to be urined. A little bit of work there I guess.' (key informant)

'I'm not a great fan of random testing I'm more inclined to test on intelligence and target test. It's an expensive operation to be paying for urine testing and if you're random testing and catching people that you know are not inclined to use drugs or have been involved in any way in the net well then it's a waste of resources.' (key informant)

Others concerns expressed by interviewees related to confidentiality and the disclosure of prescribed substances which may be present in a prisoner's urine. At the time of writing, improved informed consent processes were being developed by ACT Corrections Health Program and Corrective Services to ensure that prisoners are aware that they are not consenting to their entire health record being shared with Corrective Services, only to the release of data indicating whether substances detected in urine tests had been prescribed.

'It's a big issue at the moment because every time someone gives a dirty urine they are asked to sign a form in which they give consent to Health to provide their medical information to Corrective Services. So that's useful if you bring back a dirty urine and the information is shared in such a way that actually I'm on methadone or you know I'm legitimately receiving valium for anxiety or something so you need to know that. I've been telling prisoners don't sign it and then they've been getting disciplined for not signing it.' (key informant)

Urinalysis was widely seen by key informants as an important measure, the results of which could be used to guide other supply reduction, demand reduction and harm reduction strategies.

'Having such a small jurisdiction we can really urinalysis test them all frequently and we get an accurate picture of what's coming in.' (key informant)

'I'd say do it de-identified and random. You know get a random sample and de-identify it so that it informs your activities, it's not linked to a punishment system.' (key informant)

Stakeholders suggested that urinalysis results could inform case planning processes, rather than just disciplinary action. For example, individuals with positive results could be prioritised for referral into therapeutic programs or for treatments such as opioid pharmacotherapy.

Summary

- Positive results recorded in targeted and untargeted tests
- Numbers of tests conducted are inconsistent over time
- No strong relationship between targeted testing and positive tests resulting in disciplinary action
- Tests may be open to manipulation
- Conducting urinalysis requires substantial resources
- Privacy and confidentiality issues with disclosure of prescribed substances need to be addressed

- Urinalysis results can provide guidance on other strategies to address drug issues

9.14 Drug use in the AMC prison population

Illicit Drugs

Table 9 shows reported lifetime and recent (12 months prior to prison entry) illicit drug use among Inmate Health Survey respondents. These data demonstrate that a history of illicit drug use (most commonly amphetamines and cannabis) is the norm among people incarcerated at the AMC. Approximately two-thirds of respondents reported lifetime and recent use of heroin and injecting drug use, with heroin the most commonly reported drug used in the 12 months prior to prison entry.

Table 9 Lifetime and recent illicit drug use among AMC prisoners, Inmate Health Survey, May 2010

Drug (illicit)	Ever used Percentage (n)	Used 12 months prior to prison Percentage (n)*
Used any illicit drugs	91.0% (122/134)	
Heroin	64.8% (79/122)	64.6% (51/79)
Cannabis	99.2% (121/122)	60.8% (73/120)
Speed	82.0% (100/122)	54.5% (55/101)
Cocaine	66.4% (81/122)	31.3% (25/80)
Ecstasy	68.0% (83/122)	27.2% (22/81)
LSD/Acid	41.0% (50/122)	15.4% (8/52)
Methadone/buprenorphine		50.7% (38/75)
INJECTING DRUG USE		
Ever injected drugs	66.9% (81/121)	
Age first injected	Median = 17 years	
	Range = 12-36 years	

* Of those that reported lifetime use and responded to the question

Table 10 shows indicators of problematic drug use among Inmate Health Survey respondents, primarily relating to drug use and offending behaviour and drug dependence treatment need. Nearly four in five respondents with a history of drug use reported that they were under the influence of alcohol and/or drugs when they committed the offence for which they were imprisoned. Similar proportions reported that their current imprisonment episode was related to their alcohol and/or drug use. These data are indicative of the close relationship between crime and drug use and in turn the potential benefit of effective drug and alcohol policy and service provision on reducing crime and incarceration rates. Many of these respondents are also likely to be receptive to and benefit from quality dependence treatment, with more than half reporting having ever been told they were drug dependent by a doctor, one quarter having ever been

told they were alcohol dependent and approximately 40% reporting that they required help to quit drugs.

Table 10 Indicators of problematic drug use among AMC prisoners, Inmate Health Survey, May 2010

Problematic drug use indicator	Percentage (n)
Under influence of alcohol/drugs for offence related to this imprisonment	78.9% (97/123)
Combination of many	33.0% (32/97)
Alcohol	32.0% (31/97)
Amphetamines/speed [combined below RED]	13.4%(13/97)
Heroin	10.3% (10/97)
Cannabis	6.2% (6/97)
Other	5.2% (5/97)
Current imprisonment linked to drugs/alcohol	
No	26.1% (31/119)
Yes, alcohol	14.3% (17/119)
Yes, drugs	38.7% (46/119)
Yes, both drugs and alcohol	21.0% (25/119)
Need help quitting drugs	41.8% (51/122)
Ever told by doctor you have drug dependence	52.1% (49/94)
Ever told by doctor you have alcohol dependence	25.5% (24/94)

These quantitative data on drug use histories accord with responses from interview participants. Prison staff and other service providers consistently reported that they believed that drug use issues were prevalent among the prison population, as was drug use at the AMC.

'We've got probably 65%-70% of our prisoners are in here because of a drug related offence.' (key informant)

'We've got them incarcerated but we're still not reducing their usage.' (key informant)

'There's an enormous amount of drugs in this jail. I'm absolutely blown away.' (key informant)

The inevitability of drugs entering the AMC routinely underpinned notions of interdiction interrupting rather than preventing drugs entering the prison.

'It's a game of chess. They will try and find a way to introduce it and we will be on top of it. They'll find another creative way. It is a game. One minute we'll be on top of the introduction and they'll find some other way. Recently something as simple as lobbing a tennis ball over with a supply in the tennis ball over the actual perimeter. So we will now go to the next level of having a heightened level of perimeter security.' (key informant)

'I've had several offers of marijuana in here and the possibility of heavier drugs even but that's sort of a bit more quieter because you don't see much of the heavier stuff getting around.' (key informant)

'We've had whistleblowers to tell us that there are syringes and drugs in places... We're advised that marijuana can come over the fence in tennis balls on to the oval.' (key informant)

Trafficking of drugs by prison staff was considered to be an issue by many interviewees.

'If you've got plenty of money I'm sure you can find a guard and give them \$5-10 grand to and they'll bring you the gear.' (key informant)

'There was staff bringing it in which I saw which is quite common in all the jails I've been told as well.' (key informant)

'One of the biggest challenges is to, because we have so many staff coming and going every day in this correctional centre, one of the biggest challenges is to guard against trafficking [by staff]. I believe we have some of that.' (key informant)

'There are guards bringing in drugs.' (key informant)

Drugs entering the AMC and the subsequent availability of drugs to AMC inmates are supported by responses to the Inmate Health Survey. Table 11 shows responses on a range of in-prison drug use questions. More than half of respondents that reported lifetime use of cannabis reported using cannabis in prison and more than one-quarter of lifetime users reported speed use in prison. Of those that reported lifetime injecting drug use, nearly one third reported ever injecting drugs at the AMC and approximately one quarter reported injecting drugs in the past four weeks and that the last time they injected drugs was in prison. Of those that reported injecting in the past four weeks, approximately equal proportions reported injecting less than weekly or weekly or more often. There was no consensus among survey respondents about the availability of drugs at the AMC, with slightly less than half of respondents describing drugs as "easy" or "very easy" to obtain at the AMC (Table 11).

Table 11 In-prison drug use, Inmate Health Survey, May 2010

	Percentage (n) *
Ever used cannabis in prison	52.6% (60/114)
Ever used speed in prison	28.3% (28/99)
Ever used cocaine in prison	13.2% (10/76)
Ever used ecstasy in prison	14.3% (11/77)
Ever used LSD/acid in prison	6% (3/50)
Ever used Methadone/Buprenorphine in prison	82.7% (62/75)
Ever shared Methadone with another prisoner	26.8% (19/71)
How easy is it to obtain drugs at the AMC**	
Very easy	16.5% (13/79)
Easy	27.8% (22/79)
Difficult	36.7% (29/79)
Very difficult	19.0% (15/79)
INJECTING DRUG USE	
Last injected drugs in prison	25.9% (21/81)
Ever injected at the AMC	32.4% (24/74)
Injected in the past 4 weeks	24.2% (16/66)
Number of time injected in past 4 weeks***	
Less than weekly	46.1% (7/16)
Weekly or more often	53.9% (9/16)

* Of those that reported lifetime use and responded to the question

** Of those able to comment

*** Of those reporting injecting in the past four weeks

Consistent with Inmate Health Survey data, generally prisoners and ex-prisoners interviewed reported access to drugs at the AMC, though they did not always use them. They described it as easy to bring drugs in and easy to obtain them once inside. Cannabis was described as being more common than other drugs (again, supported by Inmate Health Survey responses), with people often using cannabis to help them sleep and cope with the anxiety associated with incarceration.

There was considerable concern among prisoners and ex-prisoners that injecting in prison was likely to result in the transmission of HCV and other health problems. Some prisoners deliberately avoided injecting in prison for this reason. Quantitative data demonstrated one incident case of HCV being detected at the AMC.

'I mean you come in without no disease and no hep or anything and then you walk out with it.... You're pretty much getting another sentence on top you know what I mean?' (key informant)

'Three guys ended up at the clinic with septicaemia through sharing needles.'
(key informant)

Health staff reported suspecting the diversion of prescription medications through their observations of behaviour changes among individuals during daily medication rounds. Health staff discussed how they shared information about these observations to prevent diversion and fulfill duty of care responsibilities. Processes for information sharing were not always described as working well.

'I'll say so and so is really weird today, oh there's drugs in blah, blah, we know what's happening, we're always tweaking, passing information so it's a very proactive process.' (key informant)

'If you normally doctor shop you're going to doctor shop. We have a set up that allows people to doctor shop in jail. They'll do it just the same and we don't, we should anticipate that and we should actually say everyone will have a care plan and if somebody knows that prisoner X is a bully in the yard and gets drugs and trades drugs then there should be a way for that to be properly communicated as appropriate.' (key informant)

Little quantitative data exists on the diversion of pharmaceuticals in prison or access to trafficked pharmaceuticals. Urinalysis data provide some insights. The Inmate Health Survey did not ask about prescription medications aside from methadone. Although an overwhelming majority of lifetime pharmacotherapy users reported using methadone in prison, this question did not distinguish between diverted or trafficked methadone and did not ask about the AMC specifically. Although about one in four of these respondents reported sharing their methadone with other prisoners, this question was also not asked in relation to the AMC specifically. More specific survey questions would be needed to assess levels of diversion occurring in the AMC.

Data on positive urinalysis detections and sanctions in relation to illicit drugs are reported in the Urinalysis section (9.13). Small numbers of prisoners have been disciplined for returning positive urine results for diverted pharmaceutical drugs. However, not all drugs likely to be diverted (for example quetiapine) are tested in urinalysis.

Tobacco and alcohol

Table 12 describes the tobacco and alcohol (pre-incarceration) consumption patterns of Inmate Health Survey respondents. A substantial majority of respondents reported being current smokers, with 70% reporting smoking 10 or more cigarettes per day. Problematic alcohol consumption among respondents was also high. Although approximately 15% of respondents reported being abstinent from alcohol (higher proportion than in the Australian population), almost half the respondents reported consuming 10 or more standard drinks on a typical alcohol consumption day and one third reported consuming six or more standard drinks on one occasion 'daily' or 'almost daily'.

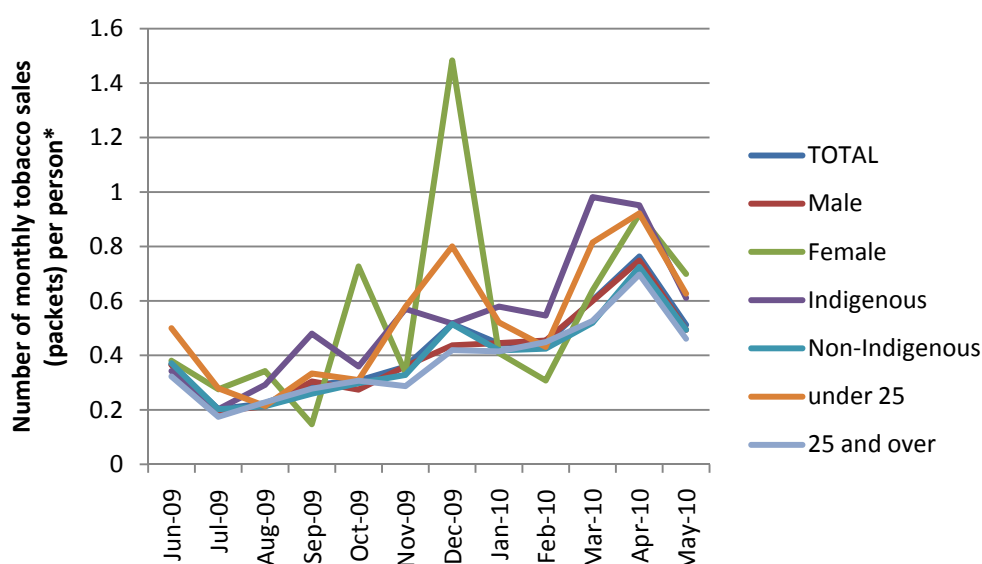
Table 12 Tobacco and alcohol consumption, Inmate Health Survey, May 2010

Tobacco	Percentage (n)
Ever smoked a full cigarette	96.3% (129/134)
Currently smoke	85.3% (110/129)
Level of smoking	
Less than once a week	0.9% (1/110)
Less than daily more than once a week	2.7% (3/110)
5 to 10 smokes a day	26.4% (29/110)
11-20 smokes per day	38.2% (42/110)
Over 20 smokes a day	31.8% (35/110)
Took up smoking while in prison	20% (22/110)
<hr/>	
Alcohol	
Pre-incarceration alcohol use – typical standard drinks per day	
0	15.3% (19/124)
1-2	9.7% (12/124)
3-4	11.3% (14/124)
5-6	9.7% (12/124)
7-9	8.8% (11/124)
10 or more	44.4 (56/124)
Pre-incarceration alcohol use – frequency of 6 or more standard drinks on one occasion	
Daily	14.5% (18/124)
Almost daily	18.6% (23/124)
Weekly	20.2% (25/124)
Less than monthly	12.1% (15/124)
Monthly	13.7% (17/124)
Never	21.0% (26/124)
Ever consumed alcohol in prison	16.1% (20/124)

Between June 2009 and May 2010, 959 packets of cigarettes were sold to AMC prisoners. The monthly number of packets sold ranged between 32 (July 2009) and 167 (April 2010). Figure 11 shows the proportion of monthly tobacco sales (packets) per prisoner (determined from average monthly prisoner numbers) and according to gender, Indigenous status and age. There was an increasing trend in tobacco sales over time in all prisoner populations. Slightly higher relative tobacco sales were recorded for Indigenous prisoners, female prisoners (although this fluctuates considerably due to small numbers) and prisoners aged less than 25 years. Responses to the Inmate Health Survey (Figure 12) show relatively similar tobacco consumption patterns, with Indigenous respondents reporting

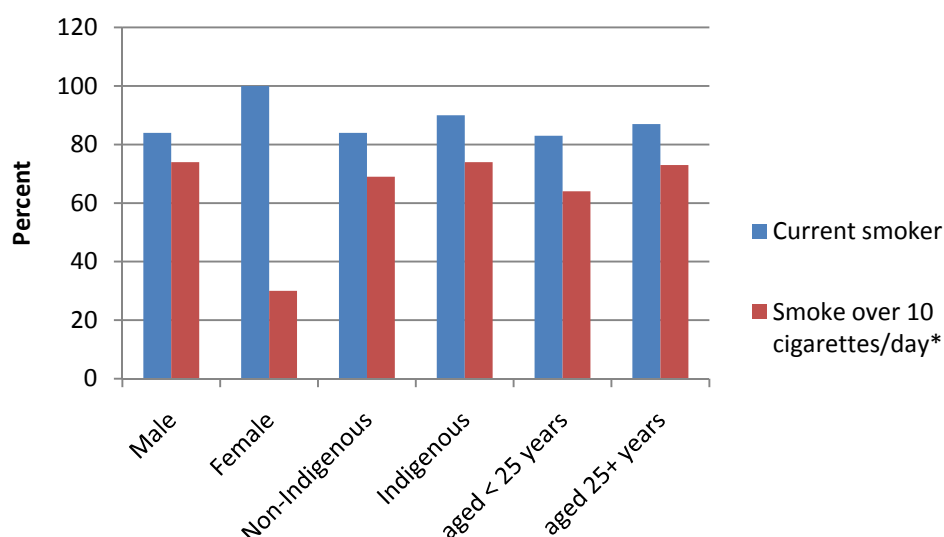
slightly higher rates of current smoking and frequency of smoking and females reporting lower rates of high frequency smoking (although data from female prisoners were obtained from only 10 respondents).

Figure 11 Number of monthly tobacco sales (packets) per person by gender, Indigenous status and age, June 2009 to May 2010



* Calculated as monthly number of cigarette packets sales divided by average monthly number of AMC prisoners

Figure 12 Self-reported smoking status by gender, Indigenous status and age, Inmate Health Survey, May 2010



* % of current smokers

AMC policy dictates that smoking can only occur in designated areas within the prison. Data from interviews suggest that this policy was difficult to monitor and enforce and prisoners often smoked in their cells, despite this being banned. It was originally intended that the AMC was to be a smokefree prison, but human rights and union issues prevented the implementation of this policy. From quantitative data, it appears that the only initiative used to address smoking at the AMC is the provision of nicotine replacement therapy, which was provided by ACT Corrections Health Program to 52 prisoners between 1 June 2009 and 30 June 2010. There is certainly interest in services to assist prisoners in quitting smoking. Responses to the Inmate Health Survey show that of the 110 current smokers, 86 (78%) reported having ever tried to quit smoking and 88 (80%) reported wanting to quit smoking. Additional smoking cessations programs such as group therapy or counselling may be required.

'They help you quit smoking if you want to do it which is good.' (key informant)

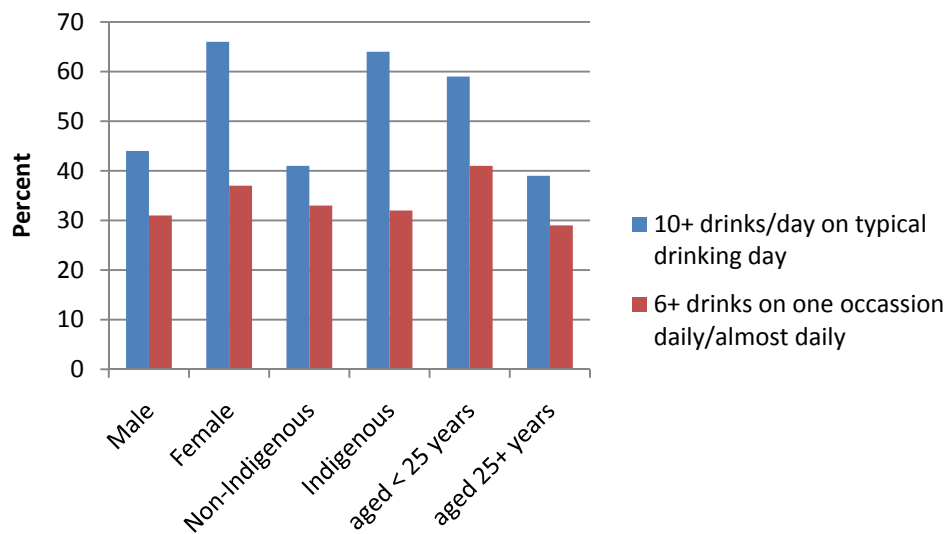
Data described in Figure 11 showing increasing numbers of tobacco sales at the AMC over time suggests that current smoking prevention strategies are having little effect on overall rates of tobacco consumption among prisoners.

Alcohol use was reported by some key informants as being problematic for prisoners at the AMC, with some reports of illicit alcohol production occurring on-site. Problematic alcohol use among AMC prisoners is also evident from Inmate Health Survey responses, with almost one third of respondents reporting being under the influence of alcohol when they committed the offence they were incarcerated for or that alcohol and/or drug use was related to their offending (see Table 10).

'So I moved to the cottage for about six weeks but then got kicked out of the cottage because we made some home made alcohol.' (key informant)

Figure 13 shows self-reported problematic alcohol consumption among Inmate Health Survey respondents. Indicators of problematic alcohol consumption were particularly high for Indigenous prisoners, female prisoners and prisoners under the age of 25 years, particularly in relation to the consumption of 10 or more standard drinks on typical drinking days.

Figure 13 Problematic alcohol consumption by gender, Indigenous status and age, Inmate Health Survey, May 2010



These results indicate a need for programs that specifically address problematic alcohol use.

Summary

- In-prison drug use occurring
- Drug trafficking occurring
- Supply reduction activities only disrupting supply, not halting it
- Varying opinions on ease of access to illicit drugs by prisoners
- Disease transmission occurring via drug use in prison
- Diversion of prescription medications occurring
- High prevalence of tobacco use
- Some illicit alcohol production on-site
- Need for specific therapeutic programs which address tobacco and alcohol use

9.15 Blood-borne viruses

Data regarding blood-borne viruses were collected from several sources; qualitative interviews, quantitative data received from ACT Health (e.g., numbers of tests conducted and results of tests), one quarterly report by ACT Corrections Health Program and the Inmate Health Survey. In addition, the evaluation team received the results of the Medical Records Audit conducted by ACT Health in May 2010.

Overall, the evaluation team believes that both the data and the clinical practices relating to blood-borne virus testing and management are problematic. This outcome is based on our assessment several factors discussed in detail below.

Testing rates

Table 13 presents data for blood-borne virus testing conducted by ACT Corrections Health Program as provided in the 4th Quarterly report. It is difficult to interpret these data in terms of the coverage of blood-borne virus testing at the AMC (i.e., the proportion of eligible prisoners that received tests) without knowledge of the period to which these testing numbers refer and the receptions and discharges that occurred over this time. This problem is compounded by lack of data regarding why prisoners were not tested (see Table 13 footnote). The lack of systematic recording and reporting of blood-borne virus testing undertaken by ACT Corrections Health Program is a limitation in terms of evaluating the current effectiveness of blood-borne virus-related services provided at the AMC and will make it virtually impossible to reliably evaluate blood-borne virus prevention initiatives at the AMC in the future.

Table 13 Blood-borne virus testing coverage and outcomes at the AMC, ACT Corrections Health Program 4th Quarterly Report of Blood-Borne Virus and Sexually Transmitted Infection Surveillance, Snapshot as at 30/3/2010*

Test	Number of tests conducted	Not tested**
HCV	117 (71 positive)	92
HAV	85 (32 positive)	121
HBV sAg	129 (4 positive)	80
HBV sAb	122 (101 positive)	96
HIV	119 (0 positive)	90
Chlamydia	48 (2 positive)	161
Gonorrhoea	35 (0 positive)	174
Syphilis	52 (1 positive)	157

* Prison population at 30/3/2010 was 209.

** Unclear whether this number represents eligible prisoners not offered tests or prisoners declining tests offered.

If we were to crudely compare the number of tests performed with the number of prisoners not tested, it appears that more than 40% of eligible prisoners present at the AMC on the 30th of March 2010 had not been tested for HCV and nearly 60% had not been tested for hepatitis A by ACT Corrections Health Program. It is difficult to determine the nature of testing outcomes for HBV (discussed further below).

Table 14 presents data for blood-borne virus testing from the Inmate Health Survey. Again, these data are limited because the percentage coverage appears to be calculated using the test outcome (number positive) divided by all respondents. There was no data in the Inmate Health Survey database that recorded if respondents had been offered a test or whether they actually had a test; therefore these data do not convey a reliable understanding of test coverage or an estimate of the prevalence of blood-borne viruses at the AMC. Upon examining HCV antibody and polymerase chain reaction (PCR) testing data, it is also difficult to determine the reliability of the clinical data recorded in the Inmate Health Survey database. Clinical practice would dictate that PCR tests are only performed on people who previously tested HCV antibody positive; however, there were many more PCR tests (90) indicated in this data than positive HCV antibody results (64). When examining data regarding the outcomes of these tests, we were only able to identify 23 PCR test results (16 positive, and 5 performed on people with no previous HCV antibody test recorded). The evaluators sought information from ACT Corrections Health Program regarding this discrepancy in PCR tests apparently conducted versus recorded results, but were unable to obtain an adequate response (these anomalies in antibody and PCR testing are discussed further in the *Testing algorithms* section below).

The data in Table 13 and Table 14 suggest that lifetime exposure to HCV (HCV antibody) and chronic infection (HCV PCR) is high among prisoners AMC but consistent with incarcerated populations in other jurisdictions (see literature review). Data in Table 14 suggest that HBV vaccination among prisoners at the AMC is high.

Table 14 Blood-borne virus testing coverage and outcomes at the AMC, Inmate Health Survey, May 2010

Blood-borne virus	Positive pathology result*	Positive result- Self reported	Ever vaccinated – self reported
Hepatitis A Virus			
HAV serology	32.1% (43/134)	1.5% (2/135)	
Hepatitis B Virus			
HBV surface antibody	59.7% (80/134)	3.7% (5/134)	69.6% (94/135)
Vaccination in prison	67.8% (61/90)		
Hepatitis C Virus			
HCV antibody	47.8% (64/134)	33.6% (45/134)	
HCV PCR	17.8% (16/90)		

*includes where 'no results available'

Data collected during this evaluation indicates that most BBV testing of AMC prisoners occurs at reception, with little occurring throughout incarceration and at discharge. While testing at admission has the potential to estimate prevalence of certain blood-borne viruses within the prison population, it will not identify incident cases contracted during time spent at the AMC. Matched ongoing testing throughout custody (to account for the window period between transmission and detection) and upon release is required to identify incident cases, although this may also result in detection of pre-prison transmission. Testing at admission, three months post-admission and at discharge would need to be routinely offered to ensure reliable incidence and prevalence estimates can be obtained from testing data. Where testing is offered, this should consistently be recorded on medical files and individual prisoners should be recalled for follow-up testing when it is due.

Current recording of blood-borne virus testing coverage and results is inadequate in terms of the data described above and also in relation to testing at admission. Data in the Medical Records Audit conducted in May 2010 suggest that many tests conducted at reception do not have results recorded (56%) in individual medical files or have only partially complete records (7%). The lack of adequate reporting of blood-borne virus testing results at receptions is likely to compromise clinical care provided to prisoners at the AMC. In addition, if more systematic blood-borne virus testing protocols (such as those described above) were to be

introduced at the AMC, the recording of blood-borne virus testing outcomes would need to be more rigorously performed to prevent unnecessary testing and to provide adequate clinical and other support.

Testing algorithms

Qualitative and quantitative data collected by the evaluation team showed that testing provided for HCV is predominantly antibody testing. Where positive antibody results are recorded, PCR testing is not routinely performed (PCR tests performed during the Inmate Health Survey are not reflective of standard clinical practice in the ACT Corrections Health Program). While antibody testing indicates lifetime exposure to HCV, PCR testing indicates if a person is chronically infected with the virus (in light of spontaneous clearance of HCV in 25-30% of cases). Given the high likelihood of lifetime exposure to HCV in prison populations, antibody testing alone is inadequate.

Of primary concern is that antibody testing alone could provide prisoners with a false indication that they are currently infected with HCV. This could lead to ongoing risk behaviours, such as sharing injecting equipment with other HCV positive individuals, in the belief that they are already infected with HCV. Alternatively, if prisoners wished to avoid transmitting HCV to others, a positive antibody test alone may be protective of injecting risk behaviours. Where individuals have actually cleared the virus, re-infection (possibly leading to chronic infection) could occur, with recent data suggesting that rates of re-infection may be higher among injecting drug users (Aitken *et al.*, 2008), including those in prison (Pham *et al.*, 2010), than rates of naive infection. Primarily utilising antibody testing may also lead individuals to believe they require or are eligible for treatment, when this is not the case. A lack of comprehensive PCR testing may also result in delays in the instigation of HCV treatment where it is needed.

Results from the Inmate Health Survey also demonstrated limitations in testing, detection and reporting of chronic HCV infection among prisoners at the AMC. Sixty-four survey participants had a lifetime exposure to HCV, as indicated by their HCV antibody test result. As alluded to above, although 90 PCR tests were reported to have occurred, results from only 23 PCR tests were recorded, five of which were performed on individuals who were antibody negative. None of the tests on antibody negative individuals was PCR positive. Sixteen of the antibody positive individuals were PCR positive.

When the evaluation team sought further information about these results, various reasons were provided to explain discrepancies, including that they related to testing being voluntary and that individuals were only routinely PCR tested when they were being referred for treatment. Another response indicated that the test results indicating 'no result available' (67 tests) were unlikely to have been conducted at all. It was indicated by staff from ACT Corrections Health Program that more PCR testing would be occurring in the future.

Hepatitis B

In relation to HBV, there were also inadequacies found in testing and vaccination practices. While testing rates appear low (46% of eligible prisoners had not been tested for HBV at the 4th Quarterly Report), 83% of those tested had detectable HBV surface antibody, indicating either vaccine or disease-conferred immunity to

HBV. However, while the evaluation team were informed that HBV vaccination was occurring whenever needed, data collected provides no information on the offering, uptake or completion rates of vaccination schedules.

The Medical Records Audit conducted in May 2010 again revealed issues in the recording of health information. For the two audit months (June 2009 and November 2009) the prison conducted 52 and 53 receptions respectively. The medical records indicated that 53 tests for HBV immunity were conducted at reception in June 2009 and 57 in November 2009; of these 110 tests, 77 (70%) had no test result recorded in the patient's record and eight (7%) had incomplete records. Again, such data gaps compromise current and future evaluation outcomes in relation to blood-borne virus prevention at the AMC and are indicative of poor record keeping practices.

Of concern is that the medical records suggest that one additional case of vaccine-conferred immunity had been recorded between reception and discharge from the AMC during June and November 2009, despite 105 receptions being recorded by Corrections in these months. Again, data recording inadequacies make it impossible to determine how many prisoners were eligible for vaccination (i.e., negative HBV surface antibody result) during these months, however, having only one recorded HBV vaccination case is clearly likely to represent inadequate coverage.

In relation to HBV testing rates presented in Table 13, it is difficult to determine the nature of testing outcomes for HBV without concurrent HBV sAg (HBV surface antigen), HBV sAb (HBV surface antibody) and accompanying HBV core antigen/antibody results for individuals; it is the combination of these testing outcomes that determines if people have vaccine-conferred immunity, past exposure conferred immunity, acute or chronic infection. However, again based on the crude comparison performed above, approximately 40% of prisoners are not being tested for HBV at the AMC (see Table 13).

Pre- and post-test counselling, record keeping and provision of results

The evaluation team notes that no accredited pre- and post-test counsellors were employed at the AMC at the time of conducting this evaluation. It is a standard procedure (guided by National HIV Testing Policy and informed by local legislation such as the *Public Health Act 1997*, section 102, which states that if a doctor or nurse has reasonable grounds to believe a patient has HIV, he or she must give the patient information about how to prevent the transmission and if the patient agrees, make reasonable arrangements for the patient to receive counselling) that any pre-test discussions and provision of results are conducted by accredited counsellors.

'Um, they're getting information, they're getting, I won't vouch for the quality of it, I won't, however the imperative, this is on advice from the sexual health specialist, and it just rings so true to me, is that it is the post-test counselling, which we're also not doing adequately.' (key informant)

The Medical Records Audit conducted by ACT Health in May 2010 uncovered problems with how blood-borne virus screening and results are recorded on client files. While it is understood that prisoners are offered blood-borne virus screening on entry, this is not recorded routinely in medical records. Over half of the files audited contained no evidence of blood-borne virus screening being

offered at reception. While 39% of the medical records reviewed contained evidence that full screening had been offered, only nine of these files contained full results. Responses from key informants from all stakeholder groups supported the findings of the Audit.

'Everybody is offered blood-borne virus screening. The issue we have had is to actually provide the evidence of that.' (key informant)

'The other thing they don't have the proper information and education on is hepatitis C. Now they're not getting tested either going in. They're meant to be tested on the way in; it's voluntary on the way out.' (key informant)

In addition to these systemic problems, it was reported by prisoners, ex-prisoners and community service providers that prisoners experienced delays in receiving results for tests and the post-test counselling that should accompany such results. These delays were considered to have a potential impact on risk behaviours and be stressful for the individuals concerned. Delays in receiving test results also have implications for the instigation of appropriate treatment and care.

'That's another thing too I had a blood test about two months ago and they still haven't given me my results... If I did contract something using I'd want to know early so I could get medicated or whatever. They take their time.' (key informant)

'I kept on asking when the results are going to come in.' (key informant)

Blood-borne virus health promotion

Table 15 describes the reach of education sessions offered by the ACT Hepatitis Resource Centre at the AMC between July 2009 and June 2010. The reach of this program appears to be high, with 146 prisoners participating in HCV education sessions in the first six months of 2010, over 1200 HCV information products being distributed and outreach strategies being employed to distribute information (e.g., training yard delegates to undertake blood-borne virus health promotion). These data suggest that this program is likely to have positive outcomes and delivers a sustainable model for blood-borne virus health promotion.

Table 15 ACT Hepatitis Resource Centre Inc., summary of services delivered at the AMC, 2009 and 2010

Prison HCV Health promotion	Jul–Dec 2009	Jan–Jun 2010	Total
HCV Education Sessions			
Number of sessions		13 (17 hrs)	13
Number prisoners attending		146 (26 F, 120 M)	146
Workforce Development			
Prison Officer Induction Sessions	2 (4 hrs)		2
Attendance	19		19
Prisoner Treatment Support (Individual sessions)			
Treatment info sessions	3	3	6
Number of prisoners	2	3	5
HCV Information			
Prisoner Induction: HCV Info Packs		130	130
HCV info re. Hume Health Centre	300	748	1048
HCV library info		30	30
HCV videos for in-house screening		6	6
Post Release HCV Treatment Support			
Support sessions (individual)		6	6
Participants		1	1

HCV treatment

Some prisoners, community service providers and prison health staff discussed access to HCV treatment. While they indicated that there had been delays in prisoners being able to access treatment, it is understood that more resources have been devoted to HCV treatment recently with the addition of a dedicated position within the ACT Corrections Health Program. It was unclear from qualitative data whether delays related to resourcing, prisoners not understanding the time period required to be worked up for treatment or a lack of access to treatment for particular prisoner cohorts. Positive feedback was received about treatment.

'Took me six months (to get on HCV treatment) but that was because I'm in remand and they don't like doing people on remand in case they get out and don't finish it but cause I was asking them for six months straight they finally just let me do it.' (key informant)

'Well there was four of us on the program, I had to push and push and push them to get the program started and there's four of them and the nurse, I don't know, 70% of the people in there have got hep C and it's the perfect time to be treating them all because you know a needle, a syringe will go through 30 people you know in there and um, so they need to, they don't have

the funding to get more nurses to get more people on the program, on the hep C program.' (key informant)

Proposed blood-borne virus prevention programs

It was recognised by all stakeholder groups consulted that blood-borne virus transmission risks could be mitigated by different programs, though support for different approaches varied significantly. NSP and bleach provision are discussed in detail below (sections 9.17 and 9.18). Other potential blood-borne virus prevention programs identified by both Corrective Services stakeholders and community service providers included a tattooing program, enabling a trained tattooist to enter the prison to perform tattooing on prisoners safely. Although receiving a tattoo in the community is considered to carry very low risk of blood-borne virus transmission in developed countries, research has found that unregulated and unsterile tattooing practices in prisons carry blood-borne virus transmission risks (e.g., Samuel *et al.*, 2001).

Table 16 shows responses from Inmate Health Survey participants in relation to tattooing practices in the community and in prison. Of the 87 respondents with tattoos, 35 (40%) reported getting a tattoo in prison. Of these 35 prisoners, 30 (86%) reported having the tattoo equipment cleaned prior to receiving their tattoos. These data clearly show that in-prison tattooing is common among prisoners at the AMC. Such practices, combined with the high prevalence of blood-borne viruses in prison settings, suggest that in-prison tattooing presents a potential risk for blood-borne virus transmission at the AMC. While the prevalence of body piercing among AMC respondents was also high (49%), relatively few of these respondents (12%) reported receiving body piercing in prison. Nevertheless, body piercing also clearly represents a high risk practice for blood-borne virus transmission in prison and any consideration of tattooing programs at the AMC should also encompass body piercing.

Table 16 Tattooing practices, Inmate Health Survey, May 2010

	Percentage (n)
Ever had any tattoos or body piercing	
No	23.9% (32/134)
Yes, both	38.8% (52/134)
Yes, tattoos	26.9% (36/134)
Yes, piercings	10.5% (14/134)
If any tattoos, where did you get your tattoos done	
Both, in prison and the community	18.4% (16/87)
Inside prison	21.8% (19/87)
Outside prison	59.8% (52/87)
If tattoo were done in prison, was equipment clean before tattoo?	
Don't know	5.7% (2/35)
No	8.6% (3/35)
Yes	85.7% (30/35)

Community service providers believed that a tattooing program at the AMC could be used as a reward for good behaviour and appropriate safeguards to regulate the program could be effectively instituted.

'It's clean, it's no danger to anybody, the prisoners can save up for them and you can even punish them by removing their tattooist rights. I talk to prisoners about it and I field their ideas and they would love a proper tattooist.' (key informant)

'Imagine if we could not have everyone come out with Hep C. Wow. It would be awesome, I'd be so proud of us. Looking at tattoo programs... how can we use the thing of prison being a positive intervention.' (key informant)

Summary

- Record keeping regarding BBV testing and vaccination is inadequate and limits current and future evaluations of blood-borne virus prevention programs at the AMC
- BBV testing predominantly occurring at reception
- BBV testing algorithm is not best practice
- No accredited pre- and post-test counsellors on staff
- Delays experienced by prisoners in obtaining BBV test results
- Good levels of blood-borne virus related health promotion
- HCV treatment available but delays occurring in accessing treatment
- Support for the introduction of a professional tattooing program

9.16 Overdose

Overdose was not a subject that came up often during qualitative interviews. Fewer than five overdoses have occurred at the AMC relating to errors in clinical management, and these are noted in the quantitative data obtained from ACT Corrections Health Program. It is understood that these events occurred as a result of prisoners being provided with a double dose of prescribed methadone in one day. No other instances of overdose have been recorded or were reported in interviews, but some occasions of individuals being heavily sedated (but not unconscious) were described by health staff.

'I've never had an emergency overdose but we've certainly had an overdose.' (key informant)

Health staff advised that naloxone was not available on-site. The clinical review conducted by Dr Adam Winstock in October 2008 suggested that a policy on the administration of naloxone was needed at the AMC. The clinical review conducted by Dr Alun Richards advised that the ACT Corrections Health Program have developed a Nurse Initiated Medication standard operating procedure for the administration of naloxone. Qualitative data collected from health staff suggested that the implementation of this policy required further staff training to ensure awareness of the policy and best practice in the use of naloxone at the AMC.

'Same as I think we're lucky here that we haven't had anybody overdose. We haven't had to give, we don't have any Narcan.' (key informant)

No information emerged to suggest that overdose prevention education was occurring at the AMC, leading the evaluation team to conclude that little or no overdose education is occurring as part of therapeutic or other programs being provided to prisoners. The absence of overdose prevention education at the AMC is a concern given the known overdose mortality risks for post-release prisoners with injecting drug histories. Responses on the Inmate Health Survey showed that 41% of respondents with a history of injecting drug use reported a lifetime history of overdose.

Community service providers suggested that providing naloxone to individuals at release was a possible overdose prevention strategy. A program such as this requires education and training of prisoners in preventing post-release overdose and use of naloxone to respond to overdose. Stakeholders also noted the importance of pre-release stabilisation on opioid pharmacotherapy and continuation of opioid pharmacotherapy after release as an important overdose prevention strategy.

Summary

- Very low rate of overdose currently occurring, none from illicit drug use
- Some heavy sedation occurring as a result of illicit drug use
- Staff may need further training on the naloxone policy to ensure effective implementation
- Naloxone provision to prisoners at release should be explored, along with appropriate education and training prior to release

- Pre-release care plans for those receiving opioid pharmacotherapy should prioritise dose stabilisation and continuation of opioid pharmacotherapy after release

9.17 Bleach provision

Qualitative interview responses from prisoners, ex-prisoners and community service providers suggested that bleach was difficult to obtain at the AMC. Access problems were due to several factors. It was reported that bleach was not available until 2010 and, when it did become available, prisoners discovered that the dispensers were often empty and took extended periods of time to be refilled.

'Bleach is really hard to get.' (key informant)

'They run out of bleach here and it takes a while to get new bleach.' (key informant)

'With regards to the bleach, prisoners say no they don't have access but the management said yes they do.' (key informant)

Quantitative data from the Inmate Health Survey presented in Table 17 did not clearly support these responses, with 41% of those that had tried to access bleach stating that bleach was either 'difficult' or 'very difficult' to access and 48% responding that it was either 'easy' or 'very easy' to obtain. However, these data were derived from general questions about access to bleach in prison rather than questions specifically related to the AMC.

Table 17 Access to bleach, Inmate Health Survey, May 2010

Access to bleach for cleaning injecting equipment	Percentage (n)
Ever tried to get bleach in prison	31.8% (42/132)
How easy to get bleach	
Easy	20.5% (9/44)
Very easy	27.3% (12/44)
Difficult	15.9% (7/44)
Very difficult	25.0% (11/44)
Don't know	11.4% (5/44)

Where prisoners had tried to access bleach, there was a sense that this could trigger retribution, for example disciplinary action, searches or urine tests. Corrective Services informed the evaluation team that this was not the case and that prisoners may access bleach for a variety of reasons.

'Whilst it is theoretically available it is not actually available to the prisoners on the floor. Yes, there is a room where there is bottles of stuff kept however the guys on the floor can't access it easily and if they try to, then they're making themselves vulnerable to corrections officers being aware of what their main thing is.' (key informant)

'The screws have told us that bleach, that bleach isn't available. We've said to them that it has to be available for harm minimisation for people using you

know what I mean. The screws, this is exactly what they said, they said... whose got the fit and they can bring it down and clean it.' (key informant)

There was also concern among community service providers that the concentration of bleach provided may not be adequate to effectively eradicate viruses present in used syringes and that prisoners were not provided with instructions about how to use the bleach effectively.

'Solution bolted to the wall that was only 20% bleach and 80% water.' (key informant)

In contrast to the concerns expressed above, the evaluation team understands that bleach is provided to the AMC by an external provider to specifications designed to provide adequate concentrations for the cleaning of needles and syringes.

Prisoners overwhelmingly agreed that bleach should be available as a method of preventing disease transmission.

Summary

- Bleach was not available until 2010
- Bleach regularly runs out and does not get replenished
- Prisoners report a fear of retribution if bleach is accessed
- Consensus among prisoners that bleach should be available to prevent disease transmission
- Effectiveness of bleach solution concentration questioned
- Instructions on how to effectively use bleach are not currently being provided

9.18 Needle and syringe program

Qualitative data suggest that injectable drugs are entering the AMC and that injecting drug use is occurring. High blood-borne virus prevalence in this population and the inevitability of risky injecting practices in an environment without access to clean injecting equipment means that disease transmissions at the AMC is highly likely. Quantitative data validate these findings, with seizure data (See Searches and seizures section 9.12) indicating that 28 syringes had been seized at the AMC in the 12 months to May 2010, seven of which had been interdicted prior to entering the AMC. Responses from the Inmate Health Survey also indicate that injecting drug use is occurring at the AMC (see Drug use in the AMC prison population section 9.14). In addition, one in-prison case of HCV transmission has been recently reported at the AMC. Although it is highly likely that other blood-borne virus transmissions have occurred at the AMC given the drug using contexts described above, current testing practices (see Blood-borne viruses section 9.15) are inadequate to reliably estimate the rate of in-prison blood-borne virus transmission at the AMC.

Many interviewees described the availability of injecting equipment, the circumstances in which injecting takes place and the types of injecting paraphernalia used at the AMC.

'Each wing has a fit.' (key informant)

'One fit for 30 blokes. Some blokes have got their own one. There are always yard ones.' (key informant)

'They went through our wing three or four days ago and I think they found seven syringes.' (key informant)

'Cut down syringes yes. We have them.' (key informant)

'The tip's the main part. To make a needle it's not hard to get a bit plastic pipe and a plunger, you just need a tip. Once you've used the tip you just throw the rest of it away. You've got your own tip. That's yours to use.' (key informant)

Table 18 shows the utilisation of needle and syringe program services by Inmate Health Survey respondents that reported ever injecting drugs. Three quarters of these participants reported having ever used an NSP service in the community and NSP was the most common source of obtaining injecting equipment in the 12 months prior to entering prison. In addition to the use of vending machine and pharmacy sources, this data indicates the high acceptability of NSP services to the target population.

Table 18 Community access to injecting equipment among self-reported injecting drug users, Inmate Health Survey, May 2010

Type of service access	Percentage (n)
Ever used NSP service in community	75.0% (60/80)
Where did you obtain injecting equipment 12 months prior to entering prison?	
NSP	57.3% (43/75)
Needle and syringe vending machine	16.0% (12/75)
Pharmacy/chemist	16.0% (12/75)
Personal source (i.e., Friend, dealer)	4.0% (3/75)
Mobile outreach service	1.3% (1/75)
Other	5.3% (4/75)

Common concerns expressed by interviewees about prison-based NSP services related to conflicts with custodial operations and professional values. From a drug dependence perspective, the contradiction of wanting to assist individuals with drug problems while providing the means for individuals to continue to use drugs was often raised. Duty of care concerns and fears that an NSP would increase drug use in prison or overdose were also raised.

'If they have a free range of needles and everyone that uses has a needle then the drugs are just going to be, they'll be dropping out of aeroplanes for gracious sake.' (key informant)

'We continually have the difficulty in understanding how we can condone giving them a syringe to put a contraband drug into their body.' (key informant)

'It would be a process that would allow criminal behaviour partly because we on the one hand are saying that drugs are illegal but it's like saying we're not going to allow bullets in the jail but you're allowed to use a gun. That's kind of stupid.' (key informant)

'I don't see how I as a manager and as a human being in conscience can allow, can say to someone I'm going to give you authority to put into your body whatever you want [drugs] and then allow you to perhaps sue me or my organisation because we haven't taken due care of you.' (key informant)

Despite these conflicts, among prisoners, ex-prisoners and community-based service providers there was overwhelming support for an NSP to be implemented at the AMC. Health staff from the prison also strongly supported the introduction of NSP services.

'There should be a needle exchange program there definitely. Some of the contraptions I've seen in there used as syringes, they're unreal you know. They're used by so many people you know.' (key informant)

'They should have a needle exchange program.' (key informant)

'What we need to talk about is this going to be the prison where we're going to trial an NSP. Why not, everyone is behind it, where's the problem? It's with the Unions. It's not with the Health Minister, it's not with the workers, it's not

with anybody else but the unions here and that's a really great example of you're in this place where you can do it and it's not being done because there hasn't necessarily been the analysis of the issue yet.' (key informant)

Custodial officers were, for the most part, strongly opposed to the notion of a prison-based NSP. Many cited a lack of consultation and dialogue as partly influencing their opposition.

'There will be strikes and I will be encouraging that.' (key informant)

'I would never [work in] a correctional centre that had a needle exchange to be quite honest with you.' (key informant)

'No one knows, I haven't been given any documentation to inform me of how, or us as officers, hence our minds are running wild with possibilities as to how they're going to do it.' (key informant)

'We've sort of ended up with this debate about a syringe program or no syringe program; it's all a yes or a no. I think we've missed all the other steps that go with it. I mean what's the model, how does it work, where does it go?' (key informant)

'There's going to have to be a really strong education program, public opinion change before we get there.' (key informant)

Health staff were aware of support for prison NSP amongst custodial officers, but knew that those officers felt unable to publicly support the concept.

'He said he wouldn't be able to stand up in a room full of officers and say that because he would be howled down. I know a lot of the senior officers here are for it.' (key informant)

There were several reports that indicated that an informal exchange program was already operating. Prisoners and ex-prisoners noted that prison staff had safely disposed of used injecting equipment on behalf of prisoners and that injecting equipment including needles and syringes and other items like alcohol swabs had been provided to prisoners by prison staff. The evaluation team also observed the presence of multiple sharps disposal bins in different areas of the prison.

Occupational health and safety was discussed by interviewees in the context of the operation of a prison-based NSP. Prisoners and ex-prisoners believed that an NSP would increase safety for officers, whereas officers were concerned that an NSP would increase risk for officers. Some officers also considered that an NSP could increase the risk of violence among prisoners.

'They all say they don't want syringes in the jail because of people getting pricked and all that sort of stuff but if there was a program where you could go get one, use it and put it in a bin, why are you going to keep it?' (key informant)

'When you open them up to general population use that will result in an incident where someone is assaulted with a syringe.' (key informant)

'No one in here would use it as a weapon. Most of the boys can use their fists for that.' (key informant)

'The screws are in danger doing their search of contraband for instance lifting up a chair that's got a hollow and bang they're getting pricked and getting a blood-borne virus [but an NSP would reduce this danger].' (key informant)

'It's going to be safer for the crims and its going to be safer for the screws that when they finish with their shot they don't have to hold on to the fit forever and ever, they can put it into a disposal bin and get a new one.' (key informant)

'You supply them to everybody or those who want them and it will create a stand-over environment whereas you won't go and get your needle because you're using drugs so you stand-over this poor little prisoner who's not using drugs and you send them off to get your needle for you.' (key informant)

Qualitative data from interviews with prisoners, ex-prisoners, prison health staff and community service providers indicated that, were an NSP to be implemented, confidentiality concerns would need to be addressed. Interviewees were concerned that if individuals accessing the NSP may be targeted for searching or urinalysis. Similar issues were raised in relation to prisoners accessing bleach. Interviewees believed this problem had the potential to compromise the success of a prison NSP and maintain the use of illicit syringes. The aim of reducing disease transmission would be negatively impacted if this were the case.

'There would have to be something in place where it was some privacy thing involved.' (key informant)

'If I wanted to use I'm not going to walk up and ask a screw for a syringe. I'm going to get urined the next day you know what I mean.' (key informant)

'You'd want some reassurance that you're not going to the nurse and going to get your fits and then the officers know so they're watching you all day.' (key informant)

'I reckon they should have a program where you swap one for one either with a nurse where you don't need an officer because the prison officer stands next to the nurse anyway so you can't go up to the nurse, you know what I mean?' (key informant)

Key informants from all stakeholder categories suggested how the introduction of an NSP and acceptable models for its operations could be successfully negotiated between parties. Many of the responses in this regard underpin the importance of appropriate systems (data collection or otherwise) being put in place to evaluate the effectiveness of a prison-based NSP, were it to be introduced.

'The impact of such a scheme has to be carefully researched. It can't be just it works in Switzerland therefore it will work for us. Most people are open-minded and we feel that if there is appropriate research done and it's been explained to us it may change our opinion.' (key informant)

'Surely we can come to some sort of an agreement, surely there could be a controlled environment where it could be tested. Perhaps in a smaller section of the prison rather than introduced as a whole.' (key informant)

'Pick up in the afternoon, drop off in the evening whichever you know and if you're signed on to have one during the day and you get caught with one then

you've signed off that you're allowed to have that. So if you get ramped, you declare it straight away.' (key informant)

'Maybe have a delegate and he's got 40 fits and each fit person gets a fit and when they're finished with that they hand it to them, he watches them put it in the bin or they give it to him and he puts it in the bin and then gives him a clean one in the packet. Then when they're finished and then he swaps those. He goes to health and says there are 20 in here and they give him 20 more fits and he takes his bucket back. It could be done like that.' (key informant)

'It would be just like a token thing with a dispensary thing on the wall like how they've got the condoms sort of thing. It would be better to have a fit dispensary rather than a bleach outlet for needle users.' (key informant)

'If you want another syringe bring the old syringe back and get a new one.' (key informant)

'It has to be a model where the prison officers feel safe, so I feel better than anything, can we start with an exchange model. If that actually gets, if we can do a trial with that, you know surely that's a start and then you know one step at a time. But we've got to do something where everybody feels safe and, but I also believe that somehow there's got to be that privacy and confidentiality around it.' (key informant)

Summary

- Evidence of injecting occurring in prison with used syringes
- Acceptability of NSP to the target population considered to be high
- Strong support for the establishment of an NSP from the majority of stakeholders
- Strong opposition to the establishment of an NSP from most prison officers
- Informal exchange currently occurring
- Occupational health and safety concerns regarding using needles as weapons and needle stick injuries
- Confidentiality concerns regarding retribution for accessing an NSP
- Broad support to explore various models of NSP implementation and operation

10.0 Discussion

Evaluation findings will be discussed and reflected upon in two ways. First, evaluation findings will be discussed in relation to each of the specified evaluation questions. Second, additional discussion will be framed around the three pillars of harm minimisation (supply reduction, demand reduction, harm reduction), as outlined in the *National Drug Strategy 2004-2009*, to reflect on the principles underpinning the development and delivery of drug policies and services at the AMC.

10.1 Evaluation questions

What are the main characteristics of the AMC's drug strategies and services?

Given that the drug-specific services and strategies provided within the AMC are described in detail earlier, this section will focus on giving an overall impression of the service system and its characteristics by examining commonalities and differences across and within service and activity types, including the consistency and quality of what is provided. This section will also explore whether the AMC's services and programs reflect the policy and overarching strategies that guided the implementation of activities that address drug-related issues.

The effective delivery of drug services and programs provided should form part of an overall strategy and policy framework and be consistent with principles that underpin that strategy; several strategies are directly relevant to the AMC (described in detail earlier - see Desktop policy review section 6.0). In the current model, which involves multiple providers delivering drug services at the AMC, staff do not always understand how different policy objectives interrelate and no single policy document guides all of the activities undertaken; this is reflected in a somewhat fragmented and uncoordinated service system and is compounded by low levels of information sharing across providers. The result is duplication and compromised quality of services.

Strategies and policy frameworks intended to guide the operations of the AMC describe a prison that will promote a healthy environment which is respectful of individual rights, whilst allowing the maintenance of security and order. Drug-related issues are to be addressed via a harm minimisation framework with due consideration of supply, demand and harm reduction objectives. Within this approach, key principles that inform how harm minimisation is delivered include individualised case management, equivalence of services with those provided in the community and the development of throughcare approaches. The success of the AMC's response to drug-related issues is dependent upon leadership and expertise which can deliver a balanced implementation of harm minimisation pillars, as outlined in the *National Drug Strategy 2004-2009*, and strong systems of case management, healthcare and throughcare.

Several positive program activities at the AMC go some way to fulfilling drug policy, service and strategic objectives, but these would be most accurately described as 'pockets of effectiveness'. These programs do not represent a

comprehensive and consistent response to drug-related issues at the AMC. The most effective services and activities are as follows:

- The Inside Out Program provided by Directions ACT;
- Individual relationships between prisoners and NGO service providers (e.g., ACT Women and Prisons, Toora, Directions ACT, Canberra Recovery Services, Canberra Men's Centre, Samaritan House);
- Forensic Mental Health counselling services;
- Basic primary healthcare services provided by ACT Corrections Health Program, particularly nursing and dental services; and
- Solaris TC program content and facilitation.

The identification of these programs as being particularly effective was based on qualitative data collected during interviews and quantitative data supplied to the evaluation team by service providers. Unfortunately, little evidence emerged regarding the effective delivery of other drug services and strategies at the AMC. Furthermore, while the quality of some aspects of the services described above was evident, the overall effectiveness of these activities was also impacted by particular shortcomings, particularly in relation to equivalence and access.

For Forensic Mental Health and ACT Corrections Health Program services, there were clear shortcomings in relation to a lack of equivalence with community-based health services. Delays in accessing primary healthcare for acute problems (e.g., broken bones and chest pain) were also considered unacceptable and not reflective of community-based responses. In addition, access to counselling in the community via general practice Mental Healthcare Plans and state/territory-based funded counselling services is readily available but relatively inaccessible in the AMC.

Areas where services have not adequately matched standards and expectations set in strategy and policy framework documents are:

- Awareness of services by prisoners;
- Access to services;
- Implementation of appropriate case management models;
- Creation of an equivalent system of healthcare and welfare service provision that matches community standards and service availability; and
- Application of throughcare principles and service approaches.

The evaluation findings suggest several reasons for this outcome. First, the current service system is fragmented and appears to have been structured around the providers of services and their accompanying funding sources rather than focused on the needs of prisoners. Second, there is no clear leadership in relation to guiding drug policy and services across multiple service providers to meet strategic and policy objectives. The lack of an effective governance structure and the absence of leadership has resulted in service providers having an insufficient understanding of the overall objectives of services, how services interrelate to achieve these objectives, and a lack of "buy-in" by some staff and managers in relation to the principles of harm minimisation. Third, expertise is lacking in key areas required to implement programs consistent with strategic

drug policy at the AMC. This lack of expertise is especially the case with regards to welfare and drug and alcohol-related services provided by Corrective Services' AOD Team and AMC Case Managers. This expertise can be found elsewhere within the service system, but it is not well utilised to strategically design and implement services and activities that comprehensively meets the needs of each prisoner. It is a finding of this evaluation that service within the AMC are not always allocated to the most appropriate or most skilled provider.

The sheer number of providers of services is evidence of the fragmented approach to drug services at the AMC. The following summary of providers and some of the areas for which they are responsible gives an indication of the likelihood of duplication in the provision of programs and services.

Corrective Services

- Searches and seizures
- Urinalysis
- Programs – therapeutic
- Case management
- Solaris therapeutic community

ACT Corrections Health Program

- Primary healthcare
- Opioid pharmacotherapy
- Detoxification
- Blood-borne viruses
- Medication management
- Case management and care coordination

Forensic Mental Health

- Mental health
- Counselling
- Medication management
- Case management and care coordination

NGOs

- Case management
- Counselling
- Solaris therapeutic community
- Blood-borne viruses

While fragmentation of service providers does not in itself mean that services cannot be delivered effectively, quality service delivery in such a service system requires processes that underpin open channels of communication. Throughout the evaluation, key informants expressed concern that communication between providers was poor and they were often completely unaware of services being provided by others. This lack of communication existed in general (e.g., some providers didn't know what the AMC Case Manager role was) and specific senses (e.g., individual providers didn't know what their clients were receiving from other providers). Some services provided in the same building were described as lacking in good communication (e.g., ACT Corrections Health Program and Forensic Mental Health).

With multiple and sometimes competing providers of similar services, overall coordination is essential to ensure that fragmentation does not compromise service delivery. However, this evaluation found that there is no coordination across providers in the AMC, that even within services coordination is sometimes inadequate, and that there is little overarching leadership and no governance and leadership structure to support effective drug service delivery across the AMC.

Inadequate service access at the AMC was another issue raised often in this evaluation. Awareness among prisoners about the services available and how to access them is often low and actual service availability is often deficient, with waiting lists, poor program scheduling, infrequency programs provision and access delays common. The accessibility of services is sometimes compromised by poor relationships between prisoners and providers. These poor relationships are caused by a range of factors that include inconsistent provision of services, past relationships with individual workers in other service provision contexts, poor record keeping practices and inadequate communication.

Needs assessments occur too infrequently to support the tailoring of services to meet individual needs. Often it is up to individual prisoners to find ways to fulfil their own needs within a system that should be well equipped to support them to make positive changes to their lives. A correctional system which fails to identify and respond to criminogenic and health needs, particularly related to drug use, is likely to lead to recidivism, ongoing substance use and related co-morbidities (Cullen and Gendreau, 2000).

Overall, the service system intended to address drug-related issues at the AMC suffers from a lack of clear policy direction and practical guidance. This is in part due to the multiple strategy and policy frameworks that inform the AMC context. There are many aspects of these strategic documents that overlap and provide guidance to the drug-related services; consolidating the relevant principles into a single document to help guide both the strategic direction and the practical activities at the AMC may be helpful. In addition, existing strategic and policy frameworks tend to focus on discrete providers of particular services; any new iteration specific to the AMC should provide overarching guidance, consistent with harm minimisation principles, to all providers of services and activities related to drugs. A clear governance structure should be established to support the delivery of programs and services under a consolidated strategic and policy framework.

What are the characteristics of the services' recipients and how do they compare with the intended recipients?

Given the number and range of services provided, we will first discuss recipients of services in general, then move to discussion of individual service types where relevant. This will help provide context around whether drug-related services are reaching those in need and where significant deficits may exist.

Although the evaluation findings suggest that, in general, services were reaching their target populations, services were not always delivered in a timely fashion and services were not always reaching all of those in most need. The predominant drug services at the AMC related to illicit drugs, thus service recipients were predominantly those with illicit drug use issues. Qualitative interviews and quantitative evaluation data suggested that problematic users of licit drugs were less well serviced. For example, therapeutic programs tended to focus on illicit drugs, whereas program content focused on tobacco and alcohol is also needed. The difference in legal status of these drugs may warrant different approaches to the provision of therapeutic programs to those with illicit and licit drug dependence.

In relation to equitable access among AMC sub-populations, differential access to services among remand and sentenced and male and female prisoners repeatedly came up as a concern. Strategic and policy frameworks underpinning drug services at the AMC make no discernible distinction between remand and sentenced prisoners from a strategic point of view; these documents direct that all those with drug-related needs should be provided with services and opportunities to address drug issues during time spent at the AMC. Indeed, female prisoners were even described as a priority population for the receipt of services. However, remand prisoners and, in many instances, female prisoners were unable to access particular services designed to address drug use issues entirely due to their classification or gender.

Service access barriers for remandees are a major concern given the very high proportion of remand prisoners at the AMC. Only male sentenced prisoners are currently able to access the Solaris TC and opportunities for intensive residential rehabilitation services for other cohorts is limited to their ability to be bailed or released to external facilities. For sentenced women, this was perceived as a very remote possibility. Men on remand had better chances of accessing external residential rehabilitation services; however, access to external residential rehabilitation even for this population declined in September 2010 in line with a change to case management arrangements.

Inequitable access is also evident in relation to the therapeutic programs First Steps, Back in Control, the Health and Wellbeing Program and the Personal Effectiveness Program. Women have had very limited access to the First Steps program and no women have entered into the Back in Control, Health and Wellbeing or Personal Effectiveness Programs. The evaluation team was informed that remand prisoners are not offered the Back in Control program. That access to any drug-related service would be dependent on whether an individual is on remand, has been sentenced or is of a particular gender conflicts with both the strategic policy and human rights principles that underpin the AMC operations. These limitations in access mean that services are provided to a much narrower

set of prisoners than what is described in policy documents, where no distinction is made between the needs of remand and sentenced prisoners, and women's needs are prioritised.

Access to services for Indigenous prisoners was also reported as an issue, but the poor reach of services to Indigenous prisoners has been described as relating to a lack of cultural sensitivity of programs, rather than systematic blocking of access based on classification.

With regards to case management services, the evaluation team concluded that, while all prisoners are likely to be documented as having a case plan that identifies criminogenic need, these plans are not developed in collaboration with prisoners and prisoners lack awareness of the plans and their content. So, while the intended recipients are receiving a service, their lack of awareness of the service as it is provided and common belief that *no* service has in fact been provided makes it difficult to evaluate the effectiveness of case management in reaching its intended participants. This situation is symptomatic of the poor access to and awareness of services described earlier, and is engendered through inadequate communication with prisoners (and indeed between services) about processes supposedly intended to be supportive of positive life changes.

Issues specific to the TC were experienced in relation to its location within the male sentenced area, which is perceived to have negatively impacted on the desirability of participation in the program, due to the ongoing exposure of participants to the broader prison environment (for example, via coercion to act violently or inappropriately towards other participants) and other prisoners who may continue to use drugs in close proximity. Similarly, the ultimate success of those who have participated was regarded as being decreased by this continued exposure. The service location has limited the actual recipients of the program to a narrow cross-section of male sentenced prisoners, a situation which could potentially be altered if the location of the facility were to move to a secure area of the AMC.

Although the intended and actual recipients of the opioid pharmacotherapy program appear to concord well in the prison context (despite some initial access issues for those not already on a program in the community), this concordance diminishes following release. Post-release monitoring indicates that many ex-prisoners on opioid pharmacotherapy at release do not continue on the program. This lack of continuity of opioid pharmacotherapy would contravene the intentions of clinical practitioners at ACT Corrections Health Program in relation to reducing post-release mortality risks among those with a history of opioid dependence. The undesirable environment of the public Woden clinic for treatment was cited by ex-prisoners as a reason for ceasing opioid pharmacotherapy after release, however the evaluation team is aware that individuals are able to access community pharmacies for dosing as well. This discrepancy points to perceived barrier among prisoners in relation to continuation and retention in opioid pharmacotherapy post-release, and clarity with regards to the range of options available. Assessment of these barriers should be undertaken urgently so that appropriate strategies to encourage retention can be put in place, and the full benefits of continuing on opioid pharmacotherapy after release are realised.

Recipients of services for blood-borne virus testing and vaccination are much smaller in number than originally intended. Up to half of the AMC population was not screened for some blood-borne viruses at reception and record keeping practices are inadequate for monitoring screening and vaccination. Lack of appropriate records means it was impossible for this evaluation to determine whether prisoners were never actually offered screening and vaccination or whether they did not consent to it when offered. A lack of follow-up screening during incarceration and at discharge further reduces the proportion of the population screened and vaccinated. This has implications for the delivery of treatment for blood-borne viruses to prisoners at a time when they may be stable enough with regards to their health and drug use to receive it. The poor record keeping here also means that future harm reduction strategies cannot be effectively evaluated.

Prisoners with mental health conditions are not receiving adequate support. Practitioner responses suggested that the main intended recipients of mental healthcare were those with acute illnesses, particularly psychotic conditions. This relatively narrow serviced population appeared to result from a lack of resources to address high prevalence but often sub-acute conditions such as depression, anxiety and sleep disorders. Although the actual service recipients match closely with the intended recipients from the practitioners' point of view, evaluation findings suggest that the need for mental health assistance is far greater than can currently be met. At a strategic and policy framework level, no distinction is made between types of mental health conditions and how conditions (e.g., severity, prevalence) might influence service access. According to policy, the recipients of mental health support should be all those who need it at the AMC, not just the most seriously unwell. This discordance with the provision of mental health support suggests that mental health policy has not been fully implemented at the AMC nor have services been sufficiently funded to do so. Furthermore, the policy of mentally ill prisoners having access to secure community-based mental health facilities also appears not to have been implemented, as the Crisis Support Unit at the AMC is the only facility currently equipped to house mentally ill prisoners. The Inside Out Program provided by Directions ACT was identified in this evaluation as a high quality program. This program provides drug and alcohol support and counselling in prison and in the community and is thus able to provide effective throughcare support for those leaving prison. The intended recipients of this program are substantially greater than the actual recipients. The Inside Out Program is currently funded to provide one full time worker to fulfil all AMC prisoner needs for drug and alcohol support and counselling; however, both qualitative and quantitative (e.g., Inmate Health Survey responses) suggested a very high level of need for these services in the prison population. The program could potentially have much greater reach than it is currently resourced to provide. Considering the high quality of the program and the high levels of satisfaction with counselling approaches described by prisoners and ex-prisoners, much could be gained by expanding the program to include all intended recipients (i.e., any prisoner with a drug use issue), resourcing the program adequately to support throughcare and to provide more intensive service to existing participants (e.g., increase counselling services provided at the AMC). It should be noted that discussion of co-morbidity and the provision of services to

address mental health issues is strongly indicated in drug policy documents that guide the AMC.

Given the high quality of relationships between NGOs and prisoners, funding of additional services at the AMC by other providers is warranted. Diversify service providers may be particularly beneficial where services are needed to meet specific gender or cultural needs.

Therapeutic programs provided by the AOD Team have been assessed as not reaching all intended participants, both due to irregular frequency of programs and poor access to programs. Some programs were not offered to all classifications, some were only run once or twice and others had poor completion rates. In particular, prisoners on shorter sentences and remandees faced particular difficulty in accessing an adequate range of therapeutic programs.

With regards to targeted urinalysis testing, the lack of a relationship between numbers of targeted tests conducted and positive results (those leading to disciplinary action) suggests that the 'intended recipients' (i.e., those who would be more likely to return positive drug tests) of targeted urinalysis differ from the actual recipients. If targeted urinalysis is entirely based on reliable intelligence, the rate of positive results should be higher and should be closely associated with the numbers of tests conducted. A lack of relationship between numbers of targeted tests and positive results is indicative either of faulty intelligence or the intent of testing being for purposes other than the detection of illicit drug use. Processes by which individuals are targeted for urinalysis testing require review to ensure they are accurate and appropriate. Similar issues have been experienced with regards to the targeting of searches, with no relationship found between numbers of cell and area searches and seizures of contraband. This is also indicative of issues with either intelligence or the intent of searches.

What has worked as expected and what has not? What barriers and challenges to implementation emerged, and how were they handled?

Several barriers and challenges to implementation of drug policy and services at the AMC have emerged. The application of human rights principles to the AMC context resulted in some interesting unintended outcomes. Some key informants considered that the emphasis on rights had diminished the focus on individual responsibility for prisoners, meaning that prisoners may be less likely to feel responsible for their crimes against the community and to make reparations for offences committed. Some consulted believed that the focus on rights had resulted in security-related incidents and reduced the effectiveness of some therapeutic programs. Change in the senior management of the AMC was believed to be linked to positive changes in prisoners' attitudes towards rights and responsibilities and the rectification of previous imbalances.

The centralisation of the case management function to the AMC Case Managers was intended to streamline service provision and ensure each prisoner has a case plan from the commencement of their incarceration onwards, as is described in a number of key policy documents that informed the implementation of the AMC. Early implementation problems with the case management model resulted in a change of structure with different case management roles now being provided by the various case managers (e.g., some focused on admission, some focused on

release). The addition of more case management staff in mid-2010 was also intended to increase capacity for case management, in recognition of the high case loads carried by individual staff. Despite these changes, findings from this evaluation suggest that the case management functions at the AMC were working sub-optimally. Prisoners expressed frustration with the system and a lack of awareness of who their case manager was and the type of assistance that they should expect from case managers. The change in structure described above did not markedly improve the quality of case management. (It should be noted that the evaluation team collected data prior to the introduction of additional staff resources, so this evaluation is unable to comment on the impact of that initiative on case management services.) Ultimately, the case management system has so far failed to meet policy expectations around creating an individually tailored system of case management and throughcare that addresses drug-related needs effectively and provides transitional support for those exiting the AMC.

The success of case management at the AMC has been hampered by a lack of comprehensive welfare and drug-related expertise among case managers. This is not surprising given case managers are drawn from community corrections rather than welfare roles and lack the relevant interests and disciplinary backgrounds. This lack of expertise has resulted in an ineffective case management system that does not address the criminogenic, social, psychological or drug dependence needs of individual prisoners, and thus is unable to prevent future re-incarceration. The evaluators recommend that approaches to case management at the AMC be holistic and individually tailored and provide a suite of coordinated services. This will require explicit and regular communication between a range of providers, and resolution of the fragmented nature of AMC drug service provision. As noted earlier, current communication between programs that have direct and indirect case management roles and from these service providers to prisoners are inadequate and do not facilitate a level of case management likely to result in sustained positive outcomes for individual prisoners.

Problems with case management provided by Corrective Services have been compounded by issues associated with care and discharge planning within ACT Corrections Health Program. It was intended that care and discharge plans would be developed for all prisoners at the AMC, but there is no evidence that plans are currently being developed or implemented. The barriers to implementation are unclear. Furthermore, no post-release monitoring of former prisoners with regards to compliance with discharge plans is occurring, limiting the ability to assess the effectiveness of care and discharge planning processes (and throughcare more broadly) were they to commence. The apparent absence of coordinated discharge planning and throughcare services is a major departure from intended drug services at the AMC. The evaluation team recommends that care and discharge planning processes should commence immediately, in line with stated strategic and policy direction, with explicit consideration of linking all case management with Corrective Services case planning processes to ensure well-coordinated services for individual prisoners and appropriate transitional and post-prison support.

Other unexpected issues in the implementation of drug-related services at the AMC include concerns raised by community service providers about access to confidential spaces in which to provide services and appropriate access to case

planning processes. While community service providers were originally allocated spaces in the Programs and Health buildings at the AMC, capacity issues have seen many services shifted to cell blocks or the visits area. These locations do not always allow confidential service provision and prevent community workers from accessing phone or computer facilities while providing services to prisoners. These limitations were reported to impact negatively on the effectiveness of the services provided.

In addition to these physical resource concerns, the throughcare model intended to be implemented at the AMC has been somewhat lacking, meaning that community service providers are not participating to adequate levels in case planning and case conferencing to support prisoners in making a successful transition back into the community. While these providers have strong and productive relationships with prisoners, poor coordination of services reduces the overall potential for positive change for individual prisoners.

With regards to therapeutic programs provided by Corrective Services, data collected by the evaluation team demonstrated that the ability to run programs other than First Steps and Back in Control (although the implementation of this program has been much more limited than First Steps) was severely limited by staffing resources and the need to deliver programs across many different prisoner classifications. These implementation barriers seem to have been responded to by withdrawing some programs, but this has limited the scope of therapeutic programs considerably, so that they focus largely on directly drug-related issues rather than taking a holistic approach. This limitation in program scope is an undesirable outcome that reduces the effectiveness of drug-specific programs and the AMC's overall approach to drugs. This approach fails to holistically and appropriately address the range of issues that affect individuals with drug dependence problems, of which drug use may be a symptom rather than a cause.

The ability of Corrective Services to introduce smokefree initiatives has been more limited than expected and difficult to police. The *Corrective Services Drug Alcohol and Tobacco Strategy 2006-2008* notes that these kinds of initiatives require sensitive and incremental implementation. The evaluation team is aware that the application of smokefree initiatives also depends upon the provision of smoking cessation programs for staff as well as prisoners, which the evaluation team understand have not occurred to date. Thus far, smokefree areas have been introduced within prison spaces, but it is still intended that the entire facility will become smokefree in the future. Key informants advised the evaluation team that there would be a human rights negotiation as part of this process that may prevent the entire facility becoming smokefree.

What assumptions have proved true and what have not? What assumptions are problematic, if any?

The evaluation team found that problematic and incorrect assumptions informed the design and delivery of drug services and strategies at the AMC. With regards to service access and need, assumptions that have led to inequitable access to services across remand and sentenced populations are problematic. The notion that there is any less need for services among remand prisoners (as indicated by

less programs being offered) is certainly incorrect, and the accompanying notion that remand prisoners would not want to do particular programs or be able to access particular services is similarly incorrect. Remand prisoners expressed a strong desire for opportunities to address their drug issues during time spent at the AMC. It is a finding of this evaluation that any service or program offered to one population within the AMC should be extended to all populations equitably.

Assumptions regarding gender issues have also proved to be problematic. It was intended that a policy emphasis on gender issues would result in practice improvements, but this has not been the case. Inequitable access to services for women persists and where inequities have been identified and advocacy has occurred, implementation of changes has been slow. The small number of female prisoners at the AMC may be considered an impediment to the provision of comprehensive service to women. However, flexible solutions that may entail the integration of service delivery to multiple prison populations (e.g., male/female, sentenced/remand) could potentially be considered. Although integration is unlikely to have occurred in other jurisdictions due to relative size and nature of individual prison populations (i.e., the AMC is unique in housing so many different classifications of prisoners and both genders), this does not preclude such innovations being explored at the AMC to suit its unique characteristics. Policy regarding gender inequities and practice responses to treating women as a priority population for service access need to be implemented as a matter of urgency.

The implementation of linked therapeutic programs that individuals can access across time spent at the AMC has occurred as a result of assumptions in relation to average length of sentence. The evaluation team were informed that, while a median sentence length of 14 months assisted in informing the development of a program delivered over approximately 12 months, the configuration of this program fails to meet the needs of individuals on shorter sentences or shorter periods of time on remand. The design of these programs needs to recognise that the offences typically (e.g., drug possession/ use, property crime, and other acquisitive crimes) committed by drug dependent offenders often result in shorter sentences so they cycle in and out of prison frequently. Under the current therapeutic programs structure, these individuals are unable to go beyond the First Steps stage of the therapeutic program, don't progress to Back in Control and certainly don't participate in the Solaris TC. Without tailored interventions that respond to shorter sentence lengths (including those that facilitate throughcare), the likelihood of individuals having successful outcomes is compromised. An explicit commitment to tailored programs for those on shorter sentences was provided in the *ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008*. This commitment has not been addressed in the development of therapeutic programs at the AMC.

The tailored intervention approach at the AMC should include a substantial expansion of individual counselling opportunities. The *ACT Health Adult Corrections Health Services Plan* indicates that counselling is intended to be provided by the ACT Corrections Health Service, however this is not currently occurring. Current counselling services are provided by NGOs and Forensic Mental Health. That ACT Corrections Health Program is not providing any

counselling and that it is indicated in policy that this should occur requires further exploration to determine how best to implement the policy.

A significant proportion of prisoner and ex-prisoner key informants had participated in First Steps, sometimes repeatedly, and had never progressed to a more intense level of therapeutic intervention due to sentence length or classification. Had individual counselling been available to these prisoners, they could potentially have made significant gains in their personal health and wellbeing and reduced the likelihood of recidivism or a return to drug use after prison due to the provision of a combination of intensive, tailored interventions (Cullen and Gendreau, 2000). The high prevalence of both drug and mental health issues (as well as individual histories of trauma, abuse and disadvantage) among the AMC prison population provides a strong indication for individual counselling, among other approaches (which may include group therapy), to adequately respond to the complexity of issues experienced by prisoners. To address service provision gaps, intensive case management (as indicated in ACT policy, individual human rights approaches, and research and policy experts (for example, Borzycki, 2005)) and counselling for those on shorter sentences is warranted. This issue is also reflected in the assumption that group programs can effectively address individual needs. If the individual is able to participate in *all* of the group programs, this could possibly be the case, but where those on remand or shorter sentences are concerned, tailored individual interventions are needed. This is not to say that individuals on longer sentences wouldn't also benefit from tailored individual interventions like counselling and intensive case management. Furthermore, access to individual counselling represents the provision of a service that is equivalent to what is accessible in the community, where individuals can access GP Mental Health Care Plans and state/territory-based funded counselling services. Currently, access to individual drug counselling at the AMC is inadequate. Improved access to counselling and intensive case management will likely improve throughcare and the success of transitioning back into the community. These services should continue after release, as needed and requested by prisoners.

Sources of funding that contribute to service provision at the AMC are diverse. This has resulted in multiple providers of sometimes similar services who often don't communicate with one another. The implicit assumption indicated by the engagement of multiple providers that these arrangements could result in a comprehensive and coordinated package of services that address individual needs effectively has been found to be untrue. Without clarity around the provider or agency responsible for coordinating services, numerous providers represent a problematic scenario that fragments the care provided to individual prisoners.

Several problematic assumptions appear to have informed the development of the case management system, as well as the case officer role. The removal of welfare officers from the Belconnen Remand Centre and the continuation of this policy at the AMC has resulted in a case management system that is ill equipped to respond to the broad health and welfare needs of individual prisoners through case planning processes. The lack of specifically trained welfare officers significantly weakens the AMC's response to drug-related issues. The notion that specialist welfare expertise is not required in the prison setting, and that effective support can be implemented in its absence, is problematic. Case managers

coming from correctional backgrounds and case officers being expected to perform support roles without appropriate training are serious deficits in the case management system and the capacity for this system to have a positive impact on prisoners with drug-related issues.

On a similar note, evaluation findings suggest that the assumption of rotating case managers through the AMC from community corrections to provide effective case management is problematic. This rotation negatively impacts on the ability of individual case managers to build rapport and form productive relationships with prisoners, which in turn decreases service continuity and throughcare. The definition of throughcare in the *Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008* as something that ends once individuals are no longer on community-based orders is also problematic. Throughcare should be operationalised more holistically to fulfil intended outcomes. Throughcare needs to include the time before, during and after prison and be sympathetic to the changing needs of the individuals concerned. Arbitrary time frames cannot be applied to this support and must be dependent on individual need. In addition, support should be welfare focused, rather than supervisory.

The findings of this evaluation and related clinical reviews question assumptions that underpin the provision of opioid pharmacotherapy. The notion that individuals need to detox fully from illicit opioids before being able to give informed consent to start a methadone program has been identified by the evaluation team as an unfounded assumption, and does not apply when services are provided in the community. Delays in commencing opioid pharmacotherapy for individuals who were not on a program in the community are unwarranted and not in line with national clinical guidelines (Henry-Edwards *et al.*, 2003). The clinical review conducted by Dr Adam Winstock in 2008 determined that delays were unnecessary and unacceptable; this finding was further supported by Dr Alun Richards, who conducted a clinical review in 2010. The assumption that access to opioid pharmacotherapy should be influenced by previous participation in a program in the community is misguided. Pharmacy dispensing arrangements should reflect equitable access to the program for all prisoners, with induction on to the program being able to occur one to two days at a maximum after prisoner request. This issue of delayed provision of opioid pharmacotherapy and opioid detoxification should be addressed as an immediate concern given the failure of ACT Corrections Health Program to implement recommendations in this area that date back prior to the implementation of the AMC.

One final incorrect assumption observed by the evaluation team was that the Solaris TC could operate effectively if situated within the male sentenced area of the AMC. This has certainly not turned out to be the case. The chosen location for the TC has restricted access to the program by prison populations other than sentenced men. The location of the TC has also limited access by male sentenced prisoners, with the program being open to the rest of the prison environment creating subsequent challenges. Some of these challenges relate to access to drugs, some relate to 'jail politics' and the change in social status that could be associated with participating in the TC program (e.g., being perceived as 'weak' for admitting to having a drug problem). Others challenges relate to protection concerns for TC participants and coercion to act in improper ways towards other TC participants. The evaluation team understands that some of these problems

are to be rectified with the removal of the Solaris TC from the male sentenced area of the AMC to an alternative, secure space on the grounds.

What has changed from the original design and why? On what basis are adaptations from the original design being made? How are these changes being documented and reflected upon, if at all?

The evaluation team identified changes to the original design intended for the AMC that occurred during the first 12 months of operation.

As noted earlier, the evaluation team is aware that the structure of the AMC's case management team has changed over the first 12 months of operation and more staffing resources have since been added. These changes were intended to streamline operations and provide a more effective service. Additional staffing resources were added to the case management team during the course of this evaluation, however the outcome of these changes was unable to be evaluated due to time constraints. However, the evaluation team was informed that more planned releases are happening now than early in the implementation of the AMC, which is a positive indication of improvements in case management over time.

More recently, the AMC Case Managers have taken on a case management role previously provided by the AOD Team, which involves assisting prisoners to access external residential rehabilitation services. Reports indicate that this change has resulted in decreased provision of case management for this purpose and decreased access to the AMC by external residential rehabilitation providers to undertake assessments and provide information to prisoners.

The content of therapeutic programs including First Steps, Back in Control and the Solaris TC has changed since they were initially introduced. These changes have occurred in response to continuous quality improvement approaches which include evaluations of individual programs and incorporation of participant feedback into the delivery of future programs. This has resulted in positive changes to programs and should be continued.

The delivery of peer education was intended to be part of demand reduction interventions introduced at the AMC, as directed by the *ACT Corrective Services Drug, Alcohol and Tobacco Strategy 2006-2008*. The evaluation team has located little evidence of peer education occurring, concluding that this is an area of policy that has not been effectively implemented. Yard delegates have been trained by the ACT Hepatitis Resource Centre to provide education to other prisoners on blood-borne viruses, but this did not begin to occur until 2010 and does not represent a strategic approach to peer education. The evaluation team is aware that some negotiations with a peer organisation have occurred recently, with the aim of delivering education sessions to prisoners; however, these activities are likely to be un-funded and initial negotiations have indicated unwillingness by AMC representatives to allow appropriate content to be included in the peer education sessions, including information about safer injecting. The evaluation team believes that to provide effective peer education, moves to sanitise education program content should be avoided.

The location of the Solaris TC came up in this evaluation repeatedly as an issue (see above for full discussion). The planned relocation of the TC, as recommended by both service providers and prisoners, will be a positive step that the evaluation team supports. The evaluation team recommends that pre-move data on participation and completion are compared with post-move data to evaluate the impact of the change on the success of the program in relation to enrolment and completion rates. Within ACT Corrections Health Program, the evaluation team is aware that new nursing positions have recently been added to the staff. One of these positions is to be focused on admissions and discharges and the other is to focus on public health, including blood-borne viruses. The addition of resources to the program is a positive step given the issues identified in this evaluation with regards to access to primary healthcare and other services provided by ACT Corrections Health Program. Furthermore, given the conspicuous absence of care and discharge planning in the ACT Corrections Health Program, and the significant issues in relation to the coverage and practices for blood-borne virus testing and vaccination, these changes are warranted and likely to lead to significant improvements. A follow-up review of care and discharge planning and blood-borne virus testing and vaccination rates in the next six months would assist in reflecting on the effectiveness of this restructure.

Since the AMC opened, more community service providers have been allowed access to prisoners. Ideally this would have occurred in recognition of service gaps, but the poor coordination of external providers of services indicates this change is unlikely to be strategic and merely in response to service provider requests. Although there are more providers now than when the AMC opened, most providers receive no specific funding to provide services at the AMC. This means that simply adding more providers is not a sustainable strategy to support both in-prison service and for ensuring throughcare for prisoners at the AMC. Providers should be selected based on their ability to sustainably provide services that address gaps in prison-based services. Ideally, these organisations would be given specific resources to provide services at the AMC. The range of services currently provided at the AMC, including service duplication and gaps, should be reviewed to better coordinate and efficiently deliver multiple services.

As previously mentioned, some community service providers have had to shift the location of the services they provide from the Programs or Health buildings to the visits area or cell blocks as a result of loss of physical space. This has impacted negatively on the provision of services. The issue of appropriate physical space for the delivery of services, with accompanying resources like telephones and computers, is integral to the delivery of quality services to prisoners. According to service providers, documentation of the impact of this change has not occurred. Such a review should occur and appropriate changes be made to support the work of community service providers at the AMC.

What governance issues have emerged, how are they being handled and what governance modifications, if any, are desirable?

The evaluation team identified multiple areas where policy was being implemented ineffectively or not at all. In particular, key principles like

integration, collaboration, throughcare, case management, tailored interventions, equity and equivalence are not being implemented into drug-related services and practice at the AMC. Earlier sections of this report included numerous examples of how these principles have been inadequately realised in service provision.

With regards to harm minimisation and its pillars of supply, demand and harm reduction, as outlined in the *National Drug Strategy 2004-2009*, governance issues have emerged in relation to a lack of leadership across operations, services and programs that these pillars should inform. This lack of leadership has resulted in unbalanced application of activities, without regard to the complementarity of initiatives or a shared purpose. Leadership and coordination across harm minimisation pillars is essential to ensure that activities are part of a concerted and comprehensive strategy to address the problems associated with drug use, rather than isolated responses where effectiveness is compromised without the support of other activities. This lack of leadership has, in part, resulted from a lack of clear policy guidance for the AMC as a whole system; rather, policies are developed separately to guide different providers, service types, or activities (e.g., health management versus corrections management). This has produced overlapping policies that, while they do not contradict one another, do not constitute a comprehensive overall strategy to guide all drug-related activity at the AMC. Furthermore, one key policy document, the *Corrective Services Drug Alcohol and Tobacco Strategy*, has been out of date since the end of 2008, well before the AMC even opened.

The lack of leadership in relation to a coordinated harm minimisation approach to drug services at the AMC has also resulted from a lack of clarity with regards to responsibility and the lack of any senior governance structure to support the sometime disparate activities that underpin harm minimisation within a prison environment. The AMC needs an overarching drug strategy that guides all providers of services at the prison. This strategy would have a governance structure that includes all providers and provides role clarity, overt coordination responsibilities for all drug-related strategies and strong leadership which encourages collaboration between providers. This structure may also better align funding and resource allocation and lead to common or complementary key performance indicators being developed and the engagement of all relevant parties in the development of policy to guide drug-related activities at the AMC. Given the size of the ACT jurisdiction and the fact that only one adult prison is operating, the numbers of providers needing to be engaged in such a strategy seems manageable. Performance against key policy objectives can then also be measured for the system as a whole, rather than just for the individual providers or types of services. Groups like the Community Corrections Coalition and the Community Integration Governance Group are examples of the kinds of structures that may inform the development and implementation of effective governance structures and the policies to guide activities at the AMC in a coordinated way. These groups also provide examples of systems to engage a range of relevant stakeholders in policy-related activities.

As noted earlier, many service providers felt that the levels of consultation that occurred prior to the development and implementation of policy were inadequate. Nevertheless, staff did note that there were opportunities to provide feedback on policy following implementation. The issue of poor integration at the policy level

was raised throughout the evaluation as an issue for all providers, and was considered to contribute to fragmentation and poor communication at the practice level.

To what extent have the strategies and services attained their stated objectives, including the targets specified in the Key Performance Indicators (KPIs)?

Area	Target	Assessment
Supply reduction		
Interdictions of supply, and types and volume of drugs and drug-related contraband interdicted.	<p>Increase in number and total volume of interdictions by drug type and drug-related contraband.</p> <p>Increase in number of searches and screens of prisoners.</p>	<p>No significant increase in number and total volume of interdictions by drug type and drug-related contraband across the evaluation period.</p> <p>No meaningful trend in numbers of strip searches. Increased number of strip searches associated with increased number of contraband seizures. Increase over time in area searches, visitor metal detector searches (all visitors routinely searched so trend relates to number of visitors). No relationship in number or area searches and number of contraband seizures. No meaningful trend in urinalysis tests over time.</p>
Random and targeted searches and screens of visitors.	Increase in number of searches and screens of visitors.	Increase in number of drug detection dog searches of visitors. Increase in number of metal detector searches (all visitors routinely searched so trend relates to number of visitors).
Random, targeted and untargeted positive drug tests by drug type.	<p>Increase in number of drug tests conducted.</p> <p>Reduction in proportion of positive tests.</p>	<p>No increase in number of drug tests conducted over time.</p> <p>No meaningful change in proportion of positive tests over time.</p>
Demand reduction		
Health promotion, prevention and early intervention evidence-based	All prisoners receive health promotion, prevention and early intervention evidence-based interventions (e.g., increase in uptake of blood-	No evidence this is currently being met. Testing rates are low and not increasing over time. Record keeping practices are inadequate to assess whether all prisoners are offered

Area	Target	Assessment
interventions provided	borne virus testing and HBV vaccination).	interventions.
Commencement and retention on opioid maintenance treatment.	Opioid replacement therapy to be made available to all inmates at high risk of opioid use in prison and / or on discharge.	All prisoners who want to access opioid pharmacotherapy are able to do so at the AMC. Low continuation of the program after discharge is a significant issue, particularly with regards to increasing mortality risk. Delays in the commencement of opioid pharmacotherapy for those not already on a program at entry are a concern.
Evidence based individual and group treatment for drug-related problems provided.	Evidence-based individual and group treatment for drug-related problems be made available to all inmates who may benefit from such treatment	All prisoners are able to access some drug related programs. Prisoners express difficulty in accessing group programs and some classifications have no access to some programs. Little offered in the way of individual treatment like counselling. Issues with facilitation quality impacted group efficacy.
Admissions of men to and retention in the therapeutic community.	<p>Increase in admissions of men to the TC.</p> <p>100% of male prisoners who commence the TC program complete the four week induction phase.</p> <p>80% of prisoners who complete the induction phase complete the twenty week treatment phase.</p>	<p>Admissions increased during the second intake, then decreased during the third and fourth intakes.</p> <p>Over 80% of participants in the first three intakes completed the induction and the treatment phases.</p> <p>50% of participants in the fourth intake completed the induction and treatment phases.</p>
Prevalence and frequency of harmful drug use within the prison.	Reduced prevalence and / or frequency of harmful drug use (i.e., alcohol, tobacco and non-prescribed drugs) as measured by random urine drug screens and any other means available in the prison.	Given that random tests are conducted at reception and there has only been one whole-of-prison screen (December 2009), it is not possible to assess this KPI. A second iteration of the Inmate Health Survey could inform the measurement of this KPI.
Prisoners with a CS pre release plan.	All prisoners have a written, individual pre-release plan that was developed in collaboration with the prisoner, and that	Prisoners are not collaborating in case planning processes with CS. Many instances reported of individuals leaving prison without any support in

Area	Target	Assessment
	includes consideration of psychosocial needs after release (e.g., accommodation).	place. Pre-release planning processes assessed as improving but still not collaborative enough.
Implementation of CS pre-release plan.	All CS pre-release plans implemented.	No systemic post-release monitoring is occurring, so this KPI cannot be assessed.
Prisoners with a CH discharge plan	All prisoners have a written, individual CH discharge plan that was developed in collaboration with the prisoner, and includes consideration of all health needs after release (e.g., appointment with GP).	There is no evidence that any discharge planning is occurring.
Development and implementation of prisoners' CH discharge plan.	Documented individually tailored CH discharge plan for all prisoners and evidence of implementation after release from custody (e.g., attendance at appointments, efforts at follow-up by CH).	There is no evidence that any discharge planning is occurring and no systemic post-release monitoring is occurring, beyond that recording retention in opioid pharmacotherapy.
Harm reduction		
All prisoners offered screening for hepatitis B and C, HIV and sexually transmitted infections at admission, during periodic health screens and at time of discharge.	Documented evidence of all prisoners being offered screening (and being screened if consent given) at admission, during periodic health screens and at time of discharge.	There is little documented evidence of prisoners being offered screening at admission or at other times during their incarceration. Record keeping practices are assessed as being inadequate.
Prisoners vaccinated against hepatitis B.	Documented evidence of all prisoners being offered vaccination against hepatitis B and vaccinated upon request.	There is little documented evidence of this occurring. Record keeping practices are inadequate.
Prisoners' level of drug risk behaviours (e.g., injecting drug use, sharing injecting equipment,	Levels of drug risk behaviours lower than reported in the 2009 NSW Inmate Health Survey.	Last injection while in prison: ACT – 26.6% NSW – 21.9% (Indig <i>et al.</i> , 2010)

Area	Target	Assessment
gambling, tobacco smoking).		<p>Last injection used a clean needle that had not previously been used by anyone else:</p> <p>ACT – 30.8%*</p> <p>NSW – 3%* (Indig <i>et al.</i>, 2010)</p> <p>Gambling:</p> <p>No data available</p> <p>Currently smoke:</p> <p>ACT – 85.3%</p> <p>NSW – 75.9% (Indig <i>et al.</i>, 2010)</p> <p>On comparable data fields, levels of risk behaviour reported in the ACT Inmate Health Survey 2010 are higher than levels reported in the 2009 NSW Inmate Health Survey.</p> <p>* These data are difficult to compare, as the ACT data relates to last injection, whereas the NSW data relates to last injection in prison. Answers to these questions may be influenced by social desirability bias and the fact that the data is based on self-report.</p>
Level of transmission of blood-borne viruses within AMC.	No transmission of blood-borne viruses within AMC.	Some incident cases have been recorded (less than five), however record keeping and testing practices are inadequate to determine incident cases.
Level of fatal and non-fatal drug overdoses by prisoners during detention and up to three months post release.	Fatal overdoses and incidence of non-fatal overdoses lower than that reported in the 2009 NSW Inmate Health Survey.	<p>Less than five cases of overdose at the AMC have been reported. No systemic post-release monitoring is currently occurring so this KPI cannot be assessed in relation to fatal or non-fatal overdose occurring after release.</p> <p>23.1% of respondents to the NSW Inmate Health Survey reported a history of overdose (Indig <i>et al.</i>, 2010). Past history of overdose by ACT prisoners was 40.5%.</p>

Area	Target	Assessment
		No data on overdose incidence in NSW prisons is reported in the 2009 NSW Inmate Health Survey.
Response to drug overdose	Documented evidence of Naloxone administered and monitoring and/or patient hospitalised as clinically appropriate.	This data is being collected to an adequate level by ACT Corrections Health Program.
Fatal overdose in the first four weeks post release.	No fatal overdoses in the first four weeks post release	No systemic post-release monitoring is currently occurring so this KPI cannot be assessed.

That so few key performance indicators have been met may be indicative of a need to review the above indicators to determine their appropriateness as outcomes for measuring the effectiveness of drug policy and services at the AMC.

Were there any unintended consequences of the implementation of the strategies and services, either positive or negative?

Several of the AMC's strategies and services have resulted in unintended consequences. Perhaps the most major unintended consequences have been observed in relation to the fragmentation of services and providers. Lack of awareness of and access to internal services by prisoners has resulted in individuals accessing external services that duplicate services provided by prison-based providers (e.g., case management). This is due to better visibility of external services, the quality of relationships (that may have existed prior to incarceration) and perceived ease of access. Furthermore, some of these duplicate services are likely to be unfunded (i.e., those provided by community-based providers), but feel a sense of moral obligation to provide services in response to prisoner requests, particularly when they are aware of the access and quality issues being experienced by prisoners who are attempting to get support from in-prison services. Advocacy by community service providers to improve service access has occurred, however this is another unfunded activity which has not resulted in sustainable access or quality improvements. The duplication of services is problematic and is not monitored due to the lack of service coordination.

Within the opioid pharmacotherapy program, the evaluation team observed conditions related to current policy and practice that are likely to lead to unintended consequences. The current dispensing arrangements for pharmacotherapy provide little opportunity for sufficient communication and consultations about changes in dosing. There is evidence that some individuals are reducing their opioid pharmacotherapy doses rapidly without appropriate clinical advice. These consequences are certainly not intended by the program,

and the lack of thorough consultative processes is contra-indicated by evidence-based practice.

The practice of administering opioid detoxification packs to prisoners not transitioning from a community methadone program has resulted in delays in initiation to methadone. This practice means that individuals completely withdraw from opioids and are then rendered physically dependent once again after they are initiated on to methadone. Whether these consequences are unintended is debatable given the explicit purpose of opioid detoxification. In addition, ACT Corrections Health Program have previously received one clinical assessment describing this delay as unacceptable, and a further assessment supporting the finding of the first assessment, yet practice has not been modified. The evaluation team can find no clinical evidence to support this practice, which is a systemic problem that requires urgent attention.

The choice not to prescribe buprenorphine at the AMC as an opioid pharmacotherapy clearly breaches principles regarding equivalence with services available in the community. Although it is unclear why, the fact that prisoners and ex-prisoners report buprenorphine as one of the most desirable and most commonly trafficked substances brought into the AMC may in part be due to a lack of availability at the AMC. Qualitative data suggests another unintended consequence of not providing buprenorphine, with reports that individuals may not be commencing opioid pharmacotherapy due to a preference for buprenorphine over methadone.

With regards to other primary healthcare services, the evaluation team are aware of some diversion of prescription medications occurring. Very low rates of diversion of pharmacotherapies have been reported to the evaluation team. Medication diversion is commonly reported in prison settings and diversion is clearly an unintended consequence of the provision of medication. However, diversion prevention requires active and effective monitoring processes, rather than the withdrawal of medications altogether.

Inadequate blood-borne virus testing practices at the AMC are likely to have unintended consequences in relation to engagement in injecting risk behaviours among people who mistakenly believe they are HCV positive. For example, people informed that they are HCV antibody positive without a subsequent PCR test to assess chronic infection may share injecting equipment with other HCV-positive people in the belief that transmission risk is inconsequential when in reality they may have cleared the virus and be risking re-infection. It should be noted that incorrectly believing they are HCV positive may also prevent the engagement in injecting risk behaviours by prisoners not wanting to transmit HCV to others.

It was reported to the evaluation team by prisoners and ex-prisoners that sessions during therapeutic programs that focused on cravings resulted in participants experiencing strong feelings of wanting to use drugs. It is understood that the content of these sessions has since been adjusted, based on prisoner feedback.

What were the monetary costs of the services provided, and was value-for-money attained?

Data supplied to the evaluation team on the costs of services provided at the AMC and staffing resources allocated to various services were limited and effective comparison across services is difficult. Undertaking a thorough cost-benefit analysis and determining value for money requires significant resources and expertise and was not possible within the scope of this project and the limitations of the data. Some description of the services and their associated costs is provided below, with a focus on determining a cost per EFT for various services. Given broader issues described earlier in the Findings (9.0) and Discussion (10.0) sections with regards to the quality of services and expertise of service providers, this cost per EFT is not indicative of quality or value for money. The figures below should therefore be interpreted alongside earlier reports regarding the quality of each program described. Data collection and implementation issues need to be resolved before further economic analysis can take place.

ACT Corrections Health Program

Total EFT = 11

Total salaries = \$1,525,729.20

Cost per EFT = \$138,702.65

Solaris TC

ADFACT

Total EFT = 4

Total salaries \$367,861

Cost per EFT = \$91,965.25

Corrective Services

Total EFT = 7

Total salaries = \$641,000

Cost per EFT = \$91,571.42

Based on the activity levels in 2009/2010 this equates to over \$58,000 per admission.

Corrective Services

1) Drug detection dog handlers

Total EFT = 4

Total salaries = \$473,821

Cost per EFT = \$118,455.25

2) AOD team members

Total EFT = 3

Total salaries = \$198,579

Cost per EFT = \$66,193

3) Other staff undertaking drug-related functions

Total EFT = 1.2

Total salaries = \$81,606

Cost per EFT = \$68,005

Directions ACT Inside Out Program

Total EFT = 1.7

Total salaries = \$108,850

Cost per EFT = \$64,029.41

This analysis provides only a snapshot of costs associated with providing select services at the AMC. Given that some services provided at the AMC are unfunded and that funding sources for others are diverse and often not funded from ACT-based sources, limited insight into value for money is able to be provided here.

What changes, if any, need to be made to the strategies and services?

Some discussion will be provided in this section on broad systemic changes which need to occur to drug-related strategies and services at the AMC. More detailed and explicit recommendations are provided in the Recommendations section (11.0).

Overall, the evaluation team concluded that the absence of clear policy guidance and a governance and leadership structure for the provision of drug-related services at the AMC severely limits the effectiveness of program activities. The development of a comprehensive and cohesive AMC drug strategy that guides the corrections, health and community-sector activities alongside an appropriate supporting governance structure is needed. Such changes should focus on providing an environment that promotes and supports a collaborative, comprehensive, efficient and coordinated approach to drug services. A coordinated strategy accompanied by collaborative governance, leadership and service provision structures would allow harm minimisation interventions to be effectively balanced across the pillars of supply, demand and harm reduction, as outlined in the *National Drug Strategy 2004-2009*.

Drug use issues at the AMC need to be considered more holistically; that is, to approach drug use as an antecedent and/or sequelae of a range of health and psycho-social issues, and therefore focus services on a range of individual needs.

Attempts should be made to provide a suite of services for prisoners that are tailored to individual needs and not structured according to traditional service provision silos. Addressing other needs (e.g., employment and mental health) will help create an enabling environment to support abstinence from or cessation of problematic drug use and help reduce recidivism.

The recommended holistic approach requires effective case management and service coordination. This case management must be welfare based and include regular meetings (increasingly often closer to release) between case managers and prisoners and case conferencing with community service providers at admission, during incarceration and prior to release. All other activities, programs and services with which prisoners engage should emerge from case planning processes that are explicitly developed and refined in collaboration with prisoners and the relevant range of service providers. These will support an improved throughcare approach, including providing care at transition into and out of prison, during incarceration and following release, for as long as individuals require support. Specific funding for transitional support services will be required to support these activities and to avoid placing an unreasonable burden on community organisations to provide unfunded services to prisoners and ex-prisoners.

Individual counselling should be made available to all prisoners on request. This service should be low threshold and include drop-in accessibility as well as regular appointments. The service should be easily visible, promoted to all prisoners and be provided in all prisoner classifications. This service should be integrated into coordinated case management (as described earlier) and complement any group therapeutic programs undertaken, enhancing these programs by addressing individual needs.

10.2 Harm minimisation pillars

Supply reduction

The findings of this evaluation demonstrate that supply reduction activities conducted at the AMC are not halting the flow of drugs into the AMC but simply intermittently interrupting that flow. Ongoing trafficking of drugs by prisoners, visitors, staff and through other means such as breaching the perimeter of the AMC were all described to the evaluation team. This information came from all categories of key informants and was supported by data on drug use from the Inmate Health Survey.

Activities such as searching and urinalysis were being conducted with some success, but rates of searching and testing were inconsistent. Furthermore, the quality and intent of searching practices were questioned by some key informants and the practices employed described as inconsistent. Considerable concern was expressed that searching was being used to victimise individuals rather than to locate contraband. Targeted urinalysis tests did not demonstrate a significant relationship between tests conducted and positive results relating to disciplinary action, suggesting intelligence may be incorrect or testing is being conducted for reasons other than intelligence.

Outcomes of supply reduction activities could be better utilised to provide positive benefits to prisoners and to inform demand reduction activities. For example, individuals returning positive urinalysis results can be prioritised for referral into therapeutic programs or other drug treatment such as opioid pharmacotherapy. This referral process could occur through case planning processes. Such processes would mean that supply reduction activities are not only punitive in nature or conducted in isolation from other drug policy and service objectives, but contribute to the overarching principle of harm minimisation.

Conflicts between Corrective Services and ACT Corrections Health Program were described in relation to urinalysis and the sharing of clinical information with Corrective Services staff. It is understood that the processes that underpin these conflicts are currently being resolved, nonetheless they highlight the importance of supply reduction being part of a coordinated harm minimisation approach in which activities complement demand and harm reduction measures.

Demand reduction

Demand reduction interventions should be focused mainly on assisting individuals to cease, reduce or abstain from drug use. Through the provision of appropriate treatments that address social and individual circumstances, drug use can be reduced, along with the accompanying harms. Demand reduction is the area in which activities at the AMC have been the most comprehensive in range, but inconsistent in quality and access. Significant gaps in demand reduction have been identified, such as the lack of provision of individual counselling and access problems with therapeutic programs.

It is likely that demand reduction activities have been over-emphasised at the cost of harm reduction interventions. This is especially problematic given evidence of risky drug use occurring in the prison setting and individuals discontinuing opioid pharmacotherapy after release.

Case management can be considered as the foundation for demand reduction interventions by providing a basis from which to identify individual needs related to drug use and developing plans to meet these needs. The implementation of case management has been problematic for many reasons, as described in detail above. To effectively address needs relating to drugs, case management needs to be holistic and welfare-focused to recognise the multiple social, health and wellbeing impacts and precedents of drug use. This approach is not currently being utilised in the case management system and many quality and access issues have been reported. Different skills are required than are currently present in the case management team at the AMC, and the use of community service providers by prisoners to address case management needs is perhaps symptomatic of this problem. Transparent and collaborative approaches to case management are needed, including explorations of the role of community service providers for the provision of in-prison and post-release services to enhance service effectiveness and support a throughcare approach.

Therapeutic programs delivered by the AOD Team have suffered from quality and access issues, with some programs not being available to some prisoner classifications within the AMC or those on shorter sentences and passive sign-up processes reducing accessibility where programs are offered. The current suite of

programs have not been consistently offered (and certainly not to all classifications) and those delivered have focused on relapse prevention, with the most prominent program being First Steps. While these programs are a positive way to reduce demand for drugs at an individual level, if delivered in isolation they do little to address the myriad other influences on drug use; they need to be an explicit part of a holistic and broad approach to drug use issues. This is especially the case when so many prisoners are unable to access the full suite of programs which together are intended to address drug use issues but alone may have little or no impact.

That the location of the Solaris TC has impacted on the success of the program has been raised many times earlier, however, this problem is in the process of being resolved. In the interim, other therapeutic programs need strengthening and should to be equitably offered to all prisoners. Access to external residential rehabilitation services also needs to be strengthened as part of improved case management support.

Limited individual counselling at the AMC is a major deficit in demand reduction strategies and needs to be addressed immediately. The lack of individually tailored interventions, particularly in a context of current limitations in group programs, is a significant problem and all groups of key informants described the lack of individual counselling as an impediment to achieving positive change for individuals with drug use issues.

Opioid pharmacotherapy is undoubtedly a key demand reduction intervention. There is no waiting list or limit on the number of individuals who can receive opioid pharmacotherapy, which is commendable compared to some other jurisdictions. Nevertheless, the current program is currently beset by some access and quality problems. Forcing individuals to undergo a detoxification regime while waiting to receive opioid pharmacotherapy is unnecessary and may be distressing. This delay in access requires immediate rectification. Prisoners have few opportunities to discuss dosing changes in a private and confidential fashion that encourages good clinical practice. This is reflected in individuals reducing doses quickly, stopping the opioid pharmacotherapy program prior to release, and being sustained on sub-therapeutic doses. Other undesirable outcomes of the program include individuals discontinuing opioid pharmacotherapy after release. These outcomes may contribute to increased overdose risk post-release.

The refusal by ACT Corrections Health Program to prescribe a buprenorphine preparation as an opioid pharmacotherapy (or to explore its use as a detoxification support) should be reassessed. This policy has resulted in a service which is not equivalent with what is offered in the community and potentially discourages individuals from commencing a strongly evidence-based treatment regimen available in prisons in other jurisdictions. The reassessment of the current practices with regards to buprenorphine preparations should also take account of potential diversion practices that may occur in prison and the adoption of appropriate dispensing models to limit such diversion. It has also been suggested that a buprenorphine preparation should be offered as an alternative detoxification medication to Doloxene. This should be explored, as it is available in the community and recommended for use in this context.

The evaluation team found that access to primary care and mental health services at the AMC is not in line with community standards. Delays in treatment for acute health problems like broken bones or chest pains and delays in continuation of pre-incarceration anti-depressant medication are unacceptable and inequitable. Similarly, the dearth of individual counselling available to prisoners is not reflective of the accessibility of the service in the community. Moreover, these access issues are at odds with the strategic and policy framework that informed the implementation of the AMC in relation to service equivalence and accessibility. Given the discussion above about the importance of a holistic approach to drug issues and addressing health and wellbeing concerns, these deficits compromise the success of demand reduction overall.

Harm reduction

The harm reduction activities undertaken at the AMC do not represent a comprehensive and effective set of interventions.

The omission of overdose prevention education in programs delivered at the AMC is worrying. Considering what is known about mortality risk post-release, and the inclusion of KPIs for this project relating to in-prison and post-release overdose, the dearth of education and poor continuation rates of opioid pharmacotherapy post-release are concerning. No post-release overdose deaths have been reported, but there is currently no monitoring of fatal or non-fatal overdose among ex-prisoners in the ACT. This is in part due to the nature of the ACT as a jurisdiction where cross-border flows are common. A prospective data linkage study may be required to determine if any fatal overdoses have occurred, but current data limitations in the ACT (e.g., no ambulance overdose attendance data) mean that the rate of non-fatal overdoses will remain unknown.

Limited safer injecting education is currently taking place, with most education focused on reducing blood-borne virus transmission. Safer injecting education needs to be much broader and include information about levels of drug use, effects of drugs and poly-drug use and vein care. Harms associated with drug use extend to injecting-related injuries and diseases such as septicaemia and endocarditis, especially where access to clean equipment is limited. No programs currently provided at the AMC address these issues. This is a major deficit when trying to implement a comprehensive harm reduction strategy.

Current blood-borne virus testing and vaccination practices and data recording processes are inadequate. There are no accredited pre- and post-test counsellors on staff and this severely compromises testing practices. It seems that many individuals are not offered routine testing at reception and no systematic testing after admission is occurring. Some blood test results are not being delivered to prisoners and the testing algorithms for HCV and HBV are not best practice. In a high risk population for exposure to HCV and HBV, antibody testing alone is inadequate and likely to lead to risk behaviours that could otherwise be prevented. The current system offers no way to reliably estimate incidence or prevalence of blood-borne viruses among the AMC population. Any estimates that have been offered (e.g., based on self-report or limited clinical data) are likely to be unreliable. This finding has implications for the introduction of other harm reduction initiatives such as a needle and syringe program, as it precludes the

possibility of measuring the impact of such a program on blood-borne virus transmission rates.

Bleach is being provided to prisoners at the AMC, but barriers to access exist. Bleach reportedly runs out frequently and is not replaced immediately, and prisoners have varying views about ease of access. Many feel that accessing bleach will be associated with sanctions such as increased surveillance, searching or urinalysis. These perceptions compromise the effectiveness of the bleach program.

Quantitative and qualitative data from several sources suggest that risky drug use is currently occurring at the AMC, despite the best efforts of Corrective Services to prevent drugs entering the prison. The use of contraband syringes within the prison to administer drugs is evident. Bleach to clean syringes has not been universally available and is not a proven strategy for entirely mitigating disease transmission risks. Disease transmission is occurring, but rates of transmission are likely to be under-ascertained due to poor testing practices. Contraband syringes also present a safety risk to staff, who may sustain needle stick injuries during search procedures. The evaluation team notes the safety concerns of custodial officers, with regards to fears of needles being used as weapons, however the evaluators also note that no incidents of needles being used as weapons have been observed where regulated, controlled NSPs exist in prisons internationally (Jurgens *et al.*, 2009). The commencement of a process to introduce a trial needle and syringe program at the AMC, as consistent with the Centre's initial policy direction, is certainly warranted. Such a trial should be considered in the context of strengthening other harm reduction activities. The feasibility and acceptability of potential models for such a trial requires further exploration that explicitly involves engagement and consultation with all key stakeholders.

11.0 Recommendations

Policy and governance

1. A consolidated strategic and policy framework should be developed specifically for the AMC to provide consistent, coordinated and clear governance and service provision guidance regarding drug-related policy and services *[see: Desktop policy review section 6.0 for discussion of various policies and strategies; Policy and governance issues section 9.1 for discussion of disciplinary conflicts and the need for leadership; Discussion section 10.0 for further synthesis]*.
2. An effective governance structure should be established to support the implementation of integrated drug policy and services, including the provision of overarching leadership to support drug policy and service coordination between Corrective Services, ACT Corrections Health Program and other service providers. Governance and leadership structures should aim to ensure that drug policy and services are complementary and consistent with the principles outlined in the aforementioned strategic and policy framework and the pillars of harm minimisation, and promotes shared objectives and role clarity among service providers and sectors *[see: Desktop policy review section 6.0 for discussion of various policies and strategies Policy and governance issues section 9.1 for discussion of the need for leadership; Discussion 10.0 for further synthesis]*.
3. Review key performance indicators used for this evaluation to better reflect the achievement of quality outcomes rather than activity volumes, if key performance indicators are to be adapted for use in future drug policy or strategy *[see Discussion 10.0 for description of key performance indicators]*.

Supply reduction

4. Searching and urinalysis testing should be conducted on a more consistent basis *[see: Searches and seizures section 9.12 and Urinalysis section 9.11 for discussion of the rates of searching and testing over time; Discussion section 10.0 for further analysis and synthesis]*.
5. The AMC should review the process by which prisoners are selected for targeted urinalysis due to the lack of any relationship between targeted urinalysis and positive results *[see Urinalysis section 9.11 for discussion of targeted urinalysis]*.
6. The AMC should review the process by which cells and areas are selected for searching due to weak relationship between cell and area searching and contraband seizures *[see Searches and seizures section 9.12 for discussion of targeted searching]*.
7. Adequate oversight of cell and area searches should occur to ensure that legislative requirements are met regarding the personal belongings of individual prisoners *[see Searches and seizures section 9.12 for discussion of searching practices]*.

8. Individuals returning positive urinalysis results should be referred to case managers so that they can be linked in with appropriate therapeutic responses *[see: Urinalysis section 9.11; Discussion section 10.0 for discussion of how urinalysis results could be utilised to inform demand reduction measures]*.
9. Further consultations and advice should be provided to all prisoners in relation to the use of the SOTER machine and the potential for accompanying risks. The quality of the provision of advice should also be strengthened in relation to AMC visitors *[see Searches and seizures section 9.12 for discussion of SOTER machine]*.
10. Revised protocols for the provision of informed consent for information sharing between ACT Corrections Health Program and Corrective Services regarding urinalysis testing and the presence of prescribed substances in samples should be finalised and implemented *[see: Urinalysis section 9.11 for discussion of informed consent processes; further highlighted in Discussion section 10.0]*.

Demand reduction

Case management

11. The case management system should be reviewed and redeveloped with an emphasis on a holistic model and the staffing of case management services with suitably qualified individuals. The redevelopment should give strong consideration to the following:
 - Exploring alternative providers or a partner provider and strengthening the role of community services to enhance throughcare arrangements *[see: Case management section 9.2 for discussion of quality and throughcare issues; Discussion section 10.0 regarding suitability of current service providers]*;
 - Ensuring that fortnightly case management meetings occur between case managers and their clients throughout incarceration, with consideration of an increase to weekly meetings in the month prior to release where appropriate *[see: Case management section 9.2 for discussion of access issues; Discussion section 10.0 for further synthesis]*;
 - Discontinuing the system of community corrections staff rotating through the AMC, with individuals appointed to permanent AMC Case Manager roles *[see: Case management section 9.2 for discussion of quality issues; Discussion section 10.0 for further synthesis]*;
 - Ensuring that case managers have strong welfare and alcohol and other drug skills and knowledge including specialist training in the prison context *[see: Case management section 9.2 for discussion of quality issues; Discussion section 10.0 for further synthesis]*;
 - Reviewing the case officer role to determine its effectiveness in the provision of support to prisoners *[see Case management section 9.2 for discussion of role clarity issues]*;

- The provision of case conferencing with Corrective Services, ACT Corrections Health Program, Forensic Mental Health and community-based providers for prisoners at admission, during incarceration and at release *[see: Case management section 9.2 for discussion of case conferencing; Discussion section 10.0 for further synthesis]*;
- Reviewing disclosure and privacy issues in light of increased collaboration *[see Brief literature review section 7.0]*;
- Ensuring that case managers are aware of and provide coordination of all services that individual prisoners are receiving, including those by internal providers (Corrective Services, ACT Corrections Health Program, Forensic Mental Health) and external providers (community service providers) *[see: Case management section 9.2 for discussion of service coordination; Discussion section 10.0 for further synthesis]*;
- Ensuring that case plans are holistic, developed in collaboration with prisoners and all relevant service providers and provide a specialised focus on the provision of transitional support at release *[see: Case management section 9.2 for discussion of access and quality issues; Discussion section 10.0 for further synthesis]*;
- Ensuring that the resources allocated to case management are adequate to respond to the often multiple and complex needs of prisoners at the AMC, including physical space resources for external providers *[see: Case management section 9.2 for discussion on under-resourcing and lack of physical space and resources to deliver services; Discussion section 10.0 for further synthesis]*

Counselling

12. Generalist individual counselling services of high quality should be made available to all prisoners classifications at the AMC, with access across classifications, gender and incarceration status. Services should include low threshold access opportunities, including drop-in services and regular appointments *[see: Individual counselling section 9.3 for discussion of lack of counselling opportunities and need for counseling; Discussion section 10.0 for further synthesis]*.
13. Counselling should be made accessible both via case planning processes and through *ad hoc* prisoner request *[see Individual counselling section 9.3 for discussion of need for counseling; Discussion section 10.0 for further synthesis]*.

Healthcare

14. Improved access to primary healthcare services should be provided including reduced delays in responding to requests for assistance. This may require more staffing resources and more hours of service provision *[see: Primary healthcare section 9.8 for discussion of access issues; Discussion section 10.0 for further synthesis]*.
15. An improved prisoner self-referral process should be instigated. Prisoners requesting healthcare during medication rounds should be directed to this

self-referral process *[see: Primary healthcare section 9.8 for discussion of access issues; Discussion section 10.0 for further synthesis]*.

16. Improved access to mental healthcare services should be provided, with reduced delays in responding to requests for assistance and service provision to all those with mental health needs. Mental health services should be appropriately resourced to respond to high prevalence sub-acute mental health conditions *[see: Mental health section 9.9 for discussion of access issues; Discussion section 10.0 for further synthesis]*.
17. Current practices with regards to the prescription of benzodiazepines should be reviewed to ensure individuals prisoner needs are responded to and to ensure continuity of treatment for those moving from the community to the prison environment *[see: Primary healthcare section 9.8 for discussion of medication issues; Discussion section 10.0 for further synthesis]*.
18. Clinical record keeping processes should be significantly improved *[see: Primary healthcare section 9.8 and Blood-borne viruses section 9.15 for discussion of record keeping; Discussion section 10.0 for further synthesis]*.
19. Care and discharge planning at ACT Corrections Health Program should occur routinely in collaboration with AMC Case Managers and other service providers where appropriate *[see: Primary healthcare section 9.8 for discussion of care and discharge planning; Discussion section 10.0 for further synthesis]*.
20. A follow-up review of care and discharge planning and blood-borne virus testing and vaccination rates should occur in the next six months to determine effectiveness of the nursing team restructure in the ACT Corrections Health Program *[see: Primary healthcare section 9.8 for discussion of access issues; Discussion section 10.0 for further synthesis]*.
21. A system for consensual post-release monitoring of prisoners should be developed that identifies fatal and non-fatal overdose events, continuation of opioid pharmacotherapy and compliance with case plans and discharge plans *[see: Overdose section 9.16 and Opioid pharmacotherapy section 9.11 for discussion of post-release monitoring; Discussion section 10.0 for further synthesis]*.

Detoxification

22. Counselling and medication support should be provided for detoxification from prescription medications (e.g., methadone, oxycodone) *[see Detoxification section 9.10 for discussion of prescription medications]*.
23. Non-medication support for detoxification, particularly counselling services, should be provided to encourage prisoners to move from clinical to non-clinical therapeutic interventions where appropriate *[see Detoxification section 9.10 for discussion of the need for non-medication support]*.
24. The adequacy of detoxification regimes should be reviewed early in treatment to ensure the alleviation of withdrawal symptoms *[see Detoxification section 9.10 for discussion of adequacy of standard detoxification regimes in individual circumstances]*.

25. Full detoxification regimes should only be commenced in response to observed signs of withdrawal *[see Detoxification section 9.10 for discussion of initiation of detoxification regimes]*.
26. Detoxification regimes should not be provided to those requesting to be inducted on to methadone *[see: Detoxification section 9.10 and Opioid pharmacotherapy section 9.11 for discussion of use of detoxification regimes with individuals requesting methadone; Discussion section 10.0 for further synthesis]*.
27. A buprenorphine preparation should be explored for use in detoxification *[see: Opioid pharmacotherapy section 9.11 for discussion of buprenorphine; Discussion section 10.0 for further synthesis]*.

Opioid pharmacotherapy

28. Procedures leading to delays in inducting individuals on to opioid pharmacotherapy who were not previously on a program in the community should be removed so that individuals don't wait more than 48 hours after requesting induction before receiving dosing. The practice of opioid detoxification as part of this process should cease as a matter of urgency *[see: Detoxification section 9.10 and Opioid pharmacotherapy section 9.11 for discussion of use of detoxification regimes with individuals requesting methadone; Discussion section 10.0 for further synthesis]*.
29. Regular opportunities for confidential discussions between prisoners and ACT Corrections Health Program staff regarding opioid pharmacotherapy dose adjustments should be facilitated *[see Opioid pharmacotherapy section 9.11 for discussion of dose adjustments]*.
30. A buprenorphine preparation should be made available at the AMC for use as an opioid pharmacotherapy. Appropriate dose supervision will need to accompany any dispensing of buprenorphine *[see: Opioid pharmacotherapy section 9.11 for discussion of buprenorphine; Discussion section 10.0 for further synthesis]*.
31. A rapid situational assessment should be undertaken to determine why individuals are not continuing on opioid pharmacotherapy after release and suitable response should be developed to encourage retention to ensure the benefits of opioid pharmacotherapy with regards to reduction in post-release mortality can be realised *[see: Opioid pharmacotherapy section 9.11 for discussion of post-release cessation of methadone; Discussion section 10.0 for further synthesis]*.
32. Review the pharmacy and medical arrangements utilised for opioid pharmacotherapy to ensure rapid access to induction doses of methadone for clients commencing opioid pharmacotherapy and for dosing changes *[see: Detoxification section 9.10 and Opioid pharmacotherapy section 9.11 for discussion of delays; Opioid pharmacotherapy section 9.11 for discussion of dose adjustments; Discussion section 10.0 for further synthesis]*.

Educational, employment and recreational programs

33. An adequately equipped gymnasium should be implemented [*see Programs – recreational section 9.5 for discussion of a gymnasium*].
34. Educational and employment programs should be expanded to include the attainment of more vocational qualifications and the incorporation of life skills programs such as cooking and parenting. Better and more creative use of the AMC grounds should occur, for example establishing self-sufficient market gardening to promote healthy eating and vocational training [*see Programs – educational and employment section 9.4 for discussion of program expansions and innovative solutions*].

Therapeutic programs

35. Therapeutic programs should be reviewed, including an exploration of alternative providers or partner providers with specialist drug and alcohol expertise. An exploration of high non-completion rates should be included in this review so that non-completion rates can be resolved. Specific key performance indicators for the delivery of therapeutic programs should be developed [*see: Programs – therapeutic section 9.6 for a discussion of quality and access issues; Discussion section 10.0 for further synthesis and discussion of the need to explore alternative providers of services*].
36. The range of therapeutic programs available should be expanded and models of program provision should be reviewed to ensure equitable access to programs [*see: Programs – therapeutic section 9.6 for a discussion of access issues and the diversity of programs; Discussion section 10.0 for further synthesis*].
37. Therapeutic programs that address anxiety disorders and sleep disorders should be introduced or related content incorporated into existing programs [*see: Mental health section 9.9 for discussion of limited support for sleep and anxiety disorders; Discussion section 10.0 for further synthesis*].
38. Alcoholics Anonymous and Narcotics Anonymous or similar self-help programs should be introduced [*see: Programs – therapeutic section 9.6 for a discussion of the limitations of current programs and the need for alternative approaches*].
39. Processes should be introduced to ensure that staff that deliver therapeutic programs are appropriately skilled and qualified [*see: Programs – therapeutic section 9.6 for a discussion of quality issues; Discussion section 10.0 for further synthesis*].
40. Therapeutic programs should ensure that gender and cultural needs are met [*see: Desktop policy review section 6.0 for a review of ACT policy relating to women and Indigenous people; Programs – therapeutic section 9.6 for a discussion of access issues; Discussion section 10.0 for further synthesis*].
41. The provision of different therapeutic program streams that address licit (e.g., tobacco and alcohol) and illicit (e.g., opioids and amphetamines) substances should be explored [*see: Programs – therapeutic section 9.6 for a discussion of range of programs currently offered; Drug use in the AMC*].

prison population section 9.14 for discussion of prevalence of alcohol and tobacco use and need for specific programs].

42. Holistic responses to licit and illicit substance issues should be provided by utilising medical (e.g., opioid pharmacotherapy and nicotine replacement therapy) and non-medical support (e.g., counselling, group work) in a coordinated and complementary approach *[see: Detoxification section 9.10 for discussion of non-medication support complementing medication support; Discussion section 10.0 for further synthesis regarding the importance of a range of programs being tailored to meet individual needs].*
43. Therapeutic programs enrolment processes should consider and be aligned with case planning processes and sentence length. Passive sign-up processes should be removed *[see: Programs – therapeutic section 9.6 for discussion of sign-up processes; Discussion section 10.0 for further synthesis].*
44. Continuous quality improvement of program content should be continued *[see: Programs – therapeutic section 9.6 for discussion continuous quality improvement; Discussion section 10.0 for further synthesis].*
45. Smokefree initiatives including making the AMC entirely smokefree and scaling up tobacco cessation programs for prisoners and staff including group work and nicotine replacement therapy should be further explored, via consultation and engagement with relevant stakeholders *[see: Desktop policy review section 6.0 for discussion of policy directions on smokefree initiatives; Drug use in the AMC prison population section 9.14 for prevalence of smoking among prisoners; Discussion section 10.0 for further synthesis].*

Therapeutic community and external residential rehabilitation

46. Solaris TC or external residential rehabilitation should be offered to all prisoner populations *[see: Therapeutic community and external residential rehabilitation section 9.7 for discussion of access issues; Discussion section 10.0 for further synthesis].*
47. The current location of the Solaris TC should be moved to an alternative, secure location within the AMC *[see: Therapeutic community and external residential rehabilitation section 9.7 for discussion of location-related issues; Discussion section 10.0 for further synthesis].*
48. The application of the partnership service provision model employed at the Solaris TC should be explored for the provision of other programs and services at the AMC *[see Discussion section 10.0 for discussion of exploring the use of alternative, more appropriate providers of particular services].*
49. Specific strategies to address low literacy among TC participants should be explored *[see Therapeutic community and external residential rehabilitation section 9.7 for discussion of literacy issues].*
50. Case management assistance should be expanded to assist with accessing external residential rehabilitation *[see: Therapeutic community and external residential rehabilitation section 9.7 for discussion of assistance with*

accessing external residential rehabilitation; Discussion section 10.0 for further synthesis].

51. Consideration should be given to funding an external residential rehabilitation program which will accept individuals from the AMC on bail or being released to the facility who are currently receiving opioid pharmacotherapy *[see: Therapeutic community and external residential rehabilitation section 9.7 for discussion of the lack of external residential rehabilitation facilities that accept individuals on opioid pharmacotherapy and how this is impacting retention in opioid pharmacotherapy post-release].*
52. Data on participation and completion rates at the current location of the TC should be compared with data on the new site to evaluate the impact of the change on the success of the program in relation to enrolment and completion rates *[see: Therapeutic community and external residential rehabilitation section 9.7 for discussion of location-related issues; Discussion section 10.0 for assessment of key performance indicators relating to program completion].*

Throughcare and transitional support

53. The definition of throughcare should be reviewed, with a view to exploring how additional support can be provided during incarceration and in any post-prison period where an individual still requires support, rather than just to the cessation of parole periods. This redefined concept of throughcare should be reflected in prisoner awareness of services and the rehabilitation process *[see: Desktop policy review section 6.0 and Brief literature review section 7.0 for discussion of importance of throughcare and policy direction of throughcare; Case management section 9.2 for discussion of throughcare and service coordination; Discussion section 10.0 for further synthesis].*
54. The importance of throughcare should be emphasised across all programs and appropriately resourced, with case management and clinical care processes developed to support throughcare *[see: Desktop policy review section 6.0 and Brief literature review section 7.0 for discussion of importance of throughcare and policy direction of throughcare; Case management section 9.2 for discussion of throughcare and service coordination; Discussion section 10.0 for further synthesis].*
55. Funding and capacity for the Inside Out Program should be reviewed to ensure that this program continues and is sustainable and capable of meeting needs of all prisoners *[see: Case management section 9.2 for discussion of program quality and capacity; Discussion section 10.0 for further synthesis].*
56. A service delivery model and sources of funding specifically for a transitional support service system should be explored *[see: Case management section 9.2 for discussion of throughcare; Discussion section 10.0 for further synthesis].*

57. Funding for other NGOs to provide culturally sensitive and gender sensitive services to prisoners should be explored *[see: Case management section 9.2 for discussion of inequity; Discussion section 10.0 for further synthesis]*.

Harm reduction

Blood-borne viruses

58. All ACT Corrections Health Program staff should receive accredited training for pre- and post-test counselling for blood-borne virus testing *[see Blood-borne viruses section 9.15 for discussion of pre- and post-test counselling]*.
59. Blood-borne virus testing should be routinely offered at admission, three months post-admission and at discharge for all prisoners *[see: Blood-borne viruses section 9.15 for discussion of testing timeframes; Discussion section 10.0 for further synthesis]*.
60. An appropriate testing algorithm for HCV should be implemented that includes automatic PCR testing for HCV in response to all positive HCV antibody tests *[see: Blood-borne viruses section 9.15 for discussion of testing algorithms; Discussion section 10.0 for further synthesis]*.
61. Clinical record keeping in relation to blood-borne virus testing and vaccination should be reviewed as a matter of urgency. Medical records should document clearly whether testing has been offered and consented to at admission, three months and at discharge, the results of tests and subsequent recommendations for future testing and/or clinical care *[see: Blood-borne viruses section 9.15 for discussion of record keeping; Discussion section 10.0 for further synthesis]*.
62. Blood-borne virus test results should be provided to prisoners as soon as they become available by trained pre- and post-test counsellors *[see Blood-borne viruses section 9.15 for discussion of results provision]*.
63. HCV treatment should be more routinely offered to all eligible prisoners with clear information on the time periods involved in preparing for treatment *[see Blood-borne viruses section 9.15 for discussion of HCV treatment]*.

Tattooing and piercing

64. A professional tattooing and piercing program at the AMC should be explored *[see Blood-borne viruses section 9.15 for discussion of tattooing and piercing]*.

Bleach provision

65. A system should be developed to ensure that bleach dispensers are always adequately stocked *[see Bleach provision section 9.17 for discussion of bleach supplies running out]*.
66. Information should be provided to prisoners on how to use bleach to most effectively clean used syringes. The development of this information should take low literacy into consideration *[see Blood-borne viruses section 9.15 for discussion of pre- and post-test counselling]*.

Safer using and overdose prevention

67. Funding should be provided to enable the delivery of a comprehensive safer using and overdose prevention peer education program to all prisoners that includes provision of written resources *[see: Overdose section 9.16 for discussion of lack of overdose prevention programs at the AMC; Programs – therapeutic section 9.6 for discussion of lack of skills and knowledge among program presenters; Discussion section 10.0 for further synthesis]*.
68. A model for the provision of naloxone to prisoners at release should be explored, with specific emphasis on training and education provided to prisoners to support the effective use of naloxone in reducing post-release mortality relating to opioid overdose *[see: Overdose section 9.16 for discussion of naloxone; Discussion section 10.0 for further synthesis]*.

Needle and syringe program

69. A process should be commenced to instigate a trial needle and syringe program at the AMC. This process should involve consultations with all relevant stakeholders to identify feasibility of such a program and appropriate models for its delivery. Consideration should also be given to ensuring that appropriate and reliable data is currently collected and will exist over the duration of the trial to evaluate the effectiveness of an NSP *[see: Needle and syringe program section 9.18 for discussion of a trial; Discussion section 10.0 for further synthesis]*.

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