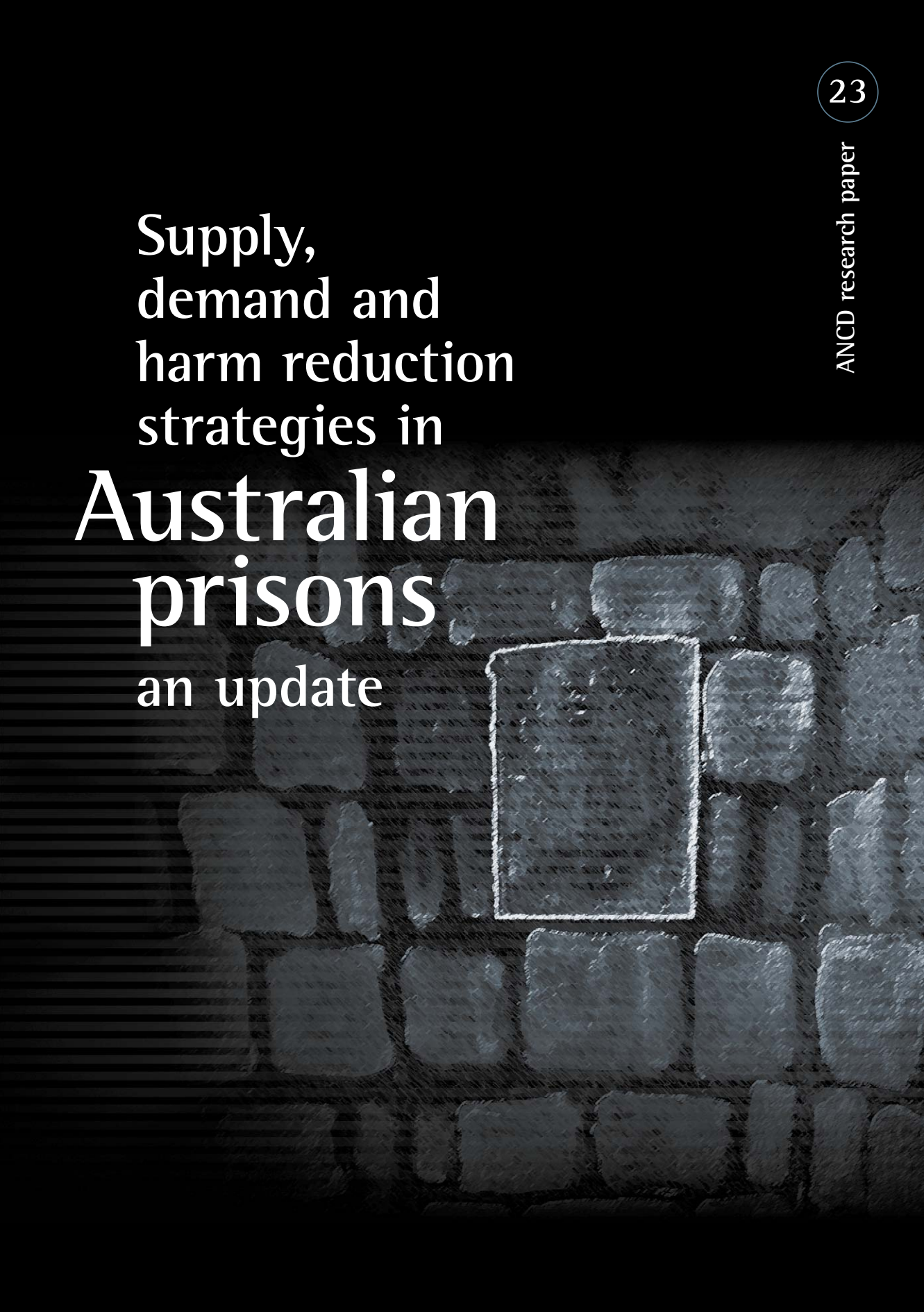


Supply,
demand and
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strategies in
**Australian
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an update



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Ana Rodas, Adam Bode and Kate Dolan

National Drug and Alcohol Research Centre
University of New South Wales

A report prepared for the
Australian National Council on Drugs, November 2011

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Published by the Australian National Council on Drugs
PO Box 205, Civic Square ACT 2608
Telephone: 02 6166 9600
Fax: 02 6162 2611
Email: ancd@ancd.org.au
Website: www.ancd.org.au

National Library of Australia Cataloguing-in-Publication entry

Rodas, Ana.

Supply, demand and harm reduction strategies in Australian prisons:
an update / Ana Rodas, Adam Bode, Kate Dolan; National Drug
and Alcohol Centre, University of New South Wales.

ISBN: 9781877018268 (pbk)

ANCD research paper; 23
Includes bibliographical references.

Prisoners – Drug use – Australia – Prevention.
Prisoners – Health and hygiene – Australia.
Prisoners – Drug testing – Australia.
Health risk assessment – Australia.

Bode, Adam.

Dolan, Kate.

Australian National Council on Drugs.

National Drug and Alcohol Research Centre (Australia)

365.660994

Editor: Julie Stokes
Design: Starkis Design
Printer: New Millennium Print

Acknowledgement:

This work has been supported by funding from the Australian
Government Department of Health and Ageing.

The opinions expressed in this publication are those of the authors and are
not necessarily those of the ANCD or the Australian Government.

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Acknowledgements

This project was funded by the Australian National Council on Drugs (ANCD). The following experts provided advice or assistance.

Steering Committee: Mr Gino Vumbaca and Ms Denise Gilchrist (Australian National Council on Drugs)

New South Wales: Dr Devon Indig, Ms Karin Lines, Ms Denise Monkley, Ms Sandy Ozols (Justice Health NSW), Ms Sue Henry-Edwards, Ms Maria Kevin, Mr Luke Grant (Corrective Services NSW), Mr Robert Hayward

Queensland: Ms Michelle Kennedy, Ms Kiley Collopen (Queensland Corrective Services), Ms Lesley Maher, Dr Alun Richards (Queensland Health)

Victoria: Ms Michelle Gardner and Mr Julian Thomas (Justice Health, Victorian Department of Justice), Mr Malcolm Feiner (Victorian Department of Justice)

Western Australia: Ms Christine Anderton (Western Australian Department of Corrective Services)

South Australia: Mr Peter May, Mr Kevin Harkin and Ms Jane Farrin (South Australian Department for Correctional Services), Mr Peter Frost, Ms Fay Clifford and Ms Karen Harlin (Adelaide Health Service)

Northern Territory: Ms Kiah McGregor, Ms Pippa Rudd (Correctional Services, Northern Territory Department of Justice) Ms Robyn Hopkins (Northern Territory Department of Health) and Mr Harry McSherry (Northern Territory Department of Health and Families)

Tasmania: Mr Garry Hancl, Mr Jonathon Field (Tasmanian Prison Service), Ms Deborah Siddell (Tasmanian Department of Health and Human Services)

Australian Capital Territory: Ms Shelley Cox, Ms Tamara Graham and Mr Tony Malone (ACT Corrective Services), Professor Michael Levy, Dr Peggy Brown (ACT Health)

National Drug and Alcohol Research Centre: Dr Anton Clifford

Abbreviations

ANCD	Australian National Council on Drugs
AOD	alcohol and other drugs
AUDIT	Alcohol Use Disorder Identification Test
BBV	blood-borne virus
CBT	cognitive behaviour therapy
CSNSW	Corrective Services New South Wales
DPT	drug prevalence testing
FTE	full-time equivalent
HBV	hepatitis B virus
HCV	hepatitis C virus
IDU	injecting drug use(r)
IHS	Inmate Health Survey
MCDS	Ministerial Council on Drug Strategy
MMT	methadone maintenance treatment
NCDS	National Corrections Drug Strategy 2006–2009
NDS	National Drug Strategy 2004–2009
NDSHS	National Drug Strategy Household Survey
NPHC	National Prisoner Health Census
NSP	needle and syringe exchange program
OPT	opioid pharmacotherapy treatment
OSP	opioid substitution program
PAD	passive alert dogs
SADCS	South Australian Department for Correctional Services
SAPHS	South Australian Prison Health Service
SESG	Security and Emergency Services Group
SMR	standardised mortality rate
STI	sexually transmitted infection
TC	therapeutic community
WADCS	Western Australian Department of Corrective Services

Executive summary

This report provides an update of the 2004 study of supply, demand and harm reduction strategies in Australian prisons (Black, Dolan and Wodak, 2004). Since the 2004 report, the Ministerial Council on Drug Strategy (MCDS) launched the first National Corrections Drug Strategy in 2008, designed to guide the provision of supply, demand and harm reduction strategies in prisons throughout Australia (Ministerial Council on Drug Strategy, 2008).

The 2004 study examined supply, demand and harm reduction strategies within Australian prisons, their associated costs and evidence of their effectiveness. The current 2009 study examined supply, demand and harm reduction strategies within Australian prisons but did not include their associated costs. Instead the 2009 study included a section on Indigenous prisoners, programs for released prisoners such as re-entry programs, mortality among recently released prisoners, transitional and pre-release services, and services to which prisoners are referred upon release.

The year 2009 was chosen as the comparison year for this report because it was the most recent year for which most jurisdictions were able to provide complete data. Since data were provided for the activities of prison departments and health departments in 2009, this report uses the relevant policy document at the time, which was the National Drug Strategy 2004–2009, as the basis for analysis of supply, demand and harm reduction strategies in Australian prisons.¹

It is important, as always, to acknowledge the limitations of the data and results obtained. Comparison of strategies employed by different jurisdictions is difficult for several reasons. Firstly, much of the data collected were incomplete or from different

time periods. Secondly, there are substantial differences in the characteristics of prison systems in different jurisdictions in Australia. Thirdly, the states and territories where the prisons systems are based also vary markedly. Some prison systems have large numbers of injecting drug users, while others have large numbers of Indigenous inmates.

Australia's prison population

Australia's prison population has grown from 22 492 (in 2002) to 29 300 at the 2009 National Prisoner Census (NPC), an increase of around 30 per cent. Of the 29 300 prisoners, 7386 were Indigenous prisoners. Indigenous males accounted for 25 per cent of male prisoners in Australia (6783) and Indigenous females accounted for 28 per cent of the female prison population (1491). The imprisonment rate among Indigenous prisoners was 14 times higher than the rate for non-Indigenous prisoners.

Government expenditure on prisons

Expenditure on corrective services across Australia was \$1.5 billion in the previous reporting period (Black, Dolan and Wodak, 2004) compared with \$2.8 billion in 2008–09 (Steering Committee for the Review of Government Service Provision, 2010).

The real net operating expenditure (which excludes capital costs and payroll tax) per prisoner per day was \$204 nationally in 2004–05 and \$210 in 2008–09 (Steering Committee for the Review of Government Service Provision, 2010).

¹ The National Drug Strategy 2010–2015 is the latest updated version of the National Drug Strategy.

Objective of this study

The objective of this study was to collate current data on the prevalence of alcohol, tobacco and/or illicit drug use problems among prisoners, and assess the availability, access and use of supply, demand and harm reduction strategies, placing these data in context by comparing the details to 2004 results. The focus was on adults in full-time custody.

Supply reduction strategies

Supply reduction refers to specific strategies designed to disrupt the production and supply of illicit drugs. The two main specific forms of supply reduction used in Australian prisons are drug detection dogs and urinalysis.

Drug detection dogs

All jurisdictions in Australia used drug detection dogs to reduce the supply of drugs in prisons. Dogs were trained to respond when detecting drugs by active or passive alert and were also used for general purposes. In 2009, most jurisdictions were seeking to expand the capacity of their dog squads. For example, in New South Wales dogs were being trained to find mobile phones being smuggled into prisons and in Victoria passive alert dogs are currently being trained to detect buprenorphine.

Urinalysis programs

All jurisdictions in Australia used urinalysis in prisons. Some evidence has suggested that urinalysis might provide a perverse incentive for prisoners to switch from smoking cannabis to injecting heroin. The rationale is that the same penalty applies to inmates with positive urine samples, whether for cannabis or morphine (a marker for heroin), although cannabis use is detectable for up to five weeks while heroin use is only detectable for up to two days. One way to address this would be to introduce differential sanctions with less severe penalties for cannabis use than for injecting drug use. Victoria adopted this approach with the introduction of its Victorian Prison Drug Strategy in 2002. This approach acknowledges the greater harms associated with injecting drugs compared to smoking cannabis, and the longer duration of cannabis detection compared to heroin detection. Heroin use was rarely detected in Australian prisons in the current study.

Victorian prisoners were subjected to the most number of urine tests, an average of nine times a year in both study periods. The most common drug detected was cannabis.

The use of supply reduction measures and whether they had been evaluated appear in Table 1.

Table 1: Supply reduction strategies: coverage and evaluation

Jurisdiction	Drug detection dogs		Urinalysis testing	
	Coverage	Evaluation	Coverage	Evaluation
NSW	Y	Y	Y	Y
QLD	Y	N	Y	N
VIC	Y	N	Y	Y
SA	Y	N	Y	N
WA	Y	Y	Y	Y
TAS	Y	N	Y	N
NT	Y	N	Y	N
ACT	Y	Y	Y	Y

Demand reduction

Demand reduction strategies aim to reduce the demand for illicit drugs and include detoxification, methadone treatment, inmate programs and counselling, and drug-free units. Refer to Table 2 for coverage and evaluation data by jurisdiction.

Detoxification

In 2004 and 2009 all jurisdictions operated a detoxification service for drug-dependent prison entrants. Evaluations of detoxification services have been carried out in Queensland and the Australian Capital Territory.

Methadone and other pharmacotherapies

There were improvements in the provision of methadone treatment for inmates in most states except in Queensland. New South Wales had 1325 inmates on methadone and 264 on buprenorphine. A ten-year follow-up study of New South Wales inmates in methadone treatment found a 20 per cent reduction in re-incarceration and a decrease in mortality for those who left prison on methadone and remained on it after release (Larney, Toson, Burns and Dolan, 2012).

While most states provided pharmacotherapies, these were restricted by a variety of factors across different jurisdictions. For example, female inmates entering Queensland prisons were able to remain on methadone or buprenorphine if they were sentenced to less than 12 months or were on remand. In other jurisdictions, availability was limited according to level of security and availability of community placement for inmates to transfer to, once released.

Inmate programs and counselling services and drug-free units

All jurisdictions operated inmate programs and counselling services in both study periods. In some jurisdictions, the range of services provided was extensive. It was not

possible to compare programs, as the types of information provided varied greatly. Most were in the form of group programs, using cognitive behaviour therapy and motivational interviewing principles. Individual counselling was less common and, in some cases, was being phased out in favour of group programs. There have been very few external evaluations of the effectiveness of group and/or individual counselling services in prisons.

Five out of eight jurisdictions operated drug-free wings or units for prisoners in both study periods. The evidence suggests that these help prisoners to remain drug-free, but usually the capacity of these services was limited.

Table 2: Demand reduction: coverage and evaluation

	Detoxification		MMT		Inmate programs/ Counselling		TC or Drug-free units	
	Coverage	Evaluation	Coverage	Evaluation	Coverage	Evaluation	Coverage	Evaluation
NSW	Y	N	Y	Y	Y	Y	Y	Y
QLD	Y	Y	Y	Y	Y	N	Y	N
VIC	Y	N	Y	N	Y	Y	Y	Y*
SA	Y	N	Y	Y	Y	N	Y	Y
WA	Y	N	Y	Y	Y	N	Y	N
TAS	Y	N	Y	N	Y	N	N	n/a
NT	Y	N	Y	N	Y	N	N	n/a
ACT	Y	Y	Y	Y	Y	Y	Y	Y ²

* Under evaluation at time of writing

2 The Australian Capital Territory introduced a therapeutic community in the latter part of 2009.

Table 3: Results for blood-borne virus testing in Australian prisons, 2007

	Hepatitis B		Hepatitis C		HIV	
	No. tested	Positive %	No. tested	Positive %	No. tested	Positive %
NSW	199	27	197	42	196	2
QLD	137	9	135	32	136	(<1)
VIC	115	23	119	41	117	0
WA	82	28	82	21	81	0
SA	1	100	21	33	20	0
TAS	32	9	32	25	33	0
ACT	—	—	3	33	3	0

Source: Butler and Papanastasiou (2008)

Harm reduction

The aim of harm reduction strategies is to reduce the harm associated with illicit drug use. In 2009, harm reduction strategies across Australian prisons included: harm reduction education; blood-borne virus testing and hepatitis vaccinations; condom and dental dams; and disinfectant (refer to Table 4 for coverage and evaluation data).

Harm reduction education programs

All jurisdictions provided harm reduction education in 2009, whereas all except Queensland did so in the earlier study period.

Blood-borne virus testing and hepatitis B vaccination

All jurisdictions provided testing for blood-borne viruses; Queensland and the Northern Territory continued to provide compulsory testing for HIV. This was in spite of HIV being rare in all Australian prisons (see Table 3).

Provision of condoms, bleach and needle and syringe programs

In 2004, condoms were available in New South Wales, Western Australia, South Australia and Tasmania. All states continued to provide condoms and Victoria has introduced condoms since the first study period. Whether condom provision to inmates prevents sexually transmitted infections remains to be evaluated.

The appropriate cleaning of injecting equipment is part of safe injecting practices. Disinfectant provision had increased but access to it remained patchy. Among the 161 prisoners in New South Wales who reported injecting in prison, 90 per cent reported they had used bleach on the last occasion of injecting, though the effective cleansing of injecting equipment by prisoners is questionable. Many inmates reported being unaware of its existence or they had trouble accessing it.

No jurisdictions provided needle and syringe programs in either study period. The Australian Capital Territory was investigating the issue of operating a needle and syringe program for prisoners. A number of countries provide sterile injecting equipment to inmates and the results of all evaluations to date have been favourable.

Indigenous prisoners

In 2009, Indigenous prison entrants were more likely to report drinking at levels that put them at risk of harm than non-Indigenous prison entrants. They were also more likely to report having ever injected drugs than non-Indigenous prison entrants and to have hepatitis C. In 2008, the diagnosis rate for newly acquired hepatitis B infection among Indigenous inmates was between one and five times higher than that of the non-Indigenous population in New South Wales, the Northern Territory, South Australia, Victoria, Queensland and Western Australia. Only Western Australia had an ongoing program linking released prisoners with a deaths register where research found that, in the immediate post-release period, Indigenous male prisoners were 4.8 times

more likely to die, and Indigenous female prisoners were 12.6 times more likely to die, than the general population. This compared with lower rates among all men (3.7) and women (7.8) in the cohort.

Re-entry programs and mortality post-release

Most prison systems provided assistance to inmates nearing release from prison. The New South Wales Connections program, administered by Justice Health, assisted over 1000 inmates and an evaluation found it assisted inmates to remain in the community without re-offending for a longer time than those not in the program.

As a proportion of all deaths, drug-related deaths were more common among women than men. In New South Wales, for example, common specific causes of death among men were drug overdose (18.1%) and suicide (16.9%). Drug overdose (27%) and suicide (11.6%) were common among women. Heroin was the major contributing drug in most drug overdoses. When compared to the general New South Wales population, death rates for released prisoners were greater by 3.7 times for males, 4.8 times for Indigenous men, 7.8 times for females, and 12.6 times for Indigenous women.

Table 4: Harm reduction: coverage and evaluation, 2009

	Harm reduction education		Illicit drug peer education		BBV testing	
	Coverage	Evaluation	Coverage	Evaluation	Coverage	Evaluation
NSW	Y	Y	Y	Y	Y	N
QLD	n/a	n/a	N	n/a	Y	N
VIC	Y	N	Y	N	Y	N
SA	Y	N	Y	N	Y	N
WA	Y	N	Y	N	Y	N
TAS	Y	Y	N	N	Y	N
NT	Y	Y	Y	N	Y	N
ACT	Y	Y	Y	Y	Y	Y

Conclusion

All jurisdictions continued their use of the two main forms of supply reduction: drug detection dogs; and urinalysis. Victoria continued with a high rate of urinalysis with inmates being subjected to an average of nine tests per year. Most urine samples test negative and those that do test positive are most commonly for cannabis. These supply reduction strategies were not evaluated or, if evaluated, the report was not available for release.

In terms of demand reduction strategies, all jurisdictions provided detoxification services in both studies. The provision of methadone improved in all jurisdictions except Queensland. Research indicated that increased methadone provision reduces re-incarceration and mortality. Again in both studies, the use of

inmate and counselling programs was extensive, although there was little or no evaluation. Drug-free wings or units were useful in helping prisoners remain drug-free, but their capacity was limited.

All jurisdictions except Queensland provided education on harm reduction in both studies. Two jurisdictions had introduced peer education since the first study (Western Australia and Northern Territory), but neither had evaluated their programs. All jurisdictions continued offering blood-borne viral testing with only the Australian Capital Territory having evaluated its use (that evaluation was being conducted at the same time as this study). All jurisdictions offered the hepatitis B (HBV) vaccination in both studies, with the Australian Capital Territory and Tasmania conducting evaluations during the term of the present study. The provision of condoms

	Hepatitis B vaccine		Condoms and dental dams		Disinfectant	
	Coverage	Evaluation	Coverage	Evaluation	Coverage	Evaluation
	Y	N	Y/Y	Y	Y	Y
	Y	N	N/N	Y	Y	N
	Y	N	Y/Y	N	Y	N
	Y	N	Y/Y	N	Y	N
	Y	N	Y/Y	N	N	N
	Y	Y	Y/Y	N	N	N
	Y	N	N/N	N	N	N
	Y	Y	Y/Y	Y	Y	Y

increased from four jurisdictions (New South Wales, South Australia, Western Australia, Australian Capital Territory) to six (now also including Victoria and Tasmania) between study periods. Disinfectants were provided in all jurisdictions except Western Australia, Tasmania and the Northern Territory and this did not change between the study periods.

Prisoners, especially women and Indigenous prisoners, faced an increased risk of death on release. The immediate time after being released from prison is a period of high risk for some inmates. Western Australia has a data-linkage system whereby data are routinely collected linking justice data with medical data for the entire Western Australian population. This system can identify mortality after release from prison.

The National Corrections Drug Strategy 2006–2009 (NCDS) has six key principles:

- **A balanced approach:** achieving an appropriate balance between supply reduction, demand reduction and harm reduction

Across all jurisdictions, more emphasis was placed on supply reduction strategies than on demand or harm reduction strategies. All jurisdictions relied heavily on supply reduction strategies, which in some cases were being expanded. In general these measures have not been evaluated, which limits any assessment of them. Meanwhile, demand and harm reduction strategies were less likely to be implemented or, if they were implemented, there were usually limits on the number of inmates who were able to participate in these programs. Evaluations of these measures were usually positive. A more balanced approach is still needed.

- **Equity of service:** achieving equity of service to that available in the wider community

It was beyond the scope of this study to assess service provision in the community and therefore it was not possible to compare prison services against community ones.

- **Focusing on the needs of Indigenous people:** developing and implementing specific policy and program initiatives that focus on the needs of Aboriginal and Torres Strait Islander peoples in prison

Most jurisdictions have attempted to focus on the needs of Indigenous people with specific services being tailored to them. Many jurisdictions have employed Indigenous staff and/or have sought advice from indigenous groups. However, when Indigenous prisoners were compared with non-Indigenous ones, they rated worse on nearly every drug or alcohol-related outcome.

- **Evidence-based policy and practice:** policies and practices should reflect research evidence and be subject to evaluation

Prison authorities still appear reluctant to evaluate supply, demand and harm reduction strategies in prison. Some jurisdictions did not complete the survey for this study or declined to provide any further information, even after all the ethical approvals had been met. Most jurisdictions have not evaluated the vast array of programs they offer or have not made the results publicly available. Vast sums of funding are spent on prison programs that are implemented without any evidence base.

- **Working in partnership:** policies and programs should be implemented in partnership with health, government and non-government organisations

- **Continuity of care:** care and treatment for problematic substance use should be provided throughout imprisonment and continue after release from prison

Most jurisdictions work with many external organisations and this appears to work well. Some prison authorities actually fund community-based services. Some services that prison authorities work with include medical, housing, legal, income security (Centrelink), mental health, alcohol and other drugs, and telephone counselling. Most jurisdictions have some focus on continuity of care for inmates after they are released from prison.

1. Introduction

Australia's National Drug Strategy (NDS) was established in 1985 to address licit and illicit drug use in Australia. Since its inception, the NDS has served as a national policy framework that is complemented and supported by and integrated with a range of national, state, territory, government and non-government strategies, plans and initiatives. The Ministerial Council on Drug Strategy (MCDS) was responsible for overseeing the NDS. However, the MCDS was discontinued on 30 June 2011. Coordination of federal, state and territory efforts to implement the NDS are to be continued by the Intergovernmental Committee on Drugs. Ministers meet when ministerial-level contributions are required (<www.nationaldrugstrategy.gov.au>).

One of the components of the National Drug Strategy 2004–2009³ is the National Corrections Drug Strategy 2006–2009 (NCDS). The NCDS has been endorsed and supported by the Ministerial Council on Drug Strategy, the Corrective Service Ministers' Conference, the Corrective Services Administrators' Conference, the Community and Disability Services Ministers' Advisory Council, Australian Juvenile Justice Administrators, the Australian National Council on Drugs and the Intergovernmental Committee on Drugs (Ministerial Council on Drug Strategy, 2008).

The NCDS is based on the National Drug Strategy's harm minimisation approach. The NDS is based on three inter-related strategic areas for dealing with drug-related harms in Australian society, involving a balance between supply reduction, demand reduction and harm reduction. These strategies are

implemented to differing extents in prison settings compared to community settings. While many of the programs available in prison mirror those in the community, the extent of access and capacity of these programs is a notable exception. In some instances, such as with needle and syringe programs (NSPs), strategies are available in the community but not in prisons.

1.1 Drug strategies

Supply reduction

Supply reduction strategies are designed to stop, disrupt and reduce the production and supply of illicit drugs and to control and manage the supply of licit drugs such as alcohol and tobacco. The major forms of drug supply reduction available in the community involve state and federal police, customs and intelligence organisations, such as the Australian Crime Commission. Strategies employed by these agencies include urinalysis testing and drug detection dogs. Similar strategies are used in prisons, with drug detection dogs and urinalysis testing being the most common measures used to control the supply of drugs in prisons. Prison urinalysis testing programs include targeted, random and therapeutic testing in most Australian jurisdictions.

³ The National Drug Strategy 2004–2009 was used as the basis for analysis because most jurisdictions were providing data from 2009. However, the most recent update of the strategy is the National Drug Strategy 2010–2015.

Demand reduction

Demand reduction measures are designed to reduce the demand for drugs, including abstinence-oriented strategies and treatment to reduce drug misuse. Services provided in the community include: detoxification; opioid substitution programs; residential rehabilitation; self-help groups; and counselling. Opioid substitution programs have been available in the Australian community since 1980. Initially methadone was used but currently buprenorphine and naltrexone have been introduced. All of these programs are available in Australian prisons. However, as this report shows, access to and capacity of programs differ across prison systems.

Harm reduction

Harm reduction measures are designed to directly reduce drug-related harms to individuals, families and communities, such as blood-borne viral infections, without *necessarily reducing drug consumption*. Examples include: needle and syringe programs; condom and dental dam provision; hepatitis B vaccination; and methadone treatment. While condoms and dental dams were distributed in most Australian prisons and all jurisdictions provided blood-borne viral testing and vaccinations, there were no NSPs functioning within Australia's prison systems in 2009. Data from NSPs in the community and in prison systems globally have found this strategy to be effective and cost-effective. An international review of NSPs in prisons found favourable results for this harm reduction measure (Dolan, Rutter and Wodak, 2003).

National Corrections Drug Strategy

The NCDS has been developed to apply to both adult and juvenile offenders within correctional facilities and community correctional services (e.g. probation and parole). The mission of the NCDS is to improve health, social and economic outcomes for all offenders in correctional and community-based facilities (Ministerial Council on Drug Strategy, 2008). To achieve this, the six key principles outlined in the NCDS are:

- **A balanced approach:** achieving an appropriate balance between supply reduction, demand reduction and harm reduction
- **Equity of service:** achieving equity of service to that available in the wider community
- **Focusing on the needs of Indigenous people:** developing and implementing specific policy and program initiatives that focus on the needs of Aboriginal and Torres Strait Islander peoples in prison
- **Evidence-based policy and practice:** policies and practices should reflect research evidence and be subject to evaluation
- **Working in partnership:** policies and programs should be implemented in partnership with health, government and non-government organisations; and
- **Continuity of care:** care and treatment for problematic substance use should be provided throughout imprisonment and continue after release from prison.

1.2 Aim of project

In 2010, the Australian National Council on Drugs (ANCD), the principal advisory body to the federal government on drug policy, commissioned the National Drug and Alcohol Research Centre (NDARC) to review the prevalence of alcohol and/or drug use problems among prisoners and the range and availability of supply, demand and harm reduction programs and services in prisons. The focus of the review was adult full-time prisoners and remand inmates. The aim of the project was to provide an update to the 2004 study: *Supply, Demand and Harm Reduction Strategies in Australian Prisons: implementation, costs and evaluation* (Black, Dolan and Wodak, 2004). This review required that NDARC:

1. collate current data on the number and proportion of prisoners reporting problematic alcohol, tobacco and/or illicit drug use, and compare it to 2004 findings
2. assess the availability, access and extent of use of the range of demand, harm and supply reduction programs and services in prisons.

This assessment paid attention to the extent to which programs and services adhered to the principles of the National Corrections Drug Strategy.

1.3 Australia's prison population

At 30 June 2009, there were 29 317 (27 192 males and 2125 female) prisoners (sentenced and unsentenced) in Australia. This represented an imprisonment rate of 175 prisoners per 10 000 adult population. Indigenous prisoners made up 25 per cent of the total prisoner population (Australian Bureau of Statistics, 2010). Around 90 per cent of prisoners spend less than 12 months on remand and the median expected term to serve on a sentence is less than two years (Australian Bureau of Statistics, 2010).

Of the total prisoner population, 72 per cent were located in just three jurisdictions: New South Wales (38%), Queensland (19%) and Western Australia (15%). However, in 2009 the Northern Territory had the highest imprisonment rate at 658 prisoners per 100 000 adult population. All states and territories, with the exceptions of Queensland and the Australian Capital Territory, recorded increased imprisonment rates in the seven years from 2002 to 2009 (Australian Bureau of Statistics, 2010). Figure 1.1 presents changes in imprisonment rates over this period.



1.4 Drug use – comparisons between prisoners and the general community

In 2010, the first report relating to the National Prisoner Health Indicators, *The Health of Australia's Prisoners 2009*, was released (Australian Institute of Health and Welfare, 2010). The report presented findings gathered through the National Prisoner Health Census (NPHC), which was conducted in 87 of the 93 public and private prisons across Australia in mid-2009. The results showed that prisoners have significant health issues with high levels of smoking and alcohol misuse, communicable diseases and illicit drug use.

Tobacco smoking

In 2009, there was a high prevalence of smoking among prison entrants. Of the 549 prison entrants who participated in the NPHC, 81 per cent were current smokers and 74 per cent smoked daily. A higher proportion of male prison entrants (75%) than female prison entrants (69%) were daily smokers. There was no difference between Indigenous and non-Indigenous prison entrants (about 80 per cent of each were current smokers) (Australian Institute of Health and Welfare, 2010). In contrast, the 2010 National Drug Strategy Household Survey (NDSHS) found that, among the general household population, 18 per cent of people aged 14 years and over were current smokers and 15 per cent were daily smokers, declining from 17 per cent in 2007. Moreover, difference in smoker status was identified between Indigenous⁴ (38%) and non-Indigenous (17%) people (Australian Institute of Health and Welfare, 2011).

Alcohol

In Australia alcohol use has been associated with violent crime and the link between alcohol and criminal behaviour is well documented (Kraemer, Gately and Kessell, 2009). Self-reported alcohol use among offenders provides insight into the relationship between alcohol and violent offending. In 2007, half of all offenders detained by police across Australia for disorder and violent offences had consumed alcohol within the 48 hours prior to arrest (Adams, Sandy, Smith and Triglone, 2008). Additionally, 30 per cent of all assault charges are likely to be attributable to alcohol (Morgan and McAtamney, 2009). Alcohol is also involved in a significant number of homicides. Data from the Australian Institute of Criminology's National Homicide Monitoring Program showed that, between 2000 and 2006, 47 per cent of all homicides in Australia were alcohol-related (Dearden and Payne, 2009).

The prisoner population is characterised by high levels of risky drinking. According to the 2009 NPHC, 52 per cent of prison entrants reported drinking alcohol at levels placing them at risk of alcohol-related harm.⁵ Alcohol consumption at levels indicating risk of alcohol-related harm were found in 65 per cent of Indigenous prison entrants,⁶ compared to 47 per cent of non-Indigenous entrants (Australian Institute of Health and Welfare, 2010). The 2002 National Aboriginal and Torres Strait Islander Social Survey found that high-risk alcohol consumption was the second most important predictor of criminal prosecution after illicit drug use, and the third most important predictor of imprison-

ment for Indigenous people for any offence (Weatherburn, Snowball and Hunter, 2006).

According to the 2010 NDSHS, 21 per cent of people aged 18 years or older reported alcohol consumption at 'risky' levels of alcohol-related harm over a lifetime. People aged 18–19 years (32%) and 20–29 years (27%) were more likely to consume alcohol at levels that placed them at risk of alcohol-related harm over their lifetime (Australian Institute of Health and Welfare, 2011).

Illicit drugs

Illicit drug use is significantly associated with violent and property crime. The 2003 Drug Use Careers of Offenders Study (DUCO) found that the majority of offenders reported ever using illegal drugs (80%) and 62 per cent reported using during the six months prior to their most recent arrest (Makkai and Payne, 2003). The 2009 NPHC reported that 71 per cent of prison entrants had used illicit drugs in the last 12 months. Poly drug use was common among prison entrants, with 59 per cent of those who had used illicit drugs in the past 12 months using more than one type of drug. The most commonly used substances were cannabis (52%), meth/amphetamine (30%) and heroin (19%) (Australian Institute of Health and Welfare, 2010). In 2010, two in five people (39%) had used an illicit drug in their lifetime and 17 per cent of people aged 18 years and over reported recent use of 'any illicit drug'. Of those who reported recent drug use, 10 per cent had used cannabis and 2.2 per cent had used meth/amphetamines (Australian Institute of Health and Welfare, 2011).

4 Due to the small sample size of Aboriginal and/or Torres Strait Islander people, the Australian Institute of Health and Welfare advises that estimates should be treated with caution.

5 Alcohol-related harm was assessed using the AUDIT screening instrument.

6 However, 18 per cent showed invalid scores, as not all questions were answered or some responses were found to be contradictory.

2. Methods

This report focuses on the in-prison and post-release programs of adult prisoners in Australia. It does not cover juvenile justice or periodic detention (which has been implemented in New South Wales and the Australian Capital Territory).

Extensive searches of all Australian prison department websites were undertaken to obtain information. Additionally all prison departments were contacted numerous times via telephone, letter and email to request information and departmental reports. Prison and health departments were also asked to provide advice on the necessary procedure to obtain further information where there was a need to do so.

A representative from each state and territory prison department and prison health department (if applicable) was asked to complete a 21-page questionnaire on supply, demand and harm reduction strategies in their jurisdiction (see Appendix). The questionnaire requested information on the prevalence of alcohol and/or drug use problems among prison entrants and the range and availability of supply, demand and harm reduction programs and services in prisons.

Each jurisdiction was provided with an opportunity to formally assess and verify the data collated on their jurisdiction and to provide an official response. A face-to-face meeting was held in Sydney for all representatives to attend and discuss the findings of this study.

2.1 Administrative structure

New South Wales

Corrective Services New South Wales is responsible for the management of prisons. Health services are provided to all prisoners by Justice Health, a branch of the New South Wales Department of Health.

Queensland

The Queensland Department of Corrective Services is responsible for management of public prisons. Health care is provided by the Health and Medical Services section of the Department of Corrective Services.

Victoria

Corrections Victoria, a division of the Victorian Department of Justice, is responsible for management of public prisons. Health care services are provided by Justice Health Victoria.

Western Australia

The Prisons Division, within the Western Australian Department of Justice (formerly the Ministry of Justice), is responsible for the management of public prisons in Western Australia. Health care in the prison system is managed by the Department of Justice through the Health Services Directorate. A number of health care services also provide health care under contract.

South Australia

The South Australian Department for Correctional Services is responsible for management of public prisons. In public prisons, health services are provided by the South Australian Prison Health Service, a division of the Royal Adelaide Hospital.

Northern Territory

Prisons are managed by Northern Territory Correctional Services, a division of the Northern Territory Department of Justice. Primary health care services are outsourced and delivered by a third-party health-care provider. The Northern Territory Department of Health and Families manages the service delivery (Australian Institute of Health and Welfare, 2010).

Tasmania

The Prison Service, a division of the Tasmanian Department of Justice and Industrial Relations, is responsible for correctional services. Health care is provided by the Corrections Health Service, a division of the Tasmanian Department of Health and Human Services.

Australian Capital Territory

ACT Corrective Services, a division of the Australian Capital Territory Department of Justice and Community Safety, is responsible for correctional services. Health services are provided under the Corrections Health program of Community Health, a division of ACT Health.

2.2 Questionnaire

The questionnaire was compiled in conjunction with the departmental representatives. A draft questionnaire was prepared and circulated to the representatives for comment on the following key points:

- **Clarity:** Does the questionnaire make sense to you? Is it easy for you to follow? Is there anything you do not understand?
- **Feasibility:** Are there any questions that you are unlikely to answer for your jurisdiction? Is there a way of rewording questions in a way that will help to overcome this obstacle?
- **Omissions:** Are there any additional issues or topics that you think should be in the questionnaire?

Following consideration of the comments from those representatives who provided feedback, a final questionnaire was prepared and circulated for completion.

The final questionnaire contained sections covering supply reduction, demand reduction and harm reduction. The supply reduction section covered drug detection dogs, urinalysis testing, metal detectors and searches (e.g. bag searches, pat-downs, etc.). Additional data were requested on the number of searches and results from staff, visitors and inmates. Representatives were also asked to provide breakdowns by gender and Indigenous status where possible.

The demand reduction section contained items relating to detoxification, methadone maintenance treatments (MMT) and other pharmacotherapies (buprenorphine and naltrexone), other drug treatment and education programs including: Getting SMART; Alcoholics Anonymous and Narcotics Anonymous; and drug-free units. Data were also requested on demand and access to these programs and services.

The harm reduction section covered harm reduction education programs, peer education programs, blood-borne virus testing, hepatitis B vaccination, condom provision, dental dam provision, and disinfectant provision. Data were sought on the number of prisoners

tested for HIV, hepatitis B or hepatitis C. Data were also requested on demand and access to these strategies. The questionnaire did not include needle and syringe programs; however, an open-ended question was included for comments on harm reduction programs.

The questionnaire also included questions on post-release programs, services and referrals to assess continuity of care for prisoners upon release into the community. Jurisdictions were also asked to report on any internal or external evaluations of the various supply, demand and harm reduction strategies.

Between April and May 2010 formal requests for information, including the questionnaire, were sent to the following jurisdictions:

New South Wales	Corrective Services NSW Justice Health
Queensland	Department of Community Safety Queensland Health
Victoria	Department of Justice/ Justice Health
Western Australia	Department of Corrective Services
South Australia	Department for Correctional Services Prison Health Services
Northern Territory	Department of Justice
Tasmania	Department of Justice Department of Health and Human Services
Australian Capital Territory	Department of Justice and Community Safety ACT Health

2.3 Ethics

Ethics approval was obtained from the University of New South Wales (HREC 10059(PI)/ Panel ref: 9-10-002). Formal ethics approval processes, involving submission to an established ethics committee, were followed for most departments in each jurisdiction, with the exceptions of Queensland Corrective Services (approval was obtained through the Commissioner), Tasmanian Prison Services (approved by the Director of Prisons) and Justice Health Victoria (approved by the Director). Approval was sought and received from the following ethics committees:

- Corrective Services NSW Ethics Committee
- New South Wales Justice Health Human Research and Ethics Committee
- Aboriginal Health and Medical Research Council of New South Wales Ethics Committee
- Western Australian Department of Corrective Services Research and Evaluation Committee
- Western Australian Aboriginal Health Information and Ethics Committee
- Human Research Ethics Committee of Northern Territory Department of Health and Families and the Menzies School of Health Research (EC 00153)
- The Aboriginal Subcommittee for the Human Research Ethics Committee of the Northern Territory Department of Health and Families and the Menzies School of Health Research
- South Australian Aboriginal Health Research Ethics Committee
- ACT Health Human Research Ethics Committee.

2.4 Other sources of information

Literature searches

As part of the data extraction process, a literature review was undertaken. The review included published literature in academic journals and Australian government reports. Alcohol and other drug/prison literature was located using specialist databases. For example, research articles were located using a range of databases including: Medline, Australian Public Affairs Information Service (APAIS), Web of Science, PsychInfo, ScienceDirect and AGIS.

Newspaper searches

Newspaper articles were also collated using a number of websites and by signing up to various email lists such as the ADCA Update-Digest, ANCD Prison Issues Update, DrugInfo Clearinghouse Resource Centre Alerts and an email information list on drug and prison issues maintained by the Research and Evaluation Unit at Corrections Victoria.

Internet searches

A wide range of reports (e.g. Corrective Services' annual reports and government reports) was gathered through web searches, including:

- general search engines
- government (Australian federal/state and worldwide)
- health-related sites (both Australian and worldwide)
- drug education sites (both Australian and worldwide).

2.5 Challenges and limitations

Compiling evidence for this report was not without its challenges. Gaining access to the data was a challenge, with many jurisdictions citing a range of reasons for failure to grant access or to provide only limited access to data. Questions of validity in their datasets, difficulty in extracting data due to lack of resources, and absence of an electronic database were all cited. In addition to these claims, a general resistance to grant access to data was experienced. On more than one occasion the research team followed all necessary protocols, only to be informed subsequently that the jurisdiction would not be participating in the study.

To facilitate data extraction in future, lodging a freedom of information application may be an alternative means of gaining access to data for this type of research project. However, it should be noted that the freedom of information process is lengthy.

While the report proposed to extract and present data for a single year, 2009, this was not feasible across all jurisdictions. Several departments either did not provide any data or did not gather the type of information requested. Where this was the case, data from publications using datasets from different years were used to supplement the evidence generated from the questionnaire. Therefore it was not possible to present a snapshot of a particular year for all jurisdictions. However, the report does provide an update of the situation across prison departments with regard to supply, demand and harm reduction strategies since 2004.

3. Results by jurisdiction

3.1 New South Wales

3.1.1 Background

Prison population

A total of 11 127 prisoners (10 273 males and 854 females) were housed in New South Wales on 30 June 2009 (Australian Bureau of Statistics, 2009). Inmates were housed across 34 prisons, two of which were privately operated. Junee and Parklea prisons were managed by the GEO (Global Expertise Outsourcing) Group Australia Pty Ltd (Corrective Services NSW website).

Health service provision

Health services in all public prisons and in the privately operated prison Parklea were provided by Justice Health. Justice Health is a statutory health corporation established under the *Health Services Act 1997* (NSW) and is funded by New South Wales Health.

Justice Health provides drug and alcohol services to New South Wales prisoners including: risk assessment and management of intoxication and withdrawal from drugs and/or alcohol; the Opioid Substitution Program (OSP) including methadone, naltrexone, buprenorphine and suboxone; and post-release care arrangements for any clients on OSP to ensure continuity of care. Justice Health has an Early Detection Program for prisoners at risk of blood-borne virus infections, including injecting drug users and other vulnerable populations. As part of this program, Justice Health provides testing for blood-borne viruses, advises on harm minimisation, offers treatment to suitable patients

with chronic hepatitis C infection, and refers patients to drug and alcohol services where necessary. Justice Health services operate a medical model of intervention for its drug and alcohol services.

Corrective Services New South Wales (CSNSW) provides case management, health promotion and relapse prevention, and a range of services and programs (e.g. Drugs: Impacts of Dependence; PATHWAYS; Getting SMART) focusing on readiness, motivation and on attitudinal and behaviour change. Programs delivered by CSNSW address offending behaviour and drug use and dependence.

Prison capacity

In 2008–09 the design capacity of all New South Wales prisons was 9505 and the total rate of utilisation was 105.9 per cent, just above the national average of 102 per cent of prison design capacity in 2008–09⁷ (Steering Committee for the Review of Government Service Provision, 2010). Each year there are over 30 000 new prison receptions and over 150 000 movements among prisoners in New South Wales (Corrective Services NSW, personal communication, 2011).

3.1.1.1 Drug use by prisoners

The 2009 Inmate Health Survey (IHS) undertaken by Justice Health used a stratified random sample of all inmates in New South Wales prisons. In 2009, 1166 inmates were invited to participate; 996 agreed to participate, resulting in a response rate of 85 per cent (Indig, Topp et al., 2010). The majority of participants (84%) in the 2009 IHS had used illicit drugs.

⁷ The optimum rate of prison utilisation is 85–95 per cent. This provides some flexibility to cater for prisoners with special needs (e.g. protection, hospital, varying security levels) by gender and also allows for short-term fluctuations in prisoner numbers (Steering Committee for the Review of Government Service Provision, 2010).

Table 3.1.1: Tobacco consumption in prison compared with the general community (if current smoker)

	Men		Women		Total	
	n	%	n	%	n	%
More now	285	48.2	80	53.0	365	49.2
About the same	136	23.0	34	22.5	170	22.9
Less now	170	28.8	37	24.5	207	27.9
Total	591	100.0	151	100.0	742	100.0

Source: Indig, Topp et al. (2010), Table 5.4.4

The CSNSW Biennial Survey 2007–08 questioned a representative sample of 358 New South Wales inmates (306 male and 52 female) about to be discharged to the community in 2007–08. The results showed that a high percentage of inmates reported having had a drug problem at some stage in their lives (80% of males and 81% of females) (Kevin, 2010).

Licit drug use – tobacco and alcohol

Tobacco smoking is a major risk factor for several life-endangering diseases, including coronary heart disease, stroke, peripheral vascular disease and cancer (Australian Institute of Health and Welfare, 2010). The 2009 IHS, which includes both reception and sentenced prisoners, reported that a large percentage of both male (75%) and female (80%) prisoners were current tobacco smokers (Indig, Topp et al., 2010). Indigenous men (83%) and women (88%) were more likely to be current smokers than non-Indigenous men (71%) and women (76%) (Indig, McEntyre et al., 2010). Of those inmates who participated in the 2009 IHS, 49 per cent of current smokers reported that they smoked more while in prison than in the community (Table 3.1.1).

In 2009, the prevalence of smoking among inmates was approximately four times higher than among the general population of Australian adults. The 2010 National Drug Strategy Household Survey showed 15 per cent of people aged 14 years or older in the general Australian population were daily smokers (Australian Institute of Health and Welfare, 2011).

The alcohol consumption patterns of New South Wales inmates participating in the 2009 IHS were assessed using the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993). In 2009, assessment of self-reported levels of alcohol consumption found that 63 per cent of men and 40 per cent of women were engaged in hazardous or harmful drinking (indicated by an AUDIT score of eight or more) in the year prior to imprisonment. The highest level of hazardous or harmful drinking was found among Indigenous male prisoners, where 74 per cent reported alcohol consumption at risky levels compared to 57 per cent of non-Indigenous male prisoners (see Figure 3.1.1).

Furthermore, one in three men (35%) and one in six women (16%) reported alcohol consumption levels indicative of alcohol dependence (AUDIT cut-off score of 20) (Indig, Topp et al., 2010). An AUDIT score indicating alcohol dependence was significantly more likely to be found among Indigenous men (44%) and Indigenous women (29%) than non-Indigenous men and women (30% and 11% respectively) (Indig, McEntyre et al., 2010).

Figure 3.1.1 shows that, in 2009, Indigenous prisoners were more likely than non-Indigenous prisoners both to engage in hazardous and harmful drinking and to be assessed as being dependent drinkers in the year prior to imprisonment. In 2009, 8 per cent of IHS male participants and 5 per cent of IHS female participants reported they had consumed alcohol while in prison (Indig, Topp et al., 2010).

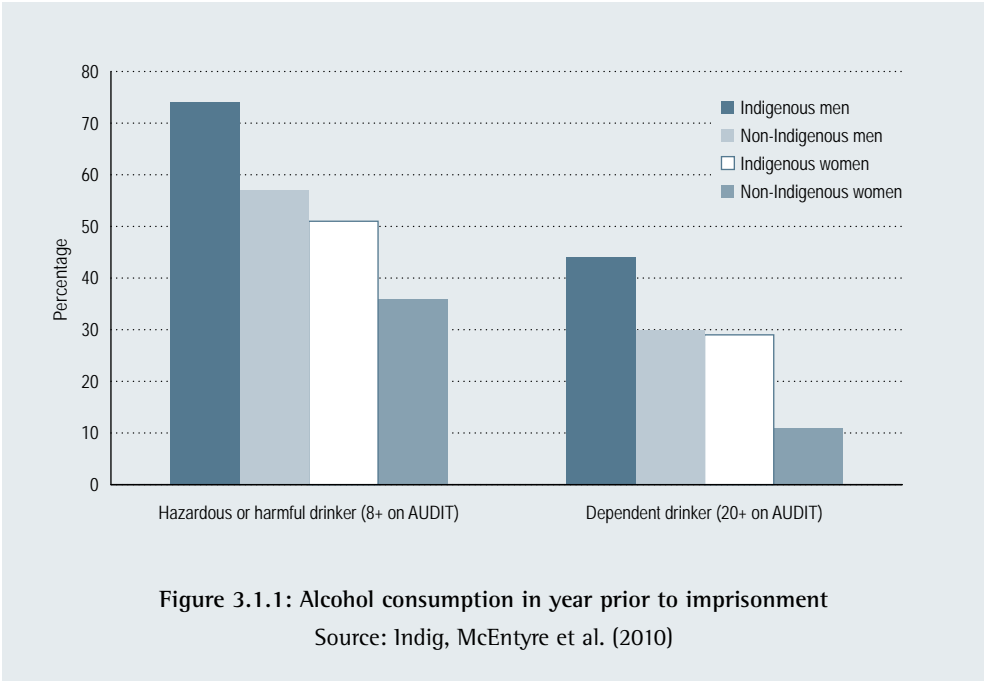


Table 3.1.2: Patterns of licit drug use by inmates, 2007–08, six months before imprisonment and during current prison term

Drug	Males		Females	
	Community (%)	Prison ⁸ (%)	Community (%)	Prison (%)
Tobacco	87.9	91.2	84.6	90.4
Alcohol	75.4*	2.6	59.6	5.8

* Some missing cases (<10).

Source: Kevin (2010), amended Tables 5 and 6

The 2007–08 CSNSW Biennial Survey also showed that tobacco and alcohol consumption were common in inmate samples. Smoking increased during imprisonment for both genders (see Table 3.1.2).

Illicit drug use

As shown in Table 3.1.3, in 2009 cannabis was reported as the most common drug ever

used by New South Wales inmates participating in the IHS (males 84%; females 71%). Indigenous prisoners (males and females 88%) were more likely to have ever used any illicit drugs than their non-Indigenous counterparts (males 84%; females 74%) (Indig, McEntyre et al., 2010). In 2009, more women (52%) than men (40%) reported a history of injecting drug use (Indig, Topp et al., 2010).

Table 3.1.3: Ever used drugs, by drug type (%)

Illicit drug use history (ever used)	Male prisoners			Female prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
Heroin	43.4	36.3	38.6	52.0	48.2	49.2
Amphetamines*	60.2	56.2	57.5	50.0	58.3	56.1
Cannabis	87.9	81.6	83.6	82.0	67.6	71.4
Cocaine	38.7	47.9	44.9	30.0	52.5	46.6
Any illicit drugs	88.3	84.2	85.5	88.0	74.1	77.8
Ever injected	46.1	37.2	40.1	50.0	53.2	52.4

* Amphetamine use reported in this table is methamphetamines (powder/paste) – data were collected for crystalline methamphetamine (ice) but this is not captured here.

Source: Indig, Topp et al. (2010)

⁸ Median term of imprisonment = six months.

In 2009, 42 per cent of male prisoners and 54 per cent of female prisoners reported having used at least one illicit drug ‘regularly’ (defined as daily or almost daily) in the year prior to imprisonment. A further 43 per cent of males and 24 per cent of females reported using an illicit drug less frequently during the same reporting period. In the year preceding incarceration, IHS participants were most likely to have used cannabis (26%) regularly, followed by meth/amphetamines (16%) – see Table 3.1.4 for further details (Indig, Topp et al., 2010).

Of the 2009 IHS sample, 42 per cent of males and 44 per cent of females reported ever having used an illicit drug in prison. Participants were most likely to report using the following drugs in prison: cannabis (31%), heroin (15%) and another person’s methadone or buprenorphine (10%). Injecting drug use in prison was reported by 17 per cent of participants in the 2009 IHS (Indig, Topp et al., 2010).

Table 3.1.4: Patterns of illicit drug use by inmates: in year preceding imprisonment and ever used in prison

Drug	Males		Females	
	Community ⁹ (%)	Prison ¹⁰ (%)	Community (%)	Prison (%)
Heroin	67 (9%)	125 (16%)	34 (18%)	25 (13%)
Amphetamines	113 (14%)	78 (10%)	39 (21%)	16 (9%)
Cannabis	208 (26%)	258 (33%)	44 (23%)	49 (26%)
Cocaine	42 (5%)	47 (6%)	28 (15%)	11 (6%)

*Amphetamine use reported in this table is methamphetamines (powder/paste) – data were collected for crystalline methamphetamine (ice) but this is not captured here.

Source: Indig, Topp et al. (2010)

⁹ Figures for community use refer to ‘regular use’, measured in daily/almost daily use in the year before prison.

¹⁰ Figures for prison use refer to ‘ever used’ illicit drugs in prison.

3.1.2 Drug strategies

3.1.2.1 Supply reduction

The two main forms of supply reduction used in New South Wales prisons were drug detection dogs and a urinalysis program. Other security measures believed to impact upon drug supply include: x-ray machines and metal detectors; iris scanners; bag searches; and pat-down searches (used routinely to screen all persons entering prisons in New South Wales). Staff and visitors are required to undergo screening on every entry to a prison in New South Wales and must carry any property they are taking into the prison in a clear plastic bag.

The most commonly experienced detection measures were cell searches (95%) and 'pat-downs' (93%) for both male and female inmates. In comparison to males, females reported a higher rate of exposure to drug testing (urinalysis).

When questioned on the perceived deterrence effect of each of the supply reduction measures, both males (74%) and females (82%) identified urinalysis as having a medium to high deterrence effect. 'Pat-down' body searches were perceived to have a low deterrence effect by both male (54%) and female (59%) inmates.

Table 3.1.5: Exposure to drug screening and detection measures during current prison term
(Base = total sample [n=358])

Type of measure	Male inmates (n=300*) %	Female inmates (n=51**) %	Total (n=351) %
Cell searches	95.3	94.1	95.2
'Pat-down' searches (body)	94.3	90.2	93.7
Drug detector dogs	69.0	70.6	69.2
Urinalysis	47.3	74.5	51.3

* Six missing cases.

** One missing case.

Source: Kevin (2010), Table 12

Drug detection dogs

CSNSW used drug detection dogs in both male and female correctional centres. Figures for the 2009–10 financial year showed that drug detection dogs were engaged in a total of 83 801 searches, with visitor and property searches accounting for the majority of searches (53%). Table 3.1.6 shows the number of searches by search type.

Table 3.1.6: Type and number of searches conducted by drug detection dog teams, 2009–10

Type of search	Number of searches
Inmate searches	21 779
Cell searches	9526
Visitor and property searches	44 522
Vehicle searches	1618
Other searches	6356
Total	83 801

Urinalysis programs

In 2009 the CSNSW urinalysis program consisted of therapeutic program tests (13 697), random tests (6320) and targeted testing (4374). Table 3.1.7 presents the positive results by drug type. The random urinalysis program functions as per the Random Sampling – Clause 150 of the Crimes (Administration of Sentences) Regulation 2008. With the use of a computer-based random sample program, a list is generated each month of 5 per cent of the inmate population for each correctional centre. The listed inmates must be tested within seven days of receiving the report.

Drug seizures within prisons

Data were not available for the number of seizures by supply reduction measure. However, data were available on the number and/or quantity of contraband detected by drug dog detection teams. In 2009–10, drug dog detection teams found a total of 55 needles, 233 syringes and 103 drug implements. Other types of contraband detected included 746 grams of green vegetable matter,¹¹ 64 grams of powder, 355 tablets and 19 295 ml of alcohol.

Table 3.1.7: Positive results for urinalysis tests in NSW prisons, by drug type

Drug	Therapeutic urinalysis tests n=13 697 (%)	Random urinalysis tests n=6320 (%)	Targeted urinalysis tests n=4374 (%)
Heroin	37 (0.3)	8 (0.1)	16 (0.4)
Amphetamines	87 (0.6)	20 (0.3)	39 (1.0)
Cannabis	1181 (8.6)	413 (6.5)	645 (14.7)
Cocaine	14 (0.1)	0 (0)	2 (0)
Other ¹²	1928 (14.1)	651 (10.3)	1048 (23.9)

Source: Corrective Services NSW, personal communication, 2011

¹¹ Cannabis.

¹² ‘Other’ includes all other drugs detected that were not legitimately prescribed or provided to the inmate, including non-psychoactive substances; could be any drug, from paracetamol to methadone or buprenorphine. Mainly covers unsanctioned use of licit drugs.

3.1.2.2 Demand reduction

Detoxification

In 2009, there were a total of 6261 inmates treated for ambulatory detoxification in New South Wales prisons. A large number of detainees (1834) in police cells also experienced some form of drug and/or alcohol withdrawal. Furthermore, there were 717 patients admitted to the four inpatient centres for detoxification. The most common drug that patients were withdrawing from was alcohol, involving 3136 of 8711 (36%) inmates.

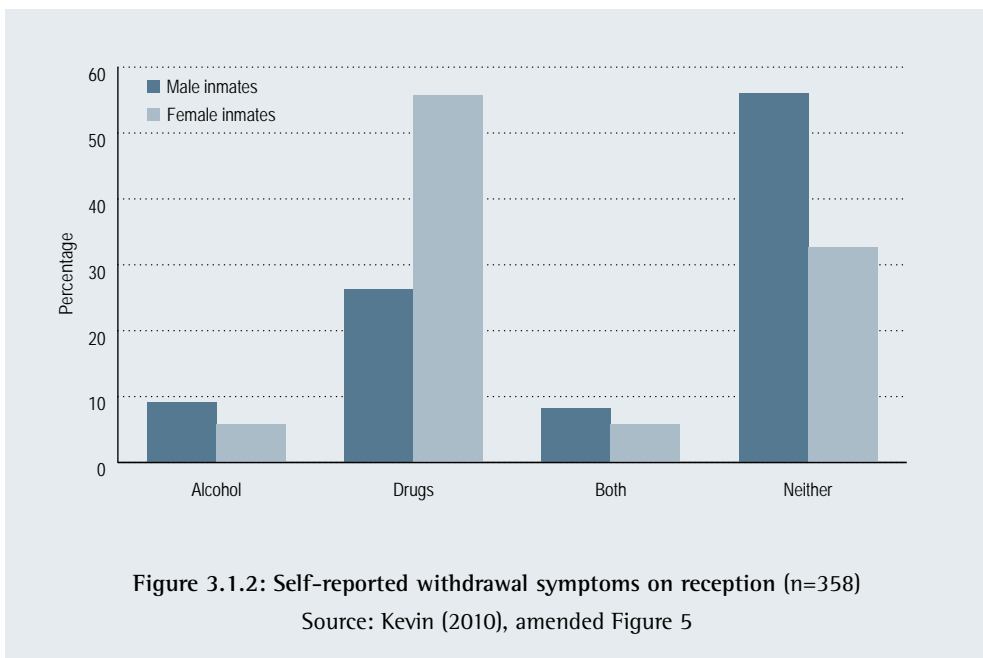
The following steps are followed by Justice Health staff when treating inmates for drug withdrawal:

- Inmate will be assessed by a Justice Health nurse at the clinic/police cells.
- Nurse contacts Justice Health's 24-hour Addiction Medicine On-Call Service, with

medical consultation occurring via telephone.

- Where appropriate, the inmate begins a withdrawal regimen and is monitored as per the Drug and Alcohol Procedure Manual.
- Inmate is held in detoxification cell or admitted to clinic area with good access by clinical staff where appropriate and available.
- Inmate is cleared to leave cell to return to mainstream population after clinical review.

In 2007–08, 44 per cent of males and 67 per cent of females in the CSNSW Biennial Survey sample reported experiencing drug withdrawal symptoms on reception to full-time custody. The following chart illustrates the distribution of withdrawal from drugs and alcohol for both men and women in survey sample.



**Table 3.1.8: Inmate drug treatment history
(counselling, structured groups or residential programs)**

(Base = inmates with a drug problem history who participated in prior drug treatment, n=250)

Treatment location	Male inmates (n=210*) %	Female inmates (n=40) %	Total (n=250) %
Community only	31.4	20.0	29.6
Prison only	18.1	15.0	17.6
Both	50.5	65.0	52.8
Total	100.0	100.0	100.0

* Two missing cases.

Source: Kevin (2010), Table 6

Imprisonment had provided the only lifetime treatment opportunity for 18 per cent of males and 15 per cent of females reporting problematic drug and/or alcohol use in the 2007–08 CSNSW Biennial Survey sample. The majority of females (95.2%) and males (87.2%) who reported a history of a drug problem had been involved in drug treatment programs (counselling, structured groups or residential programs) in the past (see Table 3.1.8).

Methadone and other pharmacotherapies

In 2009, both methadone and buprenorphine were offered in New South Wales prisons, but for maintenance only and not for detoxification. Prison inmates could remain on methadone and buprenorphine maintenance upon reception to prison. Inmates could also commence methadone or buprenorphine maintenance treatment in New South Wales prisons. In 2009, there were 1325 inmates on methadone maintenance treatment and 264 inmates on buprenorphine maintenance treatment. In 2009, Justice Health commenced a total of 1318 inmates on pharmacotherapy programs. Of these, 1316 commenced methadone maintenance treatment and two commenced buprenorphine

maintenance treatment. Also 22 per cent of males and 42 per cent of female inmates surveyed for the 2009 IHS reported that they had previously been on a methadone program and 10 per cent of males and 18 per cent of females had received buprenorphine maintenance treatment in the past (Indig, Topp et al., 2010).

Furthermore, in 2007–08 CSNSW reported that 29 per cent of males and 46 per cent of females had received methadone maintenance treatment in the past and 10 per cent of males and 17 per cent of females had received buprenorphine maintenance treatment in the past (Kevin, 2010).

Justice Health reported that their major concern was funding, ‘as clinical demand has grown by 200 per cent since 1999 and detoxification services are now required at 10 reception centres across the state – as compared to three centres when funding was originally provided. Methadone and buprenorphine services have now expanded to 27 centres across the state from the original 11 centres with no significant additional resources’ (Corrective Services NSW, Drug and Alcohol Unit, personal communication, 2010).

Inmate programs and counselling services

In 2008–09, CSNSW reported that a total of 168 drug- and alcohol-specific programs were available in New South Wales prisons and 4666 inmates had engaged in these programs during the financial year. Alcoholics Anonymous and Getting SMART were the most attended programs. Table 3.1.9 provides further details by program.

According to the 2007–08 CSNSW Biennial Survey, the majority of males who participated in alcohol and other drug (AOD) programs during their current prison term participated

in group programs (60%), whereas the majority of females who participated in AOD services during the same time participated in one-to-one counselling (81%) (Kevin, 2010). Table 3.1.10 presents a breakdown of the type of service/programs engaged in by inmates.

In 2007–08 the percentage of inmates who received treatment following reporting withdrawal symptoms was 38 per cent for males and 69 per cent for females. A further 5 per cent of male inmates and 4 per cent of female inmates were 'wait-listed' for service (Kevin, 2010).

Table 3.1.9: Drug and alcohol programs in NSW prisons, 2008–09

Program name	Individuals	Occasions ¹³	Number of programs
Alcoholics Anonymous meetings	1283	3800	n/a
Drug and Alcohol Addiction (DAAP)	311	1577	19
Drugs: The Impact of Dependence (a readiness program)	101	651	6
Getting SMART	1656	12 810	66
Narcotics Anonymous meetings	636	1970	16
PATHWAYS: Criminal Conduct and Substance Abuse Treatment (adult version)	104	2301	7
Relapse Prevention (RPP)	12	49	2
SMART Recovery Maintenance Groups	369	1454	24
Total	4472	24 612	168

Source: Corrective Services New South Wales (2009)

¹³ The programs listed in this table have varying degrees of duration. For example, Pathways is a 50-session program, whereas Getting SMART is a 12-session program. The number of occasions gives an indication of the intensity of program provision because it shows how many times individuals attended a particular program.

Table 3.1.10: Type of contact with prison-based drug treatment during current prison term

Type of treatment	Male prisoners	Female prisoners	Total
Therapeutic community	60	n/a	60
Drug-free units	9	96	105
Compulsory drug treatment programs	38	n/a	38
Drug and alcohol counselling	3451	663	4114
Drug education	n/a	n/a	n/a

Source: Kevin (2010)

Drug-free units

In 2009, there were three drug-free units¹⁴ operating in New South Wales prisons: POISE; Ngara Nura; and the Compulsory Drug Treatment Program.

POISE is classified as a high-intensity (15 hours per week over 14 weeks) AOD program for women offenders. The program aims to address alcohol and other drug concerns, addictive behaviour and the AOD and recidivism cycle. POISE utilises the Pathways program as the core intervention, with Getting SMART as a preparatory phase. In 2009, POISE was available only at Emu Plains Correctional Centre, with a total of 10 beds (Corrective Services NSW, personal communication, 2011).

Ngara Nura is designed to provide a safe and supportive therapeutic environment, enabling participants to explore their emotional, psychological and spiritual attitudes and beliefs. It aims to assist participants in reducing the harms associated with addiction, including drugs, alcohol and gambling. Additionally the program offers support to prisoners upon release. Hours of treatment offered include 1.5- to 2-hour sessions six times a week plus supplementary sessions of community

meetings six times per week; and Narcotics Anonymous and Alcoholic Anonymous meetings twice a week. Program duration is 80 sessions. In 2009, there were 35 beds available as part of the program (Corrective Services NSW, personal communication, 2011).

In 2006, a 70-bed Compulsory Drug Treatment Program (CDTP) was established in New South Wales following the introduction of the *Compulsory Drug Treatment Correctional Centre Act 2004* (New South Wales Legislative Assembly Hansard, 23 June 2004: 9966). The Act authorises the New South Wales Drug Court to order sentenced, repeat drug-related offenders to the Compulsory Drug Treatment Correctional Centre (CDTCC). The CDTP operates as a five-stage program for male offenders. Drug treatment and rehabilitation are provided in Stages 1–3 primarily from the CDTCC, followed by Stage 4 (parole) and Stage 5 (voluntary case management) in the community where appropriate (Dekker, O'Brien and Smith, 2010). Participants must stay in each stage of the program for at least six months.

¹⁴ Data for the Phoenix program were not available as the program had not run in recent years.

The CDTP is jointly administered by CSNSW and Justice Health, although Justice Health has only a small role in the overall program. The program side is managed by CSNSW with some feedback from Justice Health on each participant's progress at every stage. Justice Health staff manage physical withdrawal from drugs/alcohol, mental health and any other relevant health issues of participants as they transit through each stage.

The role of CSNSW in the practical management of the CDTP includes: (Dekker, O'Brien and Smith, 2010: vii)

- Stage 1: Managing the closed detention of participants in full-time custody at the CDTCC, while also providing adult education, work readiness and skills programs and therapeutic programs that focus on risk factors for drug-related offending.
- Stage 2: Involves semi-open detention: CSNSW manages the movement of participants, as they may leave the CDTCC to attend employment, training and approved social activities. CSNSW also delivers therapeutic programs to maintain positive behaviour change and training re-integration into the community.
- Stage 3: As participants move into community custody, CSNSW provides intense supervision, support for re-integration and re-enforcement of changes in previous stages.

The first three stages of the CDTP were subject to evaluation by the New South Wales Bureau of Crime Statistics and Research. The evaluation reported on four key areas:

- health and wellbeing
- perceived coercion, treatment readiness and therapeutic alliance
- program perceptions, and
- drug use.

Participants' health and wellbeing appeared to improve over time on the program. In spite of the coercive nature of the program, participants perceived their involvement as voluntary and interviews with participants yielded positive comments about the program. Irrespective of stage in the program, participants expressed a desire to stay on the program. With regard to drug use, 96 per cent of drug tests conducted during the evaluation were classified as 'prescribed drug-free' and only 257 tests (2%) were 'positive'. However, 66 of the 108 (61%) participants with non-baseline tests returned at least one positive test (Dekker, O'Brien and Smith, 2010).

In 2009, the profile of inmates participating in the CDTP consisted of an average age of 29 years (20–50 years age range). The primary drug of use was heroin (71%) followed by amphetamines (13%), 'ice' (5%), cannabis (4%), cocaine (3%) and alcohol/benzodiazepines (2%). Only one participant indicated no other drug usage in addition to their primary drug of use (Justice Health, personal communication, 2010).

3.1.2.3 Harm reduction

Harm reduction education programs

The aim of harm reduction strategies is to reduce the harm associated with illicit drug use. In 2009, harm reduction strategies in New South Wales prisons included: peer education; Fincol (a hospital grade disinfectant) provision; condom and dental dam provisions; and blood-borne virus (BBV) testing. In 2009 CSNSW Offender Services and Programs provided health promotion programs and resources to inmates, including:

- structured group programs
- peer support training, and
- information booklets.

It is standard practice to distribute the Health Promotion Diary¹⁵ to inmates upon reception to prison. In 2007–08, for inmates who received health promotion and education, the diary (90.2%) was the most commonly received (Kevin, 2010). A further 39.6 per cent were engaged in the Health Survival Program and 12 per cent participated in the Harm Reduction Peer Supporter Program. In some New South Wales prisons, the Health Survival Program is delivered by inmate peers. In 2009–10, CSNSW reported that 1172 inmates received harm reduction education through the Health Survival Program. The program is a two-hour group education program, delivered during the induction period and includes:

- information on communicable diseases, especially blood-borne viruses
- advice about high-risk situations and behaviours

- instructions on cleaning injecting equipment
- universal precautions
- advice to use Justice Health services.

In 2009–10, CSNSW also trained inmates to function as peer educators (28). Inmate peers were selected from inmates with long sentences in maximum security prisons. Inmates then engage in peer education through the course of their sentence, as they move across the classification system from maximum to medium and finally to minimum security.

Blood-borne virus testing

All inmates in New South Wales are offered testing for hepatitis B, hepatitis C, HIV, syphilis, gonorrhoea and chlamydia. The figures in Table 3.1.11 show the number of inmates tested as part of the Early Detection Program (n=4008). Results of tests undertaken are also shown in Table 3.1.11. Additionally, the 2009 IHS found that 54 per cent of males and 63 per cent of females surveyed reported that they had been tested for HIV, hepatitis or sexually transmitted infections in prison in the past. The IHS also showed that hepatitis B (core antibody, an indication of past exposure) was observed in 23 per cent of males and 33 per cent of females. The prevalence of hepatitis B (surface antigen, an indication of current infection) was found to be 2 per cent in males and 0 per cent in females (Indig, Topp et al., 2010). In 2009, a total of 498¹⁶ inmates completed the hepatitis B vaccination schedule.

In 2009, in addition to blood-borne viral testing, Justice Health staff also provided harm reduction education to a total of 4052¹⁷ inmates.

¹⁵ The Health Promotion Diary is described by CSNSW as an entertaining and low literacy resource that contains general health information.

¹⁶ This number includes patients who were immune or carriers, when they received the first dose.

¹⁷ This number shows only the number of patients educated by public/sexual health nurses.

Table 3.1.11: Results of blood-borne virus tests in NSW prisons, 2009

Virus	Positive results (%)	Positive results (n)
Hepatitis B	1	40/4008
Hepatitis C	15	609/4008
HIV	0.07	3/4008

Hepatitis C transmission

The Hepatitis C Incidence and Transmission study has been running in New South Wales prisons since 2000. The most recent assessment of 120 inmates who were continuously imprisoned found 16 had acquired HCV infection. This gave an incidence of 34.2 per 100 person years (CI: 19.6–55.6). Risk factors for transmission included prior imprisonment, methadone treatment and greater than 10 years of education. Although the frequency of injecting was reduced in prison, 33.6 per cent continued to inject drugs, most commonly methamphetamine, and 90 per cent of these reported sharing injecting equipment (Dolan et al., 2010).

Condom provision

During the 2009–10 financial year, a total of 365 000 condoms were distributed to inmates in New South Wales male prisons and 20 500 dental dams were distributed in New South Wales female prisons. In 2008–09, condoms and latex dams were freely available to all inmates and distributed via free vending machines. An independent contractor was responsible for refilling and servicing the machines.

Disinfectant provision

In 2007, CSNSW replaced bleach with Fincol (a hospital grade disinfectant) as a universal cleaner and made it freely available to all inmates and staff. In 2009, only 44 per cent of the IHS sample reported being aware of CSNSW policy to provide inmates with Fincol for the purposes of disinfecting injecting, piercing and tattooing equipment. Gender differences were identified with regard to awareness of this policy. Lack of awareness was more significant among women (30% were aware) than men (47% were aware) (Indig, Topp et al., 2010).

Attempted access to disinfectant in 2009 was 18 per cent compared to 31 per cent in 2001. Justice Health acknowledges that while this is a significant decrease, it is unclear whether the decrease is a result of the change from bleach to Fincol or a genuine decline in attempts to access disinfectant. Ease of access responses given by the 140 men and the 32 women who attempted to access disinfectant in the reporting period showed that the majority (62%) described obtaining disinfectant as 'easy' or 'very easy'. Women reported a greater difficulty obtaining disinfectant, with more women than men reporting ease of access as 'difficult' (25% vs 18%). A further 22 per cent of women reported that disinfectant was 'not available' (Indig, Topp et al., 2010).

Needle and syringe programs

In 2009, needle and syringe programs were not operating in New South Wales prisons.

Data from the 2009 IHS showed that the sharing of injecting equipment was a common practice among participants who reported injecting drug use in prison. Only 3 per cent of 112¹⁸ participants reported that no other person had used the needle and syringe to inject before them. A further 31 per cent reported that one other person had used the needle/syringe before them; 12 per cent reported that two other people had used it; and 27 per cent didn't know how many people had used the needle/syringe before them (Indig, Topp et al., 2010).

The appropriate cleaning of injecting equipment is part of safe injecting practices. Among the 161 IHS participants reporting injecting in prison, 90 per cent reported that the last time they injected in prison the needle/syringe had been cleaned before use. However, the effective cleansing of injecting equipment by prisoners is questionable, given that injecting equipment is contraband (Indig, Topp et al., 2010).

Other harm reduction strategies/ Further information

A variety of resources including *Hep Review*, *Transmission Magazine* and posters and pamphlets produced by Hepatitis NSW were distributed in correctional centres. The Prisons Hepatitis C Helpline, operated by Hepatitis NSW, was available to all offenders in custody as a free telephone call.

¹⁸ 161 participants reported injecting in prison; however, due to a computer programming error, 49 participants were not asked about the number of people who had used the needle/syringe before them.

3.1.3 Re-entry programs

3.1.3.1 Mortality among recently released prisoners

Data on mortality among recently released prisoners were not routinely collected in New South Wales (Justice Health, personal communication). Three studies using the same cohort of released prisoners between 1988 and 2002 estimated the prevalence and predictors of mortality among released New South Wales prisoners.

Kariminia, Butler et al. (2007) – This study reports standardised mortality rates (SMRs) for all causes of death and specific causes of death among all New South Wales prisoners released between 1988 and 2002. This study reports deaths attributable to drug overdose, alcohol, smoking-related cancers, hepatitis C liver-related problems and suicides. Mortality rates of prisoners were compared with the general New South Wales population (see Table 3.1.12) adjusted for age, sex and calendar year. Deaths were identified using data from the Australian National Death Index. There were a total of 5137 deaths among recently released prisoners in New South Wales between 1988 and 2002, averaging 342 deaths per year, with 4714 deaths identified among men and 423 among women (Kariminia, Butler et al., 2007).

Table 3.1.12: Mortality rates for recently released prisoners compared with the general NSW population

Cause of death	Men (times more likely than general population)	Women (times more likely than general population)
Drugs or alcohol	12.8	50.3
Drug overdose	14.6	77.8
Drinking alcohol	15.1	103.3
Smoking related	1.7	2.4
Hepatitis C related liver problem	27.7	0.9
Suicide	167.6	4.0

Source: Kariminia, Butler et al. (2007)

As a proportion of all deaths, drug-related deaths were more common among women (47%) than men (31%). Common specific causes of death among men were drug overdose (18.1%) and suicide (16.9%). Drug overdose (27%) and suicide (11.6%) were also common among women. The authors report that heroin was the major contributing drug in most drug overdoses. When compared to the general New South Wales population, death rates for released prisoners were greater by 3.7 times for males, by 4.8 times for Indigenous men, by 7.8 times for females and by 12.6 times for Indigenous women.

Merrall et al. (2010) – A meta-analysis of six studies reporting SMRs for drug-related mortality among recently released prisoners in six prison systems included the New South Wales cohort used by Kariminia, Butler et al. (2007). They compared all drug-related deaths at different intervals up to 12 weeks post-release (weeks 1 & 2; weeks 3 & 4; weeks 5–12; and weeks 3–12) and computed the relative risk of drug-related mortality during these intervals. The study reports that the risk of drug-related death among

the New South Wales cohort was greatest in the first two weeks post-release and the risk remains elevated until the fourth week post-release (Merrall et al., 2010). Drug-related deaths were 4.4 times more likely to occur in the first two weeks post-release than in five to 12 weeks post-release.

Predictors of mortality among recently released prisoners

Kariminia, Law et al. (2007) studied factors associated with all-cause mortality, drug-related mortality and suicide, among men and women from the same cohort as reported in Kariminia, Butler et al. (2007). They used univariate and multivariate analysis to identify factors that predict all-cause mortality, drug-related mortality and suicide.

Increased risk of drug-related mortality was found for released males aged 18–19 years old or 35 years and older who had been admitted to hospital for a psychiatric disorder while in prison, had a property offence as their most serious offence, had more than one prior period of incarceration, or had a length of imprisonment greater than two

weeks. Men were at a significantly reduced rate of drug-related mortality post-release if they were Indigenous or from an Asian or other non-English-speaking country, if they have sex offences as the most serious crime for which they were most recently imprisoned, or have no prior history of incarceration (Kariminia, Law et al., 2007).

The situation among women was less clear due to small sample sizes for some factors used in the study. A smaller number of factors was associated with drug-related mortality post-release for women rather than for men. Increased risk of drug-related mortality was found among younger women (<25 years) and reduced substantially with age, especially among those with two or more prior periods of imprisonment. A significantly reduced risk of drug-related mortality was found among women if they were 45 years or older or Indigenous (Kariminia, Law et al., 2007).

3.1.3.2 Transitional and pre-release services

In 2008–09, offenders in custody nearing their release were provided with *Planning Your Release* (2007) and *Getting Out: your guide to surviving on the outside* (2007) to assist them in planning their release. Both handbooks were joint publications by the Community Restorative Centre and the New South Wales Department of Corrective Services.

These resources were supplemented by the Nexus program, which enables offenders to plan for their release in a group setting with assistance from a facilitator, and by the Responsibilities and Rights program, which connects offenders to a range of community services. In 2008–09, 411 individuals participated in the Nexus program and 124 participated in Responsibilities and Rights (Corrective Services NSW, personal communication, 2011).

CSNSW runs several transitional centres:

- *Parramatta Transitional Centre* – transitional centre for women approaching release. On 28 June 2009, Parramatta Transitional Centre housed 15 women (Corrective Services NSW website).
- *Bolwarra Transitional Centre* – centre for women with alcohol and drug problems who are preparing for release. On 28 June 2009, Bolwarra Transitional Centre housed 14 women (Corrective Services NSW website).
- *Community Offender Support Program Centres (COSPs)* – supported-accommodation service providing access to intervention programs and assistance with re-integration into the community for offenders leaving custody.

3.1.3.3 Services to which prisoners are referred upon release

The Justice Health Connections project provides post-release linkage with health and welfare services in the community and support with re-integration for individuals with drug and alcohol problems. The program was established in 2007 and was available in all New South Wales adult correctional centres. Collaborative work agreements have been developed with a variety of services including: Housing NSW, community housing organisations, (former) Area Health Services and CSNSW.

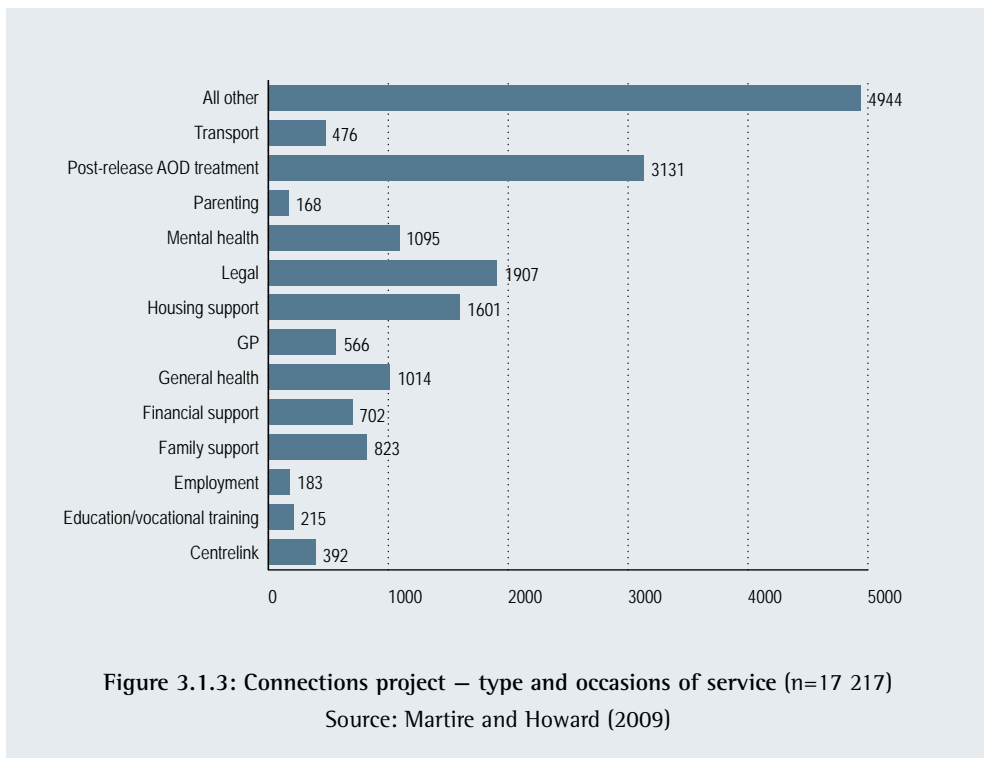
Connections staff develop and implement comprehensive, tailored release plans and liaise with various service providers to meet patient needs. For example, staff can organise post-release accommodation with Housing NSW, referrals to general practitioners and specialists in the community, a post-release

dosing point for those in an opioid substitution program, access visits with children, and advice on financial issues and debt (Martire and Howard, 2009).

In 2009, the Connections project assisted 1021 patients and provided 17 217 occasions of service. Figure 3.1.3 provides a breakdown on the type of services and the occasions on which those services were provided to inmates. Additionally, Martire and Howard (2009) conducted an external independent evaluation of the Connections project during the initial 14 months of operation. The evaluation found that the proportion of patients returning to custody within four

weeks of their release from prison reduced from pre-Connections numbers, and those who completed the project remained longer in the community than previously.

The evaluation also found that gains made by participants who reported that their offending was associated with their substance use were an average of 73 days longer in the community than those made by patients who did not report such a link. This suggests that Connections provides relatively better outcomes for those who perceive their substance use has contributed to their offending behaviour (Martire and Howard, 2009).



Martire and Howard (2009) also reported that, at follow-up, 90 per cent of participants said they were ‘better prepared’ for their return to the community post-Connections than they had been previously; 86 per cent reported that their transition was ‘easier’ this time than it had been before; 98 per cent reported having been assisted by the Connections project; and 90 per cent were ‘satisfied’ or ‘very satisfied’ with the service they received. Overall, outcomes were equally positive for Indigenous and non-Indigenous participants.

External services that CSNSW staff access to assist prisoners upon release include HSNet, an online directory and referral portal for all social welfare and health services in New South Wales. In 2009, Corrections staff also used the Alcohol and Drug Information Service (ADIS). ADIS is a 24-hour telephone information, counselling and referral service for the general public.

CSNSW has been involved in a number of interagency projects for offenders post-release; however, these generally apply to offenders who continue under the supervision of CSNSW and are run in conjunction with Community Offender Services. These include:

- Aboriginal Client Services officers in Lismore and Forbes who work with offenders participating in residential rehabilitation treatment services
- Pathways to Employment Education and Training – a joint project with TAFE NSW to improve access to education, training and employment for offenders with alcohol and other drug problems
- Co-existing Disorders Program designed to develop, refine, implement and evaluate a model of sustainable cross-agency case management for community-based offenders with co-existing alcohol and other drug disorders, mental health disorders, and/or intellectual disability or cognitive impairment.

In 2009–10 CSNSW funded several AOD services under its Community Grants Program; these are listed in Table 3.1.13.

CSNSW participates in a wide range of initiatives under the Homelessness Action Plan and other federal and state plans to reduce poverty, homelessness and disadvantage.

Table 3.1.13: Services funded by CSNSW under its Community Grants Program, 2009–10

Name of service or program	Organisation running the service or program
Intensive Alcohol and Other Drug Rehabilitation Project – Male – NSW North Coast Region	Namatjira Haven
Intensive Supported Accommodation Project – Female	Guthrie House
Intensive Supported Accommodation Project – Male	Glebe House
Transitional Supported Accommodation Project – Male	Judge Rainbow Memorial Fund

Table 3.1.14: NSW prisoners referred to community pharmacotherapy programs, by Indigenous status, 2009

	Male prisoners			Female prisoners		
	Indigenous	Non-Indigenous	Total	Indigenous	Non-Indigenous	Total
Methadone	175	1315	1490	82	393	475
Buprenorphine	20	219	239	4	40	44
Total	195	1534	1729	86	433	519

Source: Justice Health, personal communication, 2009

3.1.3.4 Referrals to community opioid substitution programs for prisoners upon release

Justice Health staff provide referrals to community methadone, buprenorphine and OSPs for male and female prisoners upon release. Justice Health commenced referrals for buprenorphine–naloxone for male prisoners upon release in September 2010.

In 2009, 1729 male prisoners and 519 female prisoners were referred to OSPs upon release. Table 3.1.14 shows the breakdown of these referrals by Indigenous status and type of pharmacotherapy (methadone and buprenorphine).

3.1.4 Research and evaluations

Justice Health has conducted a number of research studies relating to drug use and treatment in prisons, including the 2009 New South Wales Inmate Health Survey (Indig, Topp et al., 2010; Indig, McEntyre et al., 2010) and the 2009 Young People in Custody Health Survey (Indig et al., 2011). A number of studies have also been undertaken by Justice Health in partnership with other research centres or universities including the Sexual Health and Behaviour of Australian Prisoners Study (Richters et al., 2010) and the Smoking

Cessation Randomised Clinical Trial among adult male prisoners (Richmond et al., 2006), both undertaken in partnership with the University of New South Wales.

The Corporate Research, Evaluation and Statistics section (CRES) of CSNSW has conducted research and evaluation, and provided statistical information to CSNSW. These include the annual *Facts & Figures* series and the annual *NSW Inmate Census* (for the latest census, see Corben, 2011). Further CRES reports on drug use by prisoners prior to and during incarceration are included in a biennial dataset. The 2007–08 dataset is the latest, making it the fifth in the series, which began in 1998 (Kevin, 2010). This information is provided to CSNSW and used to assist in the development of harm reduction material.

A number of trials and evaluations of demand reduction and harm reduction strategies have also been conducted within New South Wales prisons. These include an economic evaluation of the prison methadone program (Warren and Viney, 2004), an evaluation of the post-release service – Connections Project (Martire and Howard, 2009), and an evaluation of the Compulsory Drug Treatment Program (CDTP) (Dekker, O'Brien and Smith, 2010).

A ten-year follow-up study of inmates in methadone treatment found a 20 per cent reduction in re-incarceration and a decrease in mortality for those who left prison on methadone and remained on it after release (Larney et al., 2012).

Other research, reports, evaluation and inquiries include:

- The Justice Health Centre for Health Research in Criminal Justice (CHRCJ) has implemented the New South Wales component of the National Prison Entrants' Bloodborne Virus Survey in 2004, 2007 and 2010. The 2010 report is currently being finalised (Butler and Papanastasiou, 2008).
- CHRCJ is also working in partnership with researchers from the National Drug and Alcohol Research Centre to implement two studies into prisoners with drug and alcohol problems. The first is a pilot randomised controlled trial intervention for male prisoners with post-traumatic stress disorder who also have a substance use disorder. The second is a prevalence study of attention deficit hyperactivity disorder (ADHD) and comorbid substance use disorders among male and female prisoners.
- CRES is currently evaluating the Drug and Alcohol Addictions Program and Relapse Prevention Program. A progress report has been published and is available on the CSNSW internet site (Furby and Kevin, 2008).
- CRES is undertaking the Corrections Treatment Outcome Study, an evaluation of the POISE and Phoenix programs and the Bolwarra Transitional Centre using a common methodology. No results have been published to date.
- Harm reduction education in New South Wales prisons has been internally evaluated by CRES and the Principal Advisor, AOD/Health Promotion. The report is not publicly available.
- The condom provision program has been evaluated by Yap and colleagues (Yap et al., 2007).
- Investigation into the introduction of contraband into the Metropolitan Remand and Reception Centre, Silverwater (Operation Montessa) (Independent Commission Against Corruption, 2004).
- Investigation into the smuggling of contraband into the John Morony Correctional Centre (Operation Cicero) (Independent Commission Against Corruption, 2010).
- Research into fine debt among prisoners with a history of problematic substance use (Martire, Sunjic, Topp and Indig, 2011).
- Research into comorbidity among prisoners (Butler et al., 2011).
- Evaluation of the Justice Health Connections project for prisoner re-integration and its effects on recidivism (Medlock, Martire and Kemp, 2011).

3.1.5 Future directions

CSNSW advised that there was currently a trial underway on the use of ion machines as a supply reduction strategy in New South Wales prisons. No further details were provided about this trial.

3.2 Queensland

3.2.1 Background

Prison population

A total of 5667 prisoners (5251 males and 416 females) were housed in Queensland prisons on 30 June 2009 (Australian Bureau of Statistics, 2009). Inmates were housed across 14 prisons, two of which were privately operated – Arthur Gorrie Correctional Centre managed by GEO Group Australia under contract to Queensland Corrective Services (QCS); and Borallon Correctional Centre managed and operated by Serco Australia Pty Ltd for QCS since 2008 (Queensland Corrective Services website).

Health service provision

Health services transitioned from QCS to Queensland Health in 2008. Since 2009, health services in public prisons have been provided by Offender Health Services, Queensland Health. The private operators GEO Group and Serco Australia continue to provide health services within their respective prisons.

In 2009, Offender Health Services employed a 0.1 full-time equivalent (FTE) addiction medicine doctor to provide clinical services and approximately 1.5 FTE opioid treatment nurses.

Prison capacity

In 2008–09 the total design capacity of Queensland prisons was 6439 inmates.¹⁹ The

rate of utilisation in Queensland prisons was 87.4 per cent. This was below the national average of 102 per cent (Steering Committee for the Review of Government Service Provision, 2010).²⁰

3.2.1.1 Drug use by prisoners

Queensland Health's Offender Health Services does not currently have an electronic patient record system. Therefore, Offender Health Services was unable to provide data for reported drug use in 2009, as summary details on the numbers of prisoners with particular conditions or treatments were not electronically available. The department hopes to implement an electronic patient record system in the near future.

Licit drug use – tobacco and alcohol

The Health of Australian Prisoners 2009 reported that tobacco smoking was highly prevalent across all Australian prisons (Australian Institute of Health and Welfare, 2010). In 2007, there was a difference in tobacco use among Queensland prison receptions based on injecting drug user (IDU) status. Prison entrants self-reporting IDU were more likely to report being current smokers (IDU 95%; non-IDU 79%) (Butler and Papanastasiou, 2008).

In 2006, 37 per cent of Queensland prisoners had a history of harmful alcohol use.²¹ Males (45%) were more likely than females (19%) to report a history of harmful alcohol use. See Table 3.2.1 for further breakdowns (Kinner, 2006).

¹⁹ Capacity increased in 2008–09 with an increase in beds at the Arthur Gorrie and Townsville Men's Correctional Centres and the newly opened Townsville Women's Correctional Centre (Steering Committee for the Review of Government Service Provision, 2010).

²⁰ The optimum rate of prison utilisation is 85–95 per cent. This provides some flexibility to cater for prisoners with special needs (e.g. protection, hospital, varying security levels) by gender and also allows for short-term fluctuations in prisoner numbers (Steering Committee for the Review of Government Service Provision, 2010).

²¹ Alcohol (AUDIT category).

Table 3.2.1: Alcohol use history

Alcohol (AUDIT category)**	Male %	Female %	Total %
Non-drinker	19	31	23
Non-hazardous	19	35	24
Hazardous	17	15	16
Harmful	45	19	47

** Statistically significant at $p < .01$

Source: Kinner (2006), amended Table 1

Illicit drug use

In 2007, 57 per cent of Queensland prison receptions surveyed as part of the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey had an injecting drug history. Of those reporting injecting drug use (IDU), 31 per cent had injected daily or more in the month prior to the survey. Furthermore, in 2007 the majority of prison receptions reported using a sterile needle and syringe during all injections in the last month in the community (64%) and 20 per

cent reported doing so most of the time (Butler and Papanastasiou, 2008).

A longitudinal study of male and female prisoners being released from custody in Queensland found that 92 per cent of Queensland prisoners had an illicit drug use history. Cannabis was the most commonly used drug (88%), followed by amphetamines (71%) (Kinner, 2006). Table 3.2.2 provides an overview of the substance use history of prisoners in this study.

Table 3.2.2: Ever used drugs, by drug type (n=160)

Illicit drug use history (ever used)	Male %	Female %	Total %
Heroin	44	33	41
Amphetamines*	76	60	71
Cannabis**	94	75	88
Cocaine	38	35	37
Any illicit drug	95	85	92
IV drug history	69	54	64

* Statistically significant at $p < .05$

** Statistically significant at $p < .01$

Source: Kinner (2006), amended Table 1

3.2.2 Drug strategies

The National Corrections Drug Strategy 2006–2009 (NCDS), which is closely linked to the objectives and ideals of the National Drug Strategy 2004–2009, recognises that prisons and services provided by prison authorities offer a unique opportunity to address drug and alcohol misuse. The NCDS states that: ‘For a variety of reasons many offenders do not access appropriate healthcare in the wider community and therefore incarceration presents an opportunity to deliver a range of health-based and criminogenic interventions’ (National Corrections Drug Strategy, 2008: 1). The NCDS is based on the National Drug Strategy’s harm minimisation approach. Harm minimisation is concerned with both licit and illicit drugs and advocates a balance between supply reduction, demand reduction and harm reduction.

Similarly, the Queensland Corrective Services’ Drug Strategy 2006 (Queensland Corrective Services, 2006) adopted a harm minimisation approach to address drug misuse in Queensland prisons. The Queensland strategy identified supply, demand and harm reduction goals against which the implementation of the strategy was to be measured. These included the following:

- effectiveness of barrier control activities
- prevalence of drug use in corrective facilities
- patterns and trends of drug use in corrective services facilities
- offender referrals to post-release services
- in-prison overdoses (Queensland Corrective Services, 2006, p.25).

3.2.2.1 Supply reduction

Supply reduction strategies aim to disrupt and reduce both the production and supply of illicit drugs, as well as control and regulate the supply of licit drugs. In 2009, QCS used urinalysis testing and drug detection dogs as primary supply reduction strategies.

Drug detection dogs

Data not provided by QCS.

Urinalysis programs

Data not provided by QCS.

Drug seizures within prison

Data not provided by QCS.

3.2.2.2 Demand reduction

Detoxification

Inmates entering Queensland prisons in 2009 were assessed at reception for evidence of withdrawal and offered a symptomatic withdrawal regimen involving reducing doses of diazepam, antispasmodics and simple analgesics. These were similar to non-buprenorphine withdrawal scales used within the general community.

Due to the absence of an electronic patient record system, the Offender Health Services section of Queensland Health could not provide details on the numbers of prisoners with particular conditions or treatments.

Methadone and other pharmacotherapies

In 2009, inmates withdrawing from heroin in Queensland prisons were not offered methadone or buprenorphine nor could inmates commence methadone or buprenorphine treatment in prison.

Female receptions to Queensland prisons were able to remain on methadone and buprenorphine maintenance treatment, dependent on the criteria specified by QCS.²² The policy for continuation of methadone and buprenorphine treatment in prison was the same for male receptions. However, male receptions generally did not continue treatment in prison because the availability of services to male prisoners was severely limited by a lack of resources allocated to pharmacotherapies and by the QCS eligibility criteria.

Inmate programs and counselling services

Data were not provided by QCS. Data available on the QCS website identified two programs that target drug and alcohol problems – Getting SMART: moderate-intensity substance abuse program; and Pathways: high-intensity substance abuse programs (Queensland Corrective Services website).

Drug-free units

Data not provided by QCS.

3.2.2.3 Harm reduction

Harm reduction education programs

Family Planning Queensland was funded by Queensland Health to develop a Correctional Facilities Education Project, which facilitated education for correctional officers and prisoners on blood-borne viruses and sexually transmitted infections. This included some face-to-face training for prisoners, as well as the development and dissemination of resources.

Blood-borne virus testing

In 2007, 100 per cent of Queensland prison receptions were tested for HIV antibody and 0.2 per cent had HIV. Further, 81 per cent of receptions were tested for hepatitis C antibody and 32 per cent of receptions had hepatitis C (National Centre in HIV Epidemiology and Clinical Research, 2010).

Condom provision

Data not provided by QCS.

Disinfectant provision

Data not provided by QCS.

Needle and syringe programs

In 2009, needle and syringe programs were not operating in Queensland prisons.

3.2.3 Re-entry programs

3.2.3.1 Mortality among recently released prisoners

In 2009, no data were available from Queensland Health or Queensland Corrective Services concerning mortality among recently released prisoners. However, one project is currently investigating mortality among released prisoners in Queensland. The Mortality after Release from Custody (MARC) study being undertaken at the University of Queensland aims to explore patterns and predictors of mortality among ex-prisoners in Queensland released between 1994 and 2007. At the time of writing, MARC had identified 2386 deaths among a cohort of 42 024 released prisoners (University of Queensland, 2011).

²² Inmates must be sentenced to less than 12 months or be on remand.

3.2.3.2 *Transitional and pre-release services and programs*

Transitional and pre-release services in Queensland were provided through the Integrated Transitional Support Model (ITSM). Between 1 July 2008 and 26 March 2009, ITSM serviced 2053 prisoners (Queensland Corrective Services, 2009). This model incorporates Transitions: release preparation program and the Offender Re-integration Support Service.

3.2.3.3 *Services and programs to which prisoners are referred upon release*

In the absence of an electronic patient management system, Offender Health Services was unable to provide a consolidated list of referrals upon release. Subject to available services in a geographic location, referral to drug- and alcohol-specific services or programs was normally made to the local hospital alcohol and drug treatment service, to a private opioid treatment provider, or to another local program (Queensland Health, personal communication, 2010).

3.2.3.4 *Referrals to community opioid substitution programs for prisoners upon release*

Queensland Health workers provide referrals to external programs where indicated or requested. No data were available on the number of prisoners referred to community pharmacotherapy upon release in 2009 (Queensland Health, personal communication, 2010).

3.2.4 Research and evaluations

A number of reports and investigations have been conducted including:

- *Sexual Health and Behaviour of Queensland Prisoners: with Queensland and New South Wales comparisons* – National Drug Research Institute (Butler et al., 2010)
- *The Post-release Experience of Prisoners in Queensland* – Australian Institute of Criminology (Kinner, 2006)
- The Passports project is conducting a randomised controlled trial of a health-based post-release intervention for adult prisoners in Queensland (Kinner, Lennox and Taylor, 2009). Baseline data collection was completed on 2 July 2010 with 1328 participants recruited into the cohort (University of Queensland, 2011).

3.2.5 Future directions

If additional resources could be made available, a more comprehensive drug and alcohol program could be introduced and be more on par with services available in the community.

An electronic patient management system similar to that currently used by Justice Health in New South Wales would facilitate the collection and extraction of information on activities currently conducted in Queensland prisons and allow for the development of evidence-based research within the prison system.

3.3 Victoria

3.3.1 Background

Prison population

A total of 4350 prisoners (4068 males and 282 females) were housed in Victorian prisons at 30 June 2009 (Australian Bureau of Statistics, 2009). In 2008–09, Victorian prisons received 5626 prisoners.

Inmates were housed across 13 prisons, two privately operated (Port Phillip Prison and Fulham Correctional Centre) and 11 publicly operated locations. A transitional facility – the Judy Lazarus Transition Centre – provided intensive transitional support for up to 25 low-risk male prisoners with identified re-integration needs. In 2009, Port Phillip Prison was operated by G4S Australia Pty Ltd and Fulham Correctional Centre by the GEO Group Australia Pty Ltd (Victoria Department of Justice website).

Health service provision

The Justice Health Unit of the Victorian Department of Justice is responsible for planning, coordination and contract administration of health services delivered in Victorian prisons. Health services in Victoria's publicly and privately operated prisons are delivered by third-party providers.

- St Vincent's Correctional Health Services, under contract to G4S, provides primary health care, outpatient mental health services and statewide secondary inpatient mental health services (through St Paul's Psycho-social Unit) at Port Phillip Prison. St Vincent's Correctional Health Services, under contract to G4S, is also responsible for secondary statewide inpatient health care services delivered at St John's at Port Phillip Prison as well as

secondary and tertiary outpatient services from St Vincent's Hospital.

- Pacific Shores Health Care (a subsidiary of GEO) provides primary health care and mental health services at Fulham Correctional Centre.
- St Vincent's Correctional Health Service provides primary health care at Marn-goneet Correctional Centre and the Metropolitan Remand Centre.
- Pacific Shores Health Care (a subsidiary of GEO) provides primary health care at the remaining nine public prisons.
- Forensicare provides psychiatric health care services, including the management and provision of services within the Acute Assessment Unit at the Melbourne Assessment Prison.

Prison capacity

In 2009 the utilisation rate of Victorian prisons was not reported by the Steering Committee for the Review of Government Service Provision (2010). However, the *Statistical Profile of the Victorian Prison System 2004–05 to 2008–09* reported that the utilisation rate of Victorian prisons in 2009 was 92.1 per cent (Corrections Victoria, 2009).

3.3.1.1 Drug use by prisoners

Licit drug use – tobacco and alcohol

Smoking levels among prisoner populations are significantly higher than in the general population. In Victoria, there are programs or interventions in place to assist prisoners to give up smoking. These interventions include: education and communication campaigns; increasing the cost of tobacco; limiting places where prisoners can smoke; nicotine replacement therapy; and cessation (Australian Institute of Health and Welfare, 2010).

According to the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey 2007, 83 per cent of prison entrants in the Victorian sample reported being current smokers. A breakdown by injecting drug user (IDU) status showed that, among IDUs, 95 per cent were current smokers compared to 68 per cent of non-IDUs (Butler and Papanastasiou, 2008).

In 1998, Quit Victoria partnered with Corrections Victoria to develop a smoking cessation program specifically designed to meet the needs of prisoners. The program was entitled 'Quitters are Winners'. The program evaluation found that, of prisoners who completed the Quitters are Winners course (n=181), 25 per cent had quit at one-month follow-up and 14 per cent had quit at three-month follow-up. While 90 per cent of those still smoking reported a reduction in cigarette consumption at one-month follow-up, 72 per cent had reduced consumption at three-month follow-up (McCarthy and Brewster, 2009).

In 2003, the Victorian Prisoner Health Study found 50 per cent of prisoners wanted to address their smoking, drinking, drug or gambling problems (Deloitte Consulting, 2003). However, prisoners face barriers that prevent them from quitting, including: a strong smoking culture in prison; high levels of nicotine dependence; mental illness; limited access to nicotine replacement therapy and cessation programs; boredom; and stressful events such as prison transfer, family and legal stressors (McCarthy and Brewster, 2009).

Alcohol consumption figures for 2009 were unknown.

3.3.2 Drug strategies

The National Corrections Drug Strategy 2006–2009 describes the principles that should guide and inform drug policy within prison settings. This policy works within a harm minimisation approach, expressed by the three key areas of supply, demand and harm reduction.

Similarly, at the state level, Victoria has had a specific drug strategy for its prisons since 1992. The Victorian Prison Drug Strategy was last updated in 2002 (Corrections Victoria, 2002). The strategy recognised that: 'It is virtually impossible to stop drug use entirely and that prisoners enter the system with existing and entrenched drug use behaviours' and identified drug use as the 'single largest factor affecting the lives of prisoners' (Corrections Victoria, 2002: iv). The Victorian Prison Drug Strategy 2002 seeks to improve ways of keeping drugs out of prison (through illicit drugs supply control, detection and deterrence strategies) and to reduce prisoner drug use (through treatment and health and safety initiatives).

3.3.2.1 Supply reduction

In 2009, barrier control and detecting measures were used to minimise the introduction of drugs into Victorian prisons. Drug detection dogs, searches (e.g. cell, area, property, prisoners and visitors), metal detectors and urinalysis testing all formed part of Victoria's supply reduction strategy (Justice Health, 2011). The use of drug detection dogs and searching were the most frequently used supply reduction measures across all Victorian public prisons in 2009. Table 3.3.1 presents the total number of visitors and staff screened by supply reduction measure.

Table 3.3.1: Supply reduction measures in Victoria’s public prisons, 2009

Supply reduction measure	Number of visitors screened	Number of staff screened
Searches of bags and possessions	2325	1165
PAD dog searches	12 215	120
Pat-downs	32	Data not collected
Strip searches	79	0

Source: Justice Health (2011)

Drug detection dogs

Passive alert detection (PAD) dogs were used in Victorian prisons to assist with searching. Drug detection dogs are trained to identify illegal drugs on people and property. PAD dogs are currently being trained to detect buprenorphine. In 2009, a total of 1895 prisoner searches were conducted by Security and Emergency Services Group (SESG) and prison staff across Victorian prisons.

Between 1 December 2010 and 31 January 2011, there were 9257 searches, including cell searches, undertaken at the Dame Phyllis Frost Centre, 3710 at Fulham Correctional Centre, and 3085 at Port Phillip Prison (Victoria Legislative Assembly, 2011). The Hon. Andrew McIntosh, Victorian Minister for Corrections, reported to the Victorian Legislative Assembly that there were no data available for the number of times dog squads had been involved in contraband searches at any of the three prisons.

Urinalysis programs

According to Corrections Victoria (cited in Victorian Ombudsman, 2008: 26), the urinalysis program across Victorian prisons consists of the following:

- Random general – random urinalysis testing consists of a sample of 5 per cent of the prison population and is determined by a computer-generated list

- Random identified drug users (IDU) – re-testing each week of those prisoners known to have used drugs in prison
- Drug-free Incentive Program – the mandatory testing component of those prisoners seeking to remove their IDU status under the Prison Drug Strategy
- Reception – obtaining benchmark samples from newly received prisoners
- Targeted – where a prisoner is suspected of using drugs following an incident where drug use may have been involved, or after unescorted leave from prison
- Program – testing of prisoners undertaking drug and alcohol treatment programs
- ‘Voluntary’ testing – where prisoners undertake regular testing as a condition of being considered for parole or because of a court order, or to satisfy the Victorian Department of Human Services in relation to the custody of children.

In 2009, 5444 prisoners were randomly tested and 15 155 were tested as part of the targeted testing program. On average, Victorian prisoners undergo urinalysis testing nine times per year (Victorian Ombudsman, 2008). While no data were made available regarding positive results from urinalysis testing across all Victorian prisons, Table 3.3.2 shows the number of tests and results undertaken at the Dame Phyllis Frost Centre (455 tests), Fulham Correctional Centre (792 tests) and Port Phillip Prison (513 tests).

Table 3.3.2: Urinalysis testing in three Victorian prisons, 1 December 2010 – 31 January 2011

Urinalysis test	Dame Phyllis Frost Centre		Fulham Correctional Centre		Port Phillip Prison	
	No. tests	Positive results	No. tests	Positive results	No. tests	Positive results
Random general	59	0	104	1	80	4
Random identified drug users	17	5	32	3	55	9
Drug-free Incentive Program	35	5	69	2	123	7
Reception	75	9	0	0	5	1
Targeted	137	15	503	34	250	35
Program	102	0	84	0	0	0
'Voluntary' testing	30	0	0	0	0	0

Source: Adapted from Victoria Legislative Assembly (2011)

Targeted testing yielded the most positive results across the three prisons but it also accounted for the most tests undertaken at each prison. Positive tests identified illicit use of the following substances: amphetamines, cocaine, benzodiazepines, cannabinoids, methadone, anti-psychotics, buprenorphine, non-opiate analgesic and anti-depressants.

Drug seizures within prisons

Cannabis and white powder were found 106 times by SESG, prison staff and/or drug detection dogs in 2009. Table 3.3.3 presents the quantities of drugs and drug paraphernalia detected across Victorian prisons in 2009.

Table 3.3.3: Paraphernalia and quantities of drug detected, by type, 2009

Drug type	Male prisons	Female prisons
White powder (grams)	129.05	12.67
Green vegetable matter (grams)	18.9	0
Tablets (prescription medication measured in tablets)	775.75	147
Syringes (numbers)	112	14

Source: Justice Health (2011)

On 26 May 2011, the Hon. Andrew McIntosh reported to the Victorian Legislative Assembly that between 1 December 2010 and 31 January 2011 a total of 95 contraband items were seized from three Victorian prisons (Dame Phyllis Frost Centre, Fulham Correctional Centre and Port Phillip Prison). Contraband seized from prisoners across the three prisons

included: syringes (8), knives (24), batons (4), smoking implements (4) and tool items (3) (Victoria Legislative Assembly, 2011).

Table 3.3.4 presents data regarding drugs seized from both visitors and prisoners in Victorian prisons. However, the data are limited to three prisons.

Table 3.3.4: Drugs seized from three Victorian prisons, 1 December 2010 – 31 January 2011

Contraband	Dame Phyllis Frost Centre		Fulham Correctional Centre		Port Phillip Prison	
	Visitors	Prisoners	Visitors	Prisoners	Visitors	Prisoners
Alcohol	3	3	1	0	0	5
Cannabinoids	0	0	0	0	1	0
White powder	1	0	0	0	0	4
Prescription medication	0	4 (10.4 tablets)	0	6 (10 tablets)	3 (6 tablets)	14 (26 tablets)
Total	4	7	1	6	4	23

Source: Adapted from Victoria Legislative Assembly (2011)

3.3.2.2 Demand reduction

The forms of demand reduction used in Victorian prisons are detoxification, substitution therapy, inmate programs and counseling services.

Detoxification

Black, Dolan and Wodak (2004) reported that in 2003 there were no specific detoxification units or programs operating in Victorian prisons. Treatment was dependent on symptoms and hospitalisation was available to prisoners experiencing complications.

Methadone and other pharmacotherapies

Methadone programs have been available on a limited basis in Victorian prisons since the late 1980s. In 2003, the Victorian Department of Justice reported that the methadone program in Victorian prisons would be expanded by increasing methadone services and the introduction of buprenorphine (subutex).

The policy proposed that prisoners would be able to continue their community treatment or commence treatment for the length of their prison sentence. However, methadone and buprenorphine were not to be used for detoxification purposes (Victoria Department of Justice, 2003). Since then, there has been a significant increase in demand for an opioid substitution therapy program (OSTP) with a growth from just over 21 000 doses given in July 2009 to nearly 24 000 in June 2010. Methadone in a liquid form remains the most commonly used OSTP agent (over 87% of doses) followed by suboxone (12%). There were only 11 doses of buprenorphine reported across the system in 2009–10. The daily average number of OSTP treatment places was 639 in June 2009 (Justice Health, 2011).

Inmate programs and counselling services

In the first report in this series, released in 2004, Black, Dolan and Wodak reported that programs available in Victorian prisons included: assessments; substance awareness/orientation; moderate intensity programs (1–40 hours); semi-intensive programs (40 hours); intensive programs (120+ hours); and harm reduction programs. Prisoner enrolment numbers in these programs were also provided to Black, Dolan and Wodak (2004) for two years: 2001–02 and 2002–03.

In 2009, the Victorian AOD programs' service delivery framework comprised two streams: a health stream and a criminogenic stream across five program levels. Table 3.3.5 describes the framework. However, no data on extent of access, availability and completion of programs were made available as of September 2011.

Drug-free units

Victoria operated a therapeutic community (Station Peak, located at Marngoneet Correctional Centre), which was under evaluation at the time of the study.

No data for 2009 had been made available as of September 2011. No other publicly available data were identified.

Table 3.3.5: Victorian prisons AOD service delivery framework

Program level	Assessed level	Equivalent program in framework	Program aims	Transitional Related Substance Abuse Services Target: All patients/clients in prison receive prior to release. Description: Brief intervention, criminogenic programs. Pre-release support, e.g. referrals to community agencies. Program aims: To reduce the harms caused by substances post-release and to prepare patients/clients for release.
Level 1	All patients/clients in prison	Prison-related harm reduction	To reduce the harms caused by substance use	
Level 2	All patients/clients in prison	Brief interventions Non-criminogenic treatment programs	To increase motivation to engage in a treatment program	
Level 3	Intermediate intensity (psychological dependence and/or low-to-medium risk of re-offending)	12-24-hour cognitive behavioural substance use programs 24-hour alcohol only program	To reduce the frequency of intensity of substance use	
Level 4	Moderate intensity (psychological and physiological dependence and moderate-to-high risk of re-offending)	24-40-hour non-residential drug treatment program 24-hour alcohol only program	To reduce substance-related re-offending	
Level 5	High intensity (high levels of dependence and moderate-to-high risk of re-offending)	Residential treatment <ul style="list-style-type: none"> • therapeutic community • unit-based 	To reduce substance-related re-offending	

Source: Justice Health (2011)

3.3.2.3 Harm reduction

Harm reduction education programs

In the previous report, released in 2004, Black, Dolan and Wodak reported that 400 additional places in harm reduction programs had been made available across the Victorian prison system. In 2009, all prisoners entering the Victorian prison system had to attend a prison-related harm reduction program within 10 business days of their reception (Justice Health, 2011).

No data were provided regarding availability and extent of access to harm reduction education programs in Victorian prisons for 2009.

Blood-borne virus testing

Testing for blood-borne viruses is voluntary in Victorian prisons. Figures of uptake for 2009 were not provided as of June 2011.

In 2007, as part of the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey, prison receptions at the Dame Phyllis Frost Centre and the Melbourne Assessment Prison were tested for HIV, hepatitis B and hepatitis C. The results are shown in Table 3.3.6.

Condom provision

In 2009, condoms were available in some Victorian prisons for prisoners participating

in the residential visits program. No data were provided regarding the extent of availability of condoms in Victorian prisons.

The Victorian Department of Justice announced in May 2011 that condoms (in two male prisons) and dental dams (in the two women's prisons) would be made available. Further availability in the remaining male prisons would be informed by implementation at the first two sites.

No other publicly available data were identified.

Disinfectant provision

Black, Dolan and Wodak (2004: 57 citing personal communications with Corrections Victoria) reported that, according to procedure, 'all prisoners should be given easy access to powdered bleach sachets in a manner that minimises the likelihood that they will be targeted as drug users'.

No data were provided regarding availability and distribution of disinfectant in Victorian prisons for 2009.

No other publicly available data were identified.

Needle and syringe programs

In 2009, no needle and syringe programs were in operation in Victorian prisons.

Table 3.3.6: Results of blood-borne virus tests, Victorian prison entrants, 2007

Virus	Number tested	Positive results (%)	Positive results (n)
Hepatitis B	115	27	23
Hepatitis C	119	49	41
HIV	117	0	0

Source: Butler and Papanastasiou (2008)

3.3.3 Re-entry programs

3.3.3.1 Mortality among recently released prisoners

Data about mortality among recently released prisoners are not routinely collected in Victoria. No studies investigating mortality among recently released prisoners since 2004 were identified.

Graham (2003) – a study investigating the prevalence of unnatural death among Victorian prisoners released from prison between 1990 and 1999 by linking prisoner information with coronial data. A total of 820 unnatural deaths were identified among the 25 429 individuals released over that period, averaging 82 unnatural deaths per year. Of these, 51.4 per cent were heroin-related deaths and 7.8 per cent were drug-related, but not associated with heroin. Heroin-related deaths were more common among women (70.2%) than men (48.2%). The study also reported that a high proportion of these deaths occurred in the first week (9.4%) and month (15.5%) after release.

The study reports that unnatural death was 10 times more likely to occur among released prisoners over the study period than in the general community. Risk of unnatural death did not differ between Indigenous and non-Indigenous ex-prisoners.

3.3.3.2 Transitional and pre-release services and programs

This section on transitional and pre-release services has been informed by resources available on the Victorian Department of Justice website.

Pre-release planning process begins six to eight weeks prior to the discharge date. This process involves the prisoner meeting with a nominated officer to address identification, accommodation, finances, employment, and

legal and medical issues. Information regarding drug and alcohol treatment options in the community is available to prisoners, with a focus on harm minimisation. Prisoners are provided with literature on tolerance levels. For those prisoners being released on probation or any instance where a treatment order is involved, an appointment for pre-release drug and alcohol assessment is made, and follow-up appointments arranged with the prisoner.

Getting Started: a guide to getting out is a handbook commissioned by Corrections Victoria and developed by the Victorian Association for the Care and Resettlement of Offenders (VACRO), consisting of a series of 10 booklets and five fact sheets. The handbook provides information about support services to prisoners preparing for and experiencing transition from custody to the community. It includes information about housing and accommodation, getting around, dealing with community and government agencies, re-uniting with family members, as well as a pre-release planner and day-of-release planning for prisoners.

Transition assistance program involves a series of pre-release information sessions, available in all Victorian prisons, to help prisoners prepare for release. The program gives prisoners tips and information about Centrelink, accommodation, drug and alcohol treatment services, employment services, legal support and Community Correctional Services.

Judy Lazarus Transition Centre in West Melbourne is a transition centre for men managed by the Department of Justice through Corrections Victoria, with a capacity of 25 beds. The transition program is based on an intensive case management model that includes risk/needs assessment, individual management planning and review, and exit planning. Case management addresses offending behaviour and successful re-integration into the community.

Women's Integrated Support Program (WISP) is a program delivered by Melbourne Citymission, the Brosnan Centre and VACRO. WISP is an initiative under the Corrections Victoria Better Pathways strategy. WISP is an intensive pre- and post-release support program offering case management to women exiting Victorian prisons. Support commences 8–10 weeks prior to release and can be maintained for up to 12 months post-release.

Link Out is a voluntary outreach support program for sentenced male prisoners released from prison. It provides release plans covering: accommodation; drug and alcohol treatment; medical and psychiatric treatment; legal issues; assistance on the day of release; finances; employment; education; and family and relationship issues. Post-release support is provided to released prisoners by the Link Out case manager who meets with released prisoners in the community regularly over the immediate post-release period, and less often after that for up to 12 months.

Corrections Victoria Housing Project is a partnership between Corrections Victoria, the Office of Housing and community-based housing and support services. The program facilitates pre- and post-release services by connecting each person with medium- to long-term (supported) housing, education, training and employment assistance, family counselling and basic living skills.

Konnect – Koori Transitional Support Program provides intensive pre- and post-release support to Koori men and women exiting prison. Konnect is an initiative under the Victorian Aboriginal Justice Agreement. It provides case management and addresses the needs of Koori prisoners, including appropriate housing, substance abuse, employment, health, life skills, reconnection to family/community, social connectedness and education.

3.3.3.3 Services and programs to which prisoners are referred upon release

No data were provided regarding services to which prisoners are referred upon release, as of June 2011. Some post-release services are funded under the Pip Wisdom Community Corrections Grants.

Pip Wisdom Community Corrections Support Program offers three-year grants to non-government organisations towards funding the delivery of support services, including accommodation, to prisoners, offenders and their families.

3.3.3.4 Referrals to community opioid substitution programs for prisoners upon release

The *Victorian Prison Opioid Substitution Therapy Program 2003: clinical and operational policy and procedures* stipulates that transfer of a prisoner to a community pharmacotherapy program should include the following steps:

- prison health staff to arrange pre-release discharge planning
- confirm referral to community program prior to release to the community
- ensure prisoner receives community referral details in the weeks leading up to release from prison.

In 2006, the post-release pharmacotherapy dispensing subsidy pilot began and involved the Department of Justice paying the dispensing fee for prisoners for four weeks post-release. The rationale was to increase adherence to the program by removing the financial cost of treatment for recently released prisoners.

In 2009, approximately 706 people were engaged in the post-release pharmacotherapy dispensing program, while close to 20 000 doses were subsidised by the Department of Justice in the same year.

3.3.4 Research and evaluations

A number of reports have been published which include data on drug use, drug strategies and related issues. These include:

- *Acquired Brain Injury in the Victorian Prison System* (Jackson, Hardy, Persson and Holland, 2011)
- *Evaluation of the 'Quitters are Winners' Course: a prison-based cessation program* (McCarthy and Brewster, 2009)
- *Investigation into Contraband Entering a Prison and Related Issues* (Victorian Ombudsman, 2008)
- *Victorian Prison Opioid Substitution Therapy Program 2003: Clinical and Operational Policy and Procedures* (Corrections Victoria, 2003).

The National Prisoner Health Census 2009 reported that the availability of condoms in Victorian prisons was under review. No further information was provided about the review.

Findings from these research investigations, inquiries and reports have been discussed throughout this chapter where appropriate.

3.3.5 Future directions

In 2011, Victoria introduced condoms into two male prisons (Marnongeeet and Dhurringile) and dental dams into the women's prison system (the Dame Phyllis Frost Centre and Tarrengower Prison). This first-stage introduction will be independently evaluated and the findings used to inform further implementation into the rest of the male prison system in 2012.

Victoria is also developing a new communicable diseases policy which will guide future activities in relation to health promotion and prevention, treatment and harm minimisation especially concerning communicable diseases (specifically blood-borne viruses and sexually transmissible infections).

3.4 Western Australia

3.4.1 Background

Prison population

On 30 June 2009, there were 4419 full-time adult prisoners (4078 males and 341 females) in custody in Western Australia. Inmates were housed in 14 prisons, of which 13 were public and operated by the Western Australian Department of Corrective Services (WADCS). The one private prison (Acacia Prison) was operated by Serco (Western Australia Department of Corrective Services website).

Health service provision

All prisons have an on-site health centre managed by either WADCS or Serco in the case of the private prison.

A total of 28.5 full-time equivalent (FTE) health services staff were employed in Western Australian prisons in 2009, including:

psychiatrists; medical officers; mental health nurses; AOD clinicians; and group workers. Health services staff provided both AOD and mental health services to inmates. Furthermore, 107.6 FTE comprising senior program officers, program officers, prison counsellors, clinicians, psychologists and social workers were employed. These staff provided AOD programs and counselling in addition to violent and sex offender services.

Prison capacity

In 2008–09, Western Australian prisons had a design capacity of 3433 and were operating at 116.9 per cent of the total design capacity. The optimum rate of prison utilisation is 85–95 per cent of the design capacity. This allows some flexibility to cater for prisoners with special needs (e.g. protection, hospital and varying security levels). Western Australian prisons were operated at 21.9 per cent over the optimum rate (Steering Committee for the Review of Government Service Provision, 2010).

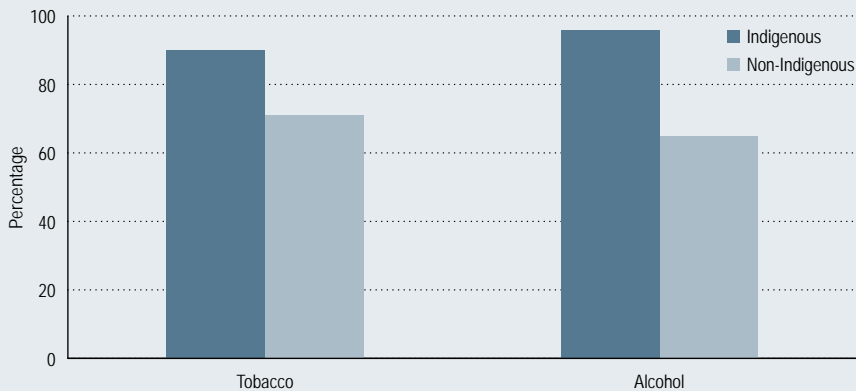


Figure 3.4.1: Smoking and hazardous drinking, by Indigenous status

Source: Adapted from Gilles et al. (2008): 550

3.4.1.1 Drug use by prisoners

Licit drug use – tobacco and alcohol

According to the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey 2007, 81 per cent of the Western Australian sample reported being a current smoker. Furthermore, 33 per cent of IDUs and 41 per cent of non-IDUs were smoking 11 to 20 cigarettes a day (Butler and Papanastasiou, 2008; Gilles et al., 2008).

High levels of hazardous drinking in the 12 months prior to incarceration were also reported by Gilles et al. (2008). Figure 3.4.1 shows the distribution of self-report tobacco and alcohol use among Western Australian prisoners. Data are presented by Indigenous status. The figure shows that smoking and hazardous drinking occur in higher levels among Indigenous than among non-Indigenous prisoners.

Illicit drug use

The Drug Use Careers of Offenders Study, which was conducted in 2000, surveyed the drug histories of sentenced adult male prisoners in Western Australia. Results showed that 80 per cent of prisoners had a history of regular illicit drug use and 50 per cent reported a high level of drug dependence (Makkai and Payne, 2003).

A more recent study found that 45 per cent of 146 prisoners reported using drugs in prison. Of those reporting drug use while in prison, 21 (over 30%) reported that the last time they injected was in a prison setting (Kraemer, Gately and Kessel, 2009). A cross-sectional audit of all medical notes for inmates at one regional prison in Western Australia found that 57 per cent of inmates had documented evidence of illicit drug use in their lifetime (Gilles et al., 2008).

3.4.2 Drug strategies

3.4.2.1 Supply reduction

In 2009, the main forms of supply reduction used in Western Australia were drug detection dogs, urinalysis, searches (e.g. bag searches and pat-downs) and metal detectors.

Drug detection dogs

In 2009, a total of 4807 searches were undertaken by drug detection dogs in Western Australian prisons. On 721 occasions dogs indicated illicit drugs. Drugs detected included 30 quantities of green vegetable matter, six tablets and one quantity of powder.

Urinalysis programs

In 2009, Western Australia's urinalysis program consisted of random and targeted testing. The drug prevalence testing regime (DPT) is the random urinalysis program used in Western Australian prisons. DPT was developed following recognition that better quality, statistically valid data were required to assist with analysis of illicit drug prevalence in the Western Australian prison population. The Australian Bureau of Statistics (Western Australian offices) was commissioned to provide statistical advice to facilitate the process. The DPT regime has been in operation in Western Australian prisons since 2005. In 2007, the Australian Bureau of Statistics reviewed the programming code used by WADCS to calculate estimates and found that all the estimates, standard errors and confidence intervals were appropriately matched.

As part of the DPT, 2342 random urinalysis tests were conducted in 2009. A further 10 546 tests were conducted as part of the targeted testing program. Table 3.4.1 lists the number of positive results by drug type. In 2009, cannabis was the most commonly detected drug.

Table 3.4.1: Positive results by drug type for urinalysis tests in WA prisons

Drug	Random urinalysis tests n (%)	Targeted urinalysis tests n (%)
Alcohol ²³	–	22 (0.2)
Heroin	3 (0.1)	205 (1.9)
Amphetamines	3 (0.1)	56 (0.5)
Cannabis	223 (9.5)	1611 (15.2)
Cocaine	–	–
Other	6 (0.2)	512 (4.9)
Total tests	2342	10 546

Source: Western Australia Department of Corrective Services, personal communication, 2010

Drug seizures within prison

A total of 203 098 visitors were screened through metal detectors and 11 179 were subjected to searches (e.g. pat-downs and bag searches). In 2009, 49 403 inmates were screened through searches, including pat-downs, cell searches and bag searches.

General searches in 2009 yielded a total of 130 syringes. Breakdown by gender was not provided. No further information was provided on other types of contraband that may have been found.

The total number of interdictions was 2341 for both visitors and prisoners.

3.4.2.2 Demand reduction

Detoxification

In 2009, of 7394 prison receptions in Western Australia, 947 (12%) experienced withdrawal symptoms. Self-reported evidence

shows that non-Indigenous men and women were most likely to be withdrawing from opioids. Indigenous men and women were most likely withdrawing from alcohol and amphetamines/prescription drugs, respectively.

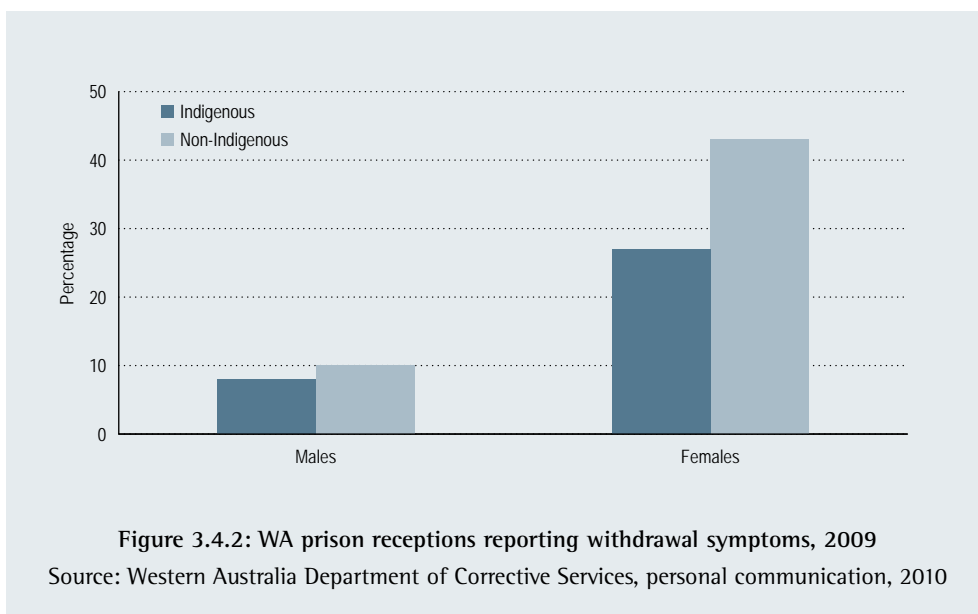
Figure 3.4.2 shows the percentage of prison receptions experiencing withdrawal, by gender and Indigenous status.

Offenders withdrawing from opioids were offered symptomatic withdrawal management using clonidine, diazepam and maxolon. Inmates withdrawing from stimulants were offered olanzapine and/or diazepam. Inmates withdrawing from alcohol or benzodiazepines were offered diazepam and/or thiamine.

Methadone and other pharmacotherapies

Prison receptions were permitted to remain on methadone maintenance treatment and buprenorphine maintenance treatment. However, women prisoners had to meet special

²³ DPT data do not give returns for alcohol and cocaine.



criteria to remain on buprenorphine. Health Services staff with responsibility for comorbidity provided methadone and buprenorphine maintenance treatment in Western Australian prisons in 2009. Table 3.4.2 presents the number and percentage of individuals registered on the prison pharmacotherapy program in 2009.

In 2009, both men and women were also able to commence methadone or buprenorphine maintenance treatment in Western Australian prisons. Inmates were able to commence on the following treatment plans: methadone only; buprenorphine–naloxone (suboxone) only; but could not generally commence on buprenorphine (subutex) only.

Table 3.4.2: Individuals registered on the WA prison pharmacotherapy program, 2009

Pharmacotherapy	Total males	Total females
Methadone	347 (5%)	67 (7%)
Subutex (buprenorphine)	4	1
Suboxone (naloxone)	54 (1%)	5 (1%)
Total all programs	405 (6%)	73 (8%)

Table 3.4.3: Treatment programs and services in WA prisons provided by external service providers, 2009

Name of program	Individuals participated/completed program (n)
Moving on from Dependencies	237
Pathways	130
Indigenous Men Managing Anger and Substance Abuse (IMMASU)	174
Women's Substance Use (*Greenough Prison)	42
Green Lighthouse (*Acacia Prison only)	207
Drug Recovery Program (*Acacia Prison only)	29
Brief Intervention Service (*Hakea and Bandyup prisons only)	411
Drug & Alcohol Through-care Service (DATS)	358

Source: Western Australia Department of Corrective Services, personal communication, 2010

Inmate programs and counselling services

Several programs in 2009 were provided in partnership with external organisations. These include: Drug and Alcohol Through-care Services (DATS); Pathways; Brief Intervention Service; and Indigenous Men Managing Anger and Substance Use (IMMASU). In 2009, a total of 319 males and 34 females participated in Pathways and Moving on from Dependencies. Table 3.4.3 lists the range of drug- and alcohol-related programs and services available to inmates in Western Australian prisons and the number of inmates who attended programs in 2009. Brief Intervention Service and Moving on from Dependencies were the most readily attended programs in 2009.

Drug-free units

In 2009, drug-free units were in operation in Western Australia. Drug-free units were available at Wooroloo, Albany, Bandyup and Acacia prisons. The units attempt to provide a drug-free environment for prisoners.

3.4.2.4 Harm reduction

Harm reduction education programs

A mandatory education program called HIP HOP, covering blood-borne viruses, sexually transmissible infections and harm minimisation practices, is run in all adult prisons. The HIP sessions are delivered to all new prison entrants within two weeks of reception. The HOP sessions are delivered to all prisoners within three months of their earliest release date, unless it has been less than six months since they completed the HIP session. This program is delivered by an external agency in all prisons (Western Australia Department of Corrective Services, personal communication, 2010).

Any data on the number of inmates who had received drug education could not be provided. There was no single data source that captured prisoners receiving drug education in Western Australian prisons. Drug education within Western Australian prisons included prisoner induction and brief intervention

services. Comorbidity staff, program officers and a range of external service providers delivered drug education and awareness, health promotion and resources with the aim of reducing or ceasing drug use.

Harm reduction education was provided by WADCS to a total of 4050 inmates (3533 males and 517 females) in 2009. Of these, 1114 were Indigenous prisoners.

Blood-borne virus testing and vaccination

WADCS Health Services has a policy of offering STI and BBV screening to all prisoners within one month of incarceration. Hepatitis B vaccine was offered to all prisoners and hepatitis A vaccine was offered to all hepatitis B carriers and hepatitis C positive prisoners.

Findings from the audit by Gilles et al. (2008) reported that 79 per cent of prisoners in the sample had been screened for HIV, 84 per cent for hepatitis B (immunity or infection) and 82 per cent for hepatitis C infection.

Condom/dental dam provision

In 2009, condoms and dental dams were provided in Western Australian prisons. Figures on the number distributed were not available.

Disinfectant provision

No data were available.

Needle and syringe programs

Needle and syringe programs were not available within Western Australian prisons in 2009.

Table 3.4.4: Results for blood-borne virus tests in WA prisons, 2009

Virus	Positive results (n)	Positive results (%)
Hepatitis B	6	3.9
Hepatitis C	13	8.7
HIV	0	0

Source: Adapted from Gilles et al. (2008): 551

3.4.3 Re-entry programs

3.4.3.1 Mortality among recently released prisoners

Western Australia has a data-linkage system whereby data are routinely collected linking justice data with medical data for the entire Western Australian population. This system can identify mortality after release from prison. In 2009, two male prisoners (one Indigenous, one non-Indigenous) died within three months of release. One death was attributed to heart attack and the other cause was unknown (Western Australia Department of Corrective Services, personal communication, 2010). Since the previous ANCD prison report (Black, Dolan and Wodak, 2004), four studies have investigated mortality among released prisoners in Western Australia. Collectively these describe a population at substantially elevated risk of death due to alcohol and drug use, which is greatest in the weeks immediately following release from prison.

Hobbs, Krazlan, Ridout, Mai, Knuiman and Chapman, 2006 – This study investigated mortality and morbidity in a cohort of 13 667 prisoners released from Western Australian prisons between 1995 and 2003 within five years of release. It reports SMRs for mortality resultant from alcohol and other drug dependence and from accidental poisoning. Accidental poisoning includes drug overdose. A total of 481 deaths among the cohort were identified, equating to an average of 69 deaths per year. Of these, 13.9 per cent were due to the effects of alcohol and other drug dependence and 11.6 per cent were due to accidental poisoning (Hobbs et al., 2006).

The study also compared the distribution of alcohol, drug dependence, injury and poisoning across three intervals from time

of release: 0–6 months; 6 months–1 year; and more than 1 year. Findings showed that crude death rates after release vary inversely with time from release. All-cause mortality rates in the first and second period were 3.6 times (19.9 crude death rate) and 1.9 times (10.5 crude death rate), respectively, greater than the rate after one year, which was 5.6 (Hobbs et al., 2006).

Merrall, Kariminia, Binswanger et al., 2010 – This meta-analysis of six studies reporting SMRs for drug-related mortality among recently released prisoners in six prison systems included the Western Australian cohort used in the study by Hobbs et al. (2006). The Merrall et al. study reports the relative risk of drug-related deaths at different intervals, up to 12 weeks post-release (weeks 1–2; weeks 3–4; weeks 5–12; and weeks 3–12). The risk of drug-related death among the Western Australian cohort was greatest in the first two weeks post-release. Drug-related deaths were 4.4 times and 4.8 times more likely to occur in the first two weeks post-release than in weeks 3–12 and 5–12 post-release, respectively (Merrall et al., 2010).

Table 3.4.5: Relative risk of drug-related death in a WA cohort of ex-prisoners

Week	Relative risk
In weeks 1–2 versus weeks 3–12	4.4
In weeks 1–2 versus weeks 5–12	4.8
In weeks 3–4 versus weeks 5–12	1.4

Source: Merrall et al. (2010): 1551

Preen and Hobbs, 2009 – This study investigated factors associated with mortality among prisoners released from Western Australian prisons from 1994 to 2004. Ex-prisoners had significantly higher mortality than the general population, the largest differences were observed in women, those under 30 years of age and Indigenous people. Especially notable was a 12-fold risk of death in female non-Indigenous prisoners aged 20–39 years compared with their community counterparts. Sixty per cent of all deaths were due to injury or poisoning, and mortality was fourfold higher in the first six months post-release than after one year (Preen and Hobbs, 2009).

Multivariate analysis identified an increased likelihood of death for ex-prisoners of lowest, compared with highest, socioeconomic status. Repeat offenders had a decreased risk of death in the 12 months post-release; prisoners incarcerated five or more times were half as likely to die as first-time releasees. Type of offence was also a significant predictor of post-release mortality, with violent offenders 9.6–47.9 times more likely to die within 12 months of release than other ex-prisoners (Preen and Hobbs, 2009).

Stewart, Henderson, Hobbs, Ridout and Knui-man, 2004 – This study compared the risk of death in a cohort of 9831 prisoners released from Western Australian prisons between January 1994 and January 2004 within a median of 1223 days post-release. A total of 326 deaths were identified, equating to an average 33 deaths per year over the study period. Alcohol- and drug-related deaths accounted for 39 per cent of deaths among

non-Indigenous prisoners and 12 per cent among Indigenous prisoners. When controlled for Indigenous status and gender, non-Indigenous women were at the greatest elevated risk of drug- and alcohol-related deaths. Non-Indigenous women were 115.9 times more likely, and non-Indigenous men were 20.1 times more likely to die from drugs or alcohol, while Indigenous women were 3.3 times more likely, and Indigenous men were 2.9 times more likely to die than non-Indigenous men and women (Stewart et al., 2004).

3.4.3.2 Transitional and pre-release service

The WADCS Re-Entry Program supports offenders pre- and post-release, and includes life skills information sessions, transitional planning and support, and outreach support services. It is a service provided by external community agencies statewide. Although no specific drug and alcohol interventions were provided by the agencies, referrals to community drug agencies can be made (Western Australia Department of Corrective Services, personal communication, 2010).

In the 2008–09 financial year, 1803 prisoners were seen while in custody: 1603 males and 200 females; 1055 Indigenous and 748 non-Indigenous. A further 645 who had been released from custody were also served. Of these, 548 were males and 105 females (310 Indigenous and 343 non-Indigenous) (Western Australia Department of Corrective Services, personal communication, 2010).

Table 3.4.6: Services and programs available to WA inmates upon release

Drug- and alcohol-specific service or program	Organisation running the service or program
Community program for opioid pharmacotherapies	WA Drug and Alcohol Office
Private pharmacotherapy services	Independent providers
Community Drug and Alcohol Services	Non-government providers
Community Mental Health Services State Forensic Mental Health Services	WA Department of Health
Residential rehabilitation providers Next Step Community Pharmacotherapy Outpatient Program Community drug service teams	Non-government providers
WA Network of Alcohol and Drug Agencies Drug & Alcohol Through-care Service (DATS)	

Source: Western Australia Department of Corrective Services, personal communication, 2010

3.4.3.3 Services to which prisoners are referred upon release

A list of the range of services and programs that Western Australian prisoners were referred to upon release in 2009 is presented in Table 3.4.6.

Drug and Alcohol Through-care Service

Through-care for prisoners being released with drug and alcohol problems is provided in all metropolitan prisons by the Drug and Alcohol Through-care Service (DATS). The service is

run by Cyrenian House, a non-government organisation that provides both residential and non-residential AOD services in Western Australia. DATS includes assessment, counselling and the development of relapse prevention plans for prisoners in custody. Post-release programs include educational and therapeutic interventions, subject to the conditions of referral. In 2008–09, DATS supported 358 prisoners. In 2009–10, DATS supported 243 prisoners pre-release and 45 prisoners post-release (Cyrenian House, 2010).

3.4.3.4 Referrals to community opioid substitution programs for prisoners upon release

Prison staff provide referrals to community methadone, buprenorphine and 'other' pharmacotherapy programs for male and female prisoners upon release. A total of 334 prisoners were referred to community pharmacotherapy programs upon release in 2009. Of the 145 men referred to this service, 11 were Indigenous. Of the 44 women referred to these programs, 12 were Indigenous.

3.4.4 Research and evaluations

In 2006, the Inspector of Custodial Services released a report titled *Thematic Review of Offender Health Services* (Western Australia Office of the Inspector of Custodial Services, 2006). One recommendation of this report was a transfer of the provision of prison health services from the WADCS to the state Department of Health.

In June 2008, the Department of Health issued a response to the Inspector of Custodial Services' report, titled *Prison Health Services: final report* (Western Australia Department of Health, 2008). The report outlined the advantages of transferring prison health services to the Department of Health and the costs to be incurred as part of the transfer were also presented.

HoPE (Health of Prisoner Evaluation): a pilot study of prisoner physical health and

psychological wellbeing was released in 2009 (Kraemer, Gately and Kessell, 2009). This study argued for the need to develop an instrument that would allow for consistent data collection for prisoner health at both state and national levels. The study tested a self-reported questionnaire on a small sample of Western Australian prisoners. The study created a framework that integrated knowledge of state-based inmate health surveys (e.g. the New South Wales Inmate Health Survey) and standardised health questionnaires into the HoPE survey.

Finally, in June 2010, WADCS released a report, *Assessment of Clinical Service Provision of Health Services of the Western Australian Department of Corrective Services* (Western Australia Department of Corrective Services, 2010). The report was an audit that assessed the clinical services provided by the Health Services section of WADCS, focusing on key areas of service provision and performance.

3.4.5 Future directions

The Department of Corrective Services was consulting with stakeholders to deliver a service in regional areas similar to DATS, which focused on alcohol misuse among Aboriginal people (Western Australia Department of Corrective Services, personal communication, 2010). In addition, the Getting SMART program was under negotiation for possible implementation in Western Australian prisons.

3.5 South Australia

3.5.1 Background

Prison population

A total of 1960 prisoners (1839 males and 121 females) were housed in South Australia on 30 June 2009 (Australian Bureau of Statistics, 2009). Inmates were housed across nine prisons; eight of these were publicly operated by the South Australian Department for Correctional Services (SADCS). One prison was privately operated. Mount Gambier Prison was managed by GSL Custodial Services Pty Ltd (South Australia Department for Correctional Services website).

Health service provision

The South Australian Prison Health Service (SAPHS) provides health services across the state's eight publicly operated prisons. SAPHS is part of Statewide Services, Adelaide Health Service and is funded by the South Australian Department of Health. SAPHS services include: provision of general health care for prisoners, including 24-hour health care at two metropolitan prisons; medical assessments of prisoners on reception; and assessment of prisoners for opioid substitution treatment.

In 2009, GSL Custodial Services was responsible for health services in Mount Gambier prison.

Prison capacity

Data for 2008–09 were not available. However, in 2007–08 the total design capacity for

South Australian prisons was 1411 inmates and the rate of utilisation was 131.5 per cent²⁴ (Steering Committee for the Review of Government Service Provision, 2010).

3.5.1.1 Drug use by prisoners

In 2008,²⁵ almost three-quarters of prison entrants had a history of some form of substance abuse. The highest level of drug use was among prisoners aged 18–24 years old (76%). In 2008, 70 per cent of male and 67 per cent of female prison entrants had used illicit drugs within the past 12 months.

Licit drug use – tobacco and alcohol

More than half of South Australian prison entrants during the 2008 census period had a history of high alcohol intake (56% of males; 78% of females), with similar levels for both Indigenous and non-Indigenous prisoners. This is in contrast to national levels, which show that 65 per cent of Indigenous prisoners show high-risk alcohol use in comparison to 47 per cent of non-Indigenous prisoners reporting high-risk alcohol use. Additionally, 76 per cent of 18–24 year olds reported high-risk alcohol use (South Australian Prison Health Service, 2008).

Nationally smoking among prison populations is a concern due to the health problems associated with the activity. Figures show that South Australian prisoners follow the norm with a high prevalence of smoking. In 2008, census data showed that 75 per cent of males and 89 per cent of females were current smokers (South Australian Prison Health Service, 2008).

²⁴ The optimum rate of prison utilisation is 85–95 per cent. This provides some flexibility to cater for prisoners with special needs (e.g. protection, hospital, varying security levels) by gender and also allows for short-term fluctuations in prisoner numbers (Steering Committee for the Review of Government Service Provision, 2010).

²⁵ SAPHS 2009 data were corrupted and lost. Thus, 2008 census data from SAPHS are used to inform parts of this chapter.

Table 3.5.1: Patterns of illicit drug use by SA inmates, 2009

Drugs	Male	Female
Heroin	10%	44%
Amphetamines*	32%	22%
Cannabis	52%	56%
Cocaine	7%	11%
Any illicit drugs	—	—
Ever inject drugs	—	—

* Amphetamines are grouped with methamphetamine.

Illicit drug use

As shown in Table 3.5.1, cannabis use was highly prevalent among South Australian prison entrants, with over half of inmates reporting having used cannabis within 12 months. Data on poly drug use were not available for 2009. However, in 2008 a study on the substance use patterns in newly admitted male and female South Australian prisoners found that 15 per cent of males and 16 per cent of females used two substances in the three months prior to screening; and 26 per cent of males and 18 per cent of females used three substances in the three months prior to screening (Holmwood, Marriott and Humeniuk, 2008).

Holmwood et al. (2008), using ASSIST (Alcohol, Smoking and Substance Involvement Screening Test), studied the substance use patterns in male and female South Australian prison receptions. The authors screened 32 per cent of 1634 prisoners admitted to South Australian prisons over a ten-month period. Results showed that there were high levels of injecting and that moderate and high-risk amphetamine use was almost twice as common as moderate or high-risk opioid use.

3.5.2 Drug strategies

3.5.2.1 Supply reduction

The major forms of supply reduction used in South Australia were drug detection dogs and a urinalysis program. Strategies that may also impact upon the supply of drugs into South Australian prisons include intelligence operations and targeted searches.

Drug detection dogs

A total of 158 searches were undertaken by drug detection dogs in South Australian prisons in 2009. Data on the quantity and drug types detected by drug detection dogs were not available. The program incorporates active and passive drug detection dogs.

Urinalysis programs

South Australia had three types of urinalysis programs in 2009: therapeutic, random and targeted tests were conducted. Tests conducted to ensure compliance with therapeutic programs yielded a total of 170 positive results. In 2009, 190 urinalysis tests were conducted as part of the random urinalysis program: nine tested positive and eight were positive for cannabis.

As part of the targeted urinalysis program, a total of 3974 tests were conducted. Of these, 989 returned a positive result. The drug with the highest positive results was cannabis, with 676 positive results. Table 3.5.2 shows the distribution of positive tests across drug type.

Table 3.5.2: Positive urinalysis results in SA prisons, 2009

Drug	Therapeutic testing	Random testing ²⁶	Targeted testing	Total
Alcohol	0	–	–	–
Heroin	–	–	46	46
Amphetamines	5	–	30	35
Cannabis	36	8	678	722
Cocaine	0	–	–	0
Other	129	1	237	367
Total	170	9	991	1170

Other forms of supply reduction / Further information

Both metal detectors and searches, including bags, cells and pat-downs, formed part of the supply reduction strategy in South Australian prisons. In 2009, 147 visitors were screened through bag searches. There were no other data available to indicate the number of visitors, staff and inmates subjected to these measures. Nor were data available on the number of interdictions.

Drug seizures within prison

According to the SADCs 2008–09 Annual Report (South Australia Department for Correctional Services, 2009), there were 782 recorded drug detection incidents in prison. Of these, eight visitors were reported or charged by South Australian police and another 30 visitors were banned from visiting due to having been detected with contraband, using false identification or for being suspected of introducing contraband into the prison system.

In 2008–09, 21 311 searches were conducted on prisoners, their cells and property. The results of these searches appear in Table 3.5.3.

Table 3.5.3: Interdictions from
all searches, 2009

Types of contraband	Number of interdictions
Drugs/drug paraphernalia	484
Homemade weapons	54
Mobile phones and related items (SIM cards and chargers)	43
Homebrews	64
Tattooing equipment	87
Other prohibited items	583
Total	1315

Source: Adapted from South Australia Department for Correctional Services (2009)

The total number of all contraband seized from prisoners, visitors or staff was unknown. However, in 2009 a total of 48 syringes were seized from South Australian prisons, 37 from male prisons and 11 from female prisons.

²⁶ Random urinalysis is conducted only at Mount Gambier Prison (Male).

3.5.2.2 Demand reduction

Detoxification

Inmates withdrawing from heroin were offered buprenorphine (subutex) for detoxification in 2009. Methadone was also available for detoxification. In 2009, 3.1 per cent of males and 0.6 per cent of female prisoners required detoxification. Prisoners were assessed by admission nursing staff upon reception to prison. Procedure for detoxification then differed across substances. For example, if patients scored 15 or higher on the alcohol withdrawal scale (CIWA-Ar), they were referred to a public hospital. If patients scored less than 14, they were put under observation in the health centre.

For opioids, patients were assessed by nursing staff using the Objective Opiate Withdrawal Scale. A history of opiate use was noted and the patient was put under observation. The patient was then referred to the Prison Opioid Substitution Treatment (POST) program for further assessment. If clinically indicated, the patient would commence on buprenorphine/naloxone detoxification over five days. The patient was then assessed for ongoing pharmacotherapy with methadone.

In 2009, SAPHS employed 10.2 FTE drug and alcohol staff (e.g. doctors, nurses, psychologists, and drug and alcohol workers).

Methadone and other pharmacotherapies

A limited prison methadone maintenance program first operated in South Australian prisons in 1990. In 1998, the POST program commenced. The program received joint support from SADCS and Drug and Alcohol Services South Australia. Independent funding from the state government was provided. POST was initially funded for 150 patients and in 2002 was expanded with funding for 300 patients. Further, since 2003 there

has not been any reported opiate overdose deaths post-release in South Australia. Since the introduction of the program there have been minimal opioid overdose or intoxication incidents requiring resuscitation and BBV infections acquired in custody are negligible. However, POST is under constant pressure due to the diversion of medication for illicit use in prison.

Inmates were able to commence methadone or buprenorphine treatment in prisons. In 2009, 4 per cent of male and 9 per cent of female prison receptions were on methadone maintenance treatment, and 2 per cent of male and 4 per cent of female receptions were on buprenorphine maintenance treatment. Both male and female patients were allowed to remain on opioid substitution treatment on reception to prison.

Inmate programs and counselling services

According to the South Australian prison health census undertaken from 29 June to 5 July 2009, 484 male and 55 female patients attended prison clinics. In any one week the health service saw about 30 per cent of the entire prison population. Women (41%) visited clinics more often than men (29%) during the survey week.

In 2009, a range of alcohol and other drug intervention programs was available to inmates in South Australian prisons. Programs ranged from low (<24 hours) to high intensity (100+ hours). A total of 1007 inmates commenced alcohol and other drug treatment in the reporting period. Table 3.5.4 presents the types of alcohol and other drug intervention programs available to inmates in South Australia and the number of individuals who commenced each program. Data on completion of the programs were not available.

Table 3.5.4: Alcohol and drug intervention programs in SA prisons, 2009

Name of program	Individuals commencing program (n)
Alcohol/Drug Brief Intervention	177
Alcohol/Drug A	322
Alcohol/Drug B	294
Moderate Intensity Alcohol/Drug	55
Alcohol/Drug Relapse	137
Ending Offending (Indigenous)	22
Total	1007

Source: South Australia Department for Correctional Services (2010)

Drug-free units

In 2009, drug-free units were operating within South Australian prisons. At Cadell, a number of cottages (capacity 44), houses (capacity 21) and dormitories (capacity 14) were designated as drug-free areas. The Mulga Unit (capacity 40) in Port Augusta was also classified as a drug-free unit. Inmates wishing to reside in any of the drug-free units must submit a request to live there and provide a clean urine sample prior to their move. Inmates in the drug-free units undergo contract drug testing on a three-monthly basis. If an inmate produced a positive result, they were placed back into the cell block to serve a sanction. Upon completion of the sanction the inmate must re-apply to be considered for the drug-free units. Inmates must again provide a clean urine sample before being considered for placement in these units.

3.5.2.3 Harm reduction

Harm reduction education programs

The *Staying Safe in Prisons* DVD is shown in all South Australian prisons on the prisoner television channel, and prisoners have access to the Hepatitis C CD-ROM in all Prisoner Education Centres.

Blood-borne virus testing and vaccinations

SAPHS provides blood-borne virus screening to all patients. Figures for the number screened in 2009 were not available. However, in 2006 South Australia screened 28 per cent of all men for HIV on entry to prison.

In 2009, 473 male and 41 female prisoners completed the hepatitis B vaccination schedule. Tests were also conducted for hepatitis C and HIV. Results of tests can be found in Table 3.5.5.

Miller, Bi and Ryan (2009) studied hepatitis C virus (HCV) infection in South Australian prisoners and estimated high HCV seroprevalence, especially in women, Indigenous prisoners and injecting drug users. The study found that the risk profile for Indigenous prisoners was affected by geography, with prisoners in metropolitan correctional centres at a greater risk than those in remote areas of South Australia. Additionally the authors found that HCV seropositive prison entrants were significantly more likely to commence injecting in prison and that needle sharing was common in the group.

Table 3.5.5: Results of blood-borne virus tests in SA prisons, 2009

Virus	Number of tests	Positive tests (n)	New notifications
Hepatitis B	1016	26	4
Hepatitis C	1146	291	32
HIV	1121	13	2

Source: South Australian Prison Health Service (2010)

Condom provision

In 2009, both condoms and dental dams were available to inmates. A total of 3569 condoms were distributed in prisons in 2009. No dental dams were distributed in the same period.

Disinfectant provision

In 2009, disinfectant was not provided; however, detergent was provided.

Needle and syringe programs

In 2009, there were no needle and syringe programs operating in South Australian prisons.

Other harm reduction strategies / Further information

Supportive counselling was available for all prisoners, including remand prisoners, in South Australia in 2009.

3.5.3 Re-entry programs

3.5.3.1 Mortality among recently released prisoners

South Australia has no method of collecting annual death data among recently released prisoners. No studies investigating mortality among recently released prisoners in South Australia were identified.

3.5.3.2 Pre-release and transitional programs

No data were provided by South Australia about transitional and post-release services. The following information comes from the SADCS annual reports for 2008–09, 2009–10 and 2010–11.

Adelaide Pre-release Centre – This is the main pre-release facility for male prisoners in South Australia. The centre was established to provide prisoners with programs to facilitate their gradual release to the community. Prisoners at the centre are generally in the last 12 to 18 months of their sentence. It has the capacity to accommodate 60 low-security prisoners in cottage accommodation. At 30 June 2009, there were 59 prisoners at the Adelaide Pre-release Centre (South Australia Department for Correctional Services, 2010).

Inmates participate in accompanied and unaccompanied family leave, education, work release and community work programs. Meaningful education is given a high priority at the centre including community learning facilities with a view to addressing literacy and numeracy deficiencies and/or obtaining vocational education qualifications to assist in gaining future employment (South Australia Department for Correctional Services, 2010).

Volunteer unit programs

The SADCS runs a Volunteer Unit in which volunteers provide support to offenders in prison and the community through a range of services. In 2009–10, 105 registered volunteers undertook over 3000 tasks and provided more than 10 000 hours of support to offenders.

Key services provided by the Volunteer Unit include:

- Transitional Support Program
- transport services to assist prisoners with their pre-release needs
- High-Intensity Offender Support
- mentor program
- Learners' Permit Assistance Program.

Housing programs

Integrated Housing Exits Program (IHEP) – IHEP is a joint program run by Housing SA and SADCS which works with non-government organisations to assist offenders on remand or who have sentences less than 12 months and are at risk of homelessness. Accommodation is provided to participants through Housing SA on a short-term lease. Additional tenancy support services are provided to offenders, to assist them in finding alternative accommodation arrangements (private rental or long-term lease with Housing SA). At 30 June 2009, 39 ex-prisoners were actively involved in the program.

Housing Outreach Program (HOP) – HOP helps offenders preparing for release with identified post-release housing issues. In 2009–10, HOP workers visited 251 prisoners in relation to identified accommodation issues across nine South Australian prisons.

3.5.3.3 Services to which prisoners are referred upon release

Prison health staff refer prisoners to a range of services that may aid them upon release. These include:

- Drug and Alcohol Services South Australia – SA Health runs this service
- private practitioners in the community, and
- Courts Intervention Programs (Drug Court) – the South Australian Courts Administration Authority runs this service.

3.5.3.4 Referrals to community opioid substitution programs for prisoners upon release

The POST program ensures that all patients released on pharmacotherapy from South Australian prisons, except the privately run Mount Gambier prison, are placed with a suitable medical practitioner and pharmacy upon release. However, in some instances patients are released in areas where services are full or unavailable.

Prisoners can be referred to community methadone, buprenorphine/naloxone, and 'other' pharmacotherapy programs upon release. Prisoners cannot be referred to buprenorphine programs upon release (South Australia Department for Correctional Services, personal communication). Neither SADCS nor SAPHS provided data on the services to which prisoners were referred upon release in 2009.

3.5.4 Research and evaluations

In 2001, Turning Point Alcohol and Drug Centre undertook an evaluation of the prison methadone maintenance program in South Australian prisons. The aim was to evaluate whether the program ran smoothly. Alberti and Cowie (2001) concluded there was a need:

- for increased availability and flexibility of related counselling, welfare programs and psychological support services
- to develop better tailored treatment plans
- to increase the number of prescribers and dispensers as a priority.

The authors also identified a concern for data collection for internal quality performance monitoring and for contractual obligations. The evaluation found that there was a poor level of data collection and analysis undertaken with regard to the program:

This dearth of data and statistical information on client outcomes presented some difficulties for the evaluation when attempting to compare the activities and approaches of different locations, monitoring general program and service performance, and in assessing the levels of continuity of care across the system. (Alberti and Cowie, 2001: 76)

An absence of adequate data made it difficult to comment on key areas and it was recommended that data be made available to measure the following:

- treatment continuity
- reduction in the risk of blood-borne communicable diseases
- prevention of death and post-release mortality rates
- reduced offending and recidivism rates.

Other research reports include:

- a 2009 internal review of opioid pharmacotherapy
- a 12-week trial of a moral reconnection therapy (cognitive behavioural therapy) program in conjunction with SADCS at Mobilong Prison.

3.5.5 Future directions

In 2010, SADCS introduced a General Offending Program called Making Changes. Making Changes is a moderate-intensity offence-focused program designed to assist male and female offenders in adopting an offence-free lifestyle. The program aims to increase participants' understanding of what led to offending and points to where different choices could have been made. The program is divided into three phases and is 140 hours long. This program includes one phase that focuses on substance abuse and drug and alcohol offence-related behaviour.

Throughout 2010 and 2011 the Prisoner Peer Support Program was to have been rolled out to three prisons. This program has included accredited modules in Certificate III delivered by Relationships Australia and harm minimisation training provided by the South Australian Hepatitis C Council.

3.6 Northern Territory

3.6.1 Background

Prison population

On 30 June 2009, the total number of prisoners housed in Northern Territory prisons was 1056 (1011 males and 45 females) (Australian Bureau of Statistics, 2009). There are two prisons, both managed by the Northern Territory Department of Corrective Services (NTDCS). In 2009, there were no private prisons.

During 2008–09 there were 3172 receptions (2377 distinct persons) into Northern Territory prisons, a 10 per cent increase from 2007–08 (Northern Territory Department of Corrective Services, 2009).

Health service provision

Primary health care services have been delivered by outsourced contractors since 1992. In 2009, health care was provided through a contract delivered by a third-party health-care provider and managed by the Northern Territory Department of Health and Families (NTDHF) (Australian Institute of Health and Welfare, 2010).

Prison capacity

In 2008–09, Northern Territory prisons had a total design capacity of 858, the total prison utilisation rate was 120 per cent, above the national average of 102 per cent of prison design capacity in 2008–09²⁷ (Steering Committee for the Review of Government Service Provision, 2010).

3.6.1.1 Drug use by prisoners

Licit drug use – tobacco and alcohol

No data were provided.

No publicly available data for the Northern Territory were identified for 2009.

Illicit drug use

No data were provided.

No publicly available data were identified for 2009.

3.6.2 Drug strategies

The National Corrections Drug Strategy 2006–2009 describes the principles that should guide and inform drug policy within prison settings. This policy works within a harm minimisation approach, expressed by the three key areas of supply, demand and harm reduction.

3.6.2.1 Supply reduction

The following supply reduction measures were available in Northern Territory prisons: drug detection dogs; urinalysis; and metal detectors.

No other information was provided.

No publicly available data were identified for 2009.

²⁷ The optimum rate of prison utilisation is 85–95 per cent. This provides some flexibility to cater for prisoners with special needs (e.g. protection, hospital, varying security levels) by gender and also allows for short-term fluctuations in prisoner numbers (Steering Committee for the Review of Government Service Provision, 2010).

Drug detection dogs

Between July and December 2009, there were 7304 searches undertaken by drug dogs in Northern Territory prisons – these figures include visitors, accommodation and vehicle searches. There was one find/seizure in the same period (Northern Territory Department of Corrective Services, personal communication, 2010).

Urinalysis programs

In 2009, the NTDCS urinalysis program consisted of both random and targeted testing. As part of the random urinalysis testing program, 404 tests were conducted. There were 13 positive results: nine for cannabis and four for ‘other drugs’. As part of the targeted testing program, 521 inmates were tested in 2009. Of these, 49 were positive for cannabis and two for ‘other drugs’ (Northern Territory Department of Corrective Services, personal communication, 2010).

Drug seizures within prisons

No information was provided. No publicly available data were identified for 2009.

3.6.2.2 Demand reduction

The forms of demand reduction used in Northern Territory prisons are detoxification, opioid maintenance and inmate programs.

Detoxification

Data on number or proportion of prison receptions experiencing withdrawal in 2009 were not available, as this information appeared only in individual prisoner files and could not be easily extracted. However, between 1 January and 31 July 2011, NTDCS’s Primary Care Information System collected data on the drugs from which receptions were most commonly withdrawing. Conclusive figures were not provided, but the NTDHF reported that alcohol was likely to be the most common drug that receptions to Northern Territory prisons were withdrawing from (Northern Territory Department of Health and Families, personal communication, 2011).

Methadone and other pharmacotherapies

Methadone and/or buprenorphine were available for withdrawal. In the event that the Correctional Centre doctor is not a qualified prescriber for the Territory, then NTDHF’s Alcohol and Other Drug Service assists (Northern Territory Department of Health and Families, personal communication, 2011).

Inmates could also commence methadone and buprenorphine maintenance treatment in prison and prison receptions could remain on the treatment upon entering prison. Figures on the number of inmates commencing or receptions remaining on opioid substitution therapy were not available.

In 2009, one inmate was on opioid substitution therapy in Northern Territory prisons (*National Opioid Pharmacotherapy Statistics Annual Data Collection: 2009 report* – correctional settings as the dosing point) (Australian Institute of Health and Welfare, 2010a). However, between 1 January and 31 July 2011 there were no prisoners on opioid substitution therapy in Northern Territory prisons (Northern Territory Department of Health and Families, personal communication, 2011).²⁸

Inmate programs and counselling services

No information was provided for 2009.

No publicly available data were identified for 2009.

Drug-free units

No drug-free units were in operation in Northern Territory prisons as at June 2011.

3.6.2.3 Harm reduction

In 2009, the forms of harm reduction strategies implemented in the Northern Territory were harm reduction education programs, blood-borne virus testing, hepatitis B vaccination and naloxone administration.

Harm reduction education programs

No information was provided for 2009. Data for the number of prisoners who received harm reduction education were not available.

No publicly available data were identified for 2009.

Blood-borne virus testing

In 2006, the Australian Federation of AIDS Organisations reported that HIV testing was compulsory in Northern Territory prisons (Butler and Papanastasiou, 2008). Between 1 January and 31 July 2011 there were no reported cases of HIV in Northern Territory prisons. Data on the total number of prisoners tested for HIV within the reporting period were not available.

Data on the number of prisoners tested for hepatitis B and the number of positive results were not available. Available figures showed that a total of 25 prisoners completed the hepatitis B vaccination schedule between 1 January 2011 and 31 July 2011. A further 122 prisoners received part of the hepatitis B vaccination course within the same reporting period.

Data on the number of inmates tested for hepatitis C were not available.

Condom provision

In 2009, condoms and dental dams were not available in Northern Territory prisons (Australian Institute of Health and Welfare, 2010).

Disinfectant provision

No information was provided.

No publicly available data were identified for 2009.

Needle and syringe programs

In 2009, needle and syringe programs were not in operation in Northern Territory prisons.

²⁸ There was one prisoner on methadone (previously on buprenorphine) but for pain relief and not as opioid substitution therapy, so this prisoner has not been included in the numbers.

3.6.3 Re-entry programs

No publicly available data were identified for Northern Territory prisons for 2009 regarding: mortality among recently released prisoners; pre-release and transitional programs; and services where prisoners were referred upon release.

With regard to referrals to community opioid substitution programs upon release, data for 1 January – 31 July 2011 showed that no referrals had been made by prison staff to methadone maintenance treatment and two referrals had been made to buprenorphine treatment (Northern Territory Department of Health and Families, personal communication, 2011).

No evaluations of post-release services and programs were provided or identified through publicly available means.

3.6.4 Future directions

Data presented here are limited due to the lack of publicly available data for the period under consideration (2009). Further data provided by NTDCS was minimal. NTDCS was unable to provide much of the data requested in the questionnaire. Further, NTDHF initially withdrew from the study due to insufficient data availability through their client information system. However, in August 2011 the Department provided limited data based on their recently implemented Primary Care Information System. These data covered only the period between 1 January and 31 July 2011. The Department's services informed the research team that they planned to write a collection of reports that would assist in future studies.

3.7 Tasmania

3.7.1 Background

Prison population

On 30 June 2009, 535 prisoners (492 males and 43 females) were housed across Tasmanian prisons (Australian Bureau of Statistics, 2009). In 2009, the Tasmanian Prison Service (TPS) reports that there were a total of 1492 prisoner receptions (1311 male and 181 female). Inmates were housed across four prisons and two remand centres. These were managed by the TPS. There were no private prisons operating in Tasmania.

Health service provision

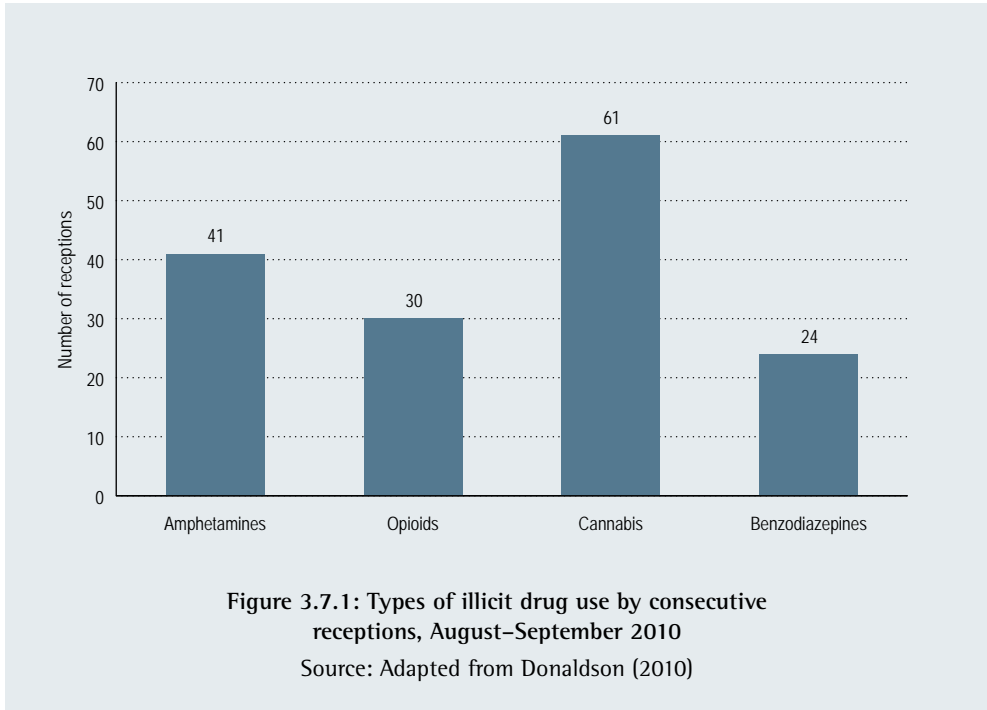
In 2009, health services for prisoners were delivered by the Tasmanian Department of Health and Human Services (TDHHS) through the Correctional Primary Health Service (CPHS).

Prison capacity

Tasmanian prisons had a total design capacity of 643. The prisons operated at 81.1 per cent of the total design capacity in 2008–09 (Steering Committee for the Review of Government Service Provision, 2010). This is below the national average of 102 per cent of prison design capacity.

3.7.1.1 Drug use by prisoners

More than 60 per cent of individuals admitted to prison in Tasmania identified alcohol and other drug use as being related to their offending (Tasmania Department of Justice, 2010).



Licit drug use – tobacco and alcohol

In Tasmania, 80 per cent of the prison population smoked cigarettes. In 2007, 89 per cent of the Tasmanian sample surveyed for the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey reported being a current smoker (Butler and Papanastasiou, 2008).

In a sample of 107 consecutive receptions to Risdon Prison Clinic, alcohol was found to be associated with previous imprisonment, physical symptoms or current offending behaviours in 86 per cent of cases (Donaldson, 2010).

Illicit drug use

In 2007, 28 per cent of receptions reported a history of injecting drugs (Butler and Papanastasiou, 2008). A history of injecting amphetamines was reported by 73 per cent of the IDU sample, while 5 per cent reported a history of injecting heroin. One person reported having injected in prison in the last month. In the IDU group, 81 per cent reported using a new needle and syringe for all injections in the last month, and 13 per cent reported using a new needle and syringe most of the time (Butler and Papanastasiou, 2008).

A study of receptions to Risdon Prison between August and September 2010 found that cannabis was the most commonly used drug in a sample of 100 who reported problematic drug use (Donaldson, 2010). Figure 3.7.1 presents the types of illicit drug use.

3.7.2 Drug strategies

3.7.2.1 Supply reduction

Metal detectors and searches including drug dog searches (e.g. bag searches, pat-downs and cell searches) formed part of the TPS supply reduction strategy for 2009. It is unknown how many visitors, staff and inmates were screened using these measures, as the TPS does not record these figures.

Drug detection dogs

In 2009, drug detection dogs were used in Tasmanian prisons. The number of searches by drug detection dogs between July and December 2009 totalled 595 (551 in male prisons and 44 in female prisons). Illicit drugs were detected by drug dogs on six occasions: green vegetable matter (five occasions) and one tablet.

Urinalysis programs

The TPS did not conduct urinalysis tests for therapeutic purposes. The urinalysis program for 2009 did include random and targeted testing. Random testing involved 5 per cent of the prison population every month. A total of 115 urinalysis tests were conducted under the random urinalysis program. Of these, a total of 14 yielded positive results. A further 599 tests were conducted as part of the targeted testing program. Of these, 208 yielded a positive result. Cannabis was identified in 105 tests (102 male and 3 female prisoners).

Drug seizures within prison

General searches in 2009 yielded a total of 30 syringes (19 in male prisons and 11 in female prisons).

3.7.2.2 Demand reduction

Detoxification

Prison receptions are assessed by the Correctional Primary Health Service nurse upon arrival. The examination includes assessing signs of intoxication and possible withdrawal symptoms. Detoxification is then provided to inmates as inpatients in the Correctional Health Facility located within the Risdon Prison Complex or in their cells, depending on the circumstances.

In 2009, methadone or buprenorphine were not offered for detoxification.

Methadone and other pharmacotherapies

Methadone maintenance and buprenorphine treatment were available to inmates wishing to commence treatment in prison. However, it was available in limited numbers according to level of risk and availability of community placement. Prison receptions could remain on both methadone maintenance and buprenorphine maintenance if they were on a community program immediately prior to entering prison. Data on the number of prisoners receiving treatment in 2009 were not reported. However, an analysis of 100 opioid users found 20 per cent were on pharmacotherapy and a further 20 per cent had been in the past (Donaldson, 2010).

Inmate programs and counselling services

The Offender Programs Unit provides a wide range of programs for prisoners; the drug-specific programs include Getting Smart and Pathways. Getting Smart is a condensed program designed to promote self-management of drug and alcohol issues. The program is run over a six-week period and requires inmates to attend twice-weekly meetings. Groups comprise 10 inmates at a time (Tasmania Department of Justice, 2010). In 2009, 33 male inmates had completed the program.

Pathways is an intensive treatment program for inmates with a history of problematic alcohol and other drug use and criminal conduct. The program runs for 120 hours over a three- to four-month period. A cognitive behavioural approach is used to change anti-social thinking and behaviour and to enhance pro-social thinking, attitudes and beliefs. The aim of the program is to assist offenders in avoiding recidivism and relapse (Tasmania Department of Justice, 2010). In 2009, seven participants completed the Pathways program.

In 2009, 24 inmates participated in drug and alcohol programs delivered by external providers. All of the participants were female. The specific programs they participated in were not reported.

Drug-free units

There were no drug-free units operating within the Tasmanian prison system during the reporting period.

3.7.2.3 Harm reduction

Harm reduction education programs

In 2009, 14 male prisoners and two female prisoners were trained as peer supporters. In 2011, there were 10 male peer supporters but no female peer supporters. The lack of female peer supporters can be attributed to the short sentences women tend to serve and the time it takes to train an inmate as a peer supporter.

Since 2009, four inmates have been trained in the Smart Recovery drug and alcohol peer support program. This peer support program is yet to be run in Tasmanian prisons.

Blood-borne virus testing

In 2009, all prisoners were offered testing for hepatitis B, hepatitis C and HIV and approximately 85 per cent of men and women accepted and were tested. Of these, a total of 10 tested positive for hepatitis B and 50 tested positive for hepatitis C.

The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) identifies prisoners as a target group for hepatitis C treatment (Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis, 2008). MACASHH cites a number of reasons for this including:

- Prisons are a large infection pool, with 50 per cent of Tasmania's notifications (1% in the community) coming from prisons. Women were likely to have higher rates of infection.
- To prevent the transmission to other people.
- To free up community places and avoid problems with appointments.
- To improve quality of life (reduce harms) and enhance opportunities for reintegration, including education and employment.

The Tasmanian Prison Viral Hepatitis Treatment Program formally commenced in 2008, with 19 patients. The treatment of hepatitis C within the prison system is a significant concern for the TPS given that the rate of infection is increasing, with the CPHS diagnosing 40 per cent of the 300 new hepatitis notifications in Tasmania each year (Tasmania Department of Health and Human Services, 2010).

Additionally, the CPHS diagnoses approximately 20 per cent of hepatitis B notifications in Tasmania. In 2009, the CPHS purchased 245 Engerix B vaccinations. This equated to approximately 100 inmates completing the HBV course. Inmates were accepted for injections only if their sentence covered the full course of treatment (six months).

Condom/dental dam provision

In 2009, condom vending machines were provided in five of the seven male facilities. The total number of condoms provided was not reported. Dental dams were provided to women prisons in Tasmania on request. A total of 20 dental dams were distributed in the reporting period.

Disinfectant provision

Under the Healthy Prisons, Healthier Communities Blood Borne Virus Strategy 2010–2013, the TPS and the CPHS propose to investigate the implementation of a multi-purpose bleach/disinfectant, such as Fincol (a hospital grade disinfectant), across all TPS facilities.

Needle and syringe programs

Needle and syringe programs were not available within Tasmanian prisons in 2009.

3.7.3 Re-entry programs

3.7.3.1 Mortality among recently released prisoners

No data were identified relating to mortality among recently released prisoners.

3.7.3.2 Transitional and pre-release services and programs

Tasmania operates a pre-release referral pathway. Inmates are referred to Holyoake to undertake drug and alcohol programs and for one-to-one counselling. Inmates may also access this service on release. In addition, the Salvation Army Bridge program has provided case workers to undertake one-to-one drug counselling pre-release which may lead to a referral on release to the Bridge or the Xcell support program. As of July 2011, the Salvation Army had received funding to provide 36 units of supported accommodation for offenders leaving prison, for drug and alcohol counselling and BBV support as required.

3.7.3.3 Services and programs to which prisoners are referred upon release

Upon release from prison, prisoners are provided with an 'exit pack'. This contains information and links to community organisations in Tasmania, including specific drug and alcohol services such as: the Tasmanian Council on AIDS, Hepatitis and Related Diseases (TASCHARD) Needle and Syringe Program; Drug Education Network (DEN); MATES program; Launceston General Hospital Detox Unit; and Launceston Alcohol and Drug Services (see Re-integrate website). It is unknown whether prison staff made any direct referrals to these services and programs in 2009.

Additional information on the wide range of re-integration and support services available to Tasmanian prisoners upon release can be found at <<http://re-integrate.net>>. The site is continuously updated.

3.7.3.4 Referrals to community opioid substitution programs for prisoners upon release

Prison workers were involved in referring prisoners to methadone and buprenorphine-naloxone treatment, as part of the pharmacotherapy program run by the Tasmanian Department of Health and Human Services' Alcohol and Drug Service. All inmates released from prison were provided with a discharge letter to a general practitioner, hospital or other medical service (after the patient had provided informed consent).

3.7.4 Research and evaluations

A BBV strategy has been developed between the Tasmanian Department of Justice and the state Department of Health and Human Services based on the guidelines for Australian custodial settings on the prevention, care and treatment of hepatitis C (Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis, 2008). The strategy, entitled Healthy Prisons, Healthier Communities Blood Borne Virus Strategy 2010–2013, was developed as a joint initiative by TPS and CPHS 'to address the issue of blood borne viruses in correctional settings, with a particular focus of hepatitis C'. The strategy has been developed for a three-year period and is to be implemented through annual action plans.

The HBV vaccine program has been reviewed and a decision was made that only prisoners sentenced to six months or longer be offered the vaccination. As details of this review have not been provided, it is unknown when or by whom the vaccine program was reviewed.

Another report of interest is the Alcohol, Tobacco and Other Drug Strategy 2010–2013 (Tasmania Department of Justice and Department of Health and Human Services, 2010: 13). Under this strategy the Justice and Health Departments propose to enhance data collection through the formation of a joint drug and alcohol 'information and data committee' to 'progress the information base in Tasmanian prisons and to contribute to research that advances evidence-based interventions in Tasmania'.

3.7.5 Future directions

Under the Alcohol, Tobacco and Other Drug Strategy 2010–2013, the TPS proposes to explore the development of a drug-free unit within the Risdon Prison Complex. Additionally, there is a proposal in the Healthy Prisons, Healthier Communities Blood Borne Virus Strategy 2010–2013 to investigate the introduction across Tasmanian prisons of a multi-purpose bleach/ disinfectant, such as Fincol.

One of the key areas of work under the new Healthy Prisons, Healthier Communities Blood Borne Virus Strategy 2010–2013 is an investigation to introduce a pharmacotherapy program within the prison system including minimum security facilities. Additionally, part of the demand reduction strategy in Tasmanian prisons for the future is the implementation of a therapeutic drug program.

3.8 Australian Capital Territory

3.8.1 Background

Prison population

A total of 203 prisoners (180 males and 23 females) were housed in the Australian Capital Territory on 30 June 2009 (Australian Bureau of Statistics, 2009). Inmates were housed in the Australian Capital Territory's only full-time correctional facility, the Alexander Maconochie Centre (AMC), which commenced operations on 30 March 2009. The AMC housed the full spectrum of prisoners, both males and females, Indigenous and non-Indigenous, people with disabilities and those with chronic, acute and multiple health conditions (ACT Health, 2008). Prior to the establishment of the AMC, prisoners from the Australian Capital Territory were incarcerated in prisons operated by Corrective Services New South Wales.

Health service provision

Health services at the AMC were provided by ACT Health through the Corrections Health Program. The provision of health services to the AMC is legislated in the *Corrections Management Act 2007* (ACT). The service was established following the principles outlined

by the Centre for Health Research in Criminal Justice (New South Wales Justice Health).²⁹ In 2009, all prison entrants to ACT Corrective Services facilities were provided with a general health and mental health assessment.

The AMC prison medical clinic provided a broad range of health services to prisoners including: nursing care; general practitioner services; dental services; pharmaceutical services; specialist medical services; and drug and alcohol services. ACT Health reported that in 2009 there were no specialist drug and alcohol staff employed. However, ACT Health employed eight medical officers who were also authorised methadone prescribers.

Prison capacity

In 2008–09, Australian Capital Territory prisons had a design capacity of 153 inmates.³⁰ With a total rate of utilisation of 76.7 per cent, this is below the national average of 102 per cent of prison design capacity in 2008–09³¹ (Steering Committee for the Review of Government Service Provision, 2010). In 2009 the AMC received a total of 492 prison receptions (432 males and 58 females).

- ²⁹ The principles include: (1) The agency responsible for providing health services must be independent; (2) It must be able to provide high-quality services; (3) it must have authority supporting its existence and operations (preferably legislative authority).
- ³⁰ Figures for 2008–09 are an average of design capacity calculated across the reporting period that takes into account a three-month period during which the AMC was operating, and therefore design capacity for only that facility applies, and a period where Australian Capital Territory prisoners were held in Australian Capital Territory remand facilities or New South Wales prisons and therefore only Australian Capital Territory remand capacity applies (Steering Committee for the Review of Government Service Provision, 2010).
- ³¹ The optimum rate of prison utilisation is 85–95 per cent. This provides some flexibility to cater for prisoners with special needs (e.g. protection, hospital, varying security levels) by gender and also allows for short-term fluctuations in prisoner numbers (Steering Committee for the Review of Government Service Provision, 2010).

Table 3.8.1: Ever used drugs and recent use, by drug type

Illicit drug use history (ever used)	Ever used %	Used in 12 months prior to prison %
Heroin	65	65
Amphetamines (speed)	82	55
Cannabis	99	61
Cocaine	66	31
Any illicit drugs	91	—
Ever injected	67	—

Source: Stoové and Kirwan (2010)

3.8.1.1 Drug use by prisoners

Data for 2009 were not collected by ACT Health, given that the AMC had only begun operation in March 2009. However, in May 2010, an Inmate Health Survey (IHS) was conducted with a sample of 135 inmates at the AMC. The majority of those surveyed (91%) reported lifetime use of illicit drugs and 52 per cent of inmates reported having been told by a doctor that they were drug-dependent (Stoové and Kirwan, 2010).

Licit drug use – tobacco and alcohol

The 2010 IHS confirmed that both tobacco and alcohol consumption patterns by inmates in the AMC were similar to other Australian prison populations. It found that 85 per cent of prisoners were current tobacco smokers (with 70 per cent smoking 10 or more cigarettes per day) and 80 per cent reported an inclination to quit smoking (Stoové and Kirwan, 2010). Stoové and Kirwan (2010) also found that alcohol consumption patterns showed that 44 per cent of inmates reported drinking more than 10 standard drinks on a typical day when alcohol was consumed. Additionally, 33 per cent of inmates surveyed reported drinking more than six standard drinks on one drinking occasion.

Illicit drug use

As shown in Table 3.8.1, in 2010 cannabis was reported as the most common drug ever used by Australian Capital Territory inmates participating in the IHS. Illicit drug use was taking place within the AMC, with 32 per cent (24 of 72) of IDUs reporting injecting at the AMC and 27 per cent (21 of 79) reported that the last time they injected drugs was in a prison setting (Stoové and Kirwan, 2010).

3.8.2 Drug strategies

The National Corrections Drug Strategy 2006–2009 describes the principles that should guide and inform drug policy within prison settings. This policy works within a harm minimisation approach, expressed by the three key areas of supply, demand and harm reduction.

Table 3.8.2: Drug screening and detection measures at the AMC, 2009–10

Type of measure	Number of searches
Cell searches	2836
Area searches (common areas, e.g. cell block kitchen or yard)	3199
‘Strip’ searches (body)	135
SOTER (body scanning machine) searches	236
Metal detectors	11 884 ³²
Drug detector dogs	50–123 ³³
Urinalysis	670 ³⁴

Source: Stoové and Kirwan (2010)

3.8.2.1 Supply reduction

Supply reduction strategies used at the AMC in 2009 included: strip searches; cell and area searches, including the use of drug detector dogs; SOTER (body scanning machine); urinalysis; and metal detectors. Table 3.8.2 shows the number of searches conducted using each supply reduction measure.

Black, Dolan and Wodak (2004) note that urinalysis and drug detection dogs are costly programs that are generally not well documented and rarely evaluated.

Stoové and Kirwan (2010), in their evaluation of cell searches, area searches and urinalysis tests conducted at the AMC, found little relationship between coverage of visitor searches and contraband seized.

Drug detection dogs

From June 2009 to May 2010, 5613 random and targeted visitor searches were conducted using drug detection dogs (Stoové and Kirwan, 2010). Between March and December 2009 drug detector dogs found drugs on a total of 13 incidents, 11 of these involved the detection of illicit drugs on visitors upon entry to the prison. Table 3.8.3 shows the distribution of incidents and quantities for both prisoners and visitors by drug group (ACT Corrections, personal communication, 2010).

³² All visitors to the AMC are screened by metal detectors.

³³ Searches conducted with drug detection dogs were not recorded for 2009. This figure is for monthly range between March 2010 and May 2010.

³⁴ In December 2009, the entire prison population at the AMC was screened. The other 73 tests were conducted between June 2009 and May 2010.

Table 3.8.3: Incidents and quantities of drugs detected by drug detection dogs at the AMC, March–December 2009

Drug group	Prisoners – incidents (quantity)	Visitors – incidents (quantity)
Powder	1 (0.8 grams)	2 (2.1 grams)
Green vegetable matter	1	5 ³⁵
Tablets	0	3 ³⁶
Other (white crystal substance)	0	1 (4.2 grams)

Source: ACT Corrections, personal communication, 2010

Urinalysis programs

Between March 2009 and December 2009, the urinalysis program in the Australian Capital Territory consisted of targeted (171 tests) and ‘untargeted’ testing (169 tests) (ACT Corrections, personal communication, 2010), while from June 2009 to May 2010, there were 501 targeted and 169 random

tests. Prisoners who participated in therapeutic programs were subject to targeted testing and no distinction was made between therapeutic and targeted urinalysis (Stoové and Kirwan, 2010). Table 3.8.4 shows the number of positive urinalysis results for both random and targeted testing that resulted in disciplinary action. The most commonly detected drug type was cannabinoids.

Table 3.8.4: Positive drug indications resulting in disciplinary action,³⁷ 2009–10

Drug	Random (untargeted) urinalysis tests	Targeted urinalysis tests
Opiates	2	11
Amphetamines	–	–
Cannabinoids	9	22
Cocaine	0	0
Other	7	32

Source: Adapted from Stoové and Kirwan (2010)

³⁵ In three of the five incidents, a total of 9.4 grams of green vegetable material was identified. The quantities in the other two incidents are unknown.

³⁶ In two of the three incidents, three tablets were identified. In the third instance, the quantity is unknown.

³⁷ Positive results leading to disciplinary action were used by Stoové and Kirwan (2010) to indicate illicit drug use.

Drug seizures within prisons

Between 1 June and 31 December 2009, all visitors (6237) and prison staff were searched by metal detectors when entering the AMC. Syringes were seized from prisoners on 12 occasions and from visitors on eight occasions. Cell and area searches produced 20 and 17 drug seizures, respectively (ACT Corrections, personal communication, 2010).

3.8.2.2 Demand reduction

Demand reduction measures available at the AMC in 2009, included: group counselling (First Steps to Recovery, Getting Me Back); individual counselling; opioid substitution treatment; detoxification; rehabilitation (therapeutic community); and drug-free wings/areas (Stoové and Kirwan, 2010).

Detoxification

Upon reception to the AMC, prisoners assessed as experiencing withdrawal received detoxification 'packs'. In 2009, packs were available for opioid, benzodiazepine and alcohol withdrawal. The packs consisted of medicated withdrawal regimes, including standardised doses of medication. If methadone cessation is the cause of the withdrawal, then it is re-initiated. No quantitative data on the administration of detoxification regimes in 2009 were available.

Methadone and other pharmacotherapies

In 2009, ACT Corrections Health Program staff were responsible for providing methadone maintenance treatment at the AMC. Prison receptions who had been on methadone maintenance treatment in the community were able to remain on methadone maintenance

treatment in prison. Inmates at the AMC were also able to commence methadone maintenance treatment. In contrast, ACT Health policy in 2009 was that buprenorphine was not to be offered to individuals in custody, except in exceptional circumstances. Exceptional circumstances included: if the inmate was a stable client in the community and/or if the inmate had been sentenced to a very short period in custody. Knowledge Consulting (2011: 217) reported that buprenorphine (as subutex and suboxone) was 'not available at AMC because of the high risk, and incidence of, diversion, even under supervision'.

Stoové and Kirwan (2010) found differential access to methadone maintenance treatment between prisoners who were already in a program in the community and those who were not. Prisoners not receiving opioid pharmacotherapy at prison entry experienced significant delays in receiving treatment in prison. Between July 2009 and July 2010, approximately 60 inmates were receiving opioid pharmacotherapy.

Inmate programs and counselling services

In 2009, ACT Health did not collect data on drug treatment and education programs in operation at the AMC. ACT Corrective Services provided data on two programs delivered by the alcohol and other drugs (AOD) team – First Steps (separate programs for males and females). The program was voluntary and delivered over a six-week period. The program aimed to support prisoners with the difficulties faced when attempting to cease or reduce alcohol and other drug use. Prisoners were provided with alcohol and drug awareness, education and relapse prevention.

Table 3.8.5: Commencement and completion rates for AOD programs

Program	Commenced program	Completed program (%)
First Steps	286 ³⁸	126 (44%)
Back in Control	20	6 (30%)
Health and Wellbeing	50	22 (44%)

Source: Adapted from Stoové and Kirwan (2010)

Stoové and Kirwan (2010) also reported that the AOD team of Corrective Services delivered two other programs: Back in Control; and the Health and Wellbeing Program (based on CBT principles and included financial management, stress management, conflict resolution, goal setting, self-esteem and parenting skills). Back in Control was delivered over a 20-week period and is an extension of First Steps. The Health and Wellbeing Program was delivered in six weeks. Completion rates for each program are presented in Table 3.8.5.

Less than half of those who commenced a program completed it. Reasons for failure to complete varied across programs and included: voluntary withdrawal; bailed and released from AMC; inmate underwent change in classification preventing further participation; disciplinary action; and 'lack of participation/dismissal' (Stoové and Kirwan, 2010).

Drug counselling at the AMC was delivered to 119 prisoners between July 2009 and June 2010. Counselling services were provided by the following external providers on an in-reach basis: Directions ACT (95 individuals); Toora WIREDD (18 individuals); and Gugan Gulwan (6 individuals). Within the same reporting period there were 600 receptions

to the AMC (Stoové and Kirwan, 2010). Of these, 42 per cent reported needing help to quit drugs, 40 per cent had been told by a doctor that they were drug-dependent, and 42 per cent had used heroin in the past 12 months (ACT Inmate Health Survey, cited in Stoové and Kirwan, 2010).

Drug-free units and therapeutic communities

Solaris Therapeutic Community is a joint venture between ACT Corrective Services and community-based service provider ADFACT (Alcohol and Drug Foundation ACT). Solaris offers structured pre-release rehabilitative treatment and care for sentenced male prisoners housed in a minimum security environment at the AMC. The prisoner's offence must be linked to alcohol or drug dependency. Solaris provides a residential environment consisting of single rooms in one of four stand-alone cottages. Each cottage houses up to 20 prisoners. Staff included therapeutic correctional officers, alcohol and other drug case managers and frontline managers from ACT Corrections and ADFACT.

³⁸ This figure reported by Stoové and Kirwan (2010) is for the period June 2009 – May 2010.

Participants were expected to present without having used alcohol or illicit drugs on the day of admission into the program and for two weeks previously. Baseline urinalysis was taken two weeks prior to admission as well as on the day of admission into the program to ensure compliance.

Between July 2009 and June 2010, Solaris housed 20 male prisoners, 15 completed the six-month program and three were involuntarily discharged (Stoové and Kirwan, 2010). ACT Corrective Services reported that education and additional support were made available to prisoners with literacy issues in any AMC program. Overall, the evaluation found that both prisoners and providers viewed the Solaris program as 'high quality' (Stoové and Kirwan, 2010: 92).

The external evaluation of policies and services at the AMC identified the following criticisms: the current location of the program (among the general prison population) was problematic; and the program did not adequately cater for those with low literacy levels (Stoové and Kirwan, 2010).

3.8.2.3 Harm reduction

Harm reduction services and programs available at the AMC in 2009 included: health promotion; peer educators; health assessments; care plans; provision of disinfectant and condoms; and staff training in universal precautions regarding blood-borne viruses and occupational health and safety issues for search procedures (Stoové and Kirwan, 2010).

Harm reduction education programs

In 2009, 125 male inmates and 17 female prisoners received drug education. Stoové and Kirwan (2010) reported that the ACT Resource Centre offered BBV education sessions at the AMC. The coverage of these education sessions was high – 146 prisoners participated in the HCV education sessions between January and July 2010. Also 1200 information products were distributed to inmates. Information distribution strategies included the training of yard delegates to undertake BBV health promotion.

Blood-borne virus testing

During the survey period, medical record audits were conducted at 30 September 2009 and 31 December 2009. At the 31 December audit, it was estimated that 53 per cent of prisoners had been tested for HIV infection, with zero positive results. Similarly, 53 per cent had been tested for HCV antibodies; of these, 65 per cent tested positive. Only 45 per cent of prisoners had been tested for immunity to hepatitis B, of which 65 per cent were immune. Most BBV testing of AMC prisoners occurred at reception, with minimal testing throughout incarceration and at discharge (Stoové and Kirwan, 2010).

Condom/dental dam provision

Condoms and dental dams were readily available from the AMC clinic and in residential areas. No data were available on the number of condoms or dental dams distributed to prisoners in 2009.

Disinfectant provision

In 2009, Fincol was provided in the AMC. Inmate Health Survey data showed that 32 per cent of inmates had ever tried to get bleach in prison. Questions of access to bleach showed that 41 per cent of prisoners who had tried to access bleach reported that it was either 'difficult' or 'very difficult' to access, and 48 per cent reported that it was either 'easy' or 'very easy' to obtain bleach (Stoové and Kirwan, 2010).

Qualitative data gathered as part of the evaluation of drug policies and services at the AMC showed that prisoners encountered several access problems. Prisoners reported that bleach dispensers were often empty and took some time to be refilled (Stoové and Kirwan, 2010).

Needle and syringe programs

The Australian Capital Territory prison commenced operation in March 2009. At that time the Australian Capital Territory Government expressed a commitment to review the need for a needle and syringe program after the AMC had been operational for 18 months. The government's position was noted in the ACT Corrections Health Plan for 2008, as follows:

A full and comprehensive evaluation of the proposed drug policies and services, and their subsequent effects on the prisoners and staff within the Alexander Maconochie Centre, will be undertaken 18 months after the commissioning. If, after this evaluation, further consideration of a trial needle exchange program is warranted, ACT Health will investigate the feasibility of introducing such a trial to the Alexander Maconochie Centre. (ACT Health, 2008: 22)

The Burnet Institute was selected by the Australian Capital Territory Departments of Justice and Community Safety and of Health to conduct the evaluation. The evaluation focused on the period between June 2009 and May 2010. The final report was released in April 2010 (Stoové and Kirwan, 2010). Recommendation 69 of the Burnet Institute report advocates that a process should be commenced to instigate a trial needle and syringe program at the AMC.

Similarly, Knowledge Consulting (2011: 165) in its 12-month evaluation of the policies and programs at the AMC reported that:

- On health grounds, introduction of a needle and syringe exchange program is an effective way to curtail harm resulting from blood-borne virus transmission.
- In practice it is very unlikely officers at AMC will support such a program at present.
- Introduction of a needle exchange program may be possible in future, but is unlikely to succeed at present given staff views.

During Estimates Committee hearings on 18 May 2010, the Australian Capital Territory Health Minister, Katy Gallagher, was asked whether she was in favour of a needle exchange in the prison, to which she replied:

From a health point of view, it is a no-brainer; you have a needle and syringe program in the jail as soon as you can. From a Corrections staff point of view – I have said this in these forums a number of times – it is more complex than that. Corrections staff have mixed and strongly held views around the commencement of a needle and syringe program. It would be a brave new step. We would be the first

jail in the country to head this way – not the first jail in the world but the first jail in the country (Australian Capital Territory Legislative Assembly, 2010: 445).

The Health Minister's comment highlights the general debate around needle and syringe programs in Australian prisons. In 2009, NSPs were not available in the Australian Capital Territory prison. However, in May 2011 the Public Health Association of Australia was engaged by the Australian Capital Territory Government to investigate and report on models for the implementation of an NSP in the AMC. The investigation identified the following models (Moore, 2011):

1. 'one-to-one' exchange (vending style) machines
2. one-for-one NSP
 - a. NSP operated by ACT Health/nursing Staff (located within the Health Centre)
 - b. NSP operated by outside agency (located within the Health Centre)
3. contained NSP
 - a. contained NSP operated by ACT Health/nursing Staff (within the Health Centre)
 - b. contained NSP operated by outside agency (within the Health Centre).

These models have been suggested because they have either the capacity or potential to address the following criteria (Moore, 2011):

- access, anonymity and the absence of negative consequences for participants
- ensuring safety
- consistency and linkages with existing health and correctional programs
- flexibility and adaptability in implementation, and
- data collection and ensuring an evidence base for evaluation.

Table 3.8.6 sets out the conceptual overview and the relative capacity of each model to meet the above criteria.³⁹

As illustrated in Table 3.8.6, the preferred initial model recommended to the Australian Capital Territory Government was NSP Model 3b: contained NSP operated by an external agency (within the Health Centre).

³⁹ The table is not meant to be definitive (Moore, 2011).

Table 3.8.6: Conceptual assessment of NSP models

Scale 1–5	Access	Anonymity	Negative impact for prisoners	Ensuring security	Consistency and linkages	Flexible and adaptable	Data, evidence, evaluation	Legal issues	Total score
Vending style machines <i>Model 1</i>	★★★	★★★★	★★★★	★★	★★	★★	★	★★★★	22
NSP – ACT Health <i>Model 2a</i>	★★★	★★★	★★★	★★★★	★★★★	★★★★	★★★★	★★★★	26
NSP – NGO <i>Model 2b</i>	★★★★	★★★★	★★★★	★★★	★★★★	★★★★	★★★★	★★★★	29
Contained NSP – ACT Health <i>Model 3a</i>	★★	★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	30
Contained NSP – NGO <i>Model 3b</i>	★★★	★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★★	★★★★	33

Source: Moore (2011)

3.8.3 Re-entry programs

3.8.3.1 Mortality among recently released prisoners

In 2009, no data were available on mortality among recently released prisoners in the Australian Capital Territory.

3.8.3.2 Transitional and pre-release services and programs

In 2009, data on services provided to inmates in preparation for their re-entry into the community were not publicly available. However, the Knowledge Consulting review included the following quote from a key informant about pre-release:

As far as is possible detainees are advised about the danger of excess drug use in the first 48 hours post-release, and the officers try to ensure that they get to their rehab programs and obtain their methadone scripts if necessary (Knowledge Consulting, 2011: 221).

Prisoners have access to a release handbook, *Staying Out: info to help you out*, developed by ACT Corrective Services. In 2009, the handbook contained information to help prisoners prepare for life outside prison. It contained advice on housing, accessing Centrelink support, employment, health and diet, drugs, family and other topics.

The AMC Transitional Release Centre (TRC), run by ACT Corrective Services, is located outside the walls of the AMC. In 2009, prisoners were case-managed by clinical workers, assisted to re-establish themselves in the community and engaged in vocational and educational pursuits, or employment. Participants could be admitted to the TRC on a pharmacotherapy treatment regime.

3.8.3.3 Services and programs to which prisoners are referred to upon release

Prisoners released in 2009 were referred to ACT Health's Alcohol and Drug Program (ADP) or Directions ACT to assist with alcohol and drug problems post-release.

In 2009, support was offered to assist prisoners and their families to access programs that address their substance use, to achieve recovery, prevent relapse and avoid incarceration. This support included case management, counselling, group contacts such as SMART Recovery, Alcoholics Anonymous, Narcotics Anonymous, the Althea Wellness Centre and Arcadia House Detoxification and Withdrawal Services.

In 2008–09, post-release drug dependence counselling services were provided by three non-government organisations to 43 ex-prisoners. Directions ACT serviced 30 individuals, Gagan Galwan (an Aboriginal service) serviced nine individuals, and ADP serviced four individuals (Stoové and Kirwan, 2010).

The Burnet Institute review found that access to residential rehabilitation services post-release was limited among prisoners receiving opioid pharmacotherapy who were not completing the Solaris program (Stoové and Kirwan, 2010).

Solaris through-care model

In 2009, Solaris, the therapeutic community program in the AMC, was developing a through-care model that ensures continuity of treatment for prisoners undertaking the program. The model includes the following services and programs:

- *ACT Corrective Services Managed Accommodation Program (MAP)* – This is a high-intensity supported accommodation program jointly managed by ACT Corrective Services and ADFACT.

- *Karralika transitional and Nexus Halfway House programs* – These are residential transitional programs servicing both released prisoners from the AMC and members of the community leaving Karralika therapeutic community. Released prisoners receiving pharmacotherapy could attend the Nexus Halfway House program.
- *Karralika therapeutic community* – This is a therapeutic community servicing Australian Capital Territory residents which could also service Solaris participants who received early release on the basis of continuing treatment within the community or who were assessed as needing continuing residential rehabilitation.
- *Through-care coordinator* – In 2009, the Solaris program had one part-time through-care coordinator.
- Knowledge Consulting (2011) – An independent review, commissioned by ACT Corrective Services, reporting on the first 12 months of operations at the AMC.
- Moore (2011) – A report by the Public Health Association of Australia for the Australian Capital Territory Government into implementation of a needle and syringe program at the AMC.

In addition, Knowledge Consulting (2011: 218) reported that Corrections Health was reviewing methadone maintenance procedures as of November 2010, 'following a clinical review recommendation that Corrections Health develop and implement specific Standard Operating Procedures or guidelines for medication administration by AMC nursing staff that adhere to ACT Community Health Medication Policy'. Information on the progress of this review and availability or access to results were unavailable as of June 2011.

3.8.3.4 Referrals to community opioid substitution programs for prisoners upon release

Referrals were made to methadone programs for both men and women prisoners upon release. In 2009, no data were available on the number of prisoners referred to community pharmacotherapy programs upon release.

3.8.4 Research and evaluations

Two key evaluations have been undertaken on the services available to prisoners at the AMC. These publications are publicly available.

- Stoové and Kirwan (2010) – An independent evaluation of drug policies and services available at the AMC including a therapeutic community. The evaluation was commissioned by ACT Health and undertaken by the Burnet Institute.

3.8.5 Future directions

Initiatives to reduce drug-related harms include consideration of implementing a needle and syringe program. In July 2011, the Australian Capital Territory Government was advised by the Public Health Association of Australia that a contained NSP operated by an external agency (within the health centre) could be implemented at AMC to assist with harm reduction (Moore, 2011). As of October 2011, an NSP had not been implemented.

4. Indigenous prisoners

The Ministerial Council on Drug Strategy (MCDS) recognises the disproportionate numbers of Indigenous Australians in correctional settings and the combined issues of social disadvantage, drug misuse and poor general health experienced by Indigenous Australians (Ministerial Council on Drug Strategy, 2008). The National Corrections Drug Strategy 2006–2009 is concerned with ‘Focusing on the needs of Indigenous people’ (Key Principle 3). The strategy calls for specific policy and program initiatives as well as effective partnerships that address the needs of Indigenous people (Ministerial Council on Drug Strategy, 2008).

A Victorian study examining STI/BBV prevention and treatment for Koori people in prison found that Koori inmates were more reluctant to access services than non-Indigenous inmates. Responses from staff showed that a significant barrier to service usage was a ‘cultural divide – expressed primarily as wariness or mistrust’. A lack of cross-cultural training and a stigma associated with STIs/BBVs were

also identified by 19 per cent of staff and 100 per cent of inmates in focus groups as barriers to service usage (Onemda VicHealth Koori Health Unit, 2007: 40).

4.1 Background

Prison population

At the 2009 National Prisoner Census (NPC), there were 29 300 prisoners in Australia; of these, 7386 were Indigenous prisoners. Indigenous males and females accounted for 25 per cent and 28 per cent of the prison population, respectively (Australian Bureau of Statistics, 2010).

The proportion of prisoners who were Indigenous varied across jurisdictions (see Figure 4.1). The Northern Territory had the highest proportion of prisoners who were Indigenous (82%) and Victoria had the lowest (6%) (Australian Bureau of Statistics, 2010).

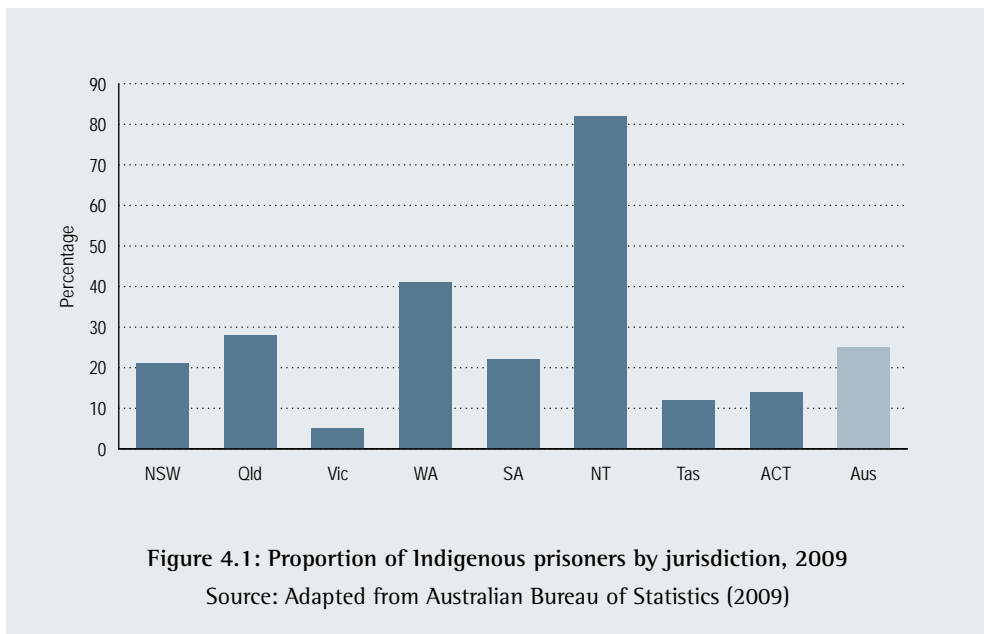


Table 4.1: Age-standardised imprisonment rates per 100 000 persons for Indigenous and non-Indigenous adults, 2009

Jurisdiction	Indigenous	Non-Indigenous
Australia	1890.7	135.6
NSW	2153.1	163.9
Vic	968.4	100.8
Qld	1427.2	128.5
SA	2072.4	133.4
WA	3328.7	163.0
Tas	470.7	146.1
NT	1699.6	152.5
ACT	759.6	63.2

Source: Australian Bureau of Statistics (2009)

Imprisonment rates

In 2009, the age-standardised imprisonment rate⁴⁰ was 1891 Indigenous prisoners per 100 000 Indigenous adults (Australian Bureau of Statistics, 2010). This compares with an age-standardised imprisonment rate of 136 per 100 000 non-Indigenous adults (Australian Bureau of Statistics, 2009). Standardised imprisonment rates varied by state and territory (see Table 4.1). Imprisonment among Indigenous prisoners was 14 times higher than the rate for non-Indigenous prisoners (Australian Bureau of Statistics, 2010).

Prior imprisonment

In 2009, a history of incarceration was more common among Indigenous prisoners (74%) than non-Indigenous prisoners (50%): see Figure 4.2 (Australian Bureau of Statistics, 2009).

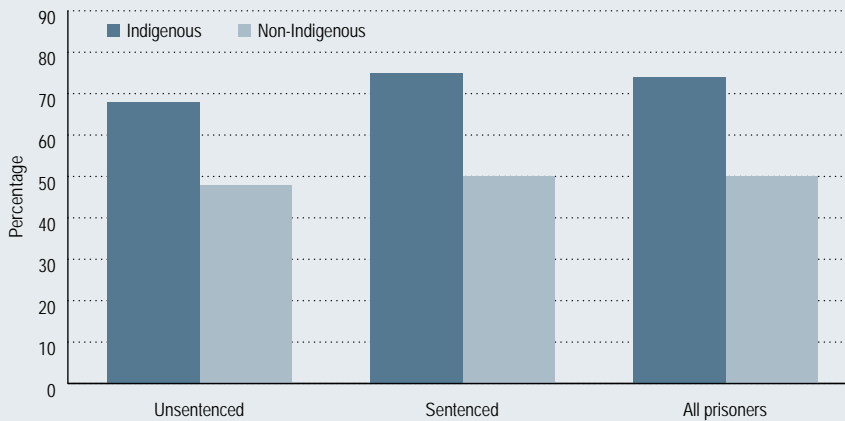


Figure 4.2: Proportion of Indigenous and non-Indigenous prisoners with a history of prior imprisonment, by sentence status, 2009

Source: Adapted from Australian Bureau of Statistics (2009)

⁴⁰ It is important to use age-standardised imprisonment rates when comparing Indigenous and non-Indigenous imprisonment rates because of the significantly younger Indigenous population (Australian Bureau of Statistics, 2009).

4.1.1 Drug use by prisoners

Licit drug use – tobacco and alcohol

Data on the proportion of prisoners or prison entrants who reported being a current smoker or drinking alcohol at hazardous levels in the 12 months prior to incarceration were available for Australia and New South Wales. Comparable data for different years were available for Western Australia, South Australia and the Australian Capital Territory.

In 2009, a similar proportion of Indigenous (82%) and non-Indigenous (80%) prison entrants in Australia were current smokers (Australian Institute of Health and Welfare, 2010). In the 2009 New South Wales IHS, Indigenous men (83%) and women (88%) were more likely to be current smokers than non-Indigenous men (71%) and women (76%) (Indig, McEntyre et al., 2010). Higher levels of current smoking were also found in one Western Australian prison in 2007 among Indigenous prisoners (89%) compared to non-Indigenous men (70%) (Gilles et al., 2008). Marginally higher levels were also found among Indigenous than among non-Indigenous prisoners in the Australian Capital Territory ($\geq 85\%$ vs $> 80\%$) (Stoové and Kirwan, 2010). Levels of current smoking did not differ substantially between Indigenous and non-Indigenous prison entrants in South Australia in 2008, at around 87 per cent for men and 75 per cent for women.

In 2009, Indigenous prison entrants were more likely to report drinking at levels that put them at risk of harm (65%) than non-Indigenous prison entrants (47%) (Australian Institute

of Health and Welfare, 2010). In New South Wales, Indigenous men (74%) and women (51%) were more likely to report drinking alcohol at hazardous levels in the 12 months prior to incarceration than non-Indigenous men (57%) and women (36%) (Indig, McEntyre et al., 2010). Almost all (96%) Indigenous prisoners in Western Australia drank at hazardous levels compared with about two-thirds (68%) of non-Indigenous prisoners (Gilles et al., 2009). Indigenous prisoners ($>60\%$)⁴¹ were one-third more likely to drink at hazardous levels than non-Indigenous ($>40\%$) prisoners in the Australian Capital Territory (Stoové and Kirwan, 2010). Hazardous alcohol consumption did not differ substantially between Indigenous and non-Indigenous prison entrants in South Australia in 2008 ($\approx 41\%$) (South Australia Department for Correctional Services, personal communication).

Data were available on alcohol consumption among prisoners in New South Wales from the 2009 Inmate Health Survey. Indigenous men were significantly more likely than non-Indigenous men to report risky drinking behaviour (74% vs 57%), dependent drinking behaviour (44% vs 30%), and usually drinking 10 or more standard drinks when drinking (58% vs 41%). Indigenous women who drank alcohol were also significantly more likely to do so as a dependent drinker (29% vs 11%) or usually consuming 10 or more drinks when drinking (31% vs 15%) compared to non-Indigenous women (Indig, McEntyre et al., 2010).

⁴¹ Specific numbers are not reported for the Australian Capital Territory in some circumstances because the actual data were not reported in the relevant report. Consequently, an estimate of the actual number has been made through visual examination of graphs and diagrams in Stoové and Kirwan (2010).

Illicit drug use

In the 2009 National Prisoner Health Census (NPHC), the proportion of Australian prison entrants reporting having ever used illicit drugs prior to being incarcerated did not differ between Indigenous (72%) and non-Indigenous (71%) prison entrants (Australian Institute of Health and Welfare, 2010). Indigenous prison entrants (59%) were more likely than non-Indigenous entrants (50%) to have ever used cannabis. Non-Indigenous prison entrants were more likely than Indigenous entrants to have used meth/amphetamines (33% vs 21%), heroin (21% vs 15%) and ecstasy (21% vs 9%) (Australian Institute of Health and Welfare, 2010) (see Table 4.2).

Nationally in 2009, Indigenous prison entrants (61%) were more likely to report having ever injected drugs than non-Indigenous prison entrants (53%) (Australian Institute of Health and Welfare, 2010). In New South Wales, Indigenous prison entrants (46%) were more likely to report a history of injecting drug use than non-Indigenous prisoners (37%) (Indig, McEntyre et al., 2010). In South Australia in 2008, Indigenous prison entrants were less

likely than non-Indigenous entrants to report recent use of analgesics (10% vs 34%) or meth/amphetamines (19% vs 36%) but did not differ substantially on other substances (South Australia Department for Correctional Services, 2009). In Western Australia, similar proportions of Indigenous (34%) and non-Indigenous (38%) prisoners had a history of injecting drug use recorded in their prison health records in 2007 (Gilles et al., 2008).

Data were available on illicit drug use among New South Wales prison entrants from the 2009 Inmate Health Survey (Indig, McEntyre et al., 2010). Significantly more Indigenous women reported having ever tried illicit drugs (88%) than non-Indigenous women (74%). Indigenous prison entrants were significantly more likely than non-Indigenous entrants to have ever used cannabis, including both men (88% vs 82%) and women (82% vs 68%). Indigenous men were significantly more likely than non-Indigenous men to have used illicit drugs on a regular basis in the year before prison (51% vs 38%) and to have ever used illicit drugs in prison (48% vs 39%) (Indig, McEntyre et al., 2010).

Table 4.2: Australian prisoners – ever used drugs, by Indigenous status

Illicit drug use history (ever used)	Indigenous (%)	Non-Indigenous (%)
Heroin	15	21
Amphetamines/methamphetamines	21	33
Cannabis	59	50
Ecstasy	9	21
Ever injected	53	61

Source: Adapted from Australian Institute of Health and Welfare (2010)

Table 4.3: NSW IHS participants – ever used drugs, by drug type and Indigenous status

Illicit drug use history (ever used)	Male prisoners			Female prisoners		
	Indigenous %	Non-Indigenous %	Total %	Indigenous %	Non-Indigenous %	Total %
Heroin	43.4	36.3	38.6	52.0	48.2	49.2
Amphetamines*	60.2	56.2	57.5	50.0	58.3	56.1
Cannabis	87.9	81.6	83.6	82.0	67.6	71.4
Cocaine	38.7	47.9	44.9	30.0	52.5	46.6
Any illicit drugs	88.3	84.2	85.5	88.0	74.1	77.8
Ever injected	46.1	37.2	40.1	50.0	53.2	52.4

* 'Amphetamines' does not include methamphetamine.

Source: Indig, McEntyre et al. (2010)

4.2 Drug strategies

4.2.1 Supply reduction

Urinalysis programs

Three jurisdictions provided data on urinalysis programs by Indigenous status and gen-

der. Two jurisdictions (South Australia and the Australian Capital Territory) reported the number of both targeted and random urinalysis tests and positive results for each type of testing regime in 2009. In addition, Western Australia provided data on the number of random urinalysis tests and positive results. Data are presented in Tables 4.4 and 4.5.

Table 4.4: Number of targeted urinalysis tests, and positive results, in SA and ACT, 2009

		Male prisoners		Female prisoners	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
SA	Prisoners*	781	2715	115	338
	Positive tests	231	663	39	56
	Ratio	0.30	0.24	0.34	0.17
ACT	Prisoners	19	131	5	16
	Positive tests**	72	261	19	43
	Ratio	3.79	1.99	3.8	2.7

SA: *Indigenous status unknown for 21 males, 7 females

ACT: 169 (whole of jail), includes therapeutic

** Includes positive tests for prescribed pharmaceuticals and could include multiple positive tests per prisoner.

Source: Corrective services departments for South Australia and the Australian Capital Territory

Table 4.5: Number of random urinalysis tests and positive results in three jurisdictions, 2009

	Number of random urinalysis tests (total)	Male prisoners – positive results		Female prisoners – positive results	
		Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
WA	2342	156	64	9	0
SA	190	2	7	–	–
ACT ⁺	–	11	69	3	10

WA = data from drug prevalence testing regime; 2035 tests on males and 307 tests on females; does not report for cocaine or alcohol

SA = Mount Gambier only; men only

ACT⁺ Testing between May 2009 and December 2009; includes positive tests for prescribed pharmaceuticals.

Source: Corrective services departments for Western Australia, South Australia and the Australian Capital Territory

Cannabis was the most common drug for which a positive test was returned in all jurisdictions that provided such data. In Western Australia, all positive results among Indigenous men were for cannabis. There were nearly three times as many positive cannabis results among Indigenous men (156) as there were among non-Indigenous men (59).

4.2.2 Demand reduction

Detoxification

States and territories were asked to provide the number of prison entrants reporting withdrawal symptoms. Western Australia provided the number of prison entrants self-reporting withdrawal symptoms and the proportion of prison entrants reporting withdrawal symptoms by demographic group in 2009.

A total of 237 Indigenous men, 376 non-Indigenous men, 157 Indigenous women and 177 non-Indigenous women reported experiencing withdrawal symptoms upon entry to Western Australian prisons in 2009 (Western Australia Department of Corrective Services, personal communication). As can be seen in Figure 4.3, self-reported withdrawal symptoms were least frequent among Indigenous (9%) and non-Indigenous (10%) males, were more prevalent among Indigenous females (28%), but were most common among non-Indigenous females (43%). Indigenous men were more commonly withdrawing from alcohol, non-Indigenous men from opioids. Indigenous women were more commonly withdrawing from amphetamines and prescription medication; non-Indigenous women, like non-Indigenous men, were more commonly withdrawing from opioids (Western Australia Department of Corrective Services, personal communication).

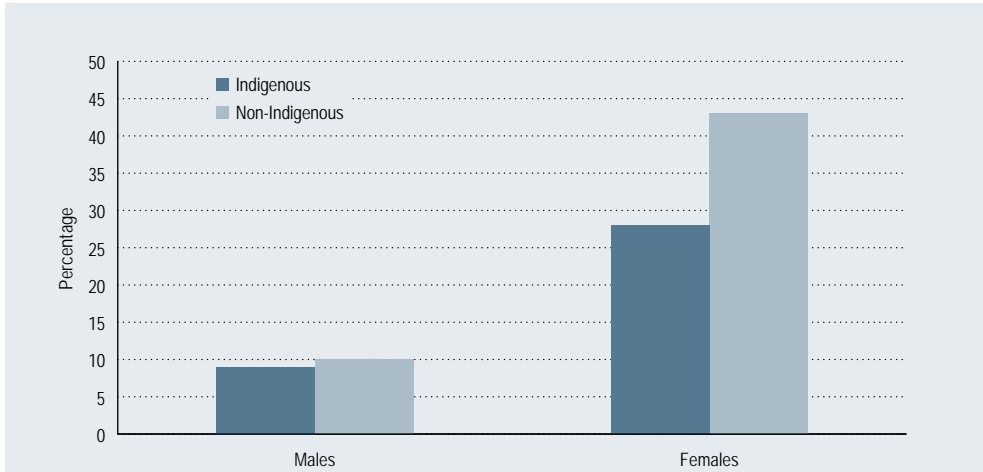


Figure 4.3: Proportion of WA prison entrants self-reporting withdrawal symptoms, by demographic group, 2009

Source: Western Australian Department of Corrective Services, personal communication, 2009

Methadone and other pharmacotherapies

States and territories were asked what percentage of prisoner receptions were on methadone or buprenorphine. New South Wales provided data on the number of prisoner receptions on opioid maintenance therapies in

2009 by Indigenous status. South Australia provided data from the 2008 Prisoner Health Census, which showed no prisoners were on pharmacotherapy upon reception to prison. SADCS noted that this was an unexpected finding (South Australia Department for Correctional Services, personal communication).

Table 4.6: NSW prison entrants on methadone or buprenorphine, by demographic group, 2009

	Male prisoners		Female prisoners	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Methadone	81	949	33	262
Buprenorphine	19	238	0	26
Total	100	1187	33	288

Source: Corrective Services New South Wales (2009)

Compared with non-Indigenous male prisoners, Indigenous male prisoners in New South Wales in 2009 were more likely to have ever been on methadone (26% vs 19%) and buprenorphine (13% vs 8%) (Indig, McEntyre et al., 2010). More than half of Indigenous female prisoners had ever been on methadone (51%) and one in five had ever been on buprenorphine (20%) (Indig, McEntyre et al., 2010). These levels are higher than the levels for non-Indigenous women who had ever been on methadone (38%) and buprenorphine (17%) (Indig, McEntyre et al., 2010).

Programs and services provided by prison staff

States and territories were asked to provide data on the number of prisoners accessing drug- and alcohol-related services and programs provided by the department responsible for corrections in 2009. New South Wales provided data on the number of prisoners accessing drug and alcohol counselling, Getting SMART programs and SMART Recovery programs (see Table 4.7).

Programs and services provided by external organisations

States and territories were asked to provide data on the number of prisoners accessing AOD services and programs provided by external organisations in 2009. Western Australia provided data in response to this question.

In Western Australia in 2009, a total of 190 Indigenous men and 17 Indigenous women took part in an AOD program provided by an external organisation: 174 Indigenous men participated in the Indigenous Men Managing Anger and Substance Abuse program which is provided in partnership with an external organisation; 21 of the 109 prisoners who took part in the Pathways program were Indigenous (the Pathways program is delivered in partnership with an external organisation); 64 of the 237 prisoners who took part in the Moving On from Dependencies program were Indigenous; and 39 of the 41 women prisoners who took part in the Women's Substance Use Program at Greenough Prison were Indigenous (Western Australia Department of Corrective Services, personal communication).

Table 4.7: NSW prisoners accessing AOD programs in prison, by demographic group, 2009

	Male prisoners		Female prisoners	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
AOD counselling	835	2616	182	481
Getting SMART	366	1304	182	481
SMART Recovery	67	391	11	30

Source: Corrective Services New South Wales (2009)

4.2.3 Harm reduction

Harm reduction education programs

States and territories were asked to provide data on the number of prisoners accessing a range of harm reduction education programs in 2009. Western Australia provided the number of prisoners accessing harm reduction education from prison staff by demographic group. New South Wales provided data on Indigenous peer educators.

In Western Australia, 1152 Indigenous male prisoners and 255 Indigenous female prisoners accessed harm reduction education programs provided by prison staff in 2009. In New South Wales, 28 Indigenous men were trained as peer educators in 2009.

Blood-borne virus testing and vaccination

It is estimated that between 13 000 and 22 000 Indigenous Australians are living with hepatitis C in Australia, representing 4 per cent of all Indigenous Australians compared with 1 per cent of the non-Indigenous population (National Centre in HIV Epidemiology and Clinical Research, 2009). In 2007, 16 per cent of the Australian population living with chronic hepatitis B infection identified as Indigenous, with levels higher in rural populations. In 2008, the diagnosis rate for newly acquired hepatitis B infection was between one and five times higher than that of the non-Indigenous population in New South Wales, the Northern Territory, South Australia, Victoria, Queensland and Western Australia (Australian Government Department of Health and Ageing, 2010). Further, the Department of Health and Ageing (2010) acknowledges that vaccination is a primary measure to control the transmission of HBV and the routine screening of people with chronic HBV is important for appropriate management of the condition.

Butler, Dolan and Wodak (2004) and Dolan et al. (2010) have found that imprisonment is a risk factor for HCV transmission. Screening for blood-borne viruses on entry to prison is crucial in preventing the spread of blood-borne viruses (Butler and Papanastasiou, 2008).

A recent study of New South Wales prisons found high HCV transmission rates, 34 per 100 prison years (Dolan et al., 2010). The limited availability of harm minimisation strategies and the continued high imprisonment rates of injecting drug users for brief periods of time have been identified as playing a crucial role in HCV transmission (Dolan et al., 2010).

Butler and Papanastasiou (2008) reported an increase over time in the prevalence of both hepatitis B and hepatitis C among Indigenous injecting drug users. Culturally appropriate education combined with hepatitis B vaccination and hepatitis C treatment were recommended as crucial to addressing these concerns in the Indigenous prison population.

Hepatitis B

According to Butler and Papanastasiou (2008), the prevalence of hepatitis B core-antibody among prisoners screened in the 2007 sample was highest in New South Wales (27%) and Western Australia (28%), and lowest in Queensland and Tasmania (9%). Table 4.8 shows the prevalence of HBV among prison entrants in 2007, by gender and Indigenous status. Indigenous prison entrants showed a higher prevalence than non-Indigenous prison entrants across all five Australian jurisdictions in the National Prison Entrants' Bloodborne Virus and Risk Behaviour Survey sample.

Table 4.8: Prevalence of hepatitis B core antibody positive among prison entrants nationally and in five jurisdictions, 2007

Hep B antibody	Male prisoners		Female prisoners	
	Indigenous %	Non-Indigenous %	Indigenous %	Non-Indigenous %
Australia	29	17	22	30
NSW	50	23	33	24
Vic	63	21	0	22
Qld	25	6	—	—
WA	36	20	60	0
Tas	50	4	—	—

Source: Butler and Papanastasiou (2008)

Hepatitis C

In 2007, the prevalence of hepatitis C among prisoners was 35 per cent nationally. New South Wales and Victoria had the highest prevalence at 42 per cent and 41 per cent, respectively. The lowest prevalence was found in Western Australia (21%). The prevalence was higher among prison entrants with an

injecting drug history (60% vs 4% for non-IDUs). Women IDUs (78%) had a higher prevalence than male IDUs (58%). Indigenous prison entrants had a higher hepatitis C prevalence than non-Indigenous prison entrants in New South Wales, Victoria, Queensland and Tasmania (see Table 4.9) (Butler and Papanastasiou, 2008).

Table 4.9: Prevalence of hepatitis C antibody positive among prison entrants nationally and in five jurisdictions, 2007

	Male prisoners		Female prisoners	
	Indigenous %	Non-Indigenous %	Indigenous %	Non-Indigenous %
Australia	37	31	72	53
NSW	53	31	92	50
Vic	63	37	100	60
Qld	37	31	—	—
WA	12	24	20	50
Tas	50	21	—	—

Source: Adapted from Butler and Papanastasiou (2008)

Table 4.10: HIV antibody positive results among prison entrants, by Indigenous status, sex and year*

Indigenous status	Male prisoners		Female prisoners		Total	
	N tested	N with HIV (%)	N tested	N with HIV (%)	N tested	N with HIV (%)
2004						
Non-Indigenous	340	1 (<1)	25	0 (0)	365	1 (<1)
Indigenous	68	2 (3)	10	0 (0)	78	2 (3)
2007						
Non-Indigenous	433	3 (<1)	35	1 (3)	468	4 (<1)
Indigenous	93	0 (0)	17	0 (0)	110	0 (0)

* Excludes equivocal test results and missing values.

Source: Adapted from Butler and Papanastasiou (2008)

HIV

According to Butler and Papanastasiou (2008), in 2007 the prevalence of HIV among prison entrants was less than 1 per cent nationally. Table 4.10 shows HIV prevalence among prison entrants nationally in 2004 and 2007, by Indigenous status. Breakdowns by Indigenous status and jurisdiction were not available.⁴²

4.3 Re-entry programs

4.3.1 Mortality among recently released prisoners (within 3 months)

Only Western Australia has an ongoing program linking released prisoners with the deaths registry.

In 2009, one Indigenous and one non-Indigenous man died within three months of release from Western Australian prisons.

The cause of death in one case was unknown and the other was classified as a heart attack (Western Australia Department of Corrective Services, personal communication).

Since 2004, studies have reported standardised mortality rates among recently released Indigenous prisoners in New South Wales and Western Australia. These studies indicate that, compared to non-Indigenous prisoners, after adjusting for age and calendar year, Indigenous prisoners have higher rates of mortality but lower rates of drug-related mortality after release from prison.

Kariminia, Butler et al. (2007) conducted a retrospective cohort study of all-cause and cause-specific mortality among 85 203 full-time prisoners after release between 1988 and 2002 in New South Wales. It reported that, in the immediate post-release period, Indigenous male prisoners were 4.8 times

⁴² As part of the questionnaire for the current study, Justice Health New South Wales did provide data on the number of prisoners tested for HIV and the number of positive tests. These findings are presented above in the section of the report on New South Wales. They have been omitted here, as this chapter is intended as a national overview of the health and AOD experiences of Indigenous prisoners.

more likely to die, and Indigenous female prisoners were 12.6 times more likely to die, than the general population. This compared with lower rates among all men (3.7) and women (7.8) in the cohort. This study did not report the SMRs for drug-related mortality by Indigenous status.

Kariminia, Law et al. (2007) studied factors associated with all-cause mortality, drug-related mortality, and suicide among men and women in the same New South Wales cohort described in Kariminia, Butler et al. (2007). Multivariate analysis indicated that Indigenous status did not increase the risk of all-cause mortality among male or female prisoners after release. However, Indigenous status was associated with a lower risk of drug-related mortality and suicide than non-Indigenous prisoners among both men and women. Combined with the higher all-cause SMR among Indigenous prisoners, this indicates that the higher SMR of Indigenous prisoners after release was due to factors other than Indigenous status, such as imprisonment history, and that suicide and

drug-related deaths are relatively less common than other specific causes of death such as accidents and injuries and cardiovascular disease.

Hobbs et al. (2006) conducted a retrospective cohort study of mortality and morbidity in prisoners after release from prison in Western Australia between 1995 and 2001. It reported age- and period-standardised ratios comparing released prisoners to the general Western Australian community. The highest relative risk of death was among non-Indigenous females (14.0) followed by non-Indigenous males (4.0) and Indigenous females (3.1); the lowest was among Indigenous male ex-prisoners.

4.3.2 Referrals to community pharmacotherapy programs for prisoners upon release

New South Wales and Western Australia provided data on the number of prisoners referred to community pharmacotherapy programs upon release by Indigenous status.

Table 4.11: Prisoners referred to community pharmacotherapy programs in NSW and WA, by Indigenous status, 2009

	Male prisoners		Female prisoners	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
NSW				
Methadone	175	1315	82	393
Buprenorphine	20	219	4	40
Total	195	1534	86	433
WA				
Total	11	134	12	32

Source: Justice Health (2009); and Western Australia Department of Corrective Services, personal communication, 2009

4.3.3 Additional information on Indigenous prisoners (provided in response to questionnaire)

New South Wales: ‘The CSNSW Aboriginal Support and Planning Unit is consulted in relation to the appropriateness of services and programs and every effort is made to provide Aboriginal facilitators or co-facilitators when group programs include Aboriginal participants. A number of correctional centres employ Aboriginal elders, and Indigenous staff comprise approximately 4 per cent of the CSNSW workforce (compared to 2% in the general community)’ (Corrective Services NSW, personal communication).

Queensland: ‘Where programs are provided, they are provided along similar lines to programs provided by other Queensland Health services. Given the very limited services currently available in this area, the services provided are not currently developed in consultation with Indigenous people. We provide some specific Indigenous drug education via a HitNet interactive kiosk’ (Queensland Health, personal communication).

Western Australia: ‘DCS consults with national and state Indigenous organisations regarding service delivery to Indigenous prisoners. An Aboriginal Facilitation Unit was developed in 2009 to recruit Indigenous staff to provide improved services and broaden partnerships with Indigenous agencies’ (Western Australia Department of Corrective Services, personal communication).

South Australia: ‘Consultation with appropriate services when caring for Indigenous clients occurs. Liaison with these services takes place for ongoing management of care and treatment’ (South Australian Prison Health Service, personal communication).

‘Correctional Services, South Australia has an internal Indigenous Unit which works closely with Indigenous offenders to ensure cultural needs are considered and dealt with appropriately. All program staff were trained in cultural awareness in recognition of an equitable approach to all offenders’ (South Australia Department for Correctional Services, personal communication).

Tasmania: ‘Criminogenic programs are run without consultation with representatives of the Indigenous community. Indigenous-specific programs for inmates involve consultation with the Aboriginal Case Coordinator and representatives of the local Aboriginal community’ (Tasmania Department of Health and Human Services, personal communication, 2011).

Australian Capital Territory: ‘Wimmunga Nimmityjah provides an in-reach service to detainees at the AMC’ (ACT Corrections Health, personal communication).

4.4 Research and evaluations

Two key reports relating to Indigenous prisoners are:

- Indig, McEntyre, Page and Ross (2010), *2009 NSW Inmate Health Survey: Aboriginal health report*.
- Onemda VicHealth Koori Health Unit, Victorian Aboriginal Community Controlled Health Organisation and the Australian Research Centre in Sex, Health and Society (2007), *Evidence Base for STI/BBV Prevention and Treatment for Koori People in Prison*.

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6. Appendix

Project questionnaire

GENERAL PRISONER INFORMATION

Annual prisoner receptions (not individuals)

Year	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Total Male	Indigenous	Non-Indigenous	Total Female
2009						

REPORTED DRUG USE

In 2009 how many or what percentage (mark clearly %) of prison receptions reported drug use in the past year?

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
Alcohol						
Tobacco						
Heroin						
Amphetamines						
Cannabis						
Cocaine						
Any drug or alcohol use						
History of injecting drug use?						

DEMAND REDUCTION

Detoxification

Factors related to detoxification of prisoners in 2009

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
What percentage of prison receptions experienced withdrawal symptoms?						
What was the most common drug (including alcohol) that receptions were withdrawing from?						
What percentage of prison receptions required detoxification services?						

Were inmates withdrawing from heroin offered methadone or buprenorphine for detoxification in 2009? (N.B. methadone and buprenorphine maintenance will be discussed below.)

Male Prisoners	Female Prisoners
No	No
Yes, methadone	Yes, methadone
Yes, buprenorphine (subutex)	Yes, buprenorphine (subutex)
Yes, buprenorphine-naloxone (suboxone)	Yes, buprenorphine-naloxone (suboxone)

Staffing levels in 2009

Question	2009
How many specialist drug and alcohol staff were employed (full-time equivalent) by your department in 2009 (e.g. doctors, nurses, psychologist, and drug and alcohol workers)?	

Methadone and buprenorphine maintenance treatment

Could inmates commence methadone or buprenorphine maintenance treatment in prison in 2009?

Male Prisoners	Female Prisoners
No	No
Yes, methadone only	Yes, methadone only
Yes, buprenorphine (subutex) only	Yes, buprenorphine (subutex) only
Yes, buprenorphine-naloxone (suboxone) only	Yes, buprenorphine-naloxone (suboxone) only
Yes, methadone or buprenorphine (subutex) or buprenorphine-naloxone (suboxone)	Yes, methadone or buprenorphine (subutex) or buprenorphine-naloxone (suboxone)

If methadone or buprenorphine maintenance treatments are not available in prisons, please mark N/A.

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many or what percentage (mark clearly %) of prison receptions were on methadone maintenance treatment?						

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many or what percentage (mark clearly %) of prison receptions were on buprenorphine maintenance treatment?						

	2009	
	Male Prisoners	Female Prisoners
Could prison receptions remain on methadone maintenance treatment? Y/N		
Could prison receptions remain on buprenorphine maintenance treatment? Y/N		

Can you please describe what happens to inmates going through withdrawal (e.g. withdrawal regimen)?

Who was responsible for providing methadone and or buprenorphine maintenance treatments in prisons in 2009 (e.g. corrections, health, contractor)?

Any additional comments about methadone or buprenorphine maintenance treatment:

For example, you may wish to comment on when the program started, the challenges or oppositions faced in running the programs.

OTHER DRUG TREATMENT OR EDUCATION PROGRAMS

The following set of definitions will assist in answering the questions regarding treatment in the next table:

Therapeutic communities: are residential communities within prison where inmates stay for several months. During that time residents are encouraged to address their drug and/or alcohol use problem and participate in group activities. <<http://www.atca.com.au/home.htm>>

SMART:

Getting SMART is a 12-session substance abuse program that teaches offenders to use cognitive behavioural therapy principles, theories, tools and techniques to abstain from any type of addictive behaviour. <http://www.correctiveservices.qld.gov.au/Publications/Corporate_Publications/Program_Factsheets/GettingSmart_staff.pdf>

SMART Recovery is a voluntary, peer-managed self help group that assists individuals to recover from alcohol and drug use. <<http://www.acon.org.au/communities/regional-nsw/news/SMARTRecovery>>

Drug-free units/prisons: inmates adopt a group effort to keep the unit/prison drug-free.

Compulsory Drug Treatment Programs (CDTP)

If a particular form of drug treatment is not available, please mark N/A. If the form of treatment is offered, but numbers requested are unavailable, please note this with a dash (–).

Please list the drug treatment or education programs available in your jurisdiction and indicate how many prisoners participate each year.

Name of treatment/ program	Treatment/program duration and type (e.g. voluntary or compulsory)
Example: AA	How many AA meetings were held in prisons in 2009? Estimated number of inmates attending AA meetings in 2009?

Drug treatment and education programs 2009

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many inmates entered therapeutic community programs or drug-free units for drug treatment?						
How many inmates entered a therapeutic community?						
How many inmates entered drug-free units?						
How many inmates entered Compulsory Drug Treatment Programs?						
How many inmates received drug and alcohol counselling?						
How many inmates received drug education?						

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many inmates attended Getting SMART programs?						
How many inmates attended SMART Recovery programs?						

Please list any programs or services that are provided in partnership with external organisations.

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many inmates were involved in drug and alcohol programs delivered by external treatment providers?						

HARM REDUCTION STRATEGIES

If a strategy is not available, please mark N/A. If a strategy is offered but the numbers requested are not available, please note this with a dash (–).

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many inmates completed the hepatitis B vaccination schedule?						
How many inmates were tested for hepatitis B?						
How many inmates tested positive for hepatitis B?						
How many inmates were tested for hepatitis C?						
How many inmates tested positive for hepatitis C?						
How many inmates were tested for HIV?						
How many inmates tested positive for HIV?						

	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
How many condoms were distributed in prisons?						
How many dental dams were distributed in prisons?						
How many inmates received harm reduction education from staff in your department?						
How many inmates were trained as peer educators?						

Any general comments about harm reduction strategies:

SUPPLY REDUCTION STRATEGIES

Drug detection dogs

In 2009 were drug detection dogs used in prisons?

Male Prisons	Female Prisons
Yes	Yes
No	No

In 2009 how many searches were undertaken by drug detection dogs?

Year	Male Prisons	Female Prisons	Total
2009			

On how many occasions did drug detection dogs detect illicit drugs?

Year	Male Prisons	Female Prisons	Total
2009			

In 2009 what quantities of the following drug groups were detected by drug detection dogs?

	Male Prisons	Female Prisons
Powder		
Green vegetable matter		
Tablets		
Other		

Syringes

In 2009 how many syringes were found?

Year	Male Prisons	Female Prisons	Total
2009			

Therapeutic testing

In 2009 how many prisoners were tested as part of a therapeutic urinalysis program (e.g. to ensure compliance with a program)?

Year	Male Prisoners	Female Prisoners	Total
2009			

Positive results for urinalysis tests in 2009

In 2009 how many positive tests were there for therapeutic, random and targeted urinalysis tests?

Drugs	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
Alcohol						
Heroin						
Amphetamines						
Cannabis						
Cocaine						
Other						

Random testing

In 2009 how many urine tests were conducted as part of the random urinalysis program?

Year	Male Prisoners	Female Prisoners	Total
2009			

Please describe the method used to select the random sample.

How many positive results were there for random urinalysis tests in 2009?

Drugs	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
Alcohol						
Heroin						
Amphetamines						
Cannabis						
Cocaine						
Other						

Targeted testing

In 2009 how many prisoners were tested as part of the targeted urinalysis program?

Years	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
2009						

In 2009 how many positive tests were there for each of the following drugs?

Drugs	2009					
	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
Alcohol						
Heroin						
Amphetamines						
Cannabis						
Cocaine						
Other						

SUPPLY REDUCTION

Were any of the following supply reduction measures used? If a particular measure is not used for a given year please mark N/A.

2009					
Supply reduction measure	Y/N	Number of visitors screened	Number of staff screened	Number of inmates screened	Number of interdictions
Electric ion machines					
Metal detectors					
Other (e.g. bag searches, pat-downs etc)					

Children

In 2009 how many or what percentage (mark clearly %) of prisoners had children?

Years	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
2009						

AFTERCARE AND TRANSITIONAL PROGRAMS

Drug-related services for prisoners on release from prison (excluding community corrections programs and services)

Do prison staff provide referrals to community pharmacotherapy programs for prisoners upon release?

Male Prisoners		Female Prisoners	
No		No	
Yes, methadone		Yes, methadone	
Yes, buprenorphine (subutex)		Yes, buprenorphine (subutex)	
Yes, buprenorphine-naloxone (suboxone)		Yes, buprenorphine-naloxone (suboxone)	
Other		Other	

Please list the services and/or programs that inmates are referred to upon their release.

Name of service or program	Organisation running the service or program
Drug and alcohol specific services or programs	

In 2009 how many prisoners were referred to pharmacotherapy programs upon release?

Years	Male Prisoners			Female Prisoners		
	Indigenous	Non-Indigenous	Male Total	Indigenous	Non-Indigenous	Female Total
2009						

Any additional information/comments on aftercare and transitional programs for prisoners after they have been released from prison (excluding community corrections programs and services)?

EVALUATIONS

Have any demand, harm or supply reduction programs been evaluated since 2004? Y/N

Strategies	Y/N	Please provide details of all evaluations (include year, by whom the evaluation was conducted and provide copies of the report if possible)
Demand reduction		
a Detoxification		
b Opioid pharmacotherapy		
c Counselling		
d Cognitive behavioural therapy (CBT)		
e Other		
Harm reduction		
a Harm reduction education		
b Illicit drug peer education		
c BBV testing		
d HBV vaccine		
e Condom provision		
f Disinfectant		
g Naloxone		
i Other		
Supply reduction		
a Drug detection dogs		
b Urinalysis programs		
c Other		

ADDITIONAL INFORMATION

Topic	Question
Mortality	Please provide any information on people dying within 3 months of release from prison
Principles of the National Corrections Drug Strategy	Do any programs and services adhere to the principles of the National Drug Strategy?
Evidence-based programs/services	List any programs or services that are guided by research evidence and the type of evidence (e.g. internal, external, quantitative or qualitative, any other source of evidence)
Indigenous prisoners	How do you ensure that services and programs meet the needs of Indigenous prisoners? (e.g. Are they developed in consultation with Indigenous people and their cultural values?)
Other drug treatment or education program	Please provide details of any other drug and alcohol treatment programs offered to inmates (e.g. type of program, number of inmates treated, results of treatment)
Programs and services not offered	Are there any drug and alcohol programs or services (demand, harm and supply reduction) that are NOT offered in your state/territory but which you would like to see introduced in prisons?
Additional comments	If you have any additional comments about drug and alcohol treatment programs, please include them here: