# ACT Corrective Services

# Drug, Alcohol and Tobacco Strategy

# 2006 - 2008

**This document details a drug, alcohol and tobacco strategy for application in a correctional setting. Details of implementation will be contained within procedures for Community Corrections and procedures for the Alexander Maconochie Centre, which are currently under development in consultation with the Human Rights Commissioner and the Ombudsman.**

**This Strategy, by the very nature of the subject which it addresses, will be a dynamic document. It will evolve over time, including in response to changes in the National Drug Strategy 2004-09, the National Corrections Drug Strategy 2004-08, the ACT Alcohol, Tobacco and Other Drug Strategy 2004-06. It will also be responsive to emerging research literature.**

**In the development of this document, ACT Corrective Services acknowledges similar documents from Corrections Victoria (*Victorian Prison Drug Strategy, 2002*) and the South Australian Department of Correctional Services (*Drug and Alcohol Strategy Project, Final Report February 1998*), and the advice of colleagues of the Compulsory Drug Treatment Correctional Centre, Parklea, NSW Department of Corrective Services.**

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# Executive Summary

- The high correlation between drug use, crime and mental health is one of the major issues confronting the criminal justice system.

- The *ACT Corrective Services' Drug Strategy 2006 – 2008 ("The Strategy")* has been written in context with: the *National Drug Strategy 2004-2009;* the *ACT Alcohol, Tobacco & other Drug Strategy 2004-2008; the National Comorbidity Project 2003* and the *Draft National Corrections Drug Strategy 2006-2009.* The relationship between drug use, mental health and blood-borne viruses is well known. Accordingly, *The Strategy* should also be read in conjunction with the *ACT Health Corrections Health Service Plan* and the *ACT Mental Health Plan.*

- The Strategy will be responsive to emerging research and new wisdom and to changes to the higher order strategies referred to above.

- Data shows that ACT has had a low percentage in recent years of prisoners* who have been sentenced for a drug offence as their most serious offence. However, this is not indicative of the prevalence of drug use among prisoners. Some prisoners are convicted of more serious offences, with drug offences attached to their sentencing, and some prisoners' primary offence was committed while under the influence of drugs, or to support their drug use.

- Many prisons have witnessed an increasing level of entrenched drug and alcohol use among prison entrants. When prisoners use drugs in prison, problems are caused by obtaining and using drugs, behaviour resulting from drug use, infection risk, overdose and continued offending. In addition, the process of introducing drugs into prisons inevitably impacts on, and sometimes compromises, the families and friends of prisoners. While prison can be a traumatic experience for some prisoners, it also provides a unique opportunity to stabilise prisoners' lives and to address issues relating to their drug use and criminality. (Poroch, 2007: 45; Levy, 1999: 4)

- The purpose of *The Strategy* is to minimise drug-related harm to prisoners and offenders, staff of ACTCS and the wider community. This purpose supports the basic principles of harm minimisation as articulated in the *National Drug Strategy 2004-09* and the *ACT Alcohol, Tobacco and Other Drug Strategy 2004-08*. *The Strategy* embraces three aims, which provide for a complementary and balanced response to the problems of drugs in the correctional setting. These are: Supply Reduction; Demand Reduction; and Harm Reduction.

- *The Strategy* contributes to ACTCS' organisational objective of seeking to detect and control drug use, and to work with prisoners to address the substance misuse component of their offending behaviour.

* In the context of this Strategy, the term "prisoner" refers both to people who have been sentenced and those who are being held on remand

- *The Strategy* acknowledges that ACT Health will have primary responsibility for the health of prisoners in the AMC. However, health is only one aspect of overall well-being of prisoners, the responsibility for which will be shared by the AMC staff and those of ACT Health.

- *The Strategy* incorporates the aims to include both current and future strategies and services, and also outlines performance measures for each aim.

- By necessity, those which relate to the future operation of the AMC must remain tentative until the tenor and substance of higher order national and ACT Government health and drug alcohol strategies which will be in force at the time of commissioning are confirmed.

- The legislative framework for *The Strategy* may be found in the *Crimes (Sentence Administration) Act 2005* and the *Corrections Management Bill 2006*.

# Introduction

## Context

### Drugs in Australia

*National Drug Strategy*

The *National Drug Strategy 2004-2009* provides a framework for a coordinated, integrated approach to drug issues in the Australian community.

Drug use contributes to significant illness and disease, injury, workplace concerns, violence, crime, and breakdowns in families and relationships in Australia. Collins and Lapsley (2002) estimated that the economic costs associated with licit and illicit drug use in 1998-99 amounted to $34.5billion, of which tobacco accounted for 60%, alcohol 22% and illicit drugs 17%.

The mission of the *National Drug Strategy* is to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society.

The principle of harm minimisation has formed the basis of successive phases of the *National Drug Strategy* since its inception in 1985. Harm minimisation does not condone drug use; rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.

Australia's harm minimisation strategy focuses on both licit and illicit drugs and includes preventing anticipated harm and reducing actual harm. Harm minimisation is consistent with a comprehensive approach to drug-related harm, involving a balance between demand reduction, supply reduction and harm reduction strategies. It encompasses:

- supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;

- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence oriented strategies and treatment to reduce drug use; and

- harm reduction strategies to reduce drug-related harm to individuals and communities.

Individual jurisdictions and non-government organisations will continue to develop plans and strategies that reflect the key elements of the *National Drug Strategy*, and will report annually on implementation of programs, activities and initiatives.

The high correlation between drug use and crime is one of the major issues confronting the criminal justice system. There is a high correlation between violent crime and excessive alcohol consumption, with research estimating that between 41% and 70% of violent crimes are committed under the influence of alcohol.

The *National Drug Strategy* identifies the following priority areas for action over the 2004-09 period covered by the document:

- Prevention.

- Reduction of supply.

- Reduction of drug use and related harms.

- Improved access to quality treatment.

- Development of the workforce, organisation and systems.

- Strengthened partnerships.

- Implementation of the *National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-06.*

- Identification and response to emerging trends.

The ACT Corrective Services *Drug, Alcohol and Tobacco Strategy 2006-8* is consistent with these priorities

## Drugs in the ACT

*ACT Alcohol, Tobacco & other Drug Strategy 2004-2008 ("the ACT Strategy)*

The four main aims of the *ACT Strategy* are to:

- Improve the health and social well-being of individuals, consumers, families and carers, and the community in the ACT;

- Minimise the harm in our community from alcohol, tobacco and other drugs while recognising the individual needs of all citizens in the ACT;

- Develop evidence-based initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way; and

- Implement *the ACT Strategy* in a manner that respects, protects and promotes human rights.

The *ACT Strategy* interprets the national agenda by continuing to approach the issues associated with harmful alcohol, tobacco and other drug use through applying the principles of harm minimisation, improving the evidence base that informs policy development and extending community partnerships beyond law enforcement and health.

The action plan of *the ACT Strategy* includes a group of actions directed at Custodial Service Delivery. These are aimed at providing full access to health services and treatments that are available to the community to prisoners, detainees and remandees. These actions also support community corrections, ACT Corrective Services programs staff and custodial officers working in conjunction with other government and non-government agencies and clients to achieve outcomes that address the assessed needs of prisoners. These actions are consistent with the ACT *Health Action Plan, 2002*. *The ACT Strategy* also describes examples of ways in which the implementation of these actions may be evaluated.

## Drugs in Corrections

ACT Corrective Services data shows that ACT has had a low percentage of prisoners who have been sentenced for a drug offence as most serious offence: 9.1% in 2001; 5.7% in 2002; 4.2% in 2003; 3.3% in 2004; and none in 2005 (CSAC, 2005).

This, however, is not indicative of the prevalence of drug use among prisoners. Some prisoners are convicted of more serious offences, with drug offences attached to their sentencing, and some prisoners' primary offence was committed while under the influence of drugs or to support their drug use. For example, in 2005 approximately 30% of prisoners in QLD and 20% in Victoria had drug offences attached to their current sentences (CSAC, 2005).

Existing data collection is not sufficiently comprehensive to explain why ACT has a low percentage of prisoners sentenced for a drug offence as most serious offence. As a consequence, there is no evidence to support the contention that it is a product of the reluctance of ACT courts to imprison people, and equally there is no evidence base to support the contention that this will change with the advent of the AMC.

*The Draft National Corrections Drug Strategy 2006-2009*

In relation to the impact of drug use in adult correctional institutions, the draft *National Corrections Drug Strategy 2006-2009* notes the following environment:

- Prisoners who take drugs generally have complex needs and may not have been engaged in, or have failed to respond to, community treatment. They require intensive treatment and support throughout custody and beyond custody to achieve positive treatment and rehabilitative outcomes.

- Many prisons have witnessed an increasing level of entrenched drug and alcohol use among prison entrants, with, for example, 55% of all prisoners in Victoria reporting that their offences were committed to support drug use or under the influence of drugs. NSW data indicates that 71.3% of male prisoners and 66.7% of female prisoners reported that their offences were related to their use of alcohol and other drugs. In addition, over 80% reported problems with alcohol and other drugs at some stage in their lives and 78.8% of prisoners had used illicit drugs in the 6 months prior to their current prison term.

- Approximately 60% of prisoners report drug use on at least one occasion during their current term of imprisonment, and around 33% of injecting drug users continue to inject drugs in prison. A smaller percentage of people also begin using drugs and injecting drugs for the first time when in prison. When prisoners use drugs in prison, problems are caused by obtaining and using drugs, behaviour resulting from drug use, infection risk, overdose and continued offending.

- Co-morbid substance use disorder and mental illness is common among prisoners in custody. In NSW correctional centres, 66% of females and around 50% of males with a substance use disorder also have a mental disorder (psychosis, anxiety disorder or affective disorder).

- Problematic drug use compounds other problems prevalent among prisoners, such as poor education levels, dysfunctional family environments, poor employment prospects, and psychiatric or health concerns.

- Harmful, drug-related behaviour, such as violence or the transmission of blood-borne viruses, threatens the health and well-being of correctional institution staff, other prisoners and the broader community.

- The prevalence of hepatitis C in male prisoners in Australia has been estimated at over 30%, with some jurisdictions reporting even higher rates.

- The prevalence of hepatitis C in female prisoners in Australia has been estimated at over 60%, again, with some jurisdictions reporting even higher rates.

- 1999 HIV rates within the correctional setting in Australia varied between 0.07% and 0.6% (ANCD, 2004).

**Implications for the ACT Corrective Services Drug, Alcohol & Tobacco Strategy**

- While the Alexander Maconochie Centre will have a commitment to prisoner habilitation or rehabilitation, it is to be a prison. It is not a hospital, not a hostel, and not a secure forensic mental health facility. Because it is a prison, its major concern, and the major concern of the community, is one of security. A major factor in the security of prisons is the introduction of illicit drugs, and the violence and intimidation that this causes (Commission of Inquiry, 1996; ABCI 2000, 2001;WHO 2001; ICAC, 2004; Gelb 2006). Notwithstanding this, the AMC Operating Philosophy reflects a commitment to the overall well-being of both prisoners and staff, and indeed, all those who visit or work inside the facility. This is expressed in the Operating Philosophy of the "Healthy Prison" (WHO 2001).

- Amongst the prisoner and offender population co-morbidity must be seen as the expectation rather than the exception. Programs and interventions are needed to deal with these problems, both within the AMC, and in the Community Corrections setting (National Comorbidity Project: 2003).

- The immediate goals of prisoner and offender drug and alcohol interventions, which must be linked to those for mental health problems, is to improve the prisoner's ability to function, to reduce drug use, and to minimise the health and social consequences of that drug use.

- The National Drug and Alcohol Research Council (2006) reports that dependent drug users die at 15 times the rate of the general population with half dead by the age of 50. Of these premature deaths, 50% were caused by overdose and another 10% as a result of suicide. 30% die by disease associated with addiction. Accordingly, as reflected in the National Drug Strategy, the goal of abstinence remains an essential element of the national approach to harm minimisation, and to the Strategy.

- Within the AMC, successful interventions will require close cooperation between ACT Health, AMC programs staff and appropriate community-based services and support. In the Community Corrections setting, close liaison will be required with ACT Health community-based resources, and those of non-government organisations.

- The AMC design endeavours to create an environment which encourages the overall well-being of prisoners and staff, and to facilitate the delivery of integrated services by ACT Health, AMC staff and, where appropriate, non-government organisations. (see Functional Brief March 2005)

- A major threat to the creation of such an environment is the tension and violence that the introduction of drugs into a prison setting fosters. AMC procedures must respond to this threat to ensure the safety of prisoners and staff, but also meet community expectation that efforts will be made to stem the potential for drugs to be introduced into the AMC. The WHO (2001) notes that *"We affirm the importance of taking all reasonable action to reduce the supply of drugs inside prisons" and "our policy is that prisons should make all reasonable efforts to ensure that prisoners do not have access to any drug, from whatever source, that has not been legitimately supplied."*

- The response to the potential introduction of drugs into the AMC needs to be balanced by the recognition of the crucial importance to prisoner rehabilitation of family visits and family contact. Thus, AMC operational procedures need to provide for a range of visit facilities and visit types. (see Functional Brief March 2005)

- To minimise the harm to individuals and to the well-being of staff, other prisoners and offenders, and the broader community, a differential sanctions response to drug use by prisoners and offenders will be followed.

- In recognition of the relationship between problematic alcohol and drug use and education underachievement, dysfunctional family environments (frequently including violence) and underemployment, AMC program delivery will target these multiple dimensions of the problems associated with alcohol and drug use. Details are contained in the Plan for Delivery of Vocational Educational and Training and Rehabilitative Programs in The Alexander Maconochie Centre.

- It has to be recognised that alcohol and drug use and the manifold problems and distress associated with such use, arise as a product of failures on many levels. Failures of the individuals, failures of families, failures of the community, and failures of government agencies to provide the necessary support services. Given these failures, in an environment better suited to rehabilitation than the custodial setting, it is unreasonable to expect that corrective service agencies in general, and the AMC in particular, can bring to an end prisoner disadvantages in multiple domains, particularly given the short duration of the average sentence. Nevertheless, AMC and Community Corrections staff will deliver their best endeavours in this area.

- The level of entrenched alcohol and drug use amongst prisoners makes it unlikely that it will be possible, within the median sentence of 14 months, to assist all dependent prisoners to become drug-free. In some cases then the focus will be on reducing alcohol and drug consumption and reducing risky drug taking practices, providing the necessary skills for prisoners to make the necessary changes in behaviours, if there is a willingness and motivation to do so, and to maintain the individual's health.

- With cottage accommodation in the AMC, there may be an opportunity to develop and implement a distinct model of a Therapeutic Community. This applies particularly with respect to the women's area of the AMC, which may have the potential to be managed as a discrete Therapeutic Community. The Transitional Release Centre similarly may have a similar potential. Linkages to community-based Therapeutic Communities will be investigated. This requires further research as it has been reported that *'studies (one quasi-experimental and one randomised controlled trial) provide little evidence that therapeutic community settings are more beneficial that other service delivery models for clients with dual diagnosis'* (National Comorbidity Project 2003). It also has been reported that in-prison therapeutic communities are not associated with a significantly improved recidivism rate as compared to that associated with cognitive-behavioural drug treatment in prison (WSIPP, 2006).

- Throughcare to, and Aftercare in, the community will be important to ensure that any improvements in well-being and reduced drug use made during imprisonment are sustained when the prisoner returns to the community.

## Drugs and the Alexander Maconochie Centre

The Alexander Maconochie Centre is being constructed as a result of extensive community consultation, Legislative Assembly and Law Reform Commission reports, which have supported the idea that ACT prisoners should not be transported to NSW to serve their sentences but, rather, should do so in an ACT prison (Biles, D. & Cuddihy, G. 1984; and ACT Council of Social Services *Policy Platform on a Prison for the ACT, April 2006)*.

It is acknowledged that the prison environment is less conducive to rehabilitative endeavours than community-based settings. Notwithstanding this, for some prisoners, the prison can provide a unique opportunity to stabilise their lives and to address issues relating to drug use, mental health and criminality (Irwin 1980; Coyle 2002; Poroch, 2007: 45; Levy, 1999: 4). Indeed, for some prisoners, the first time that their disabilities or problems have been identified and treated has been in a prison. Poroch (2007: 89) notes that 36% of a sample of Aboriginal ex-prisoners reported they exercised, kept healthy and came out fitter than when they went into custody, and also had given up drugs whilst in prison.

An holistic response is required for treatment of prisoners with drug and alcohol and mental health problems. This holistic response is encouraged by the Operating Philosophy of the Alexander Maconochie Centre, and will be further supported in the ACT Health, *ACT Corrections Health Service Plan 2006-09* (currently in draft).

Consistent with the action plan of *the ACT Strategy* and the *Corrections Health Services Plan 2006-2009, The Strategy* aims to provide support and services to prisoners and offenders equivalent to that which is available in the community. The necessary caveat to this arises from the nature of the prison setting.

## Operating Philosophy

The Alexander Maconochie Centre (AMC) is to be a secure and safe place that will have a positive effect on the lives of prisoners held there and on staff who work there (see WHO 2001). Its management and operations will give substance to the dictum of Sir Alexander Paterson that prisoners are sent to prison as punishment, not for punishment.

The AMC will reflect the "Healthy Prison" concept. A Healthy Prison is one in which:

- everyone is and feels safe;
- everyone is treated with respect as a fellow human being;
- everyone is encouraged to improve himself or herself and is given the opportunity to do so through the provision of purposeful activity; and
- everyone is enabled to maintain contact with their families and is prepared for release.

The AMC's Operating Philosophy has been the major factor influencing the design of the Centre. The Operating Philosophy for the AMC can be summarised as follows:

- it will provide protection from those who the community, through the courts, determine should be removed from its midst;

- it will provide protection from those who present a risk to other prisoners and to staff;

- it will provide security for prisoners and staff through design features, the use of technology, appropriate classification and separation of prisoners, and the appropriate categories and numbers of well-trained staff (see AMC *Functional Brief* and *Workforce Plan* www.cs.act.gov.au/amc);

- it will have regard to the recommendations of the *Royal Commission Into Aboriginal Deaths In Custody (RCIADIC)* that relate to prisons, and more recent Ombudsman reports and judicial inquiries (see Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody);

- its operating systems have been developed from the base of a thorough risk analysis carried out to Standard AS/NZ 4360 and which satisfies the requirements of the ACT *Enterprise-wide Risk Management (ERM)* framework;

- the AMC will aim to set a new standard of social and environmental sustainability in design, construction and operation especially in, but not confined to energy, water and waste (see Sustainable Design Strategy - "Beyond Compliance");

- the AMC will satisfy AS 1428 and the Department of Disability, Housing and Community Services checklist for building and facility access (guidance has also been received from the Canadian Corrective Services' 2004 document *"Designing for Offenders with Disabilities: An Architectural Perspective"*, and the Victorian Department of Human Services, Disability Services document *"Accommodation Standards and Design Guidelines for the Provision of: 1.1 Shared Supported Accommodation"*, dated June 2004);

- its programs and activities for prisoners will be based on the following: individual assessment of each prisoner as the foundation of individual Case and Sentence Plans. A key feature of Case Management in the AMC will be the continuity of the Case Management process by Community Corrections staff from court appearance, through imprisonment, to release. (see Plan for Delivery of Vocational Educational and Training and Rehabilitative Programs in The Alexander Maconochie Centre);

- the menu of programs and activities offered to each prisoner will be based on the "What Works" literature, and will be targeted towards positive change in the prisoner's habits, beliefs, attitudes and expectations, that is, a cognitive change approach to rehabilitation (Harper et al 2004; McGuire 2000; Howells et al 1999; WSIPP 2006 and Plan for Delivery of Vocational Educational and Training and Rehabilitative Programs in The Alexander Maconochie Centre); and

- it recognises that most prisoners will return to society and that the maintenance of positive changes in behaviour will be greatly influenced by relationships with family and close associates. The menu of programs and the design of individual programs will be based on a "Throughcare" model that engages family and close associates in the behavioural change process while the prisoner is in prison and ensures support to the prisoner as he or she re-enters society;

- The menu of programs will cover:

    - parenting, family and other relationships;
    - health education and promotion;
    - remedial education;
    - cognitive behaviour and skills;
    - substance abuse/mental health treatment, support and education;
    - sex offender's treatment;
    - vocational training;
    - positive recreational skills and habits;
    - skills and habits for living and working; and
    - victim awareness.

- a multi-disciplinary approach to health service, program delivery and Case Management. This will include involvement of other government and community agencies, where appropriate, in the provision of services, such as family and individual counselling, health, education and vocational training. The model of service delivery contained within *The Strategy* reflects that jointly delivered by NSW Justice Health and NSW Department of Corrective Services, that is, the former provide access to primary, secondary and tertiary health services, usually delivered by nurses, doctors, dentists and specialists, while the latter provide alcohol and other drug counsellors, psychologists, welfare officers and teachers. There is some variation to this in the ACT, where mental health professionals in addition to specialists, are provided by ACT Health.

- an integrated AMC and ACT Health Services response will pay particular attention to the needs of those with mental health problems, women and Indigenous prisoners (WHO 2001); and

- the needs of short-term prisoners will be specifically targeted. Corrections staff and appropriate professionals from other government and community agencies will work with the prisoner and the prisoner's family and close associates.

Emphasis will be directed at Throughcare, which is aimed at ensuring an integrated and seamless approach to the delivery of services for prisoners as they move between the AMC, Community Corrections and the community and to provide continuity of knowledge of the prisoner, programs and other services (WHO 2001). This aspect of the Operating Philosophy for the AMC will contribute to the achievement of whole of government objectives for crime prevention and community safety and to the principles of Restorative Justice.

The Throughcare approach will focus on providing:

- a continuum of health care, in particular addressing substance abuse and mental health issues;

- continuity of Case Management by Community Corrections staff, from court appearance, through imprisonment to release, and supervision in the community where this is required by the courts;

- individual Rehabilitation Plans based on individual prisoners' needs and presenting risk factors;

- common prisoner and offender programs based on assessment of risk and need and a menu of programs targeting those attitudes and behaviours linked to the risks of re-offending;

- opportunities for self-development, improved quality of life and social integration;

- linkages with community-based programs, supports and services;

- rehearsals and support for re-settlement; and

- the engagement of family and the community in the prisoner's correctional experience.

There will be a commitment to transparency and accountability with the Centre's performance outcomes being measured against the national average of other jurisdictions and published by the Productivity Commission in the *Report on Government Services* series.

In addition, complementary performance indicators, yet to be determined, will be detailed in the ACT Health, *ACT Corrections Health Service Plan 2006-09*. Further performance indicators may arise as a result of the requirements of the Corrections Health Services Board, when established (see Governance Arrangements p.31).

## Community Corrections

In relation to the impact of drug use in community correctional services, the *National Corrections Drug Strategy 2006-2009* notes the following environment:

*National*

- In 2003-04, there was a daily average of 50,821 persons on community corrections orders in Australia, a decrease of 2.1% from the previous year's average.

- 82% of persons on community corrections orders in Australia are men and 18% women.

- There was a daily average of 7,676 Indigenous persons on community corrections orders in 2003-04 (15% of total community corrections population).

- The national rate for persons in community-based corrections was 331.6 per 100,000 adult population in 2003-04, compared with 343.9 in 2002-03.

- The national rate for Indigenous offenders in 2002-03 was 2764 per 100,000 adult population, compared with 275.3 for non-Indigenous offenders.

*ACT*

- Approximately 90% of offenders involved with ACT Corrective Services are supervised in the community. There is no evidence on which to base the assertion that the use of community-based sanctions, by the courts, will change with the advent of the AMC.

- 2005 statistical data shows 5% of ACT offenders have been sentenced to a Community Corrections Order for a drug offence as their most serious offence.

The Community Corrections approach to managing offenders with drug and alcohol problems is two-fold.

- Firstly, it incorporates requirements to comply with Court ordered conditions, which may specify interventions, testing, monitoring and reporting regimes.

- Secondly, the Community Corrections approach to interventions and programs is based on initial and continued assessment of offenders' criminogenic risk factors.

Supervision in the community has some significant advantages:

- It enables the offender to continue to support their family;
- It allows the offender to continue working if they are employed;
- It helps the offender comply with court requirements and assists with the overall prevention of further crime; and
- It also allows the person to access community-based health care and the Alcohol and Other Drug (AOD) sector for treatment and support.

# Approach of *The Strategy*

ACT Corrective Services' (ACT CS) primary organisational objective is:

> "As a partner in the criminal justice system, to contribute to community safety through excellence in the delivery of adult correctional services that hold the confidence of the community by:
>
> - Encouraging and promoting the rehabilitation, reintegration and Throughcare of prisoners;
>
> - The safe, humane and, where appropriate, secure management of prisoners and offenders."

## Legislation

The legislative framework for *The Strategy* may be found in the *Crimes (Sentence Administration) Act 2005* and the *Corrections Management Bill 2006*.

## Purpose

The purpose of *The Strategy* is to reduce drug related harm to prisoners and offenders, staff of ACTCS and the wider community.

## Principles

*The Strategy* is guided by the following principles:

- Harm minimisation

  Harm minimisation represents a philosophical and practical approach that aims to improve health, social and economic outcomes for the community and individuals by encompassing a wide range of approaches including supply reduction, demand reduction and harm reduction.

  In interpreting and balancing the pillars of harm minimisation, the overarching requirement is to ensure the well-being of all those who are in the care, custody and employment of ACT Corrective Services. In addressing prisoner well-being, it is recognised that a balance is required with complementary responses to offending risk factors.

  In seeking to minimise harm, and to improve the well-being of each prisoner and offender, it is unrealistic to expect that every alcohol or drug dependent prisoner or offender will overcome their dependency during the period under which they are managed by ACT Corrective Services. While not giving up on this objective, it is appropriate, while improving prisoner and offender health and well-being, to seek to reduce drug-taking and, through differential sanctions, to encourage dependent persons to change their drug and risk behaviours. Such an approach also envisages developing the cognitive skills of prisoners and offenders to understand how to make changes to their lives, if they are motivated to do so. This approach provides a consistent continuum

from the abstinence-based drug policy for juveniles in the custody of the Office of Children, Youth and Family Affairs.

- Applying evidence-based practice

  The use of evidence-based practice, which has been developed from research, analysis and evaluation, supports the development of informed policy decisions that provide a framework for the implementation of effective interventions. It is important that ongoing quality improvement includes evaluation of interventions, which will inform future planning of service delivery and approaches to practice. This is reflected, for example, in ACT Corrective Services' programming based on the international "What Works" literature, and specifically with regard to its Sex Offender programs.

- Strengthening partnerships, collaborations and ownership

  *The Strategy* involves a number of ACT Government and non-government agencies, including those in the health, education and law enforcement areas. Cooperation across all areas will ensure that service development and delivery meet the needs of individuals and the community.

- Recognition of social determinants of health and well-being

  Dependency and the effects of alcohol and other drug use is one of a number of social factors recognised and published by the World Health Organisation (WHO), that influence an individual's health and well-being. The AMC's response to this is through its Operational Philosophy of the "Healthy Prison".

- Increasing access to services

  Outlining social justice principles that support equitable access to alcohol and other drugs and mental health services is important in that it provides opportunities for both individuals and communities to consider the impact of harmful drug, alcohol and tobacco use and the relationship of this use to mental health issues.

  Access to alcohol, tobacco and other drug and mental health-related care, including generalist medical care equivalent to that available to the broader community, should also be available to people within the correctional system.

  Community expectations do not yet include the notion that, notwithstanding the poor health profile of the prisoner population, prisoners will have access to services superior to those which are available to the general public.

  The primary agency responsible for the delivery of health services to the AMC and in the community is ACT Health.

- Investing wisely in the future

  A broad spectrum of health interventions that adopt a comprehensive approach including health promotion, health information and education, prevention, early intervention, treatment and continuing care, is necessary to maximise

health outcomes. This is detailed in the ACT Health, *ACT Corrections Health Service Plan 2006-09* (currently in draft).

- Enhancing health promotion, early intervention and resilience building

  Health promotion is a key element in reducing the harm associated with drug, alcohol and tobacco use. Key objectives of health promotion in this are:

  - improving or maintaining the well-being of the individual;
  - for prisoners and offenders who are drug free, the prevention or delay of the commencement of drug use;
  - for those with drug and alcohol dependencies and associated problems the reduction of problematic drug use;
  - for both cohorts, an awareness of potential drug and alcohol-related harm;
  - provision of information about the range of treatment and counselling service; and
  - the creation of an environment that fosters people making healthy choices.

- Using a quality framework

  A quality framework refers to the provision of policies and services developed embracing a continuous evaluation and improvement approach to the delivery of services. This includes a collection of accurate information to enable planning and development as well as avoidance of inadequate or inappropriate pre-emptive actions.

  ACTCS' *Continuous Improvement Framework (CIF)* provides a foundation for supporting the effective and efficient management of ACTCS' financial, environmental and social responsibilities, and the achievement of its outputs and deliverables. Adherence to the CIF and its integration into the agency's culture, philosophy and practices will enable ACTCS to fulfil these responsibilities and achieve *excellence in correctional management and innovation*. Reporting on this aspect of the endeavours of ACT Corrective Services will be in the agency's *Annual Report.*

The notion of 'effective prisoner management' views the management of prisoners as an opportunity to intervene in problematic behaviours and promote law-abiding ways of living consistent with community expectations. It encourages AMC staff and service providers to tailor the responses to the specific needs of each prisoner or offender on an individual basis, to determine the best way to help them improve their overall well-being, and to reduce or even cease their drug use.

It is important that the staff are committed to achieving the best outcome for the prisoners. Effective prisoner management can be enhanced through communication and co-operation between the AMC, ACT CS, and ACT Health management and staff, and other corrections stakeholders. Numerous coronial inquiry reports have highlighted the issue of inadequate communication between agencies providing services to prisoners.

A key issue highlighted by Coyle, A. (2002) in the International Centre for Prison Studies' publication *A Human Rights Based Approach to Prison Management*, concerns the need for the community to support those in the correctional setting who are daily working in an environment which is acknowledged as particularly stressful, and who are engaged with a range of people, many of whom are not willingly compliant, and some of whom are potentially violent and dangerous.

## Linkages

The relationship between drug use, mental health and blood-borne viruses is well known. Accordingly, *The Strategy* should be read in conjunction with the *ACT Health Corrections Health Service Plan 2006-0 (currently in draft).*

*The Strategy* should also be read in conjunction with the *ACT Alcohol, Tobacco and Other Drug Strategy 2004-08,* the *National Drug Strategy, Australia's Integrated Framework 2004-09,* and the *Human Rights Act 2004* (ACT).

# Aims and Objectives of *The Strategy*

The overarching aim of *The Strategy* is to reduce drug and alcohol-related harm to prisoners and offenders, staff of ACTCS and the wider community.

The approach embraces the following objectives: Supply Reduction; and Demand Reduction. In acknowledgement however, that these two objectives have been not totally successful in the community and other Australian prisons, the third objective is one of Harm Reduction. There is a particular challenge in the correctional setting in getting the balance right between these three objectives.

## Supply reduction

- The objective of supply reduction is to disrupt, discourage and prevent the production, supply and uptake of illicit dugs, and to control and regulate the supply of licit substances (COAG 1999; WHO 2001).

## Demand reduction

- The objective of demand reduction is through education, to discourage the uptake of harmful drug use, including abstinence oriented strategies, treatment and support to reduce drug use (WHO 2001).

## Harm reduction

- The objective of harm reduction acknowledges that illicit drug use occurs, and provides a set of actions that aim to reduce the harm that arises as a consequence of this residual drug use.

## Scope

*The Strategy* has been developed to apply equally to adult prisoners detained in correctional facilities, and offenders serving community-based sentences (probation and parole services).

*The Strategy* recognises the different challenges faced and the corresponding differences in emphasis in implementation of the aims.

*The Strategy* is applicable to all illicit drugs, the illegal use of prescription drugs, alcohol, tobacco and inhalants, and their relationship to mental health.

*The Strategy* identifies prisoners and offenders as an especially vulnerable population group in itself and seeks to develop initiatives that:

- promote, with ACT Health, an integrated response to the uniqueness of this particular population group;

- are culturally responsive and effective;

- meet the social justice needs of prisoners and offenders;

- promote greater understanding among prisoners and offenders concerning their use of illicit drugs, alcohol, tobacco, inhalants and the illegal use of prescription drugs and the impact of these on their mental health and general well-being;

- provide an environment for and support to prisoners to stabilise their lives and address the issues noted above, including co-morbidity; and

- to do so in a manner which does not compromise the safety of staff or the security of the AMC.

## Evaluation

Because of the inherent difficulties, both operational and technological, in the commissioning period, and the pressure this places on staff and management, the evaluation of *The Strategy* will not commence until the commissioning has been completed.

*The Strategy* will be evaluated over a 24-month period commencing in the second year of the operation of the Alexander Maconochie Centre.

The evaluation methodology will be developed in conjunction with ACT Health in the 12 months leading up to the commissioning of the AMC in early 2008.

# Achieving the Aims

## Supply Reduction aim:

*Current actions and services:*

- Intelligence-based interdiction of supply
- Searching prisoners, cells, areas and visitors. It is recognised that strip searching of prisoners (especially women) is a traumatic activity. To reduce its impact, a "half on-half off" procedure is to be followed. The purchase of body scanning equipment (eg SOTAR) offers the potential to further reduce the use of strip searching. Corrections staff do not strip search visitors
- Liaison and intelligence exchange with the AFP
- Referrals to the AFP for criminal investigation
- Banning of visitors who attempt to introduce drugs into the facilities (Ombudsman 2006)
- Drug testing procedures with penalties for positive results (NB. Until such time as an alternative and cost-effective testing method is available, it is envisaged that urinalysis will remain the primary testing method)
- Targeted drug testing based on intelligence, with penalties for positive results
- Alcohol breath testing at the Periodic Detention Centre
- Drug testing of community-based offenders to ensure compliance to orders

*Future actions and services* (COAG 1999; Auditor General 2001; WHO 2001)

- Searching of all people entering the AMC (Ombudsman 2006)
- Design of the AMC to minimise non-essential pedestrian traffic through the secure perimeter
- Drug detection dogs (State Coroner 2003; Mahoney 2005; Ombudsman 2006)
- Visitor signage – warning of penalties for introducing drugs into the AMC
- Ion scanning equipment
- Clear plastic valises for staff and official and other visitors' effects on entry into the AMC
- Targeted monitoring of prisoner telephone conversations

- Interception of suspect mail
- Bulk breaking of goods and supplies outside the AMC secure perimeter
- Drug testing regime (WHO 2001; Mahoney 2005)
    - Testing of all prisoners/offenders on admission
    - Random testing of 10% of the prison population per month, with penalties for positive results
    - 100% testing per month of drug free cottages
    - Testing for statistical purposes (Legislative Assembly Select Committee 1997)
- As a result of detected drug use, referrals of individuals for treatment and/or the application of differential sanctions (see Glossary) and better intelligence on drug misuse patterns
- Drug and alcohol testing of all correctional staff to reduce the risks of staff being compromised (subject to COCA negotiations)
- Selection and supervision of fruit, food, condiments and canteen items to curtail the manufacture of "home brews"
- Offenders on community-based orders will continue to be subject to urine analysis to detect the presence of substances if it is a condition of a community based order that they abstain from drug use or if drug use is considered to be a criminogenic risk

*For consideration:*

- Walk-through x-ray scanner (SOTAR), to provide an alternative to strip searching
- Engagement with and support to families and friends at risk of being complicit in efforts to introduce drugs into the AMC
- Investigation of measuring drug use other than by urinalysis, for example dermal patches and saliva testing (ANCD, 2004)

**Demand Reduction aim:**

*Current actions and services:*

- Prisoner, cell and area searches
- Rehabilitation, educational programs (eg. D&A awareness, HIV/Hep C awareness)(Centre for Substance Abuse Treatment 2005; National Institute on Drug Abuse 2006)
- Opioid substitution and maintenance programs
- Mental health support by ACT Health staff
- Community-based offenders are referred to government and non-government agencies for interventions, counselling and treatment as appropriate

*Future strategies and services:*

- Drug-free cottages within the AMC (WHO 2001)
- Smoke-free accommodation and indoor common areas. This matter needs to be managed carefully as the introduction of ill-conceived total non-smoking regimes has lead directly to prison disturbances and arson. As a result, while is it intended to make the AMC a totally smoke free environment, this will be pursued incrementally (WHO 2001; Ombudsman 2006)
- Active and productive structured day within the AMC (WHO 2001)
- Referral to post-release support services to maintain program achievements (WHO 2001)
- Enforcement of a predator policy (Inspector 2003; Ombudsman 2006)
- Negotiation with ACT Health on the provision of nicotine patches for prisoners
- Detoxification
- Access to the Crisis Support Unit
- Access to external secure forensic mental health facilities through ACT Health
- Case Management and Throughcare (WHO 2001)
- Peer education (WHO 2001; ANCD 2004; Ombudsman 2006)

## Harm Reduction aim:

*Current actions and services:*

- Opioid substitution maintenance program (eg. Methadone)
- Provision of a detergent (*R v. Secretary of State 2005*)
- Education and programs
- Staff training
- Differential sanctions for detected drug use
- Occupational Health & Safety protocols for all people under the care, custody, employment and supervision of ACT Corrective Services, eg: wearing gloves, treating all blood spills as infectious, search procedures, decontamination equipment, protective clothing
- Availability of condoms
- Nutritional requirements are met with the quality and quantity of food provided

*Future actions and services:*

- The provision of bleach or detergent (depending on the outcome of clinical advice and consultation with staff) for disinfecting needle and tattooing equipment (ANCD 2004)
- Application of appropriate assessments to establish state of change of potential program participants
- Cognitive Behavioural Therapy (CBT), education and programs including conjunction with ACT Health (WHO 2001; National Comorbidity Project 2003; Inspector 2004;WSIPP 2006)
- Programs linked to social supports, accommodation and employment issues
- Simultaneous combination of treatments
- Peer education and self-support (WHO 2001; ANCD 2004; Ombudsman 2006)
- Hepatitis B vaccinations (ANCD 2004)
- Voluntary blood testing for HIV and other blood borne viral infections (ANCD 2004)

- Provision of information on safe injecting techniques and the effects of alcohol and other drugs

- Opioid substitution programs including maintenance, pre-release and through-care components (ACT Health)

- Smoke-free accommodation units and indoor shared space within the AMC (WHO 2001; Ombudsman 2006)

- Cognitive Behavioural Therapy for dual diagnosis (National Comorbidity Project 2003) and methamphetamine dependent people, linked into the community in recognition of the extended duration of methamphetamine recovery

- Interventions to combat depressive symptoms of recently abstinent methamphetamine users (ACT Health)

- In recognition of higher rates of sero-positivity of those with a history of tattooing in prison, examine the feasibility of providing contracted sterile professional tattooing services (Kinner 2006)

- Availability of condoms and dental dams (ANCD 2004)

- Provision of hair-cutting facilities

- Visit facilities including private family visits (WHO 2001; ANCD 2004)

# Performance Measures

**Supply Reduction**

The supply reduction objective includes the following performance measures:

- Reduced number of positive drug tests;
- Apprehension of people attempting to traffic drugs into the AMC and PDC;
- Interception of drugs and related equipment concealed in goods, property, produce or vehicles;
- Number of people banned and/or charged by the AFP;
- The amount of drugs detected entering the AMC and PDC;
- Performance measures related to institutional climate, eg assaults;
- Results of drug testing regimes.

**Demand Reduction**

The demand reduction goal has the following performance measures:

- Decreased demand for drugs in the AMC, PDC and community corrections:
- Prisoners and offenders participate in a range of targeted programs to challenge their alcohol and drug use and related offending;
- Placements in the drug-free cottages;
- Placements in the CSU;
- Transfers to a secure forensic mental health facility through ACT Health;
- Prisoners with health needs are treated appropriately and community-based offenders with the same needs appropriately referred;
- Prison drug treatment is linked with post-release drug services in the community so that changes in a prisoner's behaviour are maintained following their release from custody.

**Harm Reduction**

The harm reduction goal has the following performance measures:

- Improved prisoner functioning;
- Prisoners are provided with practical information about the risks of drug and alcohol abuse and the harm that can be caused by drugs and alcohol;
- Prisoners are motivated to change their behaviour both in prison and on release in order to reduce or eliminate drug-related harm (eg. prisoners are better prepared to prevent drug overdose, attempted suicide, and the mental and physical health problems associated with drug-taking and alcohol consumption);
- Prisoners with drug-related illnesses are educated and supported to achieve the best quality of life possible and prevent transmitting infection to others;
- Prison staff are informed about drugs and alcohol-related prison activity, as well as being trained in overdose awareness, first-aid and conflict resolution strategies to enable decisive action when necessary (Mahoney 2005;
- Rate of uptake of voluntary blood testing (ACT Health data);
- Peer support sessions conducted;
- Number of prisoners and offenders on opioid substitution maintenance programs;
- Incidence of overdoses in the AMC and while under community supervision;
- Deaths and self-harm in custody;
- Reduced number of occupational health and safety incidents, eg: blood spills, needle stick injuries.

# Governance Arrangements

The Executive Director, ACT Corrective Services is responsible for the implementation and outcomes achieved by *The Strategy*.

The Chief Executive, ACT Health is responsible for the implementation and outcomes achieved by the ACT Health *Corrections Health Service Plan 2006-09.*

The provision of a holistic health service, and specifically the management of risk, to prisoners under the care of both ACT Corrective Services and ACT Health will require close collaboration and coordination.

The ACT Corrections Health Services Board (if established) may define the frequency and extent of reporting it requires to execute its role and function.

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# Glossary

**Abstinence:** refraining from drug use.

**AIDS (acquired immune deficiency syndrome):** a syndrome defined by the development of serious opportunistic infections, neoplasms or other life-threatening manifestations resulting from progressive HIV-induced immunosuppression.

**Best practice:** on the evidence available, the best intervention to produce improved outcomes for an identified issue.

**Blood-borne virus:** a virus that can be transmitted from an infected person to another person by blood-to-blood contact, including through the sharing of injecting equipment.

**Demand reduction strategies:** strategies that seek to reduce the desire for, and preparedness to obtain and use, drugs. These strategies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.

**Detoxification:** the means by which a drug dependent person may withdraw from the effects of a drug. The symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use are known as withdrawal symptoms.

**Differential sanctions:** Some drug use is more harmful than other use, and undifferentiated sanctions may provoke the use of more harmful but less detectable drugs. Differential sanctions categorise drug activity to differential management levels to reflect the variances in harm associated with different categories of drugs. For example, penalties may include minor administrative changes of regime for marijuana use, with penalties increasing in response to use of more harmful drugs or multiple offences.

**Drug:** a substance that produces a psychoactive effect. Within the context of *The Strategy*, 'drug' is used generically to include alcohol, pharmaceutical drugs and illicit drugs. *The Strategy* also takes account of performance and image-enhancing drugs, and substances such as inhalants and kava. (*The National Drug Strategy, Australia's Integrated Framework 2004-09*).

**Drug dependence:** drug dependence is characterised by a strong desire to take a drug. Among the indicators of dependence are impaired control over drug use, a higher priority given to drug use than to other activities and obligations, increased tolerance, physical withdrawal symptoms, and repeated drug use to suppress withdrawal.

**Drug free cottages:** Cottage accommodation to reduce the demand for illicit substances in the AMC environment. They are incentives for prisoners wanting to escape the pressures associated with the prison drug culture and attract prisoners with no drug-use history and those recently abstaining.

It is essential to provide a safe and supportive environment for prisoners who are committed to sustaining a drug free lifestyle away from any intimidation and standover tactics. Drug-free cottages are an ideal option for prisoners who have resolved to remain drug free and they provide a solid basis for successful release planning. To demonstrate their commitment to a drug free status, prisoners must sign an undertaking to provide a significantly greater number of voluntary urine tests. If prisoners in the drug free cottages are found to have used drugs, the appropriate response will be initiated.

**Drug related harm:** any adverse social, physical, psychological, legal or other consequence of drug use that is experienced by a person using drugs or by people living with or otherwise affected by the actions of a person using drugs.

**Evidence-based practice:** integration of the best available evidence with professional expertise to make decisions.

**Harm reduction strategies:** strategies that are designed to reduce the impacts of drug related harm on individuals and communities. Governments do not condone illegal risk behaviours, such as injecting drug use: they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.

**Harm minimisation:** refers to policies and programs aimed at reducing drug related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies. This includes preventing anticipated harm and reducing actual harm, and is consistent with a comprehensive approach to drug related harm, involving a balance between demand reduction, supply reduction and harm reduction.

**Hepatitis C:** is a blood-borne virus that affects the liver.

**HIV:** human immunodeficiency virus. A human retrovirus that leads to acquired immune deficiency syndrome (AIDS).

**Illicit drug:** a drug whose production, sale or possession is prohibited. "Illegal drug" is an alternative term. For the purposes of this Strategy, the unprescribed use of a lawfully prescribed drug to another person will be considered an illicit drug and will attract the appropriate response.

**Inhalants:** substances inhaled for psychoactive effects – for example, glues, aerosol sprays, paints, industrial solvents, thinners, petrol and cleaning fluids.

**Kava:** a drink or preparation obtained from the kava plant, *piper methysticum*.

**Licit drug:** a drug whose production, sale or possession is not prohibited. "Legal drug" is an alternative term.

**National Drug Strategy:** formerly the National Campaign against Drug Abuse, was initiated in 1985, following a Special Premiers Conference. The National Drug Strategy provides a comprehensive, integrated approach to the harmful use of licit and

illicit drugs and other substances. The National Drug Strategy promotes partnerships between health, law-enforcement and education agencies, drug users, people affected by drug-related harm, community-based organisations and industry, to reduce drug related harm in Australia.

**Opioid:** the generic term applied to alkaloids and their derivatives obtained from the opium poppy, including methadone, morphine, heroin and codeine.

**Pharmacotherapies:** Pharmaceutical drugs that either: substitute for a similar type of drug used in maintenance therapy; assist in the management of withdrawal symptoms; or, assist in the maintenance of abstinence after detoxification by either blocking the desired effects of a drug or by producing adverse affects such as nausea if drugs are taken.

**Polydrug use:** the use of more than one drug, simultaneously or at different times. The term 'polydrug user' is often used to distinguish a person with a varied pattern of drug use from someone who uses one kind of drug exclusively.

**Prevention:** within the context of *The Strategy*, prevention refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce the harms associated with drug supply and use.

**Rehabilitation:** Rehabilitation is a process, not an event, and refers to the period following a decision by the individual to reduce harm associated with their substance use. This period can begin with withdrawal from the substance, but can also include commencement on a pharmacotherapy. Rehabilitation interventions include withdrawal, attendance at a support group, residential rehabilitation or a pharmacotherapy.

**Supply reduction strategies:** supply reduction strategies are designed to disrupt the production and supply of illicit drugs. They may also be used to impose limits on access to, and the availability of, licit drugs.

**Therapeutic Community:** a structured method and environment for changing human behaviour in the context of community life and responsibility. Her Majesty's Prison Service in the United Kingdom refers to Democratic Therapeutic Communities, the purpose of which is to provide long-term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs. The degree of need may prevent them from engaging fully with a shorter program or may make shorter interventions inadequate.

**Throughcare:** an integrated and "seamless" approach to the delivery of services for offenders from initial to final contact with the ACT Corrective Services.

**Uptake:** the commencement of drug use.

**Withdrawal:** the means by which a drug dependent person may withdraw from the effects of a drug. The symptoms that can occur when a person using a drug over a prolonged period reduces or ceases use are known as withdrawal symptoms.