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**STRATEGIES FOR ADDRESSING ALCOHOL AND OTHER
DRUGS IN CORRECTIONAL SETTINGS**

A background paper commissioned by Directions ACT

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“With grief I speak it, we take little care of the bodies, and less of the souls of our prisoners.”

Josiah Dornford, UK, 1785

“Men are sent to prison as a punishment, not for punishment.”

Sir Alexander Patterson, UK, 1930s

“[N]o one truly knows a nation until one has been into its jails. A country should be judged not by how it treats its highest citizens, but its lowest ones.”

Nelson Mandela, South Africa, 1995

“Few sets of institutional arrangements created in the West since the industrial revolution have been as large a failure as the criminal justice system. In theory it administers just, proportionate corrections that deter. In practice, it fails to correct or deter, just as often making things worse as better. It is a criminal *injustice* system that systematically turns a blind eye to crimes of the powerful, while imprisonment remains the best-funded labour market program for the unemployed and indigenous peoples.

...We can also understand why building more prisons could make the crime problem worse...On this account, whether building more prisons reduces or increases the crime rate depends on whether the stigmatizing nature of a particular prison system does more to increase crime than its deterrent and incapacitative effects reduce it.”

John Braithwaite, Canada, 1996

“The prison [will] be a safe and secure environment and aim to maximise rehabilitative and re-integrative opportunities for ACT prisoners—links with community agencies will also be encouraged to facilitate a ‘throughcare’ model of case management.

There are compelling moral, social, justice system and economic benefits in accommodating the ACT’s sentenced prisoners in the ACT.

The ACT community must accept its responsibility for the administration of justice as much as it does for the allocation of justice through the courts.

The ACT can now move forward with establishing a much needed prison for ACT offenders.”

Jon Stanhope MLA, Canberra, 2004

“Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community.”

Standard Guidelines for Corrections in Australia, 2004

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EXECUTIVE SUMMARY

Directions ACT has commissioned this background paper on strategies addressing alcohol and other drugs in correctional settings. The impetus for this has been work undertaken by various agencies to develop policies and plans for the new Canberra prison, the Alexander Maconochie Centre (AMC), currently under construction. ACT Corrective Services is developing a strategy addressing alcohol and other drugs for the prison and, potentially, other parts of the correctional system for which it has responsibility. ACT Health is developing a Corrections Health Services Plan which will undoubtedly include components dealing with alcohol and other drugs.

The governments and correctional administrations of a number of Australian jurisdictions, including the Australian Capital Territory (ACT), are to be commended for adopting harm minimisation policies with respect to drugs and drug use among their correctional populations, particular prisons and prisoners. They are seeking to align their approaches to the National Drug Strategy. They face significant challenges, however, in realising these aspirations. Their task is to implement harm minimisation policies within what are too often harm maximising settings.

A number of key documents provide part of the context of these initiatives. As well as the National Drug Strategy and the ACT Government's parallel strategy we have the ACT *Human Rights Act*, national and international corrections guidelines and policy briefs and consensus statement from WHO covering this area. Work is in hand to develop a National Corrections Drug Strategy; the processes being used do not seem to include consultation and collaboration with key stakeholders outside the various government corrections agencies and the Australian National Council on Drugs.

A large corpus of information is available about the extent and nature of the problems of drugs in prisons and the associated health issues, including the transmission of blood-borne infections. This has lead, overseas, to the concept of the 'health promoting prison' or the 'healthy prison'. Unfortunately we have little information on prison drug program effectiveness reflecting, in part, the traditional reluctance of correctional administrators to authorise research in their prisons.

Many areas remain contentious, based on differing world views, knowledge, experiences and values. Underlying these differences are people's perceptions of the dual roles of prisons, namely care and control.

A comprehensive corrections drug policy should aim to meet the needs of a range of stakeholders, including inmates and their families, corrections staff and the broader community. Particular population groups have special needs. A one-size-fits-all approach is bound to be counter-productive in terms of prisoner well-being. In this context, attention is drawn to the need for special services for inmates with co-occurring mental health and substance abuse problems.

The principle of equivalence of services (that is, that prison services should be at least as comprehensive and high quality as those found in the community) is widely accepted in official statements but rarely implemented. This potentially exposes governments to litigation.

Governance issues are important. It has been suggested that the criteria for sound governance of corrections health services are that they be independent of the correctional authority, be staffed by health professionals (rather than correctional officers) and operate on the basis of legislative authority. The current ACT arrangements fall short of these standards.

The ACT Government and ACT Corrective Services are committed to implementing, at the Alexander Maconochie Centre, a throughcare model of case management, acknowledging that corrections health is public health. One component of this is potentially a significant involvement of Canberra NGOs in the prison's substance abuse and mental health services. While this could have many advantages in realising the throughcare model, it has potentially negative outcomes for the NGOs flowing from their being incorporated into the coercive correctional system.

Corrections drug programs can be classified (as per the National Drug Strategy) as supply reduction, demand reduction and harm reduction focussed. The range of options available under each of these three approaches is discussed. The report published by the Australian National Council on Drugs in 2004, *Supply, demand and harm reduction strategies in Australian prisons: implementation, cost and evaluation*, provides a framework and benchmark for assessing the ACT's corrections drug services.

The development of the Alexander Maconochie Centre and the policy work in ACT Health and ACT Corrective Services as part of this initiative raise some issues for Canberra-based NGOs working in the substance abuse, mental health, health promotion and related fields. These include the potential for them to be involved in policy development and service development and delivery, the potential that they will be swamped by increased demands for services that are not adequately funded, being scapegoated for the failure of prison programs, lose the capacity to advocate for prisoners' rights if they are part of the service delivery system, etc.

Some threshold issues need to be resolved at an early date if NGOs are to become part of the planning and service system for the AMC. They include operationalising the terms 'throughcare model of case management' and 'healthy prison', clarifying the governance arrangements (especially whether correctional AOD services will be provided by government departments or contracted out to NGOs and/or the private sector, or both), and the range of drug supply reduction, demand reduction and harm reduction interventions to be instituted.

It is crucial that an evaluation strategy for the corrections AOD services (but preferably for the new approach to corrections as a whole) be developed, funded and put in place well before the new prison opens. To treat monitoring and evaluation as an add-on at a later stage will be problematic.

The ACT Government, and through it ACT Corrective Services, are commended for the way they have characterised the Alexander Maconochie Centre as a best practice correctional facility, focusing on the rehabilitation of inmates and close links between the Canberra community and the prison. Canberra's NGOs will need to examine closely the ACT Corrective Services' Drug Strategy and ACT Health's Corrections Health Service Plan, once they are released for comment by the potentially affected NGOs, to help ensure that the prison's approach to substance abuse prevention and treatment are of a high quality, and that the implementation and evaluation processes are sound.

INTRODUCTION

Background

Directions ACT, a Canberra community-based organisation which provides a range of services related to alcohol and other drugs, has commissioned this background paper on strategies addressing alcohol and other drugs in correctional settings. The impetus for this has been work undertaken by ACT Corrective Services and ACT Health to develop policies and plans for the new Canberra prison, the Alexander Maconochie Centre (AMC), which is expected to be commissioned in 2008. ACT Corrective Services is developing a strategy addressing alcohol and other drugs for the prison and, potentially, other parts of the correctional system for which it has responsibility. ACT Health is developing a Corrections Health Services Plan which will undoubtedly include components dealing with alcohol and other drugs.

The Alexander Maconochie Centre will be a multi-purpose correctional facility. As well as accommodating sentenced adult prisoners (both female and male), it will have a remand section which will replace the Belconnen Remand Centre (BRC) and the Symonston Temporary Remand Centre (STRC). Furthermore, the ACT Government is developing a new custodial facility for young offenders to replace the Quamby Youth Detention Centre. Details on the Alexander Maconochie Centre are online at <<http://www.cs.act.gov.au/amc/home>>.

ACT Corrective Services also operates community corrections programs including probation and parole.

ACT NGOs in the alcohol and other drugs (AOD) field have a deep and continuing interest in these developments. Heartened by the Chief Minister's commitment that the new services will be world's best practice, based on the *ACT Human Rights Act* and having a strong emphasis on rehabilitation, connectedness to community and throughcare (Stanhope 2004), the agencies are keen to contribute to policy-making in this area and, to the extent appropriate, to service delivery.

Context: key documents and initiatives

A number of important documents form part of the context within which these initiatives are unfolding, including the following:

- Australia's National Drug Strategy, with its overarching objective of harm minimisation which is realised through policies and programs addressing supply reduction, demand reduction and harm reduction; addressing all drugs, legal and illegal; being evidence based; and involving partnerships between the different sections of society, particularly governments and the community. See *The National Drug Strategy; Australia's integrated framework 2004-2009* (Ministerial Council on Drug Strategy 2004).
- The Government of the ACT has its own comprehensive drug strategy, the *ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008* (Australian Capital Territory Government 2004). This policy is consistent with the National Drug Strategy, adopting its broad principles and applying them, in a practical manner, to ACT circumstances.

One element of the ACT Strategy's Action Plan deals with the 'Custodial Service Delivery' of alcohol, tobacco and other drug services. It states:

Action: Provide full access to health services and treatments that are available to the community to prisoners, detainees, and remandees.

Rationale: The Draft Standard Guidelines for Corrections in Australia 2003 (revised) states that every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Restrictions on a person's liberty should not necessarily restrict their access to continuity of treatment options.

Consistent with Health Action Plan (Australian Capital Territory Government 2004, p. 46).

- The ACT *Human Rights Act* 2004, the first of its kind in Australia, provides the normative framework within which the new corrective services initiatives are being developed; see <<http://www.legislation.act.gov.au/a/2004-5/default.asp>>. Section 10 of the Act deals with 'Protection from torture and cruel, inhuman or degrading treatment etc.'. The relevance of this is the developing international consensus that failure to provide adequate health care (including preventive and therapeutic substance abuse services) to prisoners constitutes inhuman or degrading treatment (e.g. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) cited in MacDonald 2005, p. 24).
- The draft *ACT Corrective Services Drug Strategy 2006-2008* which has been provided by ACT Corrective Services to the ACT Alcohol, Tobacco and Other Drug Strategy Implementation & Evaluation Group for comment. Note: this is not a public document as yet.
- The Australian National Council on Drugs commissioned a national study of drug strategies in Australian prisons (Black, Dolan & Wodak 2004). It provides details of the position in the ACT at the time of data collection, 2003, and a set of recommendations which provide something of a yardstick for evaluating prison services.
- The international community, especially through the World Health Organization's European office, has been active, over many years, in studying these matters and developing consensus policies and guidelines to be use by correctional policy-makers and managers. Prominent among their products are the following
 - *Prisons, Drugs and Society: A Consensus Statement on Principles, Policies and Practices* (World Health Organization & Council of Europe 2001)
 - *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users* (World Health Organization 2004a)
 - *Policy Brief: reduction of HIV transmission in prison* (World Health Organization 2004c)
 - *Policy Brief: provision of sterile injecting equipment to reduce HIV transmission* (World Health Organization 2004b)
 - *Status Paper on Prisons, Drugs and Harm Reduction* (World Health Organization, Regional Office for Europe 2005)

The web site of their Health in Prisons Project (HIPP):

<<http://www.euro.who.int/prisons>>) contains many valuable resources.

- According to ANCD, a working group has been established to develop a draft National Corrections Drug Strategy. This will be an important document but has yet to be released to the public. Apparently it is being prepared intra-murally, without a consultation process with community-based organisations with experience in corrections drugs issues. This process is in contrast to that normally used in the National Drug Strategy, where openness and inclusiveness generally characterise the development of new strategies. This is odd, considering that the National Drug Strategy includes a provision that, during its current phase (2004-2009), action will be taken to 'develop a comprehensive approach to the management of drug use and related harms in correctional settings' (Ministerial Council on Drug Strategy 2004, p. 6). (This is the only mention of corrections/prisons in the NDS policy document *The National Drug Strategy; Australia's integrated framework 2004-2009*, highlighting how overlooked this sector has been over the 21 years that the NDS has been operating.)
- International and Australian minimum standards for corrections have been adopted but none is enforceable. They contain provisions relating to health services. Details are available from the Australian Institute of Criminology's web site <<http://www.aic.gov.au/research/corrections/standards>>.

SCOPING CORRECTIVE SERVICES' DRUG STRATEGIES

General

What do we know about the problem?

The problems to be addressed by corrections drugs strategies are well known to both correctional services personnel and those of community-based agencies such as Directions ACT. Furthermore, a large amount of research and other scholarly writing exists, providing a clear picture.^{1 2}

The situation has been summarised in the ANCD report in the following terms:

A comprehensive investigation of drug use in New South Wales prisons was conducted in 2001 as part of an Inmate Health Survey. This study found that a substantial proportion of prisoners continued to inject drugs in prison, with 154 (24%) male and 56 (43%) female prisoners in the survey reporting injecting drug use. Of these, 33 (29%) males and 16 (36%) females had done so in the month prior to interview. Additionally, 103 (67%) males and 40 (72%) females had re-used a needle and syringe after someone else.

Of the prisoners who reported heroin injection, 32 (11%) male and two (2%) female prisoners said that they had injected drugs for the first time in an adult prison. Furthermore, 45 (16%) male and 13 (14%) female prisoners reported injecting heroin in preference to using cannabis during incarceration, to minimise, so they claimed, the chances of detection through urine testing.

The proportion of prisoners in the New South Wales survey meeting the criteria for substance use disorder (abuse or dependence) over the previous 12 months was 33 per cent for males and 57 per cent for females. Among prison entrants, this figure rose to 64 per cent of male and 75 per cent of female reception prisoners, respectively. Opioid dependence was the most common diagnosis, with 38 per cent of reception prisoners and 19 per cent of the general prison population meeting the diagnostic criteria.

A health survey in Queensland found that 25 per cent of female prisoners used drugs during incarceration, with cannabis being the most common drug (17%), followed by opiates (14%).

Given that New South Wales has higher rates of injecting drug use in the community, the prevalence of injecting among prisoners is likely to be lower in other Australian States and Territories, although similar large-scale studies have not been conducted in other jurisdictions.

Approximately one-third of male inmates in New South Wales...and in Victoria...were infected with hepatitis C. The prevalence of HCV among female inmates was twice that of male inmates, with two-thirds being infected. The prevalence of HCV among injecting drug use inmates was even higher, at approximately 80 per cent among male and female samples in New South Wales and Victoria. In comparison, about 1 per cent of the general population is infected with HCV.

Drug use within Australian prisons poses a considerable health risk to prisoners and the broader community, as well as an obstacle to the correctional efforts of prison authorities. It is appropriate, therefore, that this issue be addressed by the most effective strategies available, and that the implementation of any strategies occurs in an accountable manner (Black, Dolan & Wodak 2004, pp. 1-2).³

¹ The extent of research in this area is revealed by data base searches using the keywords 'prison' and 'drug'. Google Scholar returns 40,400 items, PubMed 1,342 journal articles, Informit's AustHealth 782 Australian-focussed books and articles, the Library of Congress 79 books and the National Library of Australia 56 Australian focussed entries.

² The approach to scoping taken here is adapted from Bammer 2001.

³ Epidemiological research covering drugs and the NSW prison population, which includes the ACT prisoners who will be transferred to the Alexander Maconochie Centre, includes Kevin 2003, Butler 2003, Butler 2005(a) and Butler 2005(b).

Another important source of information is the Australian Institute of Criminology's Drug Use Careers of Offenders study. It has provided valuable new insights into this matter. See Makkai 2003, Johnson, 2004 and Prichard 2005.

What is well covered now and agreed-upon?

The epidemiology of the problems of drugs in correctional settings—the extent and nature of the problems—is well known, as evidenced by the summary of Australian data quoted above from the ANCD report. A corresponding European summary may be found in the WHO Europe *Status Paper on Prisons, Drugs and Harm Reduction* (World Health Organization, Regional Office for Europe 2005).

The high levels of comorbidity between mental health problems and substance abuse have been demonstrated in health surveys (e.g. Butler & Allnutt 2005) and much work has been done to identify effective intervention modalities in community settings (e.g. Teesson & Proudfoot 2003).⁴

The options available for addressing the needs of both detainees and the correctional agencies in dealing with drugs are also well known, and are the subject of the many corrections drug strategies and policy papers that are available. These are discussed below.

The special issues concerning substance abuse treatment in prisons have been systematically researched and documented (e.g. Center for Substance Abuse Treatment (U.S.) 2005; National Institute on Drug Abuse 2006).

It is also widely agreed, as captured by the title of the Moscow Declaration, that 'Prison health is part of public health' (World Health Organization - Europe 2003). The links between the two are very close, particularly when we take into account that the median period of imprisonment in Australia is around 6-12 months.⁵ A continuum exists with thousands of our citizens passing from the community to prison and back into the community again, frequently over and over again.⁶ Prisoners take their poor health status (including problematic drug use and its antecedents) with them into prison. What they take out may be improved health and lower levels of substance abuse, but far too frequently the opposite is the case (Levy 2002).

⁴ The National Statement of Principles for Forensic Mental Health gives only passing mention to comorbid substance abuse, simply acknowledging that 'Forensic mental health services must be linked with other relevant services in order to provide treatment in the most clinically appropriate manner and setting. Other services are often required by forensic mental health clients, especially drug and alcohol services and disability support services; appropriate linkages between forensic mental health and these services must be ensured' ('National Statement of Principles for Forensic Mental Health' 2002, p. 11). The WHO Consensus Statement on Mental Health Promotion in Prisons (WHO Regional Office for Europe 1999) is more useful in this context.

⁵ Nationally, in 2005, the median time expected to be served by sentenced prisoners was 23 months. The median number of months that unsentenced detainees spent on remand was 2.8. Unsensentenced prisoner composed 20% of all prisoners in 2005 (Australian Bureau of Statistics 2005). ACT sentenced prisoners had a median length of stay of 272 days (9 months) in 1999-2000; for remandees it was just 12 days in 2001-02. These are the latest statistics on the topic provided at the ACT Corrective Services' web site <<http://www.cs.act.gov.au/amc/home/statistics>>.

⁶ ACT prisoners in both ACT and NSW correctional facilities have the highest rate of recidivism of all States and territories: 72% of the ACT prisoners at 30 June 2005 had served a sentence in an adult prison prior to the current episode, compared with the national figure of 60% (Australian Bureau of Statistics 2005).

What does the research evidence tell us about prison program effectiveness?

The landmark study on the prevention of substance use risk and harm in Australia (Loxley et al. 2004) assessed the research evidence concerning prison programs addressing drugs: chapter 13, pp. 218-221. Its findings are summarised as follows.

TABLE 1
EVIDENCE REGARDING PRISON DRUGS PROGRAMS⁷

Prison intervention	Strength of evidence	Nature of evidence	Comment
<i>Drug detection & deterrence</i>	Warrants further research	Mainly limited to counting seizures and positive tests; limited evidence on effectiveness	Vary with jurisdiction; urine testing can lead to more harmful drug use
<i>Differential penalties</i>	Warrants further research	...good theoretical base	Aims to reduce shifts from cannabis to more harmful drugs, related to urine testing
<i>Provision of drug treatment (methadone)</i>	Evidence for implementation	Methadone evaluated in two programs	Rigorous evaluations completed of methadone treatment in the community
<i>Drug free units</i>	Warrants further research	No Australian evaluations; one US evaluation recommends extension to pre-release programs	
<i>Rewards programs</i>	Warrants further research	General evidence base for effectiveness of approach; no specific evaluations	
<i>Education</i>	Warrants further research	No evidence available; peer programs successful in the community	
<i>Transitional support and release preparation</i>	Warrants further research	No direct evidence but sound theoretical base	
<i>Provision of bleach for decontamination</i>	Limited investigation	No evidence in prison setting	
<i>Needle and syringe programs</i>	Evidence for implementation	International evidence positive; no Australian experience	

The conclusion to be drawn from this is that we have little evidence as to prison drug program effectiveness. On the other hand, strong evidence exists about some of these interventions in community settings. What is missing is sound evidence covering implementation processes and outcomes in custodial settings.

⁷ Other useful recent reviews of what works, with whom, in which settings are Harper 2004, Holloway 2005 and Center for Substance Abuse Treatment 2005.

Which areas are contentious?

A number of areas of contention remain, including the following:

- Ethical issues regarding the rights of prisoners: many people in corrections agencies and the community at large, including some opinion leaders, reject Sir Alexander Patterson's dictum that '[offenders] are sent to prison as a punishment, not for punishment' (cited in Morgan 1994, p. 894). They object to the underlying rehabilitative emphasis of the Alexander Maconochie Centre.
- Getting the balance right between prison security and prisoner well-being is not easy.
- The relative emphases on prisoner well-being compared with prison staff well-being are contentious.
- The strategic usefulness or otherwise of adopting the goal of a drug-free prison.
- Harm reduction strategies are still not fully embraced by many in the corrections field (e.g. MacDonald 2005), as evidenced by the continuing opposition in Australia to introducing evidence-based interventions such as prison needle/syringe programs (McDonald, D 2005) and the patchy use of opioid substitution treatment across the country (Black, Dolan & Wodak 2004).
- The optimal governance model for corrections health services, including the AOD and mental health components (e.g. Levy 2005).
- The extent to which it is possible to create a 'health promoting prison' or a 'healthy prison', given the constraints and cultures of prisons and the expectations of conservative parts of the community.
- The objectives of mandatory urine testing, both targeted and random.
- Whether prisoners found to be using contraband psychoactive substances (e.g. through random or targeted urine or breath testing) should be subjected to penalties or, on the other hand, should be referred to treatment (MacDonald 2005).
- The extent and nature of NGO agencies' involvement in policy development and service delivery with respect to drugs in correctional services.
- The ethics of NGO involvement in coerced treatment.
- The potential for NGOs to lose their capacity to advocate on policy issues if they are incorporated into the criminal justice system as service providers (Duke 2003, pp. 150, 165).
- The role of peer education (Devilley et al. 2005) and peer-based tattooing services (Weeks 2005) within prisons.
- The lack of a culture in the corrections field of basing strategies and programs on research evidence as to policy and program effectiveness. This is an issue for the whole of the criminal justice system, not just corrections:

Sadly, considerations of cost-effectiveness don't often figure in public debates about crime. NSW remains alone among Australian Governments that have subjected any of its law and order policies to an assessment of their cost-effectiveness (Weatherburn 2002, p. 11).
- The strategic, ethical and practical issues in voluntary and mandatory testing of inmates for blood-borne viral diseases, including informed consent, counselling and the actions to be taken when individuals are identified as seropositive.
- Which drugs to cover: should prisons be smoke-free (huge disparity exists between the jurisdictions in this area; see Royal Australasian College of Physicians 2005).

- The differential treatment of women and men in the criminal justice system, and the gender-based differences in the impacts of imprisonment.
- The failure to provide treatment and case management services to many remandees and prisoners serving short sentences.
- The almost total failure of the National Drug Strategy to engage with the corrections sector.

A corrections drug strategy for whom?

A comprehensive corrections drug strategy will address the needs of a number of groups of people, including:

- inmates, both remandees and sentenced prisoners
- correctional officers
- inmates' visitors
- people visiting a correctional facility on official business, such as contractors, education officers and NGO AOD personnel
- the families and friends of inmates and people serving community-based orders
- etc.

The special needs of *female prisoners* are being addressed in the design of the Alexander Maconochie Centre as it will accommodate both female and male prisoners.

Services for female correctional service clients need to take account of the webs of risk factors for substance abuse and mental health problems that the women face. This has been highlighted in the findings of the Australian Drug Use Careers of Offenders (DUCO) study (Johnson 2004):

- 87% of incarcerated women were victims of sexual, physical or emotional abuse in either childhood or adulthood.
- Childhood and adult abuse were correlated with drug dependency and involvement in the sex trade.
- Physical abuse in childhood was a predictor of violent offending.
- Mental health problems were correlated with drug dependency, violent offending and involvement in the sex trade.
- 17% of offenders had spent time in juvenile detention and this indicator of early onset of serious offending was related to drug dependency and regular property and violent offending as adults.
- Drug-dependent women and persistent property offending women were more likely to have grown up in families with drug problems.
- Women with alcohol and drug dependencies, and those who were violent offenders, were more likely to have grown up in families with alcohol problems.
- Female offenders who used prescription drugs were between two and four times more likely to use illegal drugs.

Correctional systems have traditionally been designed by men for male prisoners. Indeed, across the whole of the criminal justice system, female offenders tend to be invisible (Williams 1994). This is in part because of their relatively small numbers—just 7 per cent of the national prison population in 2005 (Australian Bureau of Statistics 2005).

The offences that lead to prison custody differ between women and men. Among the 2005 prison population, a higher proportion of women than men had as their most serious offence homicide (11.0 % cf 10.1%), theft (10.9% cf 5.8%), deception (12.3% cf 2.8%), illicit drug offences (13.1% cf 9.5%), and offences against justice procedures (10.2% cf 7.9%) (Australian Bureau of Statistics 2005). Women's imprisonment rates are

increasing faster than those of men. Illicit drug offences is the largest offence category among women (among men it is ‘acts intended to cause injury’) and the role of poverty is highlighted by the dominance of property offences.

An outcome of this is that women’s special needs tend to be overlooked, an issue stressed by Canberra activists when a new prison for the region was first discussed (Goldflam 2000):

- Female prison entrants have higher rate of problematic drug use than their male counterparts (Butler et al. 2004; Fazel, Bains & Doll 2006).
- Women who are mothers experience particularly serious impacts from imprisonment (Miller-Warke 2000).
- Women are particularly vulnerable upon release from custody, with the risk of death from drug overdose or injury being of great concern (Davies & Cook 2000; Graham 2003).
- Societal attitudes towards female offenders tend to be more negative than towards males, with the result that their experiences of stigma and discrimination (not least within the criminal justice system) are especially problematic (Williams 1994).

Indigenous people have levels of involvement with the criminal justice system, including imprisonment, that are far higher than those of non-Indigenous people. The reasons for this discrepancy are well-known and much has been done, with only limited success, in attempting to remedy the situation (Cunneen 2006; Cunneen & McDonald 1997). A corrections drug strategy should deal explicitly with Indigenous prisoners’ needs, including the deep scars that many carry as a result of past dispossession from traditional lands, family separations and continuing discrimination. All of these factors are linked to mental health problems, substance abuse and criminal behaviour. The involvement of community-based Indigenous health agencies in serving these inmates will be a key ingredient of policy development and service delivery.

Both sentenced and remand prisoners need AOD services. Too often, in correctional systems around the world, unsentenced prisoners are denied access to services that are available to their sentenced counterparts, on the grounds of administrative convenience. Many have immediate problems of drug withdrawal: this should be treated using best practice medical approaches rather than subjecting the people to sudden, unmedicated withdrawal (Center for Substance Abuse Treatment (U.S.) 2006).

Furthermore, in accordance with the ACT’s policy on throughcare case management, drug treatment that has been commenced in the community should not come to an end by virtue of a person becoming caught up in the criminal justice system.

*Dependent and non-dependent drug users:*⁸ Policy and services should also reflect the fact that, while the majority of prison entrants have a history of problematic drug use (Butler & Milner 2003), and that it is a cause of imprisonment for a significant minority (Makkai & Payne 2003b), most are not drug dependent. Indeed, as Kevin (2003, p. i) points out, the inconsistent availability of drugs of dependence in prison means that ‘it is unlikely that injecting drug use could be sustained on a regular or consistent basis in prison’. This means that the services need to be tailored both to prisoners with established dependency (e.g. opioid maintenance and therapeutic community treatments) as well as

⁸ Documents produced by criminal justice agencies, particularly in the USA, still frequently use the terms ‘addict’ and ‘addiction’, problematically conflating the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) classifications of acute intoxication, harmful use, dependence syndrome and withdrawal state. Note that ‘addict’ and ‘addiction’ were replaced by the concept of dependence as long ago as 1981 (Edwards, Arif & Hadgson 1981).

for those who need educational and treatment interventions addressing their somewhat different needs.

Pre-and post-release programs are also part of the mix, in accordance with the throughcare model of case management to be implemented at the Alexander Maconochie Centre. The policies and models adopted in some other jurisdictions, in which every prisoner leaves the institution with a carefully-developed plan for next steps and connections to helping service already established, represent best practice in this area. The 60-bed Transitional Release Centre at the Alexander Maconochie Centre, located outside the secure perimeter (<<http://www.cs.act.gov.au/amc/home/ACTCorrectionalCentre>>), provides an ideal resource for linking soon-to-be-released inmates to the community substance abuse and related services.

People with *mental health/substance abuse comorbidity* are also over-represented in prisons and non-custodial correctional programs (Butler et al. 2005). They are another population group with special needs that can be addressed through the corrections health service and the security protocols (National Institute on Drug Abuse 2006; WHO Regional Office for Europe 1999).

What are the access issues?

Principles

The fundamental principle covering prisoners' entitlement to health care services (including those addressing their substance abuse and mental health issues), one acknowledged far more in the breach than the observance, is that of equivalence. The 2004 revision of the Standard Guidelines for Corrections in Australia (Corrective Services Ministers' Conference 2004) cover this:

2.26 Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Notwithstanding the limitations of the local-community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or stand by basis.

2.27 Every prisoner is to have access to the services of specialist medical practitioners as well as psychiatric, dental, optical, and radiological diagnostic services. Referral to such services should take account of community standards of health care.

Unfortunately these are simply what the title reveals: guidelines that are not binding on any correctional authority. They have no legislative backing and the small number of court actions that prisoners have brought against governments for failing to provide adequate health care to them have not led to the development of binding case law. Indeed, the High Court, in considering whether the NSW Government failed in its duty of care by not providing condoms to its prisoners, found that departmental policy and administrative decisions relating to the administration of prisons are not reviewable by the courts (High Court of Australia 1995).⁹

In my earlier discussion of the application of the ACT *Human Rights Act* 2004 to the corrections environment, I pointed to the European opinion that failure to provide prisoners with access to adequate health care (including substance abuse and mental health services) constitutes inhuman or degrading treatment which are offences under the

⁹ This contrasts strongly with the position in the USA, where improvements in prison health services mainly resulted from litigation which led to the Federal courts taking over the management of prisons, which in turn led to the introduction of medical professionals into prisons, and the acceptance of principle of equality of care with outside and the development of the standards movement in that country (McDonald, DC 1999).

Act (e.g. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) cited in MacDonald 2005, p. 24). It is possible that ACT NGOs with an interest in the well-being of the prisoner population will consider the application of the Act in this jurisdiction if they form the opinion that the Alexander Maconochie Centre fails to meet the test of equivalence of services.

Population groups

The traditional and ongoing orientation that prison security and compliance with regulations has higher salience than the well-being of inmates frequently leads to a lack of differentiation of the population in terms of prisoners' needs. When security is dominant, all prisoners tend to be treated the same. This is in direct contrast the core value of the helping professions that people should receive care that matches their own needs. This is another point at which the ethical challenges of coerced treatment, or treating coerced populations, arise.

A number of correctional population groups exist whose drug service needs differ, including women, Indigenous people, young detainees in adult prisons, gays and lesbians, trans-sexuals, the mentally ill, intellectually handicapped and people living with HIV and/or hepatitis C or B. Corrections drugs strategies should deal with their peculiar needs, rather than attempt to apply a one-size-fits-all model.

Service providers

Who provides the corrections substance abuse services is another aspect of access. It is mentioned in the following section on governance. The British model is largely one in which outside NGOs are funded by HM Prison Service to provide the substance abuse programs. The potential impacts of this arrangement on the capacity of the NGOs to concurrently engage in policy advocacy is an issue raised above. Another is the limitations on access to prisoners that are so frequently encountered, making continuity of treatment difficult.

On the other hand, real advantages exist with the NGO/corrections partnership model in facilitating throughcare, so long as the funds are adequate and the throughcare protocols are sound.

What are the governance issues?

A useful starting point in thinking about governance issues for a corrections drug strategy is the 2003 *Moscow Declaration on Prison as Part of Public Health* (World Health Organization - Europe 2003). The Declaration provides the following justification for this assertion:

- ...penitentiary health must be an integral part of the public health system of any country. In this connection, it is necessary for both prison health and public health to bear equal responsibility for health in prisons. The reasons for this are:
 - Penitentiary populations contain an over-representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, the vulnerable and those who engage in risky activities such as injecting drugs and commercial sex work.
 - The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system. Prevention and treatment responses must be based on scientific evidence and on sound public health principles, with the involvement of the private sector, nongovernmental organizations and the affected population.
 - The living conditions in most prisons of the world are unhealthy. Overcrowding, violence, lack of light, fresh air and clean water, poor food and infection-spreading activities such as tattooing are common. Rates of infection with tuberculosis, HIV and hepatitis are much higher than in the general population (op. cit., p. 2).

Given this principle, the issue is to develop governance arrangements for the drugs component of the corrections health services and corrections security services, with the potential inherent contradictions between the two facets and their interfaces.

The ACT Prison Community Panel considered and made recommendations on governance issues. Its report, presented in 2000, 'continues to provide guidance to policy development' with respect to the ACT Prison Project

(<<http://www.cs.act.gov.au/amc/home/communication>>). The Panel formed the view that '...responsibility for health care in the prison should be separate from correctional aspects' and recommended, *inter alia*, that:

- (i) the responsibility for prisoner health management should rest jointly with the Department of Health and Community Care and the Corrections Health Board who would report directly to ACT Corrective Services;
- (ii) health care should be based in throughcare of prisoner needs, facilitated by effective case management and involving input from a range of health care professionals...(ACT Prison Community Panel 2000, p. 33).

Governance models

A number of governance models for corrections health and drug services exist around the world and, indeed, they vary considerably between the eight Australian states and territories. The four Australian models have been summarised as follows:

- The independent health authority, funded from the health ministry, designated as the body that cares for the prisoner population. This service is supported by legislative reference in both custodial and health legislation. This is the model adopted in New South Wales since 1991.
- The health authority fully incorporated with the custodial authority. This is the model currently operating in Queensland and Western Australia.
- An intermediary entity, obtaining funds from the health authority, and administering to the health needs of prisoners, but without legislative support, and not identifiable as an 'authority' in its own right. This is the practice in Tasmania, South Australia and the Australian Capital Territory.
- Privatisation of health services—services are contracted out of the public sector through a tender process. This is the situation in Victoria and the Northern Territory (Levy 2005, p. 67).

On the face of it, none stands out as especially desirable or undesirable, in the sense that it is possible to provide either high or low quality services under any on these models. On the other hand, Levy (op. cit.) has identified three core criteria for assessing the excellence of a governance model: independence, health expertise and authority:

- Independence: the need for the health services to be managed and operate independently of the correctional authority, not subject to its direction.
- Health expertise: those providing the health services through both policy and service delivery should be health experts operating according to professional standards which are not compromised by virtue of working in correctional environments and with people who are correctional clients.
- Authority: the health service should exist and function by virtue of legislation, thereby protected (to an extent) from internal correctional agency bureaucratic forces that may compromise its roles and services.

Levy points out that NSW Justice Health is an outstanding example (globally) of a governance arrangement that meets these three criteria of excellence.

Linkages and the throughcare model

A pleasing feature of the current Alexander Maconochie Centre plans, dating back to the Community Panel's report, is the emphasis on a throughcare model of case management and the associated linkages between the custodial setting and the community, and between government and community-based organisations. This has implications for governance as the arrangements set in place must facilitate communication and deal explicitly with boundary and interface issues.

Turning the rhetoric of throughcare into reality will be a great challenge faced by both corrections agencies and others in the community, including AOD NGOs. For example, the key features of effective post-release services were recently identified by a Roundtable convened by the Australian Institute of Criminology and the Australian Government Department of Family and Community Services:

- Systematically identifying prisoner risks and needs, incorporating client input, and matching in-prison and post-release services and supports accordingly
- Case management from a base central to the offender
- Inter-agency partnerships, with a lead agency designated from among partner agencies
- Adequate funding for required services and for thorough evaluation of those services
- Long-term throughcare programs made central to the correctional agenda (Borzycki & Baldry 2003).

Reviewing the current governance arrangements

At present, in the ACT, we have a Director of Corrections Health (Ms Karen Lenihan) who is responsible for providing health services, including those addressing substance abuse and mental health, to adult remandees and to young people in juvenile justice detention facilities in the ACT. The position she occupies is not a statutory one.

Furthermore, the ACT has a Corrections Health Board, listed as one of the Advisory and Consultative Boards and Committees linked to the ACT Human Rights Office. The Office's 2003-04 Annual Report provides some information:

The Corrections Health Board was established by the ACT Government in 1997 to endorse and monitor the standard of health care to juveniles and adults in custody in the ACT. The Board has an advisory role to Government and is not a statutory body. The Board was chaired by Ms Rosemary Follett in her role as ACT Discrimination Commissioner. Ms Follett resigned from the position on the Corrections Health Board at the end of her term as Commissioner (np).

These governance arrangements do not seem to meet fully the criteria of independence, health expertise and statutory authority and so need to be reviewed in light of the establishment of the Alexander Maconochie Centre. Presumably the ACT Corrective Services' drug strategy for the prison, and ACT Health's new Corrections Health Service Plan (neither of which has been released in draft form for public comment to date) will provide details of the proposed governance arrangements.

SUPPLY, DEMAND AND HARM REDUCTION

Australian correctional agencies' drug strategies developed or substantially revised in recent years, including those of South Australia, Western Australia and Victoria, are explicitly structured around Australia's National Drug Strategy, embracing 'the Australian approach', namely harm minimisation, described as follows:

The principle of harm minimisation has formed the basis of successive phases of Australia's 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 orientated strategies and treatment to reduce drug use; and
- harm reduction strategies to reduce drug-related harm to individuals and communities (Ministerial Council on Drug Strategy 2004, p. 2).

The ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008 adopts the same approach, having been developed within the framework of the NDS (Australian Capital Territory Government 2004).

The supply, demand and harm reduction approach fits within a group of taxonomies of drug strategies that focus upon the aims of the interventions (in contrast to populations groups, stage of development of problems, implementing agencies, etc.) (McDonald, D 2004; Ritter & McDonald 2005). This approach has been found useful both in Australia and in other nations, particularly in the Asia/Pacific region (e.g. Costigan, Crofts & Reid 2003).

A wide range of services can be provided to correctional services' clients, including prison inmates. Australia's first corrections drug strategy that comprehensively adopted the harm minimisation focus of the National Drug Strategy was developed in South Australia in 1998 (Department of Correctional Services (SA) 2002, p. 4). It was based on a combination of scholarly research and consultation with key stakeholders, with the issues, findings and recommendations being summarised in a particularly important report, *Drug and Alcohol Strategy Project: final report, 1998* (Department for Correctional Services 1998). That report stressed that *The challenge for the Drug and Alcohol Strategy is to combine best practice alcohol and other drug intervention and best practice correctional intervention in order to create an integrated prison alcohol and other drug service* (op. cit., p. 18, emphasis in original).

It drew together what the authors saw as 'critical elements of an integrated approach to prison alcohol and other drug interventions', as follows:

- further research into the relationship between drug use and crime
- appropriate and tiered assessment
- coordination of services
- an integrated, system-wide approach
- strategies aimed at reducing the transmission of communicable diseases
- drug awareness programs for all prisoners

- case management
- throughcare processes which ease the transition to the community
- availability of a range of options, including drug free units
- services targeted according to need
- adequate funding
- commitment from all levels of the correctional system
- appropriate training of correctional staff and peer facilitators
- awareness of issues for special needs prisoners
- the use of more incentives than sanctions.

Best practice characteristics of prison based alcohol and other drug programs include:

- prisoners assigned to programs based on their offending history
- program integrity
- confidentiality
- a focus on relapse prevention
- development of the individual's ability to take responsibility
- improved opportunities for decision making
- cooperation of management and staff
- effective and appropriate evaluation (op. cit., p. 17).

These features continue to characterise sound corrections drug policies today, with important additions being the need for services addressing mental health/substance abuse comorbidity and attention to the governance arrangements for drug services.

Supply reduction

The National Drug Strategy defines supply reduction strategies thus:

[S]upply-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—an example is legislation regulating the sale of alcohol and tobacco to people under the age of 18 years (Ministerial Council on Drug Strategy 2004, p. 22).

The UN Office on Drugs and Crime uses this definition:

A broad term used for a range of activities designed to stop the production, manufacture and distribution of illicit drugs. Production can be curtailed through crop eradication or through large programmes of alternative development. Production (illicit manufacture) is attacked directly through the suppression of illicit laboratories and/or the control of precursor chemicals, while distribution is reduced through police and customs, and in some countries by military operations. Supply control is a term often used to cover police and customs activities (United Nations International Drug Control Programme 2000, p. 69).

As I have written elsewhere (McDonald, D 2004), perusal of the fine print in official descriptions of the Australian National Drug Strategy reveals that the terms 'reducing the supply' or 'reducing the availability' of illicit drugs are rarely used. Instead, a far softer approach is taken: 'supply reduction strategies to disrupt the production and supply of illicit drugs' (Ministerial Council on Drug Strategy 2004, p. 2). This markedly reduces the accountability of the criminal justice sector as all it is required to do, in this formulation, is 'disrupt' the supply chain, not reduce the availability of illicit drugs in the Australian community. Perhaps this reflects the acknowledged limitations of supply-side policies and programs in reducing both drug availability and drug-related harm (Friedman et al. 2006; Loxley et al. 2004; Macintosh 2006),¹⁰ highlighting the need for comprehensive

¹⁰ A more positive take on the impacts on drug markets of the criminal justice system is Australasian Centre for Policing Research 2003.

strategies combining (in a yet-to-be-determined optimal mix) the supply, demand and harm reduction approaches.¹¹

Drugs are available in Australian prisons

Correctional authorities across Australia report that drugs are widely available in their prisons. The position was summarised by the Australian Bureau of Criminal Intelligence (ABCI) in 2000:

All respondents to the Bureau's 1998-99 prisons questionnaire reported drug trafficking in their facilities. New South Wales estimated that 80 per cent of inmates were either in custody for drug-related offences or were drug affected or drug dependent at the time they committed their crime. South Australia reported that random urinalysis 'consistently indicates that approximately 30 per cent have used drugs in prisons'... The demand for drugs is high inside prisons.

Production of drugs in prisons occurs on a very minor scale...

In the absence of significant drug manufacturing inside prison, it is reasonable to conclude that the majority of drugs detected come from outside. Contraband predominately enters prison through the visitor reception area (referred to as the visitor barrier), over or under the prison perimeter, or via vehicle and pedestrian gates. Prison inmates exchange drugs for commodities such as canteen goods, cigarettes, electronic equipment, expensive clothing and running shoes. Western Australia reported that inmates 'who are not "hard" drug users have been known to trade heroin for quantities of cannabis' (Australian Bureau of Criminal Intelligence 2000, p. 102).

The Executive Director of ACT Corrective Services, Mr James Ryan AM, advised a Public Forum in Canberra in Nov 2005 that the only way to keep illegal drugs out of prison would be to institute a security regime so harsh as to be unacceptable in human rights terms. He concluded that this means that, in reality, it is not possible to keep all illegal drugs out of Australian prisons.

Interestingly, however, the unrealistic goal of the drug-free prison is far from gone. Indeed, it is the title of the new (May 2006) Irish Prison Service drug strategy: 'Keeping drugs out of prison: drugs policy and strategy'. In contrast, the UK Prison Service's Drug Strategy states that 'It is unrealistic to expect prisons to be totally drug-free' (HM Prison Service (UK) 2003, p. 2) and the Victorian Prison Drug Strategy '...recognises that it is virtually impossible to stop drug use entirely and that prisoners enter the system with existing and entrenched drug use behaviours' (Office of the Correctional Service Commissioner 2002, p. iv). This means that the Victorian Strategy is pragmatic:

The Strategy does not condone or endorse drug use in prison. What it does do is acknowledge that there are a range of potential harms associated with drug activity in prison. Furthermore, the Strategy recognises more clearly the complexity of the issues facing prison operators in managing and supervising prisoners with drug and alcohol problems.

The Strategy's pragmatic approach acknowledges it is unlikely that all prisons or prisoners will be drug-free, and that new initiatives need to be established to maintain the good order of prisons, to manage prisoners effectively and to reduce health and safety risks (op. cit., p. 5).

¹¹ One of the goals of the Drug Policy Modelling Project is to improve knowledge of the optimal mix, based on net harm analyses. See
<http://www.turningpoint.org.au/research/dpmp_monographs/res_dm_monographs.htm>

Prevalence of drug use in prison

Despite all the efforts of correctional administrators to keep illegal drugs out of prison, drug use there is commonplace. The 2004 National NSP Survey revealed that, of injecting drug users interviewed in community settings nationally, 18% stated that they had been in prison in the last year and that, of this group, 53% reported injecting in prison during the last year (National Centre in HIV Epidemiology and Clinical Research 2005, p. 11).

The 2001 New South Wales Inmate Health Survey also investigated drug use in that State's prisons (Butler & Milner 2003, pp. 119-26).¹² The study showed that:

- 48% of inmates reported using some type of illegal drug in prison (females 49%; males 48%)
- 57% of inmates reported a history of injecting illegal drugs and 51% of that group reported injecting while in prison
- cannabis use in prison: females 40%; males 45%
- heroin use in prison: females 32%; males 23%
- amphetamines use in prison: females 20%; males 10%
- cocaine use in prison: females 15%; males 7%
- alcohol use in prison: females 14%; males 13%.

Respondents to that survey also reported that illegal drugs were 'quite easy' or 'very easy' to obtain in prison, with 76% of the female inmates and 78% of the males responding this way (op. cit., p. 122).

Prison drug supply reduction interventions

Many methods are available and used in Australian prisons to disrupt the supply and use of contraband items, including syringes, mobile telephones, the drugs that are illegal in the community, pharmaceutical products and alcohol (alcohol is an illegal drug in Australian prisons), including the following:

- perimeter security
- random and targeted searches of prisoners and their visitors
- random strip searching of prisoners following visits
- prohibiting visits to prisoners who have received drugs from visitors
- searches of cells and other areas used by prisoner
- displaying notices warning about the penalties for passing drugs during visits
- fixed furniture in visiting rooms
- drug-detecting dogs
- urinalysis
- screening of mail
- intelligence gathering including the use of informants
- controls on prescribed pharmaceuticals
- intelligence-based searches and urinalysis
- ion mobility spectrometry scanning of mail or prisoners' environments
- X-ray scanning of mail
- controls over mobile phones
- monitoring of telephone calls
- biometric identification systems
- closed-circuit television cameras in various parts of the prison
- prisoners being required to wear special overalls during contact visits

¹² Another valuable source of data covering drug use in NSW prisons is Kevin 2003.

- anonymous ‘crime-stopper’-type reporting procedures
- etc.

Penalties for prisoners found in breach of the regulations, and reporting to the police visitors found with drugs, are important supply reduction interventions.

Others target corrections staff and others people who have lawful access to prisons, such as tradespeople, health and education personnel, entertainers, spiritual counsellors, contractors bringing authorised supplies such as food and clothing, etc.

Balancing care and control

The central public policy issue here is getting the balance right with respect to the two core roles of prisons, described by senior corrections personnel from Wales as caring for prisoners and controlling their environments (Heyes & King 1996). Again, the issue is finding the optimal balance by means of net harm analyses. Modern corrections drug strategies (including those of Victoria, South Australia and Western Australia) attempt this difficult task with a fair degree of success. Some aspects, discussed next, are particularly important.

Urinalysis

The Australian Bureau of Criminal Intelligence (2000) (among others) has pointed out that urinalysis is a key technique used by corrections authorities to attempt to minimise the amount of drugs in prisons: inmates with ‘dirty urines’ are punished with the aims of general and specific deterrence. They expressed the concern that this enforcement regime has unintended adverse consequences quite contrary to the harm minimisation policy on drugs adopted by all Australian Governments. The ABCI wrote:

...urinalysis may encourage inmates to change from cannabis to more harmful drugs because these drugs remain in the body for a shorter time and so there is a better chance of providing a negative urine sample. In Western Australia the Select Committee into the Misuse of Drugs Act of 1981 found that ‘some very harmful substance abuse (e.g. sniffing solvents, alcohol bingeing) which is directly related to offending may not be detected through urinalysis, whereas cannabis use is easily detected. This raises the prospect of participants being influenced towards the use of less detectable though more harmful drugs’... In South Australia the Department of Correctional Services...recommended that targeted urinalysis focus on detecting those drugs with the greatest potential to cause harm-intravenous drugs, alcohol, and other drugs that cause aggression (Australian Bureau of Criminal Intelligence 2000, p. 105).¹³

The 2001 NSW Inmate Health Survey reached a similar conclusion (Butler & Milner 2003, p. 123).

Differential response based on potential harm

The above quotation from ABCI draws attention to the desirability, in both policy/regulation and implementation approaches, to apply sanctions to prisoners that reflect the potential harm of the behaviours in question. This principle was articulated in the South Australian study referred to above, which recommended ‘Ensure that the Department’s responses to issues related to alcohol and other drugs are appropriate to the potential harm associated with the specific drug(s) involved’ (Department for Correctional Services 1998, p. 5).

This principle is usually realised through having penalties for cannabis possession and use (especially when detected through urinalysis) being lower than those for other drugs.

¹³ The SA source is Department for Correctional Services 1998.

Mandatory, voluntary, targeted and random and urine testing

Urine testing (or using other, less intrusive approaches such as hair, sweat and saliva analysis) is a complex issue—or it should be if minimising net harm is a policy goal. Testing for drug use by these means can be mandatory or voluntary and targeted or random:

	<i>Random</i>	<i>Targeted</i>
<i>Mandatory</i>	a	b
<i>Voluntary</i>	c	d

A thorough analysis underlying a corrections policy on urinalysis would attend to the objectives, implementation pathways and research-based outcomes of all four combinations within the matrix. At present, though, this is rarely done, with confusion existing as to the purposes of urinalysis and insufficient attention to the unintended adverse consequences.

For example, the introduction of mandatory urine testing for drugs in Wales:

...dealt a body blow to our own drug strategy. Our voluntary and confidential screening was effectively tarred with the same brush as Mandatory Drug Testing in the eyes of the prisoners...

There also seems to be a belief that health care urine tests are not confidential and that requests for treatment will lead to targeting for compulsory tests. Over and above this is the belief that we are primarily concerned with punishment—with ‘control’ rather than ‘care’. Our worst fears were realised: in October 1995, there were 44 requests for chemical dependency assessments. In December [following the introduction of mandatory urinalysis] there were four (Heyes & King 1996, p. 10).

A comparison of Western Australia’s and Britain’s corrections drug policies with respect to mandatory urine testing for drugs is instructive:

WA: The primary purpose of [mandatory] random urinalysis testing is to reinforce amongst prisoners that, if they use drugs in prison, they are likely to be detected and that sanctions will be imposed (Department of Justice (WA) 2003, p. 10).

UK: The Strategy additionally includes a Mandatory Drug Testing (MDT) programme. The MDT programme has three main objectives:

- to deter prisoners from misusing drugs - through fear of being caught and punished,
- to supply better information on patterns of drugs-misuse,
- *to identify individuals in need of treatment* (HM Prison Service (UK) 2003, my emphasis).

Getting the balance right between these competing goals of urinalysis is an important challenge for correctional agencies.

Drugs detected

In most jurisdictions, cannabis and pharmaceutical products are the drugs most frequently detected through prison urinalysis programs. For example, the WA Justice Drug Plan (Department of Justice (WA) 2003, pp. 10-11) reports that, in 2002, 67 random urine tests were conducted in that State, 15 of which were positive: 13 for cannabis, 2 for amphetamine and 1 for methamphetamine. In the 2001-02 year they conducted 2,826 targeted drug tests with 1,077 (38%) positive: cannabis 69%, medications 16%, amphetamine 6%, methamphetamine 5%, opioids 2% and alcohol 2%.

The long detection time for cannabis compared with the other drugs is relevant to this picture:

TABLE 2
AVERAGE DETECTION TIMES FOR DRUGS IN URINE

<i>Drug type</i>	<i>Average length of time detected in urine</i>
Amphetamine/methamphetamine	2-4 days
Cannabis (THC)	2-30 days: several days to 30 days average: 2-10 days for casual users and up to 30 days for chronic users
Benzodiazepines	2-14 days
Cocaine	1-36 hours: cocaine parent present up to approximately 3–6 hours post dose; benzoylecgonine (BE) metabolite present for approximately 24–36 hours post dose
Opioids	2-3 days: 6-monoacetylmorphine (MAM) detected up to 6 hours; morphine metabolite 2–3 days. If MAM is present it indicates definite heroin use.
Codeine	2-3 days

Source: Makkai 2000, p. 8

UK research reveals that mandatory urine testing's major impact on drug use is on the recreational use of cannabis; it has minimal impacts on the use of other drugs (Duke 2003, p. 135). On the other hand, one sometimes hear reports of prison officers turning a blind eye to cannabis use in prison, as many inmates unproblematically self-medicate with the drug. It helps them to cope with the stresses of prison life (op. cit., p. 101).

ANCD's assessment of ACT supply reduction strategies

Many readers will be familiar with the important study published by the Australian National Council on Drugs: *Supply, demand and harm reduction strategies in Australian prisons: implementation, cost and evaluation* (Black, Dolan & Wodak 2004). The authors, with the support of the ACT Corrective Services, reviewed supply reduction, demand reduction and harm reduction strategies in the Belconnen Remand Centre and the Symonston Temporary Remand Centre in 2003 (op. cit., pp. 119-120). Their findings with respect to supply reduction strategies were as follows:

- *drug detection dogs*: not operated by ACT Corrective Services though trainee Customs detection dogs visit the remand centre four times per year, no cost to Corrections, no drugs detected though 'drug residue' has been detected
- *urinalysis*: targets remandees suspected of using illicit drugs, tests conducted frequently, no data on results, expenditure data available, no outcome evaluations
- *other supply reduction approaches*: metal detectors, perimeter patrols and searches of remandees, visitors and cells/areas
- *seizures data*: not available.

It has long been acknowledged that the Belconnen Remand centre is problematic with respect to facilities for remandees, staff and visitors. Its security is below standard. For this reason the Alexander Maconochie Centre will include a 138 bed remand facility physically separated from the sentenced prisoners areas (ACT Corrective Services n.d.).

Demand reduction

Confusion exists over the meaning of demand reduction, with people sometimes stating that the best way to reduce demand is to prevent drugs entering prison in the first place, a formulation that confused supply reduction and demand reduction.

The National Drug Strategy defines demand-reduction strategies as:

[S]trategies 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 (Ministerial Council on Drug Strategy 2004, p. 19).

The UN Office on Drugs and Crime provides a more helpful definition:

International drug control conventions use this term [demand reduction] in relation to the aim of reducing consumer demand for controlled substances. Demand reduction strategies contrast with approaches which aim to reduce supply of drugs though in practice demand and supply reduction can be complementary. The success of demand reduction is conventionally measured by a reduction in the prevalence of use, i.e. by more abstinence, and hence is separate and distinct from harm reduction.

Demand reduction is a broad term used for a range of policies and programmes which seek a reduction of desire and of preparedness to obtain and use illegal drugs. Demand for drugs may be reduced through prevention and education programmes to dissuade users or potential users from experimenting with illegal drugs and/or continuing to use them; drug substitution programmes (e.g. methadone); treatment programmes mainly aimed at facilitating abstinence, reduction in frequency [*vis*] or amount of use; court diversion programmes offering education or treatment as alternatives to imprisonment; broad social policies to mitigate factors contributing to drug use such as unemployment, homelessness and truancy (United Nations International Drug Control Programme 2000, p. 19).

ANCD's assessment of ACT demand reduction strategies

The ANCD assessment of Australian prison drug services mentioned above describes the ACT corrections demand reduction position in 2003 as follows:

The forms of demand reduction used in the Australian Capital Territory (Belconnen Remand Centre) are drug detoxification, opioid maintenance treatment, inmate programs and counselling services. Drug and alcohol program nurses and a case manager...provide a range of services including assessment and screening, information, referral, detoxification services and methadone administration...Remandees identified as having an alcohol and/or other drug problem are assessed by an alcohol and drug worker and referred to appropriate services, as necessary, as part of a case management process. Problems in recruiting and retaining health staff and a lack of specialist training in areas such as alcohol and other drug treatments were also highlighted (Black, Dolan & Wodak 2004, p. 116).

Their findings were as follows

- *detoxification*: available, with medical support, frequent uptake of the service, expenditure data available, no outcome evaluations
- *methadone and other pharmacotherapies*: methadone and buprenorphine treatment available; no limit on number of clients eligible for treatment; remandees may commence opioid substitution treatment while in custody and may continue naltrexone treatment if they were receiving it in the community, but not commence it in custody; expenditure data available; no outcome evaluations but an assessment by KPMG Consulting in 2002
- *inmate programs and counselling services*: both individual and group counselling available to all remandees who wish to avail themselves of the services, waiting lists for counselling minimal or non-existent, services provided by staff counsellors and people from community agencies, expenditure data available, no outcome evaluations
- *drug-free units*: not available

- *other demand reduction strategies*: ‘Corrections and health staff receive training in alcohol and other drugs treatment education in a two-session program [*sic*]’ (op. cit., pp. 116-118).

In the absence of precise published figures, I estimate that approximately 12 people in ACT remand facilities were receiving opioid pharmacotherapy in 2005. That year, about 17 per cent of the NSW prison population was receiving this form of treatment (I do not know if there is a waiting list). If the Alexander Maconochie Centre’s inmates have the same prevalence of opioid-related problems and need for substitution therapies as their current NSW counterparts, and it has 374 inmates (maximum capacity), then some 63 inmates would require this form of treatment.¹⁴ Many more would need other forms of drug and mental health therapy.

Harm reduction

Harm reduction has been an integral part of Australia’s approach to dealing with drugs for many years. Many definitions of ‘harm reduction’ exist. The one used in the current phase of the National Drug Strategy is poor, being an exposition more likely to confuse than clarify, *viz.*:

[H]arm-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 (Ministerial Council on Drug Strategy 2004, p. 20).

The South Australian Department for Corrective Services has noted the confusion that exists over the meaning of harm reduction, and usefully clarifies the three arms of the National Drug Strategy thus:

The goal of the National Drug Strategy is to minimise the harm relating to alcohol and other drugs. This goal involves a balance between three overlapping approaches: reducing supply, reducing demand and **reducing the problems associated with residual use** (Department for Correctional Services 1998, p. 5, my emphasis).

Another clear definition comes from the UN Office on Drugs and Crime:

In the context of alcohol or other drugs, harm reduction refers to policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or other drugs, both to the individual and the larger community. The term is used particularly for policies or programmes that aim to reduce the harm without necessarily requiring abstinence. Some harm reduction strategies designed to achieve safer drug use may, however, precede subsequent efforts to achieve total abstinence. Examples of harm reduction include needle/syringe exchanges to reduce rates of needle-sharing among injecting drug users, and the use of shatterproof glassware to reduce glass injuries in pub brawls. Harm reduction strategies can be distinguished from supply and demand reduction strategies (United Nations International Drug Control Programme 2000, p. 31-32).

The Australian community shows broad acceptance for harm reduction approaches to drugs policy. It is pleasing to see that the more recently developed prison/correctional drug strategies across Australia reflect the same philosophy. Nonetheless, lingering doubts exist both in Australia and abroad about the appropriateness of harm reduction strategies, especially with respect to their applicability to prisons. The position is nicely summarised by Kerr et al. (2004, p. 345):

Throughout most of the world, the primary response to problems associated with illicit injection drug use has been to intensify law enforcement efforts. This strategy has contributed to an unprecedented growth in prison populations and growing concerns regarding drug-related harm within prisons. Despite the presence of international laws and guidelines that call for the protection of the health of prisoners, prison authorities have generally been slow to implement

¹⁴ Estimates calculated from data published in (ACT Corrective Services n.d.; Australian Bureau of Statistics 2005; Australian Institute of Health and Welfare 2006).

activities that have been proven effective in reducing drug-related harms in community settings. While a limited number of countries have made progress by implementing educational programmes, methadone maintenance therapy, bleach distribution and needle exchange, in most areas of the world, a substantially greater effort is needed to ensure that prisoners receive the same level of care offered in community settings. The current emphasis on security and abstinence from drugs within prisons is often regarded as incongruent with the goals and methods of harm reduction. However, available evidence indicates that most harm-reduction programmes can be implemented within prisons without compromising security or increasing illicit drug use.

A list of harm reduction strategies for prisons

A wide range of harm reduction strategies is used in Australian and overseas prisons. As discussed above (quoting from Loxley et al.'s 2004 study *The prevention of substance use, risk and harm in Australia: a review of the evidence*) sound evaluation evidence exists for most of these interventions in community settings. Some, but not all, have been systematically evaluated in the prison setting. The precautionary principle leads to the conclusion, however, that they should be applied in prisons unless or until evidence is available arguing against such strategies.

The following strategies compose the prison harm reduction service package:¹⁵

- harm reduction information and education
- illicit drug peer education
- blood-borne virus testing
- hepatitis B virus vaccination
- condom provision
- bleach/detergent provision¹⁶
- naloxone provision
- withdrawal support
- needle/syringe programs in prison
- offering Fitpacks to inmates on release from prison
- removing the abstinence criterion for entering and remaining in treatment
- differential penalties for different classes of drugs detected
- disregarding cannabis identified through urine testing or ion mobility spectrometry scanning of mail or prisoners' environments, unless the presence is associated with the inmate engaging in trafficking
- etc.

(Some would list opioid maintenance therapies as forms of harm reduction, but I have them under demand reduction as their focus is treatment.)

It is important to highlight the fact that none of these harm reduction interventions has been shown to have adverse outcomes in prisons in terms of the well-being of custodial staff and other people working in prisons, nor in terms of achieving the prisons' security goals. The contrary is the case: prisons that have implemented comprehensive harm reduction strategies report good outcomes for both prison staff and inmates. This is perhaps most starkly seen in the findings of the many scientific evaluations of providing sterile injecting equipment to prison inmates (summarised in Lines et al. 2006; McDonald, D 2005).

¹⁵ Sources: (Black, Dolan & Wodak 2004; Kerr et al. 2004; Thomas 2005; World Health Organization, Regional Office for Europe 2005).

¹⁶ Although the available research evidence does not show that rinsing used syringes with bleach, and other forms of disinfection, are effective in reducing HCV or HIV infection, their availability is none-the-less recommended '...as a temporary measure where there is implacable opposition to NSPs in certain communities or situations (e.g. correctional facilities)' (World Health Organization 2004a, p. 31).

ANCD's assessment of ACT harm reduction strategies

The ANCD review assessed the harm reduction services for remandees in the ACT in 2003, producing these findings (Black, Dolan & Wodak 2004, pp. 119-120):

- harm reduction education: provided; no information as to expenditure or outcomes
- peer education programs: not implemented
- blood-borne virus testing: available, voluntary, results not available, expenditure data available, no outcomes information
- hepatitis B vaccination: available for staff and remandees, expenditure data available, no outcomes information
- condom provision: available, no expenditure data available, no outcomes information*
- bleach provision: available upon request from the health clinic, no expenditure data available, no outcomes information*
- naloxone provision: available, no expenditure data available, no outcomes information**
- needle/syringe program: not available despite being recommended by the ACT Legislative Assembly's Standing Committee on Health in 2003 (Legislative Assembly for the Australian Capital Territory 2003).

It is clear that scope exists for a greater investment in harm reduction strategies in ACT corrections. The ACT Government's commitment that the Alexander Maconochie Centre will be world class in terms of its facilities and programs provides an ideal opportunity to implement the full range of evidence-based harm reduction strategies.

* The authors of the ANCD report acknowledge that uptake of condoms and bleach is minimal, so the absence of expenditure and outcome data is not an issue. The same applies to the use of naloxone: very few opioid overdoses occur, so the use of this medication is also minimal.

MONITORING AND EVALUATION

As mentioned above, traditionally correctional administrators have been reluctant to approve research within their institutions. Many researchers who have sought to obtain approval to conduct evaluation research in this context have become frustrated at the delays and the barriers to quality research that are imposed, and have abandoned the endeavour. These two factors, working in combination, mean that we have too little knowledge about what works, in what correctional settings, with what correctional populations.

We do know from evaluation research, however, that imprisonment does not reduce repeat offending and, in the country that uses imprisonment as a policy instrument for reducing drug-related crime (the USA), the experiment has had little impact on drug availability and use, but has caused an immense volume of collateral damage to that society not least of which is the fuelling of the HIV/AIDS epidemic (Friedman et al. 2006; Stevens, Trace & Bewley-Taylor 2005).¹⁷

The society goals of imprisonment are retribution, incapacitation, general deterrence, specific deterrence and rehabilitation (Dunbar & Langdon 2002). While it is clear that imprisonment as such does not rehabilitate offenders, programs within correctional settings aiming to address drug use can be effective with respect to a range of outcomes, including drug use, drug-related harms and re-offending. Indeed, evidence exists showing that in-prison drug treatment programs can have success rates similar to corresponding programs in community settings (Center for Substance Abuse Treatment (U.S.) 2005; National Institute on Drug Abuse 2006; Stevens, Trace & Bewley-Taylor 2005). In this context, though, it should be noted that Australian research into the relative cost-effectiveness of pharmacotherapy, residential rehabilitation and imprisonment shows that imprisonment is by far the most expensive way of dealing with opioid-dependent people (Moore, Ritter & Caulkins 2005).¹⁸

Monitoring and evaluating the ACT's correctional drug strategy

Monitoring and evaluation should be an integral part of the expanded correctional system in the ACT. It can be conducted at a number of levels including policies, programs and projects: the ACT correctional system as a whole, the AMC as a unit and/or its individual services. Evaluation research questions could cover such areas as program concepts and design, implementation, outcomes and attribution. Evaluation research questions covering cost-effectiveness will be an important component.

Without sound evaluation we will have no way of judging whether or not the Alexander Maconochie Centre becomes, as the ACT Government intends, a best-practice correctional facility. The lack of Australian research evidence on prison programs addressing drug use and drug-related harm, the associated mental health co-morbidity and the throughcare model of case management means that we cannot rely on evidence for effectiveness seen in community-based programs. The AMC's policies, programs and projects need to be systematically monitored and evaluated, and the necessary resources

¹⁷ A contrary argument about the impacts of imprisonment on crime rates has been put by conservative think-tanks (especially Murray 1997; Saunders & Billante 2002-03).

¹⁸ In one model, the cost per drug use year averted is \$4,226 for pharmacotherapy maintenance, \$6,517 for residential rehabilitation and \$39,939 for prison – these are data from the Drug Policy Modelling Program.

of time, expertise and money for evaluation should be part of the current planning for the prison.

An evaluation strategy for the drug abuse component of the AMC (and potentially other parts of the ACT corrective services) should be developed well before the facility is commissioned. It should be designed in such a manner as to produce:

- regular and frequent ongoing monitoring data (performance indicators)
- information on the processes of developing and implementing the programs
- information on the programs' outcomes and their attribution.

The evaluation strategy should be designed to meet the transparency and accountability requirements of the ACT Government and the community.

Specifically, it is highly desirable that a process evaluation commence some time before the correctional services' drug strategy is implemented, providing continual feedback to people engaged in policy activity and to those responsible for program articulation and implementation. It would include a component assessing the program logic, assisting staff responsible for policy and implementation activity to clarify the hierarchy of objectives and how they link to the activities carried out under the Strategy (Rossi, Lipsey & Freeman 2004, chapter 5).

Performance indicators should be developed as part of the monitoring and evaluation strategy, not dealt with separately as some type of management activity.

The evaluation of an innovative, good practice Strategy cannot be left until some years down the road. An interim evaluation report 12 months after the prison is commissioned would be in order, followed by a fuller outcome evaluation at around 24 months.

The process and outcome evaluation plan should be funded and designed before the prison drug strategy is implemented. It should not be an add-on after the programs commence operating.

IMPLICATIONS FOR THE ACT NGO SECTOR

The development of the Alexander Maconochie Centre, combined with ACT Corrective Services' commitment to developing and implementing a best practice Corrections Drug Strategy, have important implications for ACT NGOs involved in the prevention and resolution of substance abuse and related problems in our community. This is because:

- local and/or interstate NGOs could be contracted to provide substance abuse prevention, treatment and harm reduction service to prisoners and other corrective services clients and their families
and
- the huge increase in the number of offenders in custody in the ACT and being released to the community under throughcare arrangements could swamp local community services in a range of sectors including substance abuse, mental health, housing, employment, social welfare, financial security, food security, etc.

These developments entail both threats and opportunities for Canberra NGOs and their clients.

Potential threats

A number of potential threats, or at least challenges, face Canberra-based AOD NGOs in light of the development of the AMC. These include the following:

- NGOs could be scapegoated for the failure of prison drug services.
- They could lose their capacity to publicly advocate for improved corrections policies and services if they are involved in direct service delivery to the prison, particularly if their services are purchased by ACT Corrective Services (Duke 2003, pp. 150, 165).
- They could become overwhelmed by the extent of need for services.
- It is possible that insufficient resources including funds, premises and staff expertise will be provided to meet the increased demand.
- Agencies may confront ethical and professional standards issues of NGO involvement in mandatory urinalysis and coerced treatment.
- Confidentiality is frequently a problem for community agencies working in prisons, as the prison culture is traditionally one that strips inmates of this basic human right, frequently justified on the grounds of prison security but also part of the retributive function of imprisonment.

Potential opportunities

Clearly the development of the ACT corrections drug strategy and the Alexander Maconochie Centre provides many opportunities for Canberra-based NGOs to contribute to quality policy development, service development and service delivery and to AOD clients and those with whom they interact. These include the following:

- The initiatives provide opportunities for NGOs to contribute to ACT Corrective Services' and ACT Health's policy development work, to ensure that the policies developed reflect best practice and the realities of NGO work in the Canberra region.
- Greater opportunities exist for NGO facilitation of continuity of care at the front end, i.e. when offenders are arrested and taken into custody. This includes maintaining treatment regimes (including opioid substitution therapies) that were in place at the time of arrest.
- The prison provides opportunities for inmates to commence health promotion, treatment and harm reduction programs that can be continued upon release into the

Canberra community, supported both pre-release and post-release by NGO personnel and peers. Relapse prevention is one important component.

Governance issues and the NGOs

Governance issues were discussed earlier in this paper and I return to them here. Levy's (2005) principles defining excellence in governance arrangements for correctional health policy work and service delivery are independence, health expertise and authority. Some jurisdictions that rely upon outsourcing corrections health services (including the AOD component), for example by purchasing them from NGOs,¹⁹ breach these principles.

This occurs when:

- The purchasing arrangements mean that the health services agencies are not independent of the correctional services purchaser—they are subservient to them by virtue of operating as contractors
- The correctional services agency determines the nature and quality of the health services through its contractual/purchasing arrangements, rather than them being set by an independent, expert health authority
- The service providers operate solely within the bounds of their contracts with the correctional authority without their own legislative mandate to provide the optimal level of services.

Some threshold issues that need clarification with the NGO sector

The CEOs of some Canberra-based NGOs working in the alcohol and other drugs field are concerned that policy work is proceeding rapidly with respect to AOD and other services at the Alexander Maconochie Centre and potentially elsewhere in the corrections system, without adequate consultation with the NGO sector. The core issue is their concern that the policies developed behind closed doors may contain unrealistic expectations of the NGOs. Much more information is needed, soon, about current thinking on the throughcare model of case management, the proposed governance arrangements for the AOD and mental health services, the 'healthy prison' concept and the types of services to be provided to correctional clients both in prison and in the community.

The throughcare model of case management

Throughcare is an issue that needs clarification well before the AMC is commissioned. The term has yet to be operationalised within the Canberra context. Is it just a buzzword or does it have substance?

The British experience is instructive. The British Prison Service Drug Strategy places great emphasis on the throughcare model but states that:

Although the Service technically ceases to be responsible for offenders on their release from prison, in the interests of the wider resettlement agenda, the Service will continue to do all it can to ensure that what happens in prison can be a platform for the longer-term work that might be needed in the community (HM Prison Service (UK) 2003, p. 4).

While this is an admirable sentiment, we need something far more concrete in the ACT than simply an expression of intent. What will the throughcare model of case management look like? Who will design it, pay for it, implement it and evaluate it?

¹⁹ Victoria and the NT have largely privatised their prison health services, contracting them out of the public sector through tendering arrangements (Levy 2005, p. 67).

What is the role of probation and parole in throughcare? In some jurisdictions, every sentenced inmate is released on parole on the grounds that this provides incentives (backed by sanctions) for community-based rehabilitation. Increasingly, though, parole services have become over-stretched, unable to take such a significant role on throughcare (Borzycki & Baldry 2003).

The British experience in implementing throughcare has not been unproblematic. The evaluation reports on that experience warrant close study as they reveal the significant problems that British NGOs have experienced in attempting to fill their roles in the corrections/NGO partnership arrangements. See, for example, Gravett 2000, Dixon 2005, Fox 2005, Harman 2004, Home Office Research 2000 and Burrows 2001.

Governance

The governance arrangements for the corrections AOD and mental health services need to be spelled out as much flows from what is decided in this area. In particular, NGOs are keen to find out if the ACT is to have an independent, expert statutory corrections health service like NSW Justice Health (said to be the best practice model globally) or some lesser approach. Will the AOD services be provided by staff of ACT Corrective Services, ACT Health, NGOs or the private sector, or in some combination? If in combination, what will the mix be?

The 'healthy prison' concept

The ACT Government's commitment that the Alexander Maconochie Centre will be a 'healthy prison' (or, as the Europeans say, a health promoting prison) is applauded by ACT AOD NGOs. But how will this be realised? The impediments to doing so are immense, particularly when we consider the scope of standard definitions of 'health' and 'health promotion':

- Health is defined in WHO's Constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.
- Health promotion '...is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being' (International Conference on Health Promotion 1986).

What programs will be provided?

The ACT Corrective Services Drug Strategy and the Corrections Health Services Plan will need to spell out, in some detail, just what AOD and mental health services/programs will be developed and implemented at the new prison as part of its rehabilitative focus, and in the community as part of the realisation of the throughcare philosophy. These will include supply reduction, demand reduction and harm reduction interventions. NGOs are keen to see what is proposed and how they might become involved in their development and implementation.

CONCLUSION

This paper has been prepared to assist Directions ACT and other ACT NGOs involved in the psychoactive substance abuse field as they think about their involvement with prisoners and other correctional system clients. The context is the development of Canberra's new prison, the Alexander Maconochie Centre (AMC).

We should commend the ACT Government, and through it ACT Corrective Services, for the way they have characterised the AMC as a best practice correctional facility, focusing on the rehabilitation of inmates and close links between the prison and the Canberra community. The statement of philosophy for the AMC is worth repeating:

There are moral, social, justice system and economic benefits in accommodating the ACT's sentenced prisoners in the ACT. Jurisdictions have responsibility for the management of people sentenced to imprisonment, as noted by Justice Stephen Tumim, HM Chief Inspector of Prisons for England and Wales 1987- 1995:

Criminal behaviour emerges as a result of joint failures of the individual and the society of which he or she is part. As a result, society must take some responsibility for crime, and at least make an attempt to rehabilitate offenders.

The ACT community should accept its responsibility for the administration of justice as much as it does for the allocation of justice through the courts.

No other Australian criminal justice jurisdiction sends prisoners, arrested for offences against its jurisdiction and convicted by its courts, interstate to serve a period of imprisonment. This leaves the ACT system fractured and incomplete. It does not promote positive and appropriate criminal justice system outcomes (ACT Corrective Services n.d.).

Australian and international experience is that significant tensions exist between the control and security imperatives of correctional environments, on the one hand, and the desirability of meeting the health and welfare needs of prisoners, on the other. This is seen most clearly with respect to correctional services' clients who are drug users. Is drug use in prison a health or a security/regulatory issue, or both? Clearly it is both. Drugs in prisons constitute hazards for corrections personnel and inmates alike. On the other hand, it is clear that many correctional system responses to drugs have unintended adverse consequences. The solution to this dilemma is to adopt an approach to policy development that is explicitly net harm focused.

The ACT Government's drug strategy defines the net harm approach in the following terms

A net harm approach to policy and intervention development is one which takes into account both the anticipated positive and negative consequences of interventions, and weighs one against the other. It includes looking broadly to identify the consequences of one intervention for other interventions. If the likely impact of an intervention is limited to shifting the burden of harm from one sector to another...this should be made explicit in the planning process and judgements made, based upon a net harm analysis, as to the appropriateness of proceeding (Australian Capital Territory Government 2004, p. 46).

The positive, human rights and best practice-based approach that ACT Corrective Services is taking in developing its new Drug Strategy is a sound basis for Canberra NGOs to engage with them in policy activity in this field. Scope exists for the Canberra NGOs, ACT Corrective Services and ACT Health to develop a mutually-respectful partnership that will result in a world-class corrections alcohol, tobacco and other drug strategy, one that gets the balance right between care and control.

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