The role of drug and alcohol rehabilitation in custodial settings

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Executive Summary

There is a growing body of evidence that supports the strong causal link between drug use and crime. The interplay between drug use and crime is complex, and as such, simple conclusions about causality and broad generalizations should be avoided. Just as there is no one cause of crime or drug abuse, there is no one "silver bullet" solution in relation to treatment. A range of interventions across a broad continuum is required. There needs to be an acknowledgment of the severity of addiction and the complexity of issues at play in one's life when they are dealing with substance misuse issues. The people that fit into the category of "complex", often lead highly dysfunctional lives where a range of issues are at play including, housing issues, education and employment issues and often a diverse range of family and relationship breakdowns alongside their offending behaviour. They are then expected to navigate their way through a system, which is often as dysfunctional as their own life. There is also a significant body of research in the area of justice reinvestment, which has stemmed from increasing concern regarding the costs of incarceration, particularly for offenders with complex issues. This has resulted in an emergence of alternative methods of working with offenders with co-existing offending and alcohol and drug (AOD) issues.

This study has three main aims. Firstly, to provide an overview of the literature and policy relating to the topic. Secondly to present an analysis of, stakeholder interviews conducted and their relevance to the previous findings. And thirdly, to outline, fundamental considerations that should be taken into account in the processes of developing future policies in the area of AOD treatment in custodial settings.

This thesis explores some of the literature on recent developments that have been incorporated into AOD rehabilitation and treatment models. By exploring the key initiatives that have been adopted in both Australian and international prison settings, the thesis outlines the holistic approach needed to work with offenders

with drug use histories, the services that can help address these needs in prison and what level of support is required post-release. In particular, this thesis considers recent developments in corrections policies; both locally and nationally, that are specific to prisoners with AOD issues. The recommendations made in the final chapter of this report are made with consideration to the current literature and in line with the comments made during qualitative interviews conducted with Tasmanian workers.

By examining these issues and building the knowledge base regarding good practice models for offenders with drug use issues in Australia and overseas, this thesis highlights the need for the development of specific policies, practices and initiatives in Tasmania. Drug related crime is increasing, exponentially. This highlights the urgency to get it right when looking at treatment and rehabilitation options for offenders with complex substance misuse issues.

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Abbreviations

ABI – Acquired Brain Injury

AMC – Alexander Maconochie Centre

ANCD – Australian National Council on Drugs

ATDC – Alcohol, Tobacco and other Drugs Council

ATOD – Alcohol, tobacco and other drug

BBV – Blood Borne Virus

CMD – Court Mandated Diversion

CPHS – Correctional Primary Health Service

DHHS - Department of Health and Human Services

FTE – Full time equivalent

NDS – National Drug Strategy

NCDS – National Corrections Drug Strategy

NSP – Needle and Syringe Program

TC – Therapeutic Community

TPS – Tasmania Prison Service

Contents

Introduction

There is a long and detailed history of the linkages between drug use and criminal offending. Many criminal offences are either directly related to crime, i.e. possession and drug trafficking, or are the cause of committing a crime, i.e. burglary, in order to sustain a drug addiction. It is this cyclical nature of drug related offences that often sees offenders transition in and out of prison on drug related charges whilst suffering social and health issues associated with substance misuse. It is due to this ongoing history that a growing emphasis has been placed on the treatment of substance misuse issues of prisoners in custody.

Many studies have identified a need for further research and evaluation of current models of practice in relation to alcohol and drug (AOD) rehabilitation within prison settings (Dietz et al, 2003). The implication of a successful AOD rehabilitation model that is effective in a prison setting has been exemplified in Australia and abroad. The current model within the Alexander Maconochie Centre (AMC) in Canberra is one such example. Exploring the literature and investigating the current models of practice aids in uncovering the requirements for a best practice model and provides a basis for recommendations regarding the current model at the Risdon Prison Complex.

Research Methodology

A total of 15 stakeholders were interviewed between 21 August 2012 and 23 October 2012. They included representatives from nine different organisations (see appendix 1). Using semi structured in depth interviews(see appendix 2), views and experiences of interviewees were sought to explore some of the issues regarding the role of AOD rehabilitation in custodial settings. Interviewees were asked to provide their views on what works and what could be done to improve the outcomes of offenders who have AOD issues.

Quotes from stakeholders included in this report have been de-identified to preserve the confidentiality of individuals who participated and to ensure that all qualitative data is considered with equal standing. The results of this study represent the views of the people interviewed, and should not be used or perceived as a general representation of any of the sectors involved.

The project received ethics approval from the Human Research Ethics Committee (Tasmania) Network. Stakeholders were interviewed on the understanding that the data would be re-identifiable although the names and details of participants would not be published. The project was conducted under the supervision of Dr Max Travers, Senior Lecturer, School of Sociology and Social Work, University of Tasmania.

This thesis is divided into four chapters. Chapter one introduces the links between AOD use and crime, followed by a discussion on the current literature surrounding the topic of AOD rehabilitation in prisons with the aim of providing some insight into the complex issues that relate to working with offenders with complex AOD issues. It also provides a summary of the evidence that supports particular best practice models when working with these offenders in a custodial context.

Chapter two provides a review of the current national and local policy documents that are relevant. Each of the documents is reviewed and analysed in the context of AOD rehabilitation in custodial settings.

Chapter three introduces three examples of the model of care used for prisoners with AOD issues in Australia and the US. The model used by the Alexander Maconochie Centre (AMC) in the ACT, in particular the Solaris Therapeutic Community, is examined alongside the Compulsory Drug Treatment Centre (CDTC), at Parklea Correctional Centre in NSW. The Sheridan Correction Centre National Model Drug Prison and Reentry Program in the United States is also explored as another example of drug treatment and rehabilitation in custodial settings. Each of

these models has been previously evaluated in depth and as such a summary of those findings will be provided.

Chapter four analyses the views of the 15 stakeholders interviewed for this study. It explores the limitations, achievements and general workings of AOD rehabilitation and treatment within Tasmania Prison Service and highlights some of the areas of concern amongst the stakeholder group.

The thesis concludes with an overview of the major issues highlighted through the stakeholder review, in light of the literature, state and federal policy, and best practice models discussed in the previous chapters.

Chapter 1:

Best Practice in AOD treatment and rehabilitation in correctional settings: Australia and beyond

This chapter will review the literature and conceptual frameworks related to the topic of AOD rehabilitation in custodial settings and provide a theoretical background as to why more research in this area is required. It will look at individual perspectives as well as local, national and international policy to examine the role of AOD rehabilitation in custodial settings to address the criminogenic need of offenders experiencing substance misuse issues.

1.1 The Drug/Crime Cycle

Since the 1980s there has been a significant focus on breaking the cycle of crime and substance misuse. Drug use by offenders is one of the biggest challenges facing Australia's criminal justice system. It is estimated that between 37 and 52% of offenders in Australia report that their offending is attributable to their drug problem (NCDS, 2006). Lifetime and current prevalence of illicit and injecting drug use is substantially higher among the prison population than the general population (Kinner, 2006; Butler and Papanastasiou, 2008). Lifetime heroin use is up to 10 times higher in prison populations and prisoners are 20 times more likely to inject drugs than the general population (Kanato, 2008; Galea & Vlahov, 2002). High prevalence of drug use histories among prisoners is indicative of a need for comprehensive drug-specific services and programs during prison sentences and following release (Graham, 2003; Bird & Hutchinson 2003; Dolan *et al.*, 2005).

Evidence tells us that only a small percentage of individuals experiencing complex substance misuse issues, seek treatment voluntarily, therefore, the incarceration of an offender with significant alcohol and drug issues provides a unique opportunity for intervention and treatment.

The 2009 National Prisoner Health Census (NPHC) reported that 71 per cent of prison entrants in Australia had used illicit drugs in the last 12 months and noted that poly drug use was also a concern. Fifty nine (59%) per cent of those who had used illicit drugs in the past 12 months, had used more than one type of drug. The most commonly used substances were cannabis (52%), meth/amphetamine (30%) and heroin (19%) (Australian Institute of Health and Welfare, 2010).

1.2 Recidivism

Without treatment, incarceration is unlikely to have any reduction in the recidivism rates of offenders with complex substance use issues. In fact, the recidivism rates across the world are upwards of 50% for offenders with substance use issues. A recent Australian study looked at reoffending rates within 24 months of release and found that for offenders with comorbidities (co-existing mental illness and substance misuse) the recidivism rate was 67%. For offenders with only substance disorder, the rate was 55% and for only a mental health disorder, the recidivism rate was 49% (Smith & Trimboli, 2010).

There is substantial evidence that treating mental health disorders, particularly substance disorders, can reduce re-offending. This has obvious benefits for the community. Furthermore, treatment would benefit the prisoners in terms of improved health and social outcomes. Investment in well-designed and well-implemented programs appears to be warranted (Smith & Trimboli, 2010). Therefore it seems clear that in the absence of an effective AOD treatment program, there is a high likelihood that prisoners in this cohort will go on to persist in crime.

1.3 What is drug and alcohol rehabilitation?

According to the 2012-13 Alcohol and Other Drug Treatment Services (AODTS) National Minimum Data Set (NMDS) Specifications and Collection Manual, AOD rehabilitation is defined as

> "an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings" (AIHW 2012, p.96)

There are two main points to draw from this definition. Firstly, that AOD rehabilitation is an intensive program with high-level support and can be multi-faceted in the methods used to work with clients. It also specifies that AOD rehabilitation tends to involve medium to long term durations, rather than short term interventions. It also highlights the gap for those offenders on short terms sentences and questions the validity of imprisoning offenders with substance misuse issues, to short term sentences.

1.4 Prison based drug and alcohol programs and treatment

There are a range of various programs and treatment options that are provided to prisoners in a custodial setting across the world. More recently there has been a shift toward rehabilitative programs for prisoners, as described above, that include counselling, behavioural therapy, and activity based programs and also pharmacotherapy options to address withdrawal and maintenance of licit and illicit drugs. There is some distinction made between treatment and rehabilitation. Often, pharmacotherapy and other medical interventions are viewed as treatment and counselling and behaviour therapy is seen as rehabilitation.

AOD programs used in corrective settings can be broadly defined into four categories:

1. **Harm reduction programs** which seek to enhance awareness of high risk behaviours (such as overdose, blood borne viruses and other disease transmissions) and the physiological effects of substance use, including pharmacotherapy
2. **Psycho-educational programs** which aim to improve understanding and awareness of the link between substance use and criminal offending and to enhance motivation to enter more intensive program
3. **Therapeutic programs** are generally of a moderate intensity and involve participation in groups which focus on understanding substance use and offending, developing mechanisms to cope with cravings and withdrawal, developing alternative behaviours, managing emotions, enhancing problem solving and communication and developing relapse prevention plans
4. **Prison – based therapeutic communities** are the most intensive form of program, with participants separated from prison culture and immersed in a dedicated therapeutic environment.

Source: adapted from Heseltine et al, (2011)

It is widely acknowledged that there is a need for a bio psychosocial model which encompasses harm reduction, pscyho-educational and therapeutic programs, to address prisoners' needs in a holistic manner.

Pharmacotherapy programs

Pharmacotherapy programs in custodial settings were established in the late 1980s and one of the longest running prison based methadone programs in the world continues to operate today. There have been a number of issues including: the mismatch between the punitive nature of prisons and the therapeutic intent, experienced by custodial staff and also a number of security concerns raised regarding the dispensing and subsequent diversion of methadone. A strong case exists for making methadone maintenance treatment available to prisoners to

maximize the potential treatment benefits associated with continued methadone therapy (Dolan and Wodak, 1998). Opioid substitution therapy is used to reduce the harms associated with illicit opioid use. Opioid substitution treatment can help: reduce transmission of blood-borne viruses; prevent post-release overdose; reduce drug-related crime; make an opioid dependent individual's life more normal; integrate them back into the community; retain opiates in treatment; and reduce cravings of opiates.

Therapeutic programs

The inadequacy of incarceration as a standalone approach to addressing substance misuse or addiction is evident in the statistics. According to Jensen et al (2004), punishment alone is a futile and ineffective response to drug abuse. As such, there has been a lot of work in the area of developing adequate programs that address all areas of an offender's life. Andrews and Bonta (2006) identified eight central risk factors that are major predictors of criminal behaviour and therefore need to be addressed when developing programs.

- A history of offending
- Antisocial personality pattern (e.g. impulsive, aggressive, pleasure seeking)
- Antisocial attitudes, values, beliefs, rationalizations and identity
- Antisocial associates
- Substance abuse
- Unsatisfactory family and or/marital situation
- Poor performance at and/or lack of education/employment
- Lack of involvement and satisfaction in pro-social recreational leisure activities.

Since the primary goal of offender rehabilitation is to address the criminogenic risk factors relevant to the offender, it makes sense that treatment models for substance using offenders in correctional settings should also uphold the same principles. There are several treatment modalities and program options available to

corrective services for implementation in custodial environments and many of these options are evaluated in the literature.

In prison treatment, especially when followed by residential aftercare has been found to reduce recidivism (Hiller et al, 1999). An American review by Wilson and MacKenzie (2006) demonstrated that in-prison Therapeutic Communities (TCs) can reduce recidivism by 5%. When aftercare is included, recidivism can be reduced by 7%. Australian researchers have reviewed evidence for four interventions for drug-dependent prisoners: detoxification, drug-free units, therapeutic communities, and opioid substitution treatment (Larney *et al* 2007). They found, there needs to be a focus on increasing the evidence base of TCs and opioid substitution therapy. On current evidence, methadone maintenance treatment is the most effective treatment for reducing drug use and criminal recidivism. It may also assist in reducing HIV and other blood borne virus transmission. However, this treatment is suitable only for opioid-dependent populations; users of psychostimulants and other non-opioid drugs remain poorly served by current treatment approaches, both in the community and in prison (Larney et al, 2007).

1.5 The Therapeutic Prison as a model for AOD rehabilitation

One of the most common and emerging treatment programs being adapted for correctional settings across the world is the in prison therapeutic community (TC). The model is based on the community TC model and has been modified to work within correctional settings, in a separate part of the prison away from the main population. According to the Australasian Therapeutic Communities Association (ATCA) a therapeutic community is:

> "A treatment facility in which the community itself, through self-help and mutual support, is the principal means for promoting personal change. In a therapeutic community, residents and staff participate in the management and operation of the community, contributing to a psychologically and physically safe learning environment where change can occur...there is a focus on the biopsychosocial, emotional and spiritual dimensions of

substance use, with the use of the community to heal individuals and support the development of behaviours, attitudes and values of healthy living"

The majority of the principles listed above easily correlate to an in prison TC. There is less emphasis on the peer leaders and a greater emphasis on clinically trained staff. Generally in prison TCs tend to have shorter treatment duration. In prison TCs have been evaluated previously on a number of occasions and provided empirical support for the development of these programs. In the first large scale study (N= 1,500), Wexler, Falkin, Lipton & Rosenblum (1992) provided convincing evidence from the "Stay'n Out" program, that prison-based TC treatment can produce significant reductions in recidivism rates for males and females. The KEY-CREST program in the US represents a treatment continuum that mirrors the offender's custody status (Inciardi et al, 1997). Inmates with drug use histories are referred to the KEY in prison therapeutic community program and upon release are forwarded to the CREST program, a TC based work release program (Nielsen, Scarpitti & Inciardi, 1996). The last stage of this program for prisoners includes supervised outpatient aftercare. According to follow up data, recidivism rates were significantly lower than for program dropouts and the non-treatment control group.

The United States have been adopting the TC model in prisons for a number of years and have significant evidence to suggest positive results. A 1999 meta-analysis of drug abuse treatment in prisons found support for the effectiveness of TCs in reducing recidivism (Pearson & Lipton, 1999). A more recent meta-analysis conducted in 2007 found that in prison TCs were effective in reducing recidivism and post release drug use (Mitchell, Wilson, & MacKenzie, 2007). According to Miller and Drake (2006) when analysing six in prison TCs with community aftercare components, there was a statistically significant 6.9% reduction in recidivism rates for these types of programs when compared to treatment-as-usual group. Further US research has found that substance abuse treatment works to reduce AOD use as well as crime (Gerstein et al, 1997).

Some components of the TC can be utilized without implementing the full TC environment. For example, according to Dietz et al (2003) in a review of the research on therapeutic communities, the benefit of housing inmates in pods and the effects for the management of non treatment units in a prison is beneficial.

> "By holding inmates accountable to one another and by involving them more directly in the daily responsibilities of running the unit, one might see the same positive effects that were shown in the treatment unit" (Dietz et al, 2003:222).

The evidence supporting the success of in prison TCs emphasizes the need for aftercare in additional to prison based treatment to see improved post prison outcomes. The use of transitional programs prior to release, half way houses and graduated release into the community have all shown positive results (McCarthy & McCarthy, 1997; Clear & Braga, 1995).

As with any best practice model of care, there are always a range of issues that present at implementation stage. Burdon et al (2002) discuss the implementation and operational issues that have arisen in evaluations of TCs over the past two decades. They identify three system related issues; collaboration and communication, supportive organizational culture, sufficient resources, and a further four treatment related issues; screening, assessment, and referral; treatment curriculum, incentives and rewards; and coerced treatment.

Smith and Schweitzer (2012) have made insightful observations as to the key components of a therapeutic prison and include that the interventions offered within a therapeutic prison need to be evidence based best practice and utilize formal links with other agencies to ensure services are available to meet the diverse needs of offenders. Some of the issues associated with the development of a TC within a prison environment will be discussed in more depth in chapter 3.

1.6 Coercive/compulsory treatment

Compulsory or mandated treatment is the most ethically contentious form of coerced treatment as it deprives the offender of any choice and provides limited treatment options (usually abstinence focused). According to Hall and Lucke (2010) offenders need to have a choice as to whether they take up treatment and if they choose to do so, they should have a choice of treatment, rather than being compelled to enter a particular form of treatment. From an individual viewpoint, treatment choice is important as no single treatment option is suitable for all offenders. There is significant evidence to suggest that many offenders have benefited from a range of treatment approaches that enable them to have personal investment in their treatment and that is specifically relevant to their drug problem and their offending.

Compulsory treatment does not necessarily result in worse outcomes than voluntary treatment, and motivation is important in terms of problem recognition, treatment readiness, and help seeking behaviour (Stevens et al. 2005). Better evaluation is required on the overall effectiveness of all forms of drug treatment under legal coercion.

1.7 Prison health and support services

Many prisoners continue to use licit and illicit drugs while in prison. The health of Australian prisoners 2009 report published by the Australian Institute of Health Welfare found the health of prisoners to be poorer than the general community on a range of indicators including AOD use and mental health concerns:

- 52% of prison entrants reported drinking at levels that place them at significant risk of alcohol-related harm
- 71% of prison entrants had used illicit drugs during the 12 months prior to their current incarceration
- 35% of prison entrants tested positive to hepatitis C, 21 per cent tested positive to the hepatitis B and less than 1 per cent tested positive to HIV.

According to Dr Michael Levy, Justice Health Services director, prisoners arrive in prison with a range of complex health problems

> Their needs are so great, their immediate survival needs are so great in terms of mental health needs, addictions, their drug seeking behaviours...Overwhelmingly the majority don't have a regular GP clinic in the community, don't access the walk in centre. [They] use the Emergency Department as their health service, so its always a crisis (Canberra Times, 26 May 2012).

Whilst offenders are incarcerated an opportunity exists for them to access education, prevention, assessment and treatment of a range of health issues (Butler et al, 2007); MacGowan et al, 2003; Butler and Papanastasiou, 2008; Skipper et al, 2003).

Different health outcomes across Australia exist because the management of correctional health services is jurisdictionally differenct. Up until 2006 the Correctional Health Services were provided by the Tasmania Prison Service under the Department of Justice. In 2006, DHHS took over this arrangement and services are now provided Independently by the DHHS under the guise of Correctional Primary Health Services (CPHS).

1.8 Throughcare, aftercare and post release assistance

There is a significant body of research that suggests that aftercare is crucial in limiting re-offending and reduction of relapse. Unfortunately many prisoners who complete treatment in a custodial environment do not attend aftercare or are not offered aftercare as a post release option. Prisoners need a central point of contact where they can obtain assistance in relation to housing, employment and education support and AOD treatment. Best practice suggests that the most effective method of delivering such a service to newly released prisoners is through a drop-in centre. Such centres exist in many jurisdictions throughout the world (see Fretz 2002; Ashford and Cox 2000; Wiebush, MxNalty and Le 2000; Josi and Sechrest 1999). One study found that 39% of young offenders, who received aftercare services re-offended, compared with 73% of those who did not receive such services (NACRO

2003). According to recent studies, communication between community based workers should be facilitated to continue post release and ideally be initiative during sentences and post release (Borzycki, 2005: Burrows et al, 2000; VAADA, 2003; Ward, 2001).

The importance of throughcare in pharmacotherapy treatment should not be underestimated. The commencement of a prisoner on a pharmacotherapy program whilst incarcerated without the opportunity to continue the treatment in a community placement upon release can be deadly. Hiller et al (2009) found that corrections based treatment policy should emphasise a continuum of care model with high quality programs and services.

The Burnet Institute conducted an external review of the AMC in 2011 and noted

> "Accessible and effective pre- and post-release programs and services have been shown to be effective in enabling individuals to overcome disadvantage, reduce morbidities and recidivism and to bring wider community benefits as a result" (Stoove & Kirwan, 2011, p.43).

Among other things, the review emphasized the importance of throughcare, aftercare and pre-release planning to ensure that appropriate support is provided post release for prisoners to achieve good outcomes.

Comparisons of US studies of a wide range of community based programs and in-prison treatment programs including methadone maintenance treatment and substance abuse education reveal similar success rates (Prendergast, Podus, Chang & Urada, 2002, Pearson & Lipton, 1999). It is crucial to note, however, that some studies show that similarities in success rates only apply to in-prison therapeutic communities for which aftercare after imprisonment is a very important component of success (Inciardi, Martin, Butzin, Hooper & Harrison, 1997). It would seem, therefore, that imprisonment presents an opportunity for effective rehabilitation of drug addicted people, but that equally successful treatment can be delivered more easily, and cheaply, outside of prison.

1.9 Harm reduction

According to the National Drug Strategy,

> "Harm reduction recognises that an individual's engagement in drug misuse, illegal drug supply or illegal drug manufacture generally has flow-on health, social, economic, environmental and other consequences for those around him or her including for family, workplace, neighbourhoods and the broader community"

The ACT government has recently agreed to trial a Needle and Syringe Program (NSP) in the AMC prison. The ACT will be the first Australian jurisdiction to provide this service. There are currently more than 50 prisons in 12 countries hosting NSPs, including Spain, Portugal and Germany. There are a variety of delivery models including: vending machines, exchange programs operated by doctors and health staff, or alternatively by community sector providers. There are also contained programs where clean equipment is provided and used in a dedicated injecting area within the prison.

According to Jurgens et al (2009), prison based NSPs have contributed to reductions and in some cases, cessations in sharing of injecting equipment. In prisons with NSPs there have been no new cases of HIV and HBV being reported. In general, NSPs are also associated with reductions in overdose numbers, greater engagement with drug treatment, improved relationships between prisoners and staff, increased awareness off BBV transmission and increased staff safety (Jurgens etc al, 2009).

The ACT trial is expected to begin in 2013 and has been welcomed by the heath sector, including Hepatitis Australia who argued a trial needed to start "sooner rather than later and the longer the delay, the worse the personal and public health impacts and their associated costs would be" (Hepatits Victoria, 2011). There have been lengthy delays in the preparation of the trial due to trade unions having concerns about the possibility of needles being used to threaten or harm correctional officers and other staff. This however has not been the case in prisons

where NSPs have been implemented, according to Jurgens et al (2009) no incidents of needles being used as weapons have been reported, and prison NSPs have not resulted in "increased number of prisoners injective drugs, an increase in overall drug use, or an increase in the amount of drugs in prisons" (Jurgens, 2009).

In Tasmania the possible trial of an NSP at Risdon Prison has been raised in the workplan for the DHHS Hepatitis and HIV Working Group. According to the World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prisons (1993), "preventative measures for HIV/AIDS in prison should be complementary to and compatible with those in the community". As such, there is a clear argument that if people in the community are able to access clean equipment, then prisoners should be afforded the same rights.

Other harm reduction strategies such as overdose prevention and distribution of naloxone prior to release has also been heavily evaluated. Offering these types of programs, alongside accessible AOD programs and pharmacotherapy has shown to diminish overdose risk post release (Karminia et al, 2007).

1.10 The role of prison administration in AOD rehabilitation

There are a number of issues that often arise concerning the administration and general day to day organizational issues of a prison when trying to implement improved AOD programs. There are two potentially conflicting parties at play in a corrections setting. There are the prison administrators and managers whose aim is to contain the prison population and then there is the therapeutic/programs staff who want to rehabilitate and treat prisoners. In other words, there are those in the corrections system that see drug misuse as a crime and those that view it as a chronic disease. There is a need for two divergent systems to unite for greater outcomes. Prendergast and Burdon (2002) talk about the development of a 'culture of disclosure' whereby a common set of goals are agreed upon. Burdon et al (2002) also point out the need for meaningful integration of the criminal justice and treatment systems. There is a need to work within the bureaucratic nature of a prison but remain aware of this conflict. Commitment and support of managers is imperative to make this work effectively.

Sufficient resourcing and funding is always raised as an operational issue in the management of prisons across the world. Properly directed funding, competitive staff salaries, experienced and stable workers are all crucial to the success of a TC or similar drug program in a custodial environment according to Burdon et al(2002). According to a 2009 review conducted by Heseltine et al, all jurisdictions have recognized the need for staff to receive formal training and the importance of investing significant human and financial support to training. This is consistent with the concept posed by Andrews and Bonta (2010) that staff practices can have a significant impact on the success of programs.

Heseltine et al (2011) asserts that many correctional departments across the country have a variety of issues surrounding retention of program delivery staff. Some of the issues raised in their study included: being unable to fill positions, limited career pathways for facilitators resulting in recruitment and retention problems, difficulty with recruitment in remote custodial settings, a lack of suitably qualified staff, difficult recruiting and retaining psychologists, difficulty recruiting appropriately qualified indigenous facilitators and staff movement.

A consistent theme across the literature in the area of AOD rehabilitation is the importance of evaluation and considered analysis of data. Across the country evaluation is becoming more routinely regarded as a necessity rather than an unnecessary extra and pre and post program measures of change are more routinely accepted as part of the program. (Heseltine, 2011). Unfortunately this does not seem to be replicated in the Tasmanian context. When speaking with Tasmania Prisons program staff it became clear that data collection and evaluation were not of a high priority.

Heseltine et al (2011: 36) also examined staff workloads.

> "There continued to be political pressure to deliver programs to a greater number of offenders regardless of risk or need, thereby increasing staff workload without enhancing program efficacy or arguable affecting longer term change"

It was acknowledged that the main problem for jurisdictions in collecting data and evaluating programs was the political sensitivity of the reports. The Tasmanian Department of Justice conducted a full audit of sex offender programs offered and noted that since 2003, no sex offender who completed the Sex Offender program has returned to prison for a sexual offence. This is something that could also be done for the AOD programs area. Currently recidivism data for offenders who complete the AOD programs offered at Risdon prison are not collected.

Summary

As highlighted in the literature examined above, there are a number of things that need to be considered when developing programs and treatment models for prisoners with complex substance misuse issues. It seems clear from the current evidence that the TC movement has spread to the corrections world and is now gaining momentum and receiving positive results. At the centre of this discussion is the importance of communication between different areas of the prison and the role of the community sector in the delivery or support of these services.

Central to this discussion are the barriers often faced by ex-prisoners upon release in continuing to stay abstinent and avoid relapse and recidivism. The importance of the throughcare model which incorporates both pre-release support and aftercare support has been highlighted above. Addiction remains a stigmatized disease not often regarding by the criminal justice system as medical conditions: as consequences, treatment is not constitutionally guaranteed as is the treatment of other medical conditions (Chandler et al 2009: 186).

There has been a considerable effort in the last two decades in evaluating current treatment and rehabilitation for offenders with AOD issues, however there still remains a lack of guidance in best practice models of care for this cohort. However, chapter three highlights the positive results being achieved at the AMC prison where a TC has been successfully implemented.

The importance of policy and strategic direction from a State and National level is discussed in the next chapter with a focus on the more recent policy directions in Tasmania and Australia more broadly.

Chapter 2

Drug Policy: A local and national context

Both nationally and locally there has been a strong policy emphasis in the area of AOD rehabilitation and treatment in custodial settings. The Tasmanian Government's recent Breaking the Cycle Strategy has had a significant impact on the Tasmanian Corrections system although implementation of many of the strategies is yet to be illustrated. Similarly, the Palmer Review made a range of recommendations, many of which have not been complete. This chapter reviews a number of relevant policy documents at an organisational, state and national level. The most relevant elements of each of the policy documents are explored in detail, with particular reference to their relevance to this project and future developments in the area of correctional rehabilitation of substance misusing offenders.

National Policy

National Drug Strategy 2010 -2015

The National Drug Strategy (NDS) provides a framework for action to minimise the harms to individuals, families and communities from alcohol, tobacco and other drugs. The NDS informs all drug policy developed across the nation; federally and within jurisdictions.

At the heart of the framework are the three pillars of harm minimization; supply reduction and harm reduction. Prevention is an integral theme across the pillars.

Since its inception in 1995, the NDS had an overarching approach of harm minimization. As stated in the NDS the three pillars are as follows:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of

tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community

- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs
- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.

Particularly relevant in the context of this thesis is the importance of partnerships between the health and legal sectors, as central to the implementation and success of the objectives and activities listed in the National Drug Strategy:

> "Strong partnerships and integrated service approaches with alcohol and other drug treatment, social welfare, income support and job services, housing and homelessness services, mental health care providers and correctional services are needed if people with multiple and complex needs are to be assisted to stabilise their lives, reintegrate with the community and recover from alcohol and other drug related problems"

The application of these pillars is described in more detail as the foundation of many of the Tasmanian State policies and strategies relating to the topic of corrections.

National Corrections Drug Strategy

A component of the NDS is the National Corrections Drug Strategy 2008 (NCDS). The NCDS is based on the National Drug Strategy's strong harm minimization focus and has the same three strategic directions: supply, demand and harm reduction. The mission of the NCDS is :

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

preventing the uptake or continuation of drug misuse, reducing the harm effects of drugs, and reducing re-offending"

To achieve the goals of the NCDS the following six principles are outlined:

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

Source: Supply, Demand and Harm Reduction in Australian Prisons, ANCD Report 2012

Again the importance of a continuum of care for problematic substance users in the correctional setting is emphasized, particularly the importance of aftercare post release.

Tasmanian Government Policy

There have been a number of significant policy developments in Tasmania in the last decade and more recently in the last five years. Risdon Prison received significant media and public scrutiny in 1999 following the deaths of five men in custody, over a period of just four months. Four of the men had been hanged and the fifth died of un determined causes. The suicides prompted an inquiry by the

Tasmanian Ombudsman and a Deaths in Custody inquest by the state coroner. A series of policy statements and further inquiries shortly followed in the mid to late 2000s. The Tasmania Prison policy document, Breaking the Cycle was released by Government in 2011 following consultations which began in 2008, and the Risdon Prison Complex Inquiry (The Palmer Review) was completed by Mick Palmer in 2011.

Risdon Prison Complex Inquiry (The Palmer Review)

The 2011 report prepared by Mick Palmer for Minister for Corrections and Consumer Protection Nick McKim MP, has been instrumental in the recent changes at the Risdon Prison Complex. The intention of the review was to provide impartial, objective and accurate advice to Government on the Risdon Prison Complex operations and provide a realistic way forward that was appropriate for Tasmania. The report contained several adverse findings on operational practice and behavioural issues, and made detailed recommendations in many areas of the Prison's operations. According to Palmer (2011:9-10):

> "The reality is that there is currently a lack of clear and decisive leadership within the TPS at RPC. Further, there is a high level of distrust between management and staff, where operational practices have served to cause staff to withdraw from interaction with prisoners, compounding excessive lockdowns (particularly of maximum security rated prisoners) and, overall, to apply what can only be described as little more than containment policy across the prison as a whole....The current situation is, however, unsustainable and, if allowed to continue, can only lead to further deterioration and a likely occurrence of serious riot and disorder"

Palmer proposed that reform in this area must be driven and supported from the top and be 'unequivocal in its commitment'. He suggested a two pronged approach to achieve change: first to drive and steer change management processes and secondly to provide continuing independent monitoring and inspection of prison operations.

Recommendation 1(a)

That the Government secure the services of a competent and skilled prisons administrator with a reputation for effective change management to drive the implementation of the operational reforms outlined in this report and to:

- *Have direct line responsibility to the Director of Corrective Services;*
- *Lead and mentor the Senior Management Team and work closely with a selected internal change management team during the change processes; and*
- *Develop a success plan and capacity.*

Since the release of the Palmer Review, Government has employed, Brian Edwards into the newly created position of Change Manager at Risdon Prison in February 2012. Barry Greenberry also was appointed to the position of Director of Tasmania Prison Service in June 2012, following the retirement of the previous long serving Director.

The second of the recommendations made in the Palmer Review detailed the establishment of a Commission:

Recommendation 1(b)

The government establish a commission to be responsible for the executive management of the TPS. The commission to comprise:

A commissioner;

- *Director of Tasmania Corrective Services;*
- *Director of Tasmania Prison Service; and*
- *Two part time members of the health and welfare sectors and broader community groups*

Recommendation 2

That government establish an independent, competent, inspection authority to provide for the periodic inspection of custodial services and the publication of all inspection reports.

The Palmer Review also proposed an Independent Inspection Process to be established. Chapter 2 of the Palmer Review sets out a range of recommendations. Many of the recommendations relate to prisoner access to a range of educational and social activities and programs, better connection between senior management roles and the day to day running of the prison, that the case management system be reviewed, that program and education capacity be increased and also that the Government give urgent consideration to funding more communication accommodation. Nick McKim reported to the media in May 2012 that 24 of the 38 recommendations from the Palmer Review had been implemented although there seems to be little evidence in the public sphere regarding the implementation of these recommendations.

Breaking the Cycle: A Strategic Plan for Tasmanian Corrections 2011-2020

Beginning in 2008, following the Deaths in Custody, the Department of Justice began a consultative process to assist in the development of a strategic policy for Tasmanian Corrections. Several of the underpinning principles of the Breaking the Cycle Plan (see appendix 3) are specifically relevant when looking at the role of AOD rehabilitation in correctional settings. Generally, the principles stipulate that the Tasmanian corrections system should provide treatment and services that are directly aimed at rehabilitation and reintegration with a focus on addressing criminal behaviour and risk. There is also a significant emphasis on community organisations being given the opportunity to interact with the prison wherever possible to assist in offender rehabilitation. The plan identifies seven goals with goals 1, 4 and 5 directly relevant to this study.

1. *To reduce re-offending by providing rehabilitation and reintegration services to address issues which contribute to offending*

The first goal highlights the importance of services delivered by partner organisations and acknowledges that by working more closely with non government partners, an increase in the provision of programs and services for offenders with complex needs will be seen. Action 1.1.3 specifically addresses the need for increased provision of services that address key criminogenic issues such as substance misuse.

4. *To provide more effective and accessible service delivery through better integration with service providers*

The fourth goal focuses on collaboration and communication which are both essential in providing adequate access for offenders with substance misuse issues. The strategies of this goal provide a strong focus on the importance of communication between Tasmanian Prison Service and Community Corrections. Increased communication with partner organisations is also listed. Of significant importance is Action 4.1.4: *explore the possibility of centralizing funding for service delivery by NGOs to support longer-term and cross-disciplinary projects.*

5. *To increase community engagement with the corrections system and the rehabilitation of offenders*

Goal five focuses strongly on communication with the broader community regarding corrective services. Action 5.2 specifically notes the following: *expand community involvement in corrective services, particularly rehabilitation and reintegration activities.*

The Breaking the Cycle Plan provides clear direction on a range of activities aimed at reducing recidivism and breaking the drug/crime cycle. However at times, it does not truly reflect the level of commitment required to put many of the key directions into action. Only time will tell if actions identified in the Plan come to fruition. It is disappointing that the Strategy has been operational for one full year and yet little activity has commenced to address some of the major concerns.

Healthy Prisons, Healthier Communities Alcohol, Tobacco and Other Drug Strategy 2010-2013

In 2010 the Tasmania Prison Service (TPS) in conjunction with Correctional Primary Health Services (CPHS) released a strategy aimed at addressing "drug and alcohol issues in a whole of prison community and whole of individual person context". The document is aligned with both the National Corrections Drug Strategy and the Tasmania Alcohol and Drug Strategy. It is clearly stated in the introduction of the document that the strategy will be subject to annual review although it is not clear if this annual review has taken place, at least within the first year.

The Strategy outlines 13 main principles agreed to by TPS and CPHS with many of the principles directly relevant to this study. The Strategy then focuses on key activities under the headings of Supply, Demand and Harm Reduction. Some of the most relevant points include:

Failure to address drug and alcohol service demand among prisoners is associated with further offending behaviour

- This point is particularly interesting as AOD services are only provided in the minimum security part of the prison by Holyoake. Also, pharmacotherapy and the other more intensive AOD programs run by IOM are not available to minimum security inmates.

Organize a coordinated, integrated and multidisciplinary approach to case management and expansion of post release options

- The Tasmania Prison Service does not provide any case management assistance to prisoners post release. The only way ex offenders can access post release case management is through interaction with the community sector organisations that deliver post release programs such as REO (Reintegration for Ex Offenders). It is also important to note that many CSOs do not have the capacity to provide intensive case management support to ex offenders because the Department of Justice does not provide funding to organisations to provide these services. This is markedly different to other states and territories

where case management support is provided to ex offenders through various CSO's that receive funding directly through their Department of Justice or equivalent.

Another point made is the use of prisoners as peer AOD educators

- Whilst this has been raised as an option within the Prison, anecdotal evidence from stakeholders indicates that getting access to deliver peer education programs is difficult and that there are several barriers in place to deter peers from engaging in this type of work.

The document goes on to name nine key future directions with the first and third points being the most relevant to this discussion:

1. *A joint review of current alcohol, tobacco and other drug programs to prisoners in Tasmania and identification of gaps in programs. This will include consideration of education, counseling and treatment services and joint representation for resourcing to the Department of Justice and Health.*
3. *Explore the development of a drug free unit within Risdon Prison Complex by the Tasmania Prison Service*

A review of AOD programs in the prison would certainly identify a number of service gaps that need serious consideration to improve the opportunities for offenders to break the drug/crime cycle. A review would also assist in determining the best way for the Prison and any auxiliary agencies to work together to collect useful and relevant data to aid future developments and improvements in this vital program area.

Tasmania and the Northern Territory are the only two jurisdictions in Australia without a drug free unit operating in the corrections system. The establishment of a drug free unit in the Risdon Prison Complex will be discussed further in this study.

Healthy Prisons, Healthier Communities Blood Borne Virus Strategy 2010-2013

The BBV strategy follows a very similar line to the ATOD strategy discussed previously. It has also been developed in partnership between the TPS and CPHS and it too is based on the philosophy of harm minimization. The use of annual action plans is again mentioned although there seems to be no indication as to whether this has in fact occurred. Ten specific principles are listed in the Strategy and most relevant to this discussion are principles 7 and 8:

> *7. The necessity for education and provision of information for both staff and prisoners is paramount to the success of the strategy.*
>
> *8. Where possible, a peer education and supporter philosophy will be adopted*

Each of these points relates to actions currently being undertaken by the Prison and which seem to be working effectively. Of most significant importance to this study are the following two points listed in the key result areas section of the BBV strategy:

- *Investigate the introduction of a pharmacotherapy program within the prison system, including minimum security facilities*
- *Implementation of a therapeutic drug program within the Tasmania prison facilities.*

The first point has been partially addressed as there are now 27 prisoners accessing the pharmacotherapy program run by CPHS. However pharmacotherapy is still not provided for prisoners housed in the minimum security prison. CPHS staff also report that while 27 prisoners are in receipt of pharmacotherapy, there are dozens more who would benefit from the treatment but cannot be treated due to logistical difficulties.

The second point, which recommends the implementation of a therapeutic program is particularly interesting, and there is little suggestion that this has begun. The concept of a therapeutic prison will be discussed further in the stakeholder analysis section of this report.

Summary

There are several consistent themes that emerge from the national and state policies and strategies examined in this chapter. The principle of harm minimization informs each of the policies and strategies examined and is the underlying theme. There is also a strong focus on collaborative practice. While this is a significant improvement from previous policy approaches, where organisations, agencies and departments worked in complete silos, there is still a significant road ahead to improve the relationships between government and non-government ATOD treatment services and other auxiliary services.

Australia has a long and detailed history of developing AOD strategies to tackle the issues of working together and collaborating to achieve positive health outcomes for individuals. Working collaboratively has also been a strong focus in the corrections sector. It is widely accepted that for strategic direction and policy development to make a difference, key stakeholders and players must be involved from the beginning.

There is a clear commitment from the Department of Justice and the Tasmania Prison Service that working with outside CSOs is imperative to reduce recidivism amongst offenders with substance misuse issues. These relationships however need to be formalized and included in the organizational structure, to avoid the possibility that implementation becomes reliant on particular individuals. .

According to policy evaluators, a key measure of policy coherence is the extent to which individual policies accord or conflict with other policies. In this case, the policies reviewed and discussed in this chapter certainly meet the test of policy coherence as there do not seem to be any major conflicts between national and state policies on any level. The role of evaluation and review in any area of policy is imperative to the success of the ideas contained in the policy. As such, the review process is central to the development of policies discussed in this chapter. Although the Breaking the Cycle Strategy has been operational since 2010, there has been no formal evaluation or review of the effectiveness of the key directions and activities. The same applies for each of the internal Tasmania Prison Service Strategies. For

policy to be effective and reach the intended outcomes, review needs to be thorough and issues need to be identified at the outset so that they can be resolved. Until this occurs, it will be difficult for change to progress in this environment.

Whilst there are new strategies in place in the area of Alcohol, Tobacco and other Drugs as well as Blood Borne Viruses, there seems to be little evidence that any of the activities and recommendations listed in the respective documents have been implemented. Whilst there seems to be an acknowledgment of the importance of continuity of care for offenders with complex issues and the relevance of the role community sector organisations can play in this, many of the policies and strategies developed by the Tasmanian Government and more specifically Tasmania Prison Service have not resulted in significant improvements in these areas. In considering the future development of correctional AOD responsive policies, agencies need to note the importance of such policies to continue to recognize the specific needs of offenders with significant substance misuse issues and related health concerns – from admission to release and beyond – and should encompass all aspects of their care.

Chapter 3: Current models of practice in Australia and the US

In this thesis, the literature concerning examples of good practice in AOD rehabilitation for offenders in Australia is reviewed. Key international developments are also considered, although it is acknowledged that the potential for transfer of such models in Australia may at times be limited. This chapter will focus on two Australian prisons where AOD rehabilitation is the focus of the offender management model. The Solaris Therapeutic Community in the AMC Prison in the ACT and the Compulsory Drug Treatment Centre at the Parklea Correction Centre in NSW will form the basis of the Australian examples and the The Sheridan Correction Centre National Model Drug Prison and Reentry Program will also be discussed.

3.1 Solaris Therapeutic Community, Alexander Maconochie Centre, ACT

The SOLARIS Therapeutic Community became operational within Canberra's new prison, the Alexander Maconochie Centre in July 2009. Solaris occupies one of four 20 bed low security men's cottages. Solaris operates under the mandate of a modified therapeutic community that provides a safe, secure and supportive learning environment within a correctional setting, where participants are able to explore and establish change within both a social and personal context (Cox & Rosenburg, 2011).

There are six clear objectives including: (1) to create a psychologically and physically safe TC environment underpinned by the health prisons concept where change and personal growth can occur; (2) to reduce the incidence of AOD related recidivism through the provision of targeted interventions to support the development of new skills, pro social behaviours, attitudes and values; (3) to deliver a comprehensive range of programs including education, vocational training, therapeutic interventions and culturally appropriate support utilizing current evidence based practice; (4) to increase participants' educational achievements and

employment capacity; (5) encourage and promote the reintegration and post release support of participants by providing an integrated throughcare system designed to support and sustain recovery; (6) to ensure the provision of health services so as to provide a holistic treatment approach (Solaris program information, ADF, 2009).

Treatment in the Solaris Therapeutic Community begins 6-12 months prior to release and is a three-tiered program. Those who have a stable history of being on a pharmacotherapy, are able to access the program however men with a history of sex offences are ineligible. Participants engage in a range of activities including psychotherapeutic and psychoeducational groups, community projects, debates, parenting, creative therapy, healthy lifestyles plan, Tai Chi and a range of other activities. The theory behind this is pro social modeling and cognitive resilience skills.

Level 1 is the readiness phase is four weeks in length. Strategies to enhance motivation, orientation to the TC environment, introduction to social, cognitive and emotional skills, and life style narratives underpin this phase. Level two is the treatment phase and is 12 weeks in length. The focus of this phase is work education and therapy and also includes pscyho-education and psychotherapeutic group's aimed at reducing the incidence of recidivism through the provision of targeted interventions. Level three is the transition phase and works towards seamless transition from prison to the community. Transitional worker establish a rapport with participants and accommodates aftercare needs of each participant.

The key to the SOLARIS TC is the intensive throughcare supports that exists to enhance each participants transition and reintegration into the community. The Solaris TC is a co-managed and co-funded program initiative between ACT Correctional Services and Karralika programs Inc (a community AOD residential rehabilitation organisation). This unique management model between Government and non Government agencies is further enhanced through the participation of specially selected and trained Correctional Officers, who are dedicated to the TC, and work closely with both Karralika and Corrections clinicians. Given this program is relatively new, there has been little opportunity for evaluation so far. However initial

data suggests, the program is working successfully and that treatment outcomes for the client group are greatly improved.

3.2 Compulsory Drug Treatment Centre, Parklea Correction Centre, NSW

The NSW Compulsory Drug Treatment Correction Centre (CDTCC) was established in 2006 to provide a comprehensive program of compulsory rehabilitation for recidivist drug offenders that would treat their drug problems and reduce their recidivism after release (Birgden, 2008). The Compulsory Drug Treatment Program (CDTP) allows the New South Wales Drug Court to order sentenced, repeat drug related offenders to a prison that provides comprehensive drug treatment and rehabilitation.

According to the Compulsory Drug Treatment Correctional Centre Act 2004, the objects of compulsory drug treatment are:

- to provide a comprehensive program of compulsory treatment and rehabilitation under judicial supervision for drug dependent persons who repeatedly resort to criminal activity to support that dependency, and
- to effectively treat those persons for drug dependency, eliminating their illicit drug use while in the program and reducing the likelihood of relapse on release, and
- to promote the re-integration of those persons into the community, and
- to prevent and reduce crime by reducing those persons' need to resort to criminal activity to support their dependency.

According to Birgden (2008) the program is an interagency effort of the New South Wales Drug Court, Justice Health and the Department of Corrective Services, and reports to the Attorney General, the Justice Minister, and the Health Minister. The CDTC is a three staged process. Stage one involves closed detention where the participants are in full time custody. Stage two is semi open plan detention where the participant can access the community for education, employment, or social programs. And stage three, is community custody where the participant resides

under intensive supervision at accommodations approved by the Drug Court Offenders must meet the following five criteria to be eligible for the program: The offender must be: (1) sentenced to imprisonment with an unexpired non parole period of eighteen months to three years; (2) convicted of at least two offences in the previous 5 years; (3) not convicted of specified offences such as drug trafficking, sexual assault, and murder; (4) reside in the broader Sydney region; and (5) be over the age of eighteen. Treatment in the program includes drug abstinence and intensive cognitive behavioural programs. CBT and contingency contracticing are the two major therapeutic approaches used in the CDTCC with abstinence being the overall treatment goal.

The program was evaluated in 2010 with some interesting results being demonstrated. Significant improvements were found for mental and physical health. Although the program was coercive, the vast majority of participants felt their participation was voluntary. Participants made positive comments about the program and consistently expressed their desire to be in the program regardless of what stage they were in. However, whilst these positive results are commendable, Illegal and non-prescribed drug use was detected in at least one of the drug tests for the majority of participants.

Whilst there are some distinct differences between the Solaris model and the CDTC, namely the mandated element for prisoners, there are also some commonalities. The elements of throughcare and aftercare are both heavily emphasized and clearly have a role to play in the reduction of recidivism rates.

3.3 The Sheridan Correction Centre National Model Drug Prison and Reentry Program, United States of America

Sheridan is a drug treatment program providing in prison substance abuse treatment and a throughcare release program. It is a medium security, fully dedicated modified TC. Sheridan houses and serves only inmates in need of substance abuse treatment and provides ongoing treatment during their prison stay. Sheridan inmates are required to participate in vocational and or/educational

training, employment readiness programing, and reentry case management alongside the substance abuse treatment. Sheridan services approximately 1650 offenders daily, with a maximum length of stay 36 months.

The classification screening process identifies inmates who are eligible to enter the program including males who:

- Voluntarily chose to participate
- Are in need of substance abuse treatment
- Have at least 9 to 36 months left to serve in prison
- Are eligible for placement in a medium security prison
- Have no current or prior murder or sex offence convictions
- Do not suffer from severe mental illness that would interfere with their participation

Upon release from Sheridan, each inmate is supervised on Mandatory Supervised Release (parole) and referred to Illinois Department of Corrections (IDOC) funded aftercare services and participate in community based case management. The community based cased management organisations links releases to planner services, monitors their progress and responds to additional needs that emerge.

The aftercare component typically lasts 90 days and is a condition of parole. Aftercare placements include halfway houses, recovery homes, transitional homes and home with either an intensive outpatient or outpatient treatment recommendation. Releasees can also access a range of community care including substance abuse treatment services, case management, vocational and education training and general welfare support.

A recent study examined a group of 50 re-incarcerated men who successfully completed in the in prison phase of the Sheridan program and what led to their re-incarceration. It was designed by a group of national and local criminal justice and social service policy makers, practitioners, and researchers based on best practices in the field. Among this group of offenders, over half (60%) felt that Sheridan prepared them for success upon release. Over seventy five per cent (76%) indicated they had a

job at some point after graduating Sheridan and before their re incarceration. A high number (84%) reported having little difficulty finding housing and the majority (86%) said Sheridan helped them more than a traditional prison.

Reichert & Ruzich (2012) noted that in their study younger participants engaged in criminal activity and relapsed sooner than older participants. After prison, those who returned to their original neighborhood relapsed sooner than those who didn't return to their original neighborhood. Unemployed participants engaged in criminal activity sooner than employed participants and those who did not complete aftercare engaged in criminal activity and relapsed sooner than those who did.

Summary

The three examples above provide a case study for how AOD rehabilitation and treatment can be administered in different correctional environments. The mandatory nature of the program in NSW has both benefits and short comings, although as illustrated in the initial evaluation, many participants didn't identify as being involuntary in the program. For many offenders, the opportunity to participate in an intensive AOD program and be supported in a throughcare model to continue the new learned behaviour post release was a positive one. Central to the success in each case is the provision of aftercare which continues to support offenders for some time after release.

The model used in the AMC highlights the importance of the connection between non government and government services. Providing funding to both the non government service and correctional services has allowed both to have "buy in" for the project and has subsequently assisted in the positive results that have been witnessed. Another key element in each of the models is evaluation and data collection. It is evident that data collection assists with the justification and legitimization of the need for greater access to AOD programs for prisoners with complex substance misuse issues. Heseltine (2012) sums up the situation,

> "Continued pooling and sharing of resources across jurisdictions is essential if the impetus for ongoing program development is to continue. We have seen this

occur, with the sharing of programs and models across the country and the inclusion of other jurisdictions in staff training, in the development of intra jurisdictional models of supervision and in the presentation of outcome-related material at conferences and workshops."

The models illustrated in this chapter present alternative options to the current model being used at Risdon Prison. If Tasmania is to continue to move forward toward a more appropriate model of care and more effective program delivery then we need to work with other jurisdictions with similar population sizes such as the ACT to improve AOD rehabilitation options for prisoners. The TC model developed at the AMC is an excellent example of how a collaborative Government and Community Sector response has been developed to achieve excellent outcomes for the specific cohort.

Chapter 4: The reality of AOD rehabilitation and treatment of prisoners in Tasmania

The reality of the program and treatment options for offenders with substance misuse issues who become incarcerated in the Tasmania corrections system is very different to that suggested in the best practice literature. There are a number of limitations and failings of the current system which have been identified through a number of reviews and enquiries as illustrated in previous chapters. This chapter will provide a discussion of the stakeholder views obtained through this study in light of the general demographic and service information made available by Tasmania Prison Service.

Gaining access to the general demographic and service information from Tasmania Prison service was a lengthy process and whilst information was provided in the final instance, the perceived lack of transparency is concerning. According to the Department of Justice (11/10/2012) 475 prisoners are currently housed in the five prisons operated by the Tasmania Prison Service. In Tasmania, adult inmates are housed in one of five prisons. Risdon Prison Complex, Ron Barwick Minimum Security Prison, Mary Hutchinson Women's Prison, Hobart and Launceston Reception Prisons. Of the 427 male prisoners, 81 are currently un sentenced, 53 are sentenced to less than 6 months and 293 are sentenced to more the 6 months.

The prison currently delivers are range of programs under the Integrated Offender Management unit at the prison (see appendix 4). As detailed in the appendix, evaluation of these programs is listed as being "planned" in 2009, yet there is no evidence to suggest that this evaluation has occurred.

Alongside the programs offered by TPS, there are a range of CSOs that are engaged with the prison to provide services. These include specific AOD programs and also general education and community engagement activities. Appendix 5 shows

the community organisations currently engaged with the prison and the basis on which they work with the prison.

As reported by the recently released ANCD report (2012), Tasmania is the only jurisdiction in Australia along with the Northern Territory not to have a TC or drug free unit available for prisoners.

The Correctional Primary Health Service (CPHS) nurse assesses prison receptions on arrival. Examination includes assessment of intoxication and possible withdrawal symptoms. Detoxification is then provided to prisoners as inpatients in the Correctional Health Facility located within the Risdon Prison Complex or in their cells, depending on the circumstances.

According to data from the CPHS in the prison, as of September 2012 there were a total of 27 clients receiving pharmacotherapy treatment. Medium classification prisoners made up 14 of the 27, with two prisoners receiving biodone, 11 receiving suboxone and one receiving MS Mono. Thirteen prisoners housed in maximum were receiving pharmacotherapy with one on biodone and 12 on suboxone. Pharmacotherapy dosing is currently only available to medium and maximum security inmates in the Risdon Prison Complex.

According to prison data, one prisoner left the program in September 2012 to be re classified as a minimum security prisoners. This demonstrates a gap in services where if a prisoner wants to reduce their classification, they must then go without the benefit of pharmacotherapy. It was noted that if a prisoner is re classified to minimum security level, they are afforded medically supervised withdrawal from the program and if deemed necessary, will return to RPC for re-induction into the program shortly prior to release. There are again issues with this model as finding a place for that prisoner in the community may be limited and as such may not be an available option.

Stakeholder views: AOD rehabilitation in Tasmania Prison Service

Qualitative data was collected from various stakeholders in formal and informal processes over the course of the research period. The key themes raised by stakeholders in interview will be discussed in depth below. The results of this study overwhelmingly indicate that offenders with AOD issues represent a large proportion of the population in the Tasmania Prison Service and that whilst there have been some significant improvements in the services available to prisoners in recent times, there is still a significant challenge ahead to ensure that each prisoner is afforded the right to access adequate and effective treatment and services for their AOD issues.

4.1 Policy and Governance Issues

A number of policy and governance issues were raised in stakeholder interviews. A lack of consultation with prisoners and staff was raised by internal and external stakeholders. The main issue was that policies are being developed and implemented without sufficient consultation with the people who are effected most; prisoners and staff. A recent example was given which highlights the concern. Changes had been made to the prison laundry process and no effort had been made to communicate these changes to inmates. As a result of this lack of communication, inmates were reprimanded for not adhering to a policy that they were not aware had changed.

Program development was identified as an area where consultation with prisoners and staff would be useful.

"I think that they should ask inmates what sort of programs that they would like to see."

"Set up a consumer group and a working party with officers and get the two groups to meet and have an open discussion about what they need...And then this information gets fed up the way it was intended. "

Several CSO stakeholders mentioned that there were significant difficulties in the process of accessing training rooms due to the small amount available and the rostering of internal programs. This is another area where the Prison can work with outside organisations to develop policies to alleviate these concerns.

"Access of rooms at the prison, far too few. In RPC we are battling for three rooms"

"We are competing with other external service providers and lawyers"

"They have blocked out Tuesdays and Wednesdays as training days for the staff...staff have training Tuesday and Wednesday therefore they are unable to escort an inmate to education"

"I've sat in the court yard at times"

There was a strong sentiment felt by stakeholders that the recent policy and strategic changes within the prison were conducted without appropriate consultation. In particular, Breaking the Cycle was raised a number of times.

"Breaking the cycle was always flawed from the beginning...because it doesn't deal with drug and alcohol problems. You cant break the cycle when 80% of people are in here because of drug and alcohol problems, unless you have a major revamp of drug and alcohol services...you are wasting your time talking about rehabilitation"

Summary:

- Lack of consultation and transparency across most delivery areas of the prison
- Greater consultation with staff and prisoners is required
- Inadequate communication strategies are engaged when changes to policy are made

4.2 Case Management

The interviewees raised best practice models of care for prisoners with AOD issues. Both TPS staff and CSO staff noted the importance of a strong case management focus.

Holistic/Integrated care

Discussion focused on using an integrated and holistic model to addresses underlying issues relating to criminal behaviour. The strengths of working across the corrections field from prison to community was also emphasized.

"GPs should be the primary gateway to everything. If there were such an integrated system then GPs would be the hub."

"To take the next step where the community gets value for money, whether its prevention in the community before they get here, or when they return out of prison or whether prison is the turn around. Needs to be joint initiative from community corrections and prison."

"If you can get prison and community corrections working together hand in hand it is a good way of addressing drug and alcohol problems."

A Therapeutic Community

The model of TCs was raised throughout discussion The holistic nature of TCs was identified as a main element when working with this complex group.

"I agree that we need to have a drug and alcohol unit, I think that practicality is the issue. I think we need to be looking at the bio psychosocial approach as holistic"

"I really think a drug prison is a good idea. I think it's what you have got to be working towards. It means you have all of the services there geared at offenders ...there is a concentration of services."

"I think they ought to be looking more at other ways of detention rather than prison. I don't think prison is always the answer when you are talking about addiction"

Throughcare/Aftercare

The topic of throughcare and aftercare attracted a high level of interest amongst respondents, largely associated with the lack of support currently offered at RPC. Many of the respondents referred to the counter-productive method of working in a therapeutic model with offenders to address their underlying criminogenic behaviours and then to release them without any further support and assistance. Whilst many of the CSOs engaged with the prison currently operate from a throughcare model, none of the prison operated programs follow this model.

"It would be good to have some supports that start internally and continue externally"

According to internal staff, the capacity of the programs team is severely limited, *"we haven't got enough staff to do both...we don't have the follow up to do a relapse plan before they get out"*

"there is no throughcare, I cant treat people in here because I cant refer to anyone out there"

Discussions focused on the positive impact and results being achieved by CSO's providing services to prisoners both pre and post release. Many of the stakeholders acknowledged that any aftercare services were being provided by CSO organisations, yet the Department of Justice does not provide any organisations with funding to do this work.

Interviewees acknowledged the importance of adequate throughcare and were aware of the main principles and how they reduce relapse and recidivism.

"I think it would be an encouraging thing to see the risk needs and good lives model. Explaining to them the expectations and giving them every opportunity to join in. giving them relapse prevention strategies and giving them encouragement...and also having a pre-release environment."

"When the offender changes their lifestyle (through the PROP) program, this has a ripple effect on the community, on their partners etc and addressing the intergenerational crime cycles."

Others expressed their frustration with the system and noted that the current throughcare system is inadequate and needs to be reviewed to be implemented more effectively.

"Throughcare has been a buzzword for a number of years and its lost its buzz"

Post Release Options

There was considerable discussion among stakeholders about the overwhelming need greater post release programs. The importance of transitional and step down programs for prisoners was also raised.

"I think there probably needs to be a lot better transitional programs for when people are getting out."

"The main gap is preparation for release. A lot of people are released and have no one to go to."

Current prison staff members alluded to a step down facility currently being constructed. According to sources four units have been built on the RPC site to accommodate up to 16 prisoners in a self-contained facility. The purpose is to improve exit opportunities for inmates and address institutionalization.

"we have four units up on the hill which are going to be used as like a therapeutic community for minimum inmates that are close to the end of their sentence"

Individual counseling

A staff member in the programs unit of the RPC commented that individual AOD counselors are required as currently this is not a service offered to prisoners.

"I believe than individual drug and alcohol counselors in the prison are needed"

Recreational programs

Surprisingly the topic of Hays Prison Farm, recently closed by the Department of Justice, was not discussed in depth. Some stakeholders did note that they saw the closing of Hays as a "waste".

"The loss of the farm is really short sighted. Those guys had something to aim for. They came out with skills, they took pride in their work"

The effect of the closing of Hayes is yet to be seen although it is anticipated that many of the inmates that were being housed at Hayes will be moved into the transitional cottages currently being built.

Custodial Information System – CIS

Several of the prison staff and also a number of community sector organisations raised the effectiveness of the CIS system as a useful case management tool. It was generally agreed that whilst in theory the principles are sound, it's practical application is limited.

Many of the prison staff interviewed expressed concern with the way CIS was currently being used to record a prisoner's negative behaviour and not being used to record the positive behaviours. The example was given of a prisoner who had been involved in an issue within his unit and notes were written up using CIS, it was later discovered that the issue was not the fault of the inmate, yet the notes were not removed from the system. According to staff it is also common for CIS not to be used to record program and employment attendance and therefore when the system is consulted regarding an inmates parole hearing, the evidence is not their to support the developments that have been made. These inconsistency were of real concern to those interviewed, however there was also comments that shared the sentiment that communication between the officers had improved

"Communication is 20 times better than it was, but it still needs to improve"

Summary:

- Holistic case management is required, preferably in the form of a therapeutic environment
- The current system results in prisoners 'falling through the gaps'
- Throughcare models of practice need to be engage by the prison
- The option of a therapeutic community within the RPC be addressed
- Funding for Community Sector organisations delivering programs using a throughcare model needs to be addressed
- Individual AOD counseling needs to be made available to prisoners
- Communication issues need to be addressed
- The use of the CIS systems needs to be reviewed

4.3 Program Delivery

The delivery of programs in the prison environment was the focus of much of the discussion. Many of the respondents were able to adequately identify the programs currently delivered in the prison although there was some concern that community sector staff entering the prison to provide support are unaware of internal programs that are operating alongside their programs.

Sentence length

Responses to issues surround minimum sentence length requirements were varied with many stakeholders acknowledging the issues facing prisoners sentenced to imprisonment for a period of less than 6 months. Many stakeholders identified a significant service gap for inmates sentenced to 5 months or less that narrowly miss out on having access to programs.

"I think where the gap is, is the guys that are serving short sentences, they don't have the opportunity to get into these programs. "

The relevance of providing programs to prisoners who have more than 5 years of their sentence remaining was raised by a number of service providers. There were

also indications from staff that some of the programs delivered by CSO outside organisations were more approachable and relatable for prisoners.

"Anecdotally the feedback we get is that our program works a lot better...because its not as literature based. That's what they keep telling us"

Resources: Funding and staffing

Limits in the resources available to the Programs Unit was raised by many of the stakeholders, both community sector workers and workers from the Prison.

"In an ideal world...instead of the 7 in the programs team, we would have 14 or 15 and be able to do more"

"IOMS is grossly under resourced"

Alongside the issues of resources, was the issue of cohort size. Many of the programs and custodial staff mentioned that the size of the prison population is difficult as there is only a "limited pool of inmates" to work with. This has been raised in previous evaluations where group programs are highly reliant on the size of the cohort.

"Having a cohort that works in a group situation is difficult in a small prison with only a limited pool of inmates."

"If there were more programs you might have more variety of people engaging."

Evaluation and Data Collection

According to TPS staff, data is not collected on the recidivism rates associated with participating in the programs area. Whilst data is collected on the number of prisoners that access and subsequently complete programs, there are no resources available for a full evaluation of this data. If prisoners were involved in a more thorough evaluation process the programs team may be able to identify some of the issues and barriers facing prisoners when attempting to remain engaged and complete programs.

Table 1: Programs Delivered in Tasmania Prison Service

Type / Issue	Program	07-08	08-09	09-10	10-11	11- 12
Introductory / motivation to change	***Preparing for Change***	5	4	4	-	2
	Talking Up Change	4	-	-	-	-
	Turning Point	-	-	3	4	4
Drug & Alcohol	***Getting Smart***	5	1	3	11	7
	Pathways	1	1	3	2	4
	Gottawanna	-	-	-	-	4
General offending	***Making Choices***	1	3	-	2	-
	Offending Is Not The Only Choice	1	-	-	-	-
Violent offending	***Anger Management*** *(new)*	-	-	-	-	9
Sexual offending	***New Directions*** *(ongoing)*	✓	✓	✓	✓	✓

Source: Tasmania Prison Service Summary Service Data 2011

Table 2: Prisoner Program Participation:

	08-09		09-10		10-11		11 - 12	
	Enr.	Comp.	Enr.	Comp.	Enr.	Comp.	Enr.	Comp.
Preparing for Change	38	28	50	39	13	10	19	15C 4NC
Turning Point	-	-	29	27	23	19	4	4P
Getting Smart	12	6	34	19	110	79C 8P	45	36C 9NC
Making Choices	34	18	-	-	21	8C 9P	-	Scheduled for Sept 2012

Pathways	12	7	36	29	21	20*	43	12* C 24P 7 NC
Anger Management	-	-	-	-	-	-	25	19C 4P 2 NC
Gottawanna program (delivered by Holyoake under the direction of TPS programs unit)	-	-	-	-	-	-	28	18 C 2NC 8P
Total	**96**	**59**	**149**	**114**	**153**	**136**	**164**	**140 C & P** **24 NC**

* Pathways is a multi-stage program. Some complete only Phase 1 while others complete Phases 1-3.

"C" = completed "P" = participating "NC" = non completion (dropped out)

Source: Tasmania Prison Service Summary Service Data 2011

The tables above illustrate the participation rate for programs is quite high although the numbers enrolling in the course are relative low given that the rate of prisoners entering prison with drug related issues is around 60%. This means that there should be upwards of 250 prisoners accessing these programs, however the prison does not have the capacity to offer these services currently.

Several other issues surrounding the delivery of programs at Risdon were also raised. The issue of continuity in language and program formation was raised by a number of CSOs. They noted that they had received positive feedback from inmates regarding their program delivery because it "made sense" and followed on from programs delivered internally by TPS IOM staff.

"Certainly in our experience we've found it's really good if we go in after they have done their program (pathways etc)."

"In our experience if we've gone in behind them a done one (session) straight afterwards, it helps marry that information that they've already got. [Pathways seems to be] quite theoretical in some senses. And we bring it down to that emotional content...seems to be quite effective. "

Communication was continually raised throughout discussions with stakeholders in relation to a number of areas, including the delivery of programs. Unfortunately anecdotal evidence from some stakeholders seems to indicate that there is a lack of consistent process when prisoners attempt to access services.

"Programs are limited in its resources and there are pressures within the system that would deter people from accessing their support."

"It surprises me how many inmates don't know that there are programs offered in the prison"

"If you are on level 1 or level 2 you do not qualify for a program. Only level 3 and 4 to access programs"

"If they are in maximum, there is usually problems accessing programs"

There were also issues raised with the level of communication between programs staff and the custodial officers. Whilst many of the stakeholders reported that this relationship has improved dramatically in recent times, there is still a lack of coherency between the goals and focus of Integrated Offender Management (IOM) and the custodial staff.

A suggestion made by one of the stakeholders to address communication problems in the prison was to hold regular forums and meetings with prisoner involvement. He stressed the need for inmate consultation in changing processes and raised the idea of holding an open day with IOM where all service providers are involved.

Summary:

- Access to programs needs to be assessed on need not sentence length
- Data in relation to programs needs to be collected, analysed and improvements made accordingly
- A greater number of programs need to be offered to prisoners identifying with substance misuse issues
- Communication between services needs to improve – possible solution through open forums utilizing staff, prisoners and outside stakeholders

4.4 Medical interventions

Primary health care

Primary health care was not a significant focus of the study although there was a range of issues raised during the interview process. The health of prisoners is an important area, as we know that 1 in 4 prisoners have a chronic health condition upon entry into prison, with asthma being the most common condition.

Acquired Brain Injury

The identification and assessment of prisoners with acquired brain injury (ABI) was raised as a concern amongst many of the interviewees. According to respondents, there is little acknowledgement of the extra assistance and support required by prisoners who have an ABI, especially when transitioning from prison back into the community. Respondents commented that the Brain Injury Association of Tasmania had been involved in some training of new custodial officer recruits, although this was now not common practice.

Relationship between CPHS and TPS

Systematic problems with communication were again raised in regards to health care for prisoners. According to both TPS and CSO staff members, communication between the CPHS and TPS is not effective and silos between the two areas are clearly evident.

"...The department of health and their place within the justice system certainly needs to be there but...its like we have silos. I've always asked when we are looking for different ways to develop strategies, is health going to be sitting at the table? And most of the time they are not"

The frustration illustrated above was common amongst respondents. Stakeholders raised concern with the issue that whilst they are all working toward the one common goal, little effective collaboration between agencies is existent.

Significant praise was directed toward the CPHS staff involved in the Hep C program currently running at the prison. Many respondents expressed admiration for the tireless work of those involved in the program and the subsequent results that they are achieving.

Summary

- Communication between TPS and CPHS is strained
- ABI amongst prisoners is generally unidentified and untreated

4.5 Mental Health and Comorbidity

According to the *Health of Australian Prisoners* (2011), 3 in 10 male prison entrants reported having a mental health disorder. For female prison entrants, the rate is 4 in 10. 1 in 3 prison entrants experienced high or very high levels of psychological distress in the four weeks prior to prison entry. Further, a total of 16% of prison entrants reported currently being on medication for a mental health disorder: this represents just under half (46%) of those who reported ever having been told they have a mental illness.

Frustrations were felt by staff regarding the numbers of prisoners who they identified as having comorbidity but not receiving adequate care for this condition. This frustration extended to respondents who felt that prisoners with complex mental health issues are "lost" in the system and have the ability to fall through the gaps.

"I think in general terms a person who comes I into prison with a mental illness is lost and just becomes part of the machine...they are not noticed because everybody is trying to do their own time...they don't access services and fit in, or they are problematic. They find ways to not be problematic. "

"I think that its fair to say that in recent months since the new order is in place, health has been marginalized, we've been put aside, no one is speaking to us"

The comments above have more to do with the culture of a prison than it does necessarily with the health services available in a prison. It is not uncommon for prisoners not to access services due to the perceived negative responses and experiences received by their fellow inmates.

Summary

- High prevalence of comorbidity amongst prisoners at RPC
- Difficulties experienced in accessing adequate treatment for comorbidity or dual diagnosis issues
- Culture of prisoners is to deny treatment or assistance for fear of being persecuted by peers

4.6 Opioid Pharmacotherapy

The topic of opioid pharmacotherapy was raised in most of the interviews conducted for this study. According to information provided by the Correctional Primary Health Service (CPHS) staff, as of Tuesday 4th September 2012, there were 25 males and 5 females currently on the pharmacotherapy program under the supervision of CPHS. According to staff in the CPHS facilitate, this is only approximately 20% of the number of prisoners that actually require this service but due to resources and the high intensity of staff support that is required to dose prisoners in a correctional facility, this is the number that they are able to provide services to. There are also issues regarding places available for soon to be released prisoners in the community at the DHHS ADS facility at St Johns Park. According to

CPHS staff, they are not likely to put a person on the program whilst in prison if there is no place available for them in the community upon release.

Most key stakeholders agreed that there was a gap for minimum-security prisoners when it comes to the provision of opioid pharmacotherapy. Opioid Pharmacotherapy is currently only available to prisoners in the medium and maximum areas of the Risdon Prison Complex – these prisoners are dosed in the CPHS centre. Limited pharmacotherapy is available to women in the Mary Hutchinson Women's Prison where dosing is done on site.

"Some of them have real trouble depending on their security clearance whether or not they can even access pharmacotherapy"

"We are curtailed by facility, and the will of Tasmania Prison Service...Not trying to be negative...if staffing facilities improved we would endeavor to provide those services"

According to recent data collated by the Australian National Council on Drugs (ANCD) in 2012, there is a significant difference in the percentage of prisoners accessing opioid substitution therapy (OST) across the jurisdictions. Illustrated in the table below, only 0.9% of the prison population in Tasmania access OST, this is compared to 25.1% in the ACT and 17.5% and 16.7% in NSW and Victoria respectively.

Table 3: OST provision to prisoners cross jurisdictionally

	NSW	QLD	VIC	SA	WA	TAS	NT	ACT
% of prisoners in OST	17.5	0.6	16.7	13	6.9	0.9	0.2	25.1
Evaluated	Y	Y	N	Y	Y	N	N	Y

Source: ANCD report 2012

Opioid pharmacotherapy dosing was available for minimum-security inmates up until 2006 when it was shut down. There have been suggestions made that dosing in the yards would be a better use of resources. According to interviewees, the facilities are available for this to happen; however cooperation from TPS is what is needed to make it happen.

There was also the suggestion that given there are reported "stand overs' occurring within the prison due to pharmacotherapy availability, if the numbers that could access pharmacotherapy were increased this would then see a subsequent decrease in this type of anti-social behaviour.

"All the pharmacotherapy individuals are confined here to RPC. That was a unilateral decision of TPS in 2009.the consequence of it has been a major flare up in violence...the pussy cats are left here in maximum because they cant go to minimum because of the program"

"This prison is running alive with drugs, that's going to continue to be the case until you treat the need...if we don't treat the need, they will get it from somewhere else"

Diversion

Some interviewees raised the issue of diversion of pharmacotherapy drugs (such as suboxone film) as an issue for a number of reasons. Currently, inmates are dosed in the CPHS where nurses administer the film and correction officers observe the process. Inmates mouths are then checked to ensure that the suboxone film has fully dissolved before they are allowed to leave the secure area. Diversion of the film can occur when an inmate "hides" the film in a cavity in their mouth and then later pulls it out after leaving the secure area. A suggestion by a stakeholder was made that to avoid diversion of suboxone film, a die could be used. That way if they remove the film or try to 'divert' it then the officers would see die on their hands.

Community access to pharmacotherapy post release

Current dosing methods in the community are available through the ADS Pharmacotherapy Unit at St Johns Park (SJP) New Town or by community pharmacy.

There are also a number of private prescribers that prescribe to ex- prisoners in the community.

"Our hands are tied because we can't treat people in the prison, because we don't have somewhere to send them"

As mentioned previously, CPHS is limited in offering pharmacotherapy to prisoners if there is no place available for them in the community upon release. Most access treatment post release at the ADS dosing facility in New Town and the majority do this quite successfully. For some though, it is an opportunity to meet up with people that they associate with their "offending life" and therefore it provides a toxic environment for someone who is trying to start over post release.

"To put them straight back out to that environment...it's not good."

Interviewees accounted anecdotal evidence regarding the dealing and stand overs that happen at SJP on a regular basis.

"Basically they do their apprenticeship, so to speak, in custody and then they come out here, they re-engage, not only with us but with other clients groups and we introduce them to a whole range of new environments where they can score really easily. It is no secret that we have got people up here who are dealing. It is a smart business move for a dealer"

Another issue raised was that of location of the one dosing site. Many clients who receive dosing once or sometimes twice a day need to make their way to SJP to access this service. If a client lives in New Norfolk and does not have access to a vehicle then this can become problematic.

Forensic dosing facility

Two interviewees mentioned the concept of a forensic dosing facility that is a step down approach from accessing pharmacotherapy in the prison, before accessing it from the community facility. The facility would only be for ex-prisoners and a client must be compliant before being able to step down to the community facility. Those clients who have been compliant whilst accessing the program in

prison would then be stepped down to the forensic dosing facility upon release. Upon good behaviour in accessing the forensic dosing facility, they would then be stepped down to the community facility (ADS) and the final step would then be to access from a community pharmacy.

"We need a special service, a forensic service. Which like ours, is linked to mental health services, complex drug and alcohol care, complex BBV care, complex medical care...the logical people to deliver this is us."

"I think buprenorphine should be in the water. I haven't prescribed methadone for four years; it should be taken off the market. Subutex should only be used for pregnant women and otherwise suboxone should be it. "

When speaking with staff from the ADS, several internal organizational issues were raised as being interference to the way that community dosing of AOD clients works.

"Doctor availability is a big thing. We have funding for 4 full time doctors and we have only got two part time doctors working. We would be able to provide a lot better care for clients if they had more doctors. Less doctors puts more pressure on the other workers"

A staff member noted that the recent launch of the Tasmanian Opioid Pharmacotherapy Policy (TOPP) had been hugely restrictive on the delivery of services for people with complex issues.

"I think the launch of the TOPP is hugely restrictive... I would happily work to it if we had more staff...it needs to have the resourcing built into it."

Staff from the CPHS also acknowledge the introduction of the new pharmacotherapy policy and noted its restrictions for increasing the number of clients that it currently sees.

Summary

- Limited number of prisoners accessing pharmacotherapy – approximately 20% of the population that require it
- Issues for prisoners accessing pharmacotherapy in prison if there is not a space for them on release in the community
- No access to pharmacotherapy if residing in RBMSP
- Throughcare is inadequate to ensure program retention post release
- Community options (ADS) are fraught with issues – dealing occurring at SJP dosing facility
- Further exploration required into suggested forensic dosing facility as a step down approach

4.7 Blood Borne Virus

Given that we know that there is a cohort of prisoners at Risdon Prison injecting drugs on a regular basis (approx. 30), the issue of blood borne virus transmission is a serious concern. The CPHS team was forthcoming with a large quantity of data relating to BBV acquisition and transmission rates at the RPC. The team from CPHS has completed a lot of work recently into researching the current trends of BBVs in the prison and subsequently identified successful treatment modalities. Approximately 1 % of the Tasmanian population have hepatitis C antibodies, this equates to a population of approximately 4000 people. A number of studies both national and local confirm that 25% of those entering our system are hepatitis C antibody positive. The turnover through the Tasmanian system is 1200 per year on a muster of 500. This means that 300 or so new hepatitis C cases enter Risdon Prison each year. The most recent data from Correctional Health indicates that the percentage of Hep C prevalence at the Risdon Prison Complex is 34%.

Table 4: HCV antibody prevalence by Tasmanian Prison

PRISON	Muster	HCV + n	%
Risdon Prison	252	86	34
Hobart Remand	23	08	35
Launceston Remand	24	06	25
Mary Hutchison Women's	31	10	32
Ron Barwick Minimum	101	12	12
Hayes Prison Farm	42	07	17
TOTAL	473	129	27

Source: Health and Wellbeing in Tasmanian Prisoners with and without Hepatitis C antibodies-APSAD Hobart 2011

Table 4 is a breakdown of the muster for one day across Tasmanian Prisons. It shows that hepatitis C antibody positive prisoners tend to cluster in maximum security areas of the prisons such as Risdon and the remand prisons rather than minimum security areas such as Ron Barwick Minimum Prison and the Hayes Prison Farm.

According to data provided by Correctional Health, the Hep C transmission rate at RPC is 12.5%. 16 prisoners in a 12 month period were identified as acquiring Hep C whilst incarcerated at the RPC.

"This prison has the highest rates of hep c transmission in Australia"

Given the high prevalence rate at RPC, the current health team has worked hard to implement a Hep C treatment program within the prison. The program formally commenced in 2008 and 30 people have since commenced on treatment. There have been 3 treatment failures with a 90% success rate. As with many of the services in the prison, there is a greater need for the program than the CPHS is able to provide.

"Less than 30 people are on treatment, however we have 70 other prisoners who need treatment."

Eligibility requirements for the program include that an inmate must be sentenced for at least the length of the treatment program and that those who have been infected the longest receive priority in accessing the program.

The vast majority of those receiving treatment indicated that either they would not have started treatment on the outside or would not have completed it had they commenced (Wake & Sidall, 2011, APSAD presentation).

There are a number of reasons why the success rate of treatment has been so high for this program. The health team are able to practice directly observed therapy in a controlled environment and for the inmates themselves, there is an informal network of others who have already received treatment that provide support. This is illustrated by a quote from a prisoner completing the program,

"My mates vacuumed my room and made me drinks" (Sidall & Wake,APSAD presentation 2011)

Follow up with prisoners also indicated that there would be a greater reluctance to inject in prison in the future and if they did, they would ensure that they used their own equipment.

Whilst the work of the team at Correctional Health needs to be acknowledged, there was also a sense of frustration that was evident in speaking with staff.

"We are doing some very high quality work, almost in total isolation with the rest of the prison"

There has been support from TPS regarding the implementation of the recent Blood Borne Virus Strategy mentioned previously. It is yet to be seen if the recommendations and activities listed in the strategy will all be addressed.

Whilst the work completed by the CPHS in developing and implementing the Hep C program has been both positive and successful, a number of interviewees noted that there was still some way to addressing the whole issue.

"I think there should be more access for people who want to clear Hep C while they are in prison...they are doing a great job at the moment in the correctional health centre but cant see everyone who wants to access it"

This was acknowledged by the team in CPHS, with comments suggesting that there are approx. 70 additional prisoners who want/need to access the program but they are unable to offer it due to funding and resource restrictions.

According to the coordinator of the Hep C program in CPHS, formal education sessions around BBV for prisoners and correctional staff is "very limited". Approximately 10 hours per year of education sessions are provided through the Red Cross Peer Mentor program. BBV information is also provided to prisoners through Risdon link TV and written information and pamphlets are available in the health centre.

The attitudes of workers were also raised informally throughout the interview process with many of the stakeholders. One stakeholder suggested that the more we are seen to be doing in reducing the effects of BBVs, the greater the public awareness will be and hopefully an improvement in public perception will be witnessed.

Several of the stakeholders noted that there was a need for greater education of BBVs in both the prisoner population and for correctional staff. Stakeholders raised future developments in the management of BBVs in prison and in the community. A

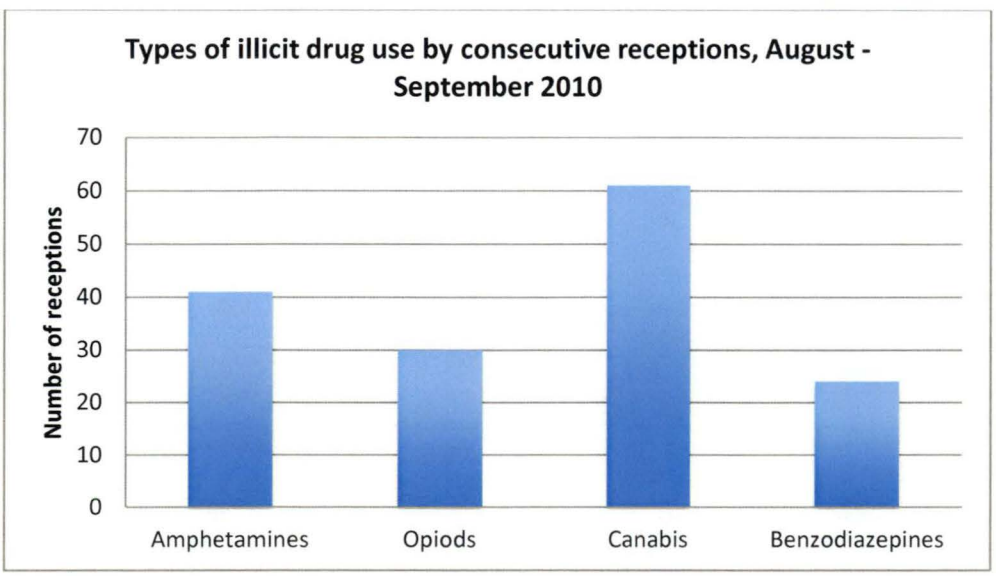
positive message that there will be a new program commencing in the future that will provide a "safe haven" in the community, where complex clients can be treated effectively. This new initiative will be funded by the Department of Population Health and will see CPHS, the Royal Hobart Hospital and Anglicare working in collaboration.

Summary:

- At 12.5%, RPC has the highest rate of prison acquired Hep C in the country
- Treatment for Hep C is currently is available through CPHS
- Treatment is limited to 30 inmates, however approximately 70 inmates need to access it
- Greater education and awareness programs about BBV need to be implemented, both in the prison and the community

4.8 Drug Use in Risdon Prison Complex

Access and use of drugs within the prison was a significant concern for each of the stakeholders interviewed. According to the 2011 Health of Australian Prisoners data, 2 in 3 prison entrants used illicit drugs in the 12 months prior to prison.



Adapted from Donaldson (2010) taken from ANCD report 2012

Several of the key stakeholders identified drug availability in the prison setting as one of the major challenges in working with prisoners with substance misuse issues.

"There are a lot of people that are in prison for drug related crime that prison probably isn't really the best place for them. And unfortunately for some of them it just makes them harder"

"I do think that the availability of drugs in prison is always an issue. I believe that the lack of hope and purpose amongst inmates contributes to the issue"

"Reducing the accessibility to the substance. Like anything that is organised and illegal and funded through a black economy, there is a wealth of money to get things through systems. "

Stakeholders identified a number of ways that drugs make it into the prison.

"It's like water, it will find its way to even and balance itself out. If there is a crack in the system it's going to get through. Whether that be through laundry processes, or visitors who feel compelled to bring it in through their persons. "

"Fighting a war. Sometimes you get some good wins but sometimes you don't. Best target is abstinence but in a prison culture where people have limited opportunity to escape their social parameters...it's very difficult for the inmate to break away. And when they do sometimes they are ostracized quite severely...and makes them hard to manage internally."

It seemed clear that the majority of stakeholders believed that a drug free prison was an unachievable goal. Trafficking of drugs by prison staff was considered to be an issue by several interviewees.

"The guards are bringing it in"

As mentioned previously, health staff identified that the diversion of opioid pharmacotherapy and mental illness medications was a constant issue and a concern that they are working to address.

4.9 Smoking

Eight one (81) percent of prisoners are current smokers, and 74% smoke daily. In contrast 18% of the general population are current smokers, and 15% smoke daily (ANCD report 2012). TPS has recently implemented a smoke free unit within the Ron Barwick Minimum security prison area. It is a unit that non-smoking prisoners may elect to go into. Other recent developments at the prison include a Smoke Free policy that has been drafted by the CPHS. At the time of writing, this document was unavailable for public release, although it is expected that Risdon Prison will be considering the option of going smoke free using a gradual process over the next 3 years.

This is a key example of where the prison needs to engage with prisoners and relevant stakeholders in the development and implementation of a policy with such wide-ranging implications. It is noted that this issue is only in the initial stages of development and that the TPS may be intending to conduct wide-ranging consultations in the future to address this.

Summary:

- Drugs are readily available at the Risdon Prison Complex
- Drug trafficking is occurring
- Disease transmission through drug use is occurring
- Diversion of prescription medications is occurring
- There is a need for drug free unit
- TPS looking at the possibility of a smoke free prison

4.10 Harm Reduction

The provision of naloxone and associated education campaigns relating to drug overdose prevention has been demonstrated to significant reduce the rate of overdose. Prisons are a particular environment where the opportunity for targeted and directed harm reduction strategies such as the provision of naloxone and information on how it is used can be effective and as such, save lives.

Overdose Prevention Education

The subject of overdose was only raised by a small number of those interviewed in the study. However it seems clear that there is a significant concern for prisoners exiting prison without adequate case management and support. Anecdotally, one worker reported that on release, some ex-prisoners have managed to "score" before getting to the bottom of the driveway at Risdon. According to stakeholders interviewed in this study, there is no overdose prevention education program at RPC.

Naloxone availability

There is a significant body of evidence to suggest that expanding the availability of naloxone and training potential overdose witnesses and victims to administer naloxone is a remarkably safe and effective intervention for preventing opioid overdose fatalities. In Tasmania, Naloxone is not prescribed to users or peers for the purpose of overdose prevention. As such, the Tasmanian government needs to look at ways that a trial of a peer administered naloxone, like the recent ACT trial can be implemented. The Tasmanian Government needs to have a stronger policy and strategic direction regarding overdose in Tasmania.

Needle and Syringe Programs (NSPs)

Data provided by the CPHS indicates that there are approximately 31prisoners currently injecting drugs at Risdon Prison. Tasmania also has the highest prevalence of BBV transmissions at RPC as reported earlier.

According to data supplied by the CPHS, 24% of the HCV + group are injecting in prison. This means that approximately 31 prisoners are injecting at Risdon.

Interviewees expressed concern regarding some of he ways prisoners have identified that they are using to inject in prison. One example of this is of a prisoner using a shelled out AA battery as a fit. The interviewee who shared this story was horrified at what lengths prisoners will go to, to inject.

The majority of stakeholders interviewed for this study raised and were positive about introducing an NSP in the prison as a sensible and progressive harm minimization approach. Despite the current trend of dismissing the possibility of NSP's in prison many of the interviewees were approachable to the idea of implementation of an NSP in Risdon Prison.

"Needle exchange would be a great improvement. I think the risk to staff is so great because of the picks that are used over and over again, having a safer option where is reduced the on flow of all of the hepatitis and other diseases "

"It's not condoning drug use, for harm minimization it would be great."

"If they are monitored well, then they work really well. I think there should be some form of needle exchange in the prison"

"I think that exposure of information in the prison would be brilliant"

Custodial staff and programs staff, as well as CSO staff were positive about the prospective of initiating the discussions on this topic. There were of course some common concerns raised including the possible danger to custodial staff and also other prisoners.

"I don't like the idea of needle exchange, but it may be the only way ahead with a number of prisoners. It won't stop the use of dirty needles. There are a number of prisoners who want to keep their drug use under wraps so they won't access the clean needles"

Concern was also raised as to the quality of the drugs that they will therefore be injecting.

"I guess my main concern about it is that we are issuing needles, to do what, use drugs that we haven't given them...there is still a trade. The only good outcome would be the harm reduction outcomes"

Summary:

- Greater education and awareness of overdose prevention strategies needs to be implemented
- Need to increase knowledge of naloxone and its uses amongst ex-prisoners
- Evidence to support the implementation of a peer administered naloxone program
- Strong evidence of IDU occurring in prison with make shift syringes and fits
- General support for discussions around the establishment of an NSP
- Confidentiality concerns regarding the identification of IDU through the implementation of an NSP
- Concerns regarding the use of dirty needles as weapons

4.11 Organizational and Culture Issues

Prison Culture

The organisational culture of the TPS was raised by many of the stakeholders. As identified in the Palmer Review, a consistent tension between custodial staff and other allied, health and management staff is problematic. There is a significant tension between different models of corrections (e.g. Punitive vs. rehabilitative).

"At the moment you'd have to say it continues to not look very good. You have a dysfunctional correctional service where the prison officers are divorced from their senior management and we as health providers are disempowered, we are not in an equal relationship. Some of the things going on, I view them as sinister."

The interviews showed that there is a concern with the way that prisoners with complex AOD issues are viewed.

"This idea that they are all druggies and they always will be...this can come across quite a lot from custodial officers."

Some stakeholders noted that there has been an inroads made toward changing the culture over the last 12 months,

"The majority are actually really good. Then they get paired up with someone that has the wrong attitude"

A staff member from the programs area noted that there is often a conflict in the working relationship between program staff and the custodial officers. It is difficult to get inmates to work on their new behaviour strategies in such a coercive environment.

"I think that custodial staff and professional staff have different perspectives in working with inmates. We do see them at their best and they (custodial staff) see them at their worse"

"It is difficult for them to go out and practice different types of thinking when the environment is not conducive to that"

Staff issues

All stakeholders raised recruitment and retention of staff. The programs team currently runs with seven FTE positions, although according to programs staff interviewed in this study, an additional 7 are required.

"I think the major issue we have is lack of capacity...it's a capacity issue"

"Yes we do provide a number of good supports, however we are well under resourced to provide total supports given some of the statistics around drug and alcohol in prisons"

Access to prisoners

There was discussion on the topic of accessing facilities within the prison in which programs can be run and also accessing prisoners that have been moved into other areas of the prison. CSOs raised the issue that at times, accessing rooms is difficult and that booking a room does not always mean it will be available.

"Somebody might be in Derwent and then might get put in Huon or Tamar and you have to find out not just where they are but how you get to them. The nature of the relationships changes. It doesn't mean it's impossible and doesn't mean it can't be effectively managed but sometimes it can be problematic."

"Insufficient rooms for visiting. I've sat in the court yard at times"

This frustration, illustrated above, is detrimental to the working relationship between the CSO staff and the TPS staff and ultimately affects the services that can be provided to inmates.

The issue of resourcing and funding for both prison services and also for community organisations that provide services in the prison was raised by the majority of stakeholders.

In Tasmania the Department of Justice does not fund any of the services that are engaged with the prison to provide services. These organizations do this from other state and federal funding, or more often than not, off the side of their desk. Many of the community stakeholders expressed their frustration about this.

"I think justice has a responsibility to fund such programs. We have the same goals as community corrections – to reduce reoffending. "

According to programs staff, AOD support for prisoners is provided in a limited capacity due to under resourcing.

"Yes we do provide a number of good supports, however we are well under resourced to provide total supports given some of the statistics around drug and alcohol in prisons"

"The challenges for our organisation is that we need more staff to provide the service that we want to"

Stakeholders also raised the issue that the prison does not have a good media reputation. The media in Tasmania only ever report on the negative part of Risdon and do not report on any of the positive cases.

"If something goes haywire and doesn't work, it makes front page...not very often to you hear a positive story about Tasmania prison service...the public don't see that:"

Again, the issue of consultation with staff and prisoners was raised in this context.

"I would like us to all get our heads together in the one place and not just do a beak the cycle motherhood statement, but actually create something that includes the prisoner in the consultation process...if we could all get on the same page and work together more than we do, that would be very helpful."

Discussion and Recommendations

This investigation sought to achieve an insight from current stakeholders on how AOD rehabilitation and treatment is currently addressed within the Tasmanian Prison Service and what areas need improvement. The fifteen stakeholders have provided a rich information source regarding future developments in this area and have made valid suggestions about how to develop and maintain effective services for prisoners with AOD issues. As with any small study, there are a number of areas that warrant further exploration, particularly the feasibility of a drug free unit within the prison that operates as a TC. The key theme throughout the literature and the stakeholder analysis conducted in this study is the need for a collaborative response from Government and the community sector that works with prisoners using a throughcare approach that takes into account the holistic needs of an offender and works toward addressing each of them to ensure that recidivism and relapse are avoided. A number of other common themes emerged with comparing the current literature and the comments from stakeholders. Further discussion in these areas is required if we are to move towards a model of care for prisoners with complex substance misuse issues.

Communication

Significant concerns from both prison and community sector staff were raised regarding communication and consultation across the prison. Communication amongst corrective services staff, program staff and health staff was described as being at an all-time low and this was greatly affecting the way that the prison operated. Each of the stakeholders noted that for change to occur within the prison, communication and consultation are key elements to the success of the changes. As Budon et al (2002) has noted, there is a need for meaningful integration of the criminal justice and treatment systems for AOD rehabilitation in custody to work effectively.

Drug Use

Risdon Prison is not a drug free prison, and realistically, may never be. It would be hard to argue that any prison in Australia is "drug free". Given that we know this, we need to be looking at methods that address issues such as Hep C transmission and other BBV transmission. The data provided by CHPS tells us that there are prisoners in RPC currently injecting drugs, if this is the case, it can be argued from a population health perspective that the only answer to reducing the risk in this case is to implement some form of NSP in Risdon Prison. The trial of an NSP in the AMC prison in Canberra may provide an opportunity for Tasmania to further investigate and evaluate the possible implementation of a needle exchange program at Risdon Prison.

Demand Reduction

The current lack of consistency and availability of demand reduction strategies and policies within RPC is contributing to an increase in harm to prisoners and subsequently to staff. The current case management system has major flaws and needs to be addressed. Consistencies in the use of the CIS software also need to be tackled. The therapeutic and targeted AOD programs provided the prison engages achieving good results in the small number of cases that prisoners are able to access a problem and remain for the length of the program. Funding and resourcing in this area is placing a strain on the benefits that staff can provide to inmates and as such is diminishing any effort being made in the reduction of relapse and recidivism for these inmates. Evaluation in the area of program development, implementation and delivery is also a serious concern that needs to be addressed by the prison. At this stage, recidivism data is not collected or analysed for participants of AOD programs and as such there is no evidence to suggest that they are achieving the intending outcomes.

A holistic approach to AOD treatment and rehabilitation of offenders needs to be acknowledged by the prison. The development of a therapeutic community within Risdon prison would be a possible solution to address this issue. It is understood that

the TPS is currently working on a step down model for minimum-security inmates that may potentially have to flexibility to operate in a similar manner to a TC.

Harm Reduction

Harm reduction methods across the Tasmania Prison Service are considerably limited. The lack of BBV education and prevention programs offered, along with the absence of overdose prevention and awareness education is currently inadequate and needs to be addressed. Current BBV treatment in the prison is achieving positive results and should be extended beyond the current capacity of 30 participants.

Rehabilitation: Programs and treatment

Whilst there have been significant improvements noted in the model of care used to work with offenders with complex AOD issues in recent times with Risdon, there is still some way to come in working with this client group in a more holistic sense. As discussed in the literature, case examples and the stakeholder feedback, the implementation of a TC within the grounds of Risdon would go some way to working in a more holistic way with this cohort. Aftercare has been highlight as imperative to reductions in recidivism and relapse in the previous chapters and as such, a comprehensive aftercare programs for prisoners upon release needs to be developed in collaboration with the community sector. CSOs are best placed to run this service and should be funded accordingly.

Funding and Resources

As mentioned earlier in this chapter, the Department of Justice does not currently fund any community organization in Tasmania to deliver services in the prison or work with prisoners upon release. They also do not fund any of the AOD residential rehabilitation services across Tasmania. Although funding is not provided, several of the community organizations represented this study said, pressure is placed on them to accommodate ex-prisoners upon release, or provide case management and aftercare support as there is no one else to do this.

How do the stakeholder comments compare with the literature?

The comments and discussion invoked through this study from the stakeholder's perspective are consistent with previous evaluations (eg. Stoove and Kirwan, 2010). Comments support the improvement of AOD programs for prisoners with complex substance use issues including the investigation of a therapeutic community model to be implemented in the prison and at least the start of conversations around a harm minimization model for injecting drug users (needle exchange).

The three models presented in chapter three offers different options of how AOD issues amongst prisoners can be dealt with. As illustrated in chapter 3, the way these programs are implemented is central to the success of them. Implementation and development needs to be done in consultation with all parties, including prisoners, custodial staff and community sector staff. Without this, any developments will inevitably fail.

Finally, the stakeholder's comments on funding and resources cannot be ignored. Whilst Tasmania is a state with significant financial constraints, there needs to be an acknowledgement that there are things that can be done to improve the current services without attributing large financial costs. As one stakeholder put it, we need to continue, "doing what we do" and while doing this we need to be evaluating whether what we are doing is working. Without evaluation and data collection, how are we to improve our current programs and continue to work towards reduced recidivism and better outcomes for this client group?

Recommendations

The following recommendations are based on current literature and policy discussion in chapter one and two of this thesis and also on feedback received from key stakeholders, as noted in chapter four.

1. **Improve linkages and partnerships with community organisations to better support prisoners pre and post release**

    i. Development of closer links with community and external AOD health service providers
    ii. Develop a model for throughcare in consultation with the Community Sector to improve outcomes for prisoners post release
    iii. Implement cross sector networking days where CSOs are introduced to the prison and partnerships can be established
    iv. Increase funding to community organisations to deliver post release case management support for prisoners, including residential rehabilitation facilities

2. **Address communication issues across the prison to ensure better implementation of new policies, programs and general developments**

    i. Implement a communication strategy that enhances prisoner and staff involvement in policy and decision making across the prison

3. **Increase prisoner access to pharmacotherapy and other AOD rehabilitation programs and services**

    i. Provide dosing for minimum security inmates

ii. Establish working party with the DHHS ADS to work through issues in finding community placements for prisoners on release
iii. Evaluate current programs available to prisoners and make improvements, amendments as required
iv. Collect data on recidivism and use in an evaluation process
v. Increase the number of AOD programs delivered across the TPS, including the investigation of a drug free unit (TC) within the prison

4. **Enhance access to primary health care services such as the Hep C treatment program**

i. Increase the number of places in the Hep C treatment program
ii. Increase education and health promotion opportunities for prisoners

5. **Increase commitment to harm minimization and the principles of harm reduction**

i. Implement a trial of needle and syringe exchange programs within Tasmanian correctional settings to reduce the spread of blood borne viruses
ii. Improve transitional supports and treatment options for people exiting prison to assist reintegration into the community and reduce their risk of re-offending
iii. Investigate the option of distribution of naloxone to drug using prisoners on release
iv. Removal of negative attitudes toward drug using offenders

Conclusion

This thesis has explored the role of AOD rehabilitation in custodial settings through a review of the literature, analysis of the policy and strategic direction, an examination of case examples, both nationally and internationally and finally through the exploration of comments and issues raised by stakeholders interviewed in the study. More research is required to determine the most appropriate way of implementing any recommendations made by this study or other studies. Greater evaluation of the current range of programs delivered in the Tasmanian Prison Service is also needed to determine the effectiveness of current programs in addressing relapse and recidivism among participants.

The importance of learning from our peers in this environment should not be underestimated. Other jurisdictions have put together successful models of care that have been evaluated and have provided excellent outcomes. We need to learn from these experiences and develop appropriate relationships with other jurisdictions. The need for closer engagement with the community sector has also been highlighted throughout the research conducted for this study and is another area that needs to be progressed by both the TPS and leaders in the community sector.

The stakeholder findings have identified a range of issues with the delivery of AOD rehabilitation and treatment services both within the Tasmania Prison Service and also in the community. The majority of the stakeholders expressed a sense of frustration with the system, although acknowledged the recent developments that have been made.

This thesis has made a range of recommendations for future developments in this area and while it is acknowledged that these recommendations are based on securing adequate funding and resources for the implementation phase, there are also some suggestions for improvements that can be made without subsequent funding dollars being utilised.

We need to not only "keep doing what we are doing" as expressed by one interviewee, but also keep doing what we can to improve and build on the services that we provide. This study has demonstrated a passion and belief in working with prisoners with complex AOD issues, the key is to harness the passion and push forward to further develop services available for this cohort.

This study provides greater understanding of the complexities involved when working with offenders with substance misuse issues and has provided a range of recommendations for future developments. It is hoped that this will see the continuation of the positive work conducted by the Tasmania Prison Service and also a significant progression towards a model of care that adequately addresses the needs of offenders experiencing complex substance misuse issues in Tasmania.

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Appendix

Appendix 1: List of Stakeholders

1	Andrew Verdouw	Department of Justice, Tasmania Prison Service
2	Anthony Rees	Department of Justice, Tasmania Prison Service
3	Caroline Lewis	Department of Justice, Community Corrections
4	Dr Chris Wake	Department of Health and Human Services, Correctional Primary Health Services
5	Daniel Stebbings	Department of Health and Human Services, Alcohol and Drug Services
6	Deb Sidall	Department of Health and Human Services, Correctional Primary Health Services
7	Don McRae	The Salvation Army, Reintegration of Ex Offenders (REO)
8	Gerard Tracey	Bethlehem House, Post Release Options Project (PROP)
9	Janine Oneill	Holyoake
10	Jill Murray	The Salvation Army, EXCELL
11	Karena Spruce	Department of Justice, Community Corrections
12	Peter Cairns	Department of Health and Human Services, Correctional Primary Health Services
13	Ray Metcalfe	Prison Fellowship of Tasmania
14	Tom Clarke	Department of Justice, Tasmania Prison Services
15	Tracie Bowes	Red Cross

Appendix 2: List of questions used for stakeholder interviews

1. What is your job role/position?
2. How long have you worked in this sector?
3. How long have you delivered services at the prison?
4. What services/programs does your organisation deliver at the prison?
5. What is your highest qualification?
6. Can you tell me what specific drug and alcohol programs are currently offered at Rison Prison?
7. What is the minimum sentence length for offenders to access these programs?
8. Do you think that there is enough support for prisoners who have substance misuse issues at Risdon Prison?
9. Do the AOD programs at Risdon work? Are they reaching the target population? Why?
10. Are there any service gaps that you can identify?
11. Does the current model address the needs of prisoners with complex issues? Ie. Mental illness, primary health issues etc.
12. Does the Prison engage in a through care model with outside community sector organisations?
    a. Does this work?
    b. Could more be done? What would this look like?
13. What are the challenges that you see in addressing the needs of offenders with substance misuse issues?
14. Do you have any suggestions for future changes or developments?
15. How would you address the gaps that you have mentioned?
16. Are you aware of other AOD programs offered in other States? Do you think these programs might work in Tasmania?
17. What do you think the ideal AOD model for offenders in custody would look like?
18. Any other comments?

Appendix 3: Breaking the Cycle: A Strategic Plan for Tasmanian Corrections 2011-2020

Goal 1: To reduce re-offending by providing rehabilitation and reintegration services to address issues which contribute to offending

Reasons for this Goal

Expanding the range of interventions available to offenders to address the underlying causes of an individual's offending behaviour, both within the Tasmania Prison Service and Community Corrections, was identified by stakeholders as a key priority to reduce reoffending. Issues which have been shown to impact on offending ("criminogenic needs") may include substance misuse, lack of education or employable skills, anti-social attitudes, values and beliefs, and lack of activities and interests that are "pro-social" (i.e. positive towards others and in tune with social norms).

Other factors may not directly impact on offending, but may impact on our ability to work with the offender to address the criminogenic needs. For example, intellectual disability may make it difficult for an offender to participate in a group program. The presence of multiple issues, or "co-morbidity" (for example, substance misuse combined with mental health problems) may make offenders difficult to treat.

Additionally, some services may not directly address offending behaviour, but are important to provide positive activity within the prison context.

As discussed in the Background, while some interventions are provided directly by the Tasmania Prison Service and Community Corrections, many important services are delivered by partner organisations. By working more closely with our government and non-government partners, we will be able to increase the provision of programs and services for offenders with needs such as substance or gambling addictions, mental health issues or intellectual disability.

The transition from prison to the community is also a key time in an offender's rehabilitative pathway. Supporting the reintegration needs of offenders by expanding transitional services such as accommodation, assisting in engagement with education and employment, and increased assistance with reconnecting with family and support networks will help to reduce an offender's risk of re-offending on release and will enhance community safety.

Issues of compliance with community-based orders and enforcement of conditions are also linked to community safety. Public concern in relation to community-based sentences often focuses on the risk of reoffending while on such a sentence. Ensuring appropriate sanctions are applied for breaches of orders, such as failure to attend planned community service work or drug and alcohol counselling, will

increase both compliance rates and community confidence in the corrections system.

Strategies for Achieving this Goal

1.1 Increase the provision of interventions addressing issues which contribute to offending behaviour

Actions:
1.1.1 Increase the number and diversity of therapeutic group programs addressing criminogenic needs delivered by Community Corrections
1.1.2 Explore options for the expansion of service provision to remandees and inmates on short sentences
1.1.3 Work with partners to increase the provision of programs and services addressing key criminogenic issues such as substance misuse, including where co-morbidities are present
1.1.4 Work with partners to increase the provision of programs and services tailored to offenders with special needs e.g. intellectual disability, acquired brain injury
1.1.5 Work with partners to explore options for family support and family-based interventions
1.1.6 Investigate options for increasing the provision of services in regional / outlying areas (internally and through partner organisations)

1.2 Improve internal procedures supporting provision of programs, services and rehabilitative support to offenders

Actions:
1.2.1 Review case management practices
1.2.2 Provide staff with training and resources to allow them to deal confidently and sensitively with offenders of culturally and linguistically diverse backgrounds, including Indigenous offenders, and with GLBTI offenders

1.3 Provide prisoner education and employment opportunities which contribute to employability on release

Actions:
1.3.1 Work in partnership with the Department of Education to implement the Tasmania Prison Service Education and Training Strategic Plan
1.3.2 Expand employment support for inmates and offenders
1.3.3 Support the Literacy Co-ordinators provided by the Department of Education to expand provision of literacy and numeracy education to offenders (in prison and in the community)
1.3.4 Increase the relevance of prison vocational education and prison industries employment to employable skills

1.4 Expand services to support reintegration into the community and social inclusion

Actions:
1.4.1 Enhance support for transition between the Tasmania Prison Service and Community Corrections
1.4.2 Continue to work to increase accommodation options for inmates on release
1.4.3 Engage the broader community (including key groups e.g. employers) to improve reintegration opportunities (see also 5.2)

1.5 Enhance monitoring of and enforcement of compliance with community-based orders

Actions:
1.5.1 Review breach and compliance procedures within Community Corrections (see also 3.1.5)
1.5.2 Increase the provision of services for compliance monitoring (e.g. urinalysis)
1.5.3 Investigate options for introduction of electronic monitoring as an option for compliance monitoring of community-based offenders (see also 3.1)

Goal 2: To provide infrastructure to meet the goals of the corrections system

Reasons for this Goal

Having an appropriate range of prison facilities which enable the delivery of services and safe containment of inmates has been identified as critical to the safety of the community and effective rehabilitation of inmates.

Planning for additional maximum-security facilities is already underway. The lack of appropriate accommodation options for maximum-rated inmates, particularly those considered to be high risk or with behavioural issues or other special needs, has also been highlighted by the Ombudsman's Report into the Tamar Unit and Behaviour Management Program.

Community safety can be improved if on release offenders have the required skills to live responsible and offence-free lives in the community. Options for open, low-security correctional facilities include transition / reintegration centres, which would allow inmates to live in a shared-house setting and to take responsibility for their day-to-day lives while remaining in a supervised environment. This would also provide an incentive for good behaviour within the prison system.

The need for a remand centre in the North-West of the state has also been raised.

Strategies for Achieving this Goal

2.1 Provide a range of prison facilities appropriate to the Tasmanian prison population

Actions:
2.1.1 Consider options for the restructure of resources to provide open, low-security facilities appropriate to the needs of the prison population, including transition /

reintegration centres
2.1.2 Continue to progress the development of additional maximum-security facilities in line with need
2.1.3 Explore options to expand facilities for the delivery of programs and education (in line with 1.1 and 1.4)
2.1.4 Expand and improve prison industry facilities (in line with 1.4)
2.1.5 Explore options to improve facilities for interactions between offenders and their families

2.2 Explore options for the provision of better regional services

Actions:
2.2.1 Explore options for the provision of short-term custodial facilities in the north-west

Goal 3: To support an appropriate range of sentencing options

Reasons for this Goal

It is acknowledged that some offenders should be subject to substantial prison sentences and removed from the community to protect the safety of the public. However, imprisonment is not always the most appropriate or effective rehabilitative option. The cost to the community goes far beyond the cost per prisoner per day and includes a broad range of social and economic costs including family dysfunction, the loss of housing and employment.

The expansion of sentencing options available to the Courts is seen as important, particularly non-custodial sentencing options. Community-based sentences provide an opportunity for offenders to address issues which contribute to their offending behaviour, while at the same time also including an element of punishment and accountability to the community.

To achieve this goal, the Department will need to work closely with those who have primary responsibility for sentencing, including the Attorney-General, judges and magistrates. The work of the newly-established Sentencing Advisory Council will also be of key importance.

Strategies for Achieving this Goal

3.1 Work with Attorney-General, judges, magistrates, police and other key stakeholders to develop and implement a wider range of sentencing options

Actions:
3.1.1 Work with Tasmania Police to develop a proposal to trial electronic monitoring equipment for accused people on bail
3.1.2 Carry out a feasibility study of home detention with electronic monitoring as a sentencing option
3.1.3 Participate in the ongoing exploration of a "problem solving" court to improve

provision of diversionary and treatment responses to a wide range of issues that contribute to offending behaviour
3.1.4 Explore options for the provision of hostel-style accommodation for accused persons on bail and parolees
3.1.5 Investigate options for improving legislation regarding community-based sentences to increase ease of enforcement (see also 1.5)

Goal 4: To provide more effective and accessible service delivery through better integration with service providers

Reasons for this Goal

Many offenders have difficulty accessing appropriate services. In addition to government departments there is a wide range of non-government organisations providing support and rehabilitative services to offenders.

Although the privacy of offenders must be respected, improved communication and information sharing among agencies would reduce duplication and improve service delivery. It would enable an offender's case plan, for example, to be shared on an as-needs basis with other service providers. This would generally be contingent on the offender's permission; however in some situations consent is not legally required.

Strategies for Achieving this Goal

4.1 Increase co-operation and collaboration between arms of corrective services, the broader justice system, and other relevant government departments and service providers

Actions:
4.1.1 Enhance through-care for offenders moving between TPS and CC (see also 1.4.1)
4.1.2 Explore the expansion of multi-disciplinary treatment teams (MTTs) for offenders with complex needs
4.1.3 Increase communication and interaction with partner organisations (see also 6.3)
4.1.4 Explore the possibility of centralising funding for service delivery by NGOs to support longer-term and cross-disciplinary projects
4.1.5 Enhance relationship with UTAS for professional development and research

4.2 Increase information sharing within corrective services and with other government and non-government organisations

Actions:
4.2.1 Expand information sharing between TPS, CC and other justice outputs
4.2.2 Explore options for integrated assessment and case planning ("One Plan") with other agencies and NGOs

4.2.3 Explore options to integrate information technology systems to facilitate the sharing of information (see also 7.3)

Goal 5: To increase community engagement with the corrections system and the rehabilitation of offenders

Reasons for this Goal

Engaging the community and encouraging community participation in the rehabilitation of offenders is seen as critical. Building partnerships with community organisations and employers, for example, would increase opportunities for offenders on release and improve long-term outcomes.

Providing the community with an opportunity to become increasingly involved will add to the community's understanding of and confidence in the corrections system.

Local communities may be best placed to identify opportunities to assist in rehabilitation and reintegration, including the provision of advice on employment or training for offenders. They may also identify appropriate community service order worksites or provide information on the types of issues of concern to their local area. The Community Justice Panel model provides a forum for local communities to participate in this way.

Strategies for Achieving this Goal

5.1 Improve communication with the broader community regarding corrective services

Actions:
5.1.1 Develop a communications strategy for corrective services
5.1.2 Investigate opportunities for community outreach
5.1.3 Regularly publish key information regarding corrective services

5.2 Expand community involvement in corrective services, particularly rehabilitation and reintegration activities

Actions:
5.2.1 Research models for Community Justice Panels
5.2.2 Support non-government service providers who wish to develop schemes for volunteers to work with offenders (e.g. literacy, mentoring)
5.2.3 Improve communication with offenders' families

5.3 Expand opportunities for offenders to participate in restorative justice schemes

Actions:
5.3.1 Consider the development of a formal framework for, and enhance delivery of, victim-offender mediation

5.3.2 Work with local government to expand ways for offenders to repay the community

Goal 6: To provide appropriate workforce development, training and support

Reasons for this Goal

Increasing the capacity of those who work within the corrections system and ensuring they have the skills, abilities and experience and appropriate ongoing training to enable them to carry out their work effectively and to support the delivery of best practice in correctional services is critical to providing appropriate correctional services, including rehabilitation services to offenders.

Strategies for Achieving this Goal

6.1 Enhance recruitment and retention

Actions:
6.1.1 Review recruitment strategy for key roles
6.1.2 Review working conditions and arrangements to enhance support of flexible working hours and work-life balance

6.2 Enhance training and development opportunities for corrections staff

Actions:
6.2.1 Implement a professional development strategy to identify development needs, provide appropriate support and manage performance issues
6.2.2 Deliver additional training in areas of identified need

6.3 Support sector-wide skills and knowledge development

Actions:
6.3.1 Continue to hold sector-wide forums for sharing of views and expertise
6.3.2 Investigate opportunities for shared training with partner organisations

6.4 Enhance staff engagement and involvement in strategic decisions

Actions:
6.4.1 Develop formal policies in relation to workplace consultation to enhance decision making and staff involvement
6.4.2 Work with staff and Workplace Standards Tasmania to address concerns and identify opportunities to improve safety in the workplace

Goal 7: To improve oversight, governance and research functions

Reasons for this Goal

In order to increase the community's trust in the corrections system in Tasmania, it is considered desirable to introduce additional oversight mechanisms to ensure the

policies and practices of the corrections system are appropriate and that we are delivering a system that meets our national and international obligations.

The Department believes that by providing improved information about what happens within the system and ensuring appropriate resources are available for oversight, the confidence of the community can be increased.

Strategies for Achieving this Goal

7.1 Improve integrity and oversight functions

Actions:
7.1.1 Explore options for the establishment of an independent Prisons Inspectorate

7.2 Expand data collection, evaluation and research functions

Actions:
7.2.1 Establish a mechanism for sharing relevant research among key staff
7.2.2 Investigate ways of recruiting research students to key projects

7.3 Enhance information technology functions

Actions:
7.3.1 Increase capture and analysis of strategic items of internal data
7.3.2 Enhance transfer of information between internal systems

7.4 Continuously improve strategic planning and implementation

Actions:
7.4.1 Work with partner organisations to align strategic directions

Appendix 4: Programs offered by the Tasmania Prison service

- High Intensity Criminogenic Programs
    - Pathways: - a medium/high intensity substance abuse program
- Low Intensity Programs
    - Getting SMART: - a low to medium intensity substance abuse program
    - Turning Point: - a brief motivational program
    - Preparing for change – an introductory cognitive behavioral skills program.
    - Currently developing Anger Management
- Therapeutic Program
    - New Directions: - sexual offending program
- Programs not offered
    - Making Choices: - a medium/high intensity general offending program was not offered as the last program completed in June 2011. Pathways has been run three times and Making Choices is again being offered and will begin in September 2012.
- Group and individual programs
    - An increasing effort towards the higher security rated inmates has resulted in a number of the introductory programs being delivered individually.

Pathways

The Pathways program is an evidence-based criminogenic treatment program for adults with a history of criminal conduct and alcohol and other drug (AOD) use problems. The program uses a cognitive behavioural approach to change antisocial thinking and behaviour and to enhance pro-social thinking, attitudes and beliefs, aimed at helping offenders avoid both recidivism and relapse. The program is built around key topics (or themes) for self improvement and change, including:-

- Engaging in a working alliance with participants and facilitators;
- Increased self awareness through self-disclosure and receiving feedback;
- Developing knowledge about the processes of change, patterns of AOD use, criminal conduct, the process of relapse and recidivism and its prevention and increasing awareness of self, others and the community;
- Applying knowledge and skills to prevent relapse and recidivism, establish self-control, develop and maintain effective interpersonal relationships and establish a positive and harmonious relationship with the community.

The Pathways program is delivered as three phases, all of which can be conducted as either closed or open groups. The program is a total of 120 hours in duration. Successful completion of Phase I is required before entry into Phase II and III.

Phase I

Challenge to change engages the participant in a reflective-contemplative process. A series of modules are covered to increase motivation for change. Sessions also provide information on the benefits to change, the role of thought and behaviour in change and the connections between substance abuse and criminal conduct.

Phase I of the program involves 20 sessions.

Phase II

Commitment to change involves the participant in an active demonstration of implementing and practicing change. Sessions focus on strengthening, through practice, basic skills for change and helping the participant to learn key

Cognitive Behavioural Therapy models to change thoughts and behaviour that contribute to substance abuse and criminal conduct.

Phase II of the program involves 22 sessions

Phase III

Is the "ownership of change" component and encourages healthy living and lifestyle balance in participants. Phase III is 8 sessions

Pathways was developed by Wanberg, K., & Milkman, H., 2006, *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change*

Making Choices

Making Choices is a medium to high intensity program, which targets general offending behaviour, replacing both the anger management and cognitive skills programs.

The program utilises a range of treatment methods shown to be effective in reducing recidivism, including relapse prevention planning, problem solving, safety planning, mood management techniques and the use of cognitive behavioural methods.

Key themes of accepting responsibility and being personally and socially accountable for one's own behaviour are threaded through the program.

The program is 100 hours long and will usually run over three to four months, with three to four sessions a week

Making Choices was developed by HMA developed around the work of Ken McMaster (Hall McMaster & Associates Limited). Ken McMaster has a long history of

work in the stopping violence, sex offenders, alcohol and drug, and criminal justice areas in New Zealand and is the author of the Tasmanian Safe at Home program..

Turning Point

Turning point is a brief (20 hour) motivational program, designed to target offenders' responsivity issues surrounding their readiness to change. The program is based on the 'cognitive behavioural' and 'stage of change' models of behaviour change. Offenders who exhibit responsivity issues surrounding readiness to change may benefit from participating in the Turning Point program as a first stage in their intervention sequence to prepare them to gain optimally from future interventions identified through further assessments or recommendations.

The Turning Point program runs three or four times a week over the course of two to three weeks, each session being approximately one and a half to two hours long.

Turning Point was developed by the U.S. Addiction Technology Transfer Centres (ATTC) under the co-operative agreement from the Centre for Substance Abuse Treatment (CSAT) of the Substance Abuse Mental Health Services Administration (SAMHSA).

Getting Smart

Getting SMART is a low to medium intensity Drug and Alcohol program designed to promote self management when it comes to drug and alcohol use. It is run twice or three times a week over the course of 4-6 weeks and can accommodate 12 participants at a time. It is suitable for inmates who have identified drug and alcohol issues.

The program uses a cognitive behavioural approach to change maladaptive thinking and behaviour and to enhance pro-social thinking, attitudes, beliefs and actions.

Getting Smart was developed in 2005 by the NSW Department of corrective services as a tool to enhance inmates' understanding of the concepts, tools and techniques to support their struggle with addiction

Preparing for Change

Preparing for Change is a low-level cognitive behavioural skills program developed by the TPS.

The program has been designed to increase the readiness of inmates for participation in the intensive programs. It covers areas such as stress management, the learning process, anger management, communication and self esteem.

Preparing for change was developed by staff at TPS using recognised theory and practice.

Anger Management

Anger management is a brief (24 hour) program being trialed in late 2011. Its focus is on encouraging inmates to learn to manage anger, stop violence, and develop self control over thoughts and actions. Successful completion of this program should be followed by referral to either Making Choices or Pathways dependant on ongoing treatment need.

Anger management was developed by the U.S Department of Health and Human Services: Substance Abuse and Mental Health Services Administration – Center for Substance Abuse Treatment.

New Directions

The New Directions program is a medium to high intensity therapeutic program for offenders who have committed a sexual offence. Male offenders who have committed a sexual or sexually motivated offence can be referred. Following sentencing they undergo specialised assessment to determine eligibility and their treatments needs. New Directions is a psycho- therapeutic program that is less content, whiteboard and manual driven than the other programs offered by the Unit.

The program uses a cognitive behavioural approach with a "Good Lives" and relapse prevention model to change antisocial attitudes and behaviour. Participants address their personal risk factors and identify strengths to promote a holistic pro-social lifestyle.

New Directions program was developed by Marshall, W. & Marshall, L. (2005). Rockwood Psychological Services Training for Therapists who work with Sexual Offenders. *Proceedings of training presented to the Queensland Department of Corrective Services, July 4 -8, 2005*, Queensland Department of Corrective Services Training and Development Centre, Brisbane (pp. 1-217).

Appendix 5: Programs / services provided by external service providers

The Tasmania Prison Service also receives the support and assistance of a number of community and other organisations in the delivery of rehabilitation and personal development programs. These programs include:

- *Alcoholics Anonymous*
- *Anglicare Debt & Money Matters*
- *Bethlehem House men's accommodation*
- *Centrelink - social security payments*
- *Coastcare - Community Service*
- *Colony 47 COSS for housing assistance*
- *Hobart City Mission - Community Service*
- *Hobart Dogs Home - Community service*
- *Holyoake Gottawanna program*
- *Indigenous programs - Ask Gail Brown 6216 8090*
- *Launceston City Mission Bus to Tasmania Prison Service*
- *Max Employment*
- *Newpin family parenting program*
- *Prison Fellowship, prisoner mentoring and S42 resocialisation*
- *PROP Post Release Options Project*
- *Reclink sport and recreation programs*
- *Red Cross Peer Mentors*
- *Relationships Australia – Gambling counselling*
- *Relationships Australia - Men's Health Counsellor*
- *REO Reintegration for Ex-Offenders – Salvation Army supported accommodation*
- *Rosny LINC Literacy Tutors*
- *STAY Centacare and Red Cross – supported accommodation*
- *The Lea Scouts Campsite - Community Service*
- *Tools for Men Anglicare*
- *Xcell Prison Support Service - positive lifestyle and anger management*