



Reducing crime through “best practice” on alcohol and other drugs in prison settings

*Report of the workshop
Wellington, 4 July 2005
New Zealand Drug Foundation
Te Tūāpapa Tarukino o Aotearoa*

About the workshop

On July 4 2005, the New Zealand Drug Foundation hosted a national workshop, *Reducing crime through best practice on alcohol and other drugs in prison settings*, at Te Papa Tongarewa, the Museum of New Zealand, in Wellington.

Background

The workshop aimed to start a discussion on how using “best practice” in dealing with alcohol and other drug issues in prison settings may help reduce crime in New Zealand.

There has been increasing concern about alcohol and other drugs issues in prisons, ranging from intravenous drug use to smoking cessation. Evidence from New Zealand and overseas shows that the majority of offending (as much as 80 percent in some studies) is connected to alcohol or other drugs, and that a significant proportion of prison inmates have some level of alcohol or drug dependency. For some people, prison is their introduction to drugs; for others, it is an opportunity to change their lives and deal with their problems.

There is also increasing evidence that support for return to the community, including continuing alcohol and drug treatment, is critical to help former inmates avoid being drawn back into crime.

Drug use in prisons has also been identified as a source for the spread of communicable diseases; notably hepatitis C, but also HIV. Reducing the harm caused is a significant public health concern, so that we reduce both human suffering, and the costs to society of these preventable diseases.

While there is clearly a major problem, fresh approaches are being evaluated here and overseas. Recent New Zealand initiatives include the Department of Corrections formalising their “harm minimisation” approach to alcohol and other drugs in prisons, and prison-based treatment programmes, such as the therapeutic community at Arohata Women’s Prison. In the community, initiatives such as Wellington’s Inner City Project are attempting to provide integrated services to support people coming out of prison with housing and employment needs.

Structure and aims of the workshop

The New Zealand Drug Foundation saw this workshop as the first opportunity to bring together policy-makers, service providers, researchers and advocates who had an interest in addressing alcohol and drugs issues in prisons settings. Forty-six invited guests attended the workshop, which was chaired by Professor Sir John Scott.

The aims of the day were to:

- outline how alcohol and other drugs issues are currently being addressed in New Zealand prison settings, and for people coming out of prisons;
- identify key elements of best practice, including whether or how treating alcohol and other drugs (AOD) problems in prisons may contribute to reducing recidivism;
- identify other issues, such as impacts on families or whānau;
- increase attention among agencies and services to the value of dealing with alcohol and other drugs issues for prisoners and families and whānau; and
- identify opportunities for developing collaborations to address issues

The keynote speaker was Associate Professor Michael Levy, Director of the Centre for Health Research in Criminal Justice in New South Wales. Michael Levy shared his knowledge at this workshop while in Wellington to speak at the NZ Public Health Association conference, supported by the NZ Drug Foundation and the Department of Corrections.

Other presenters were Ross Bell from the NZ Drug Foundation; Barry Matthews and Phil McCarthy from the Department of Corrections; Mark Jacobs and Kayleen Katene from the Ministry of Health; Tim Harding from Care NZ; Anthony Pompallier and Rapai Te Hau from the Wellington Inner City Project; Rhonda Robertson from Bay of Plenty DHB Community Alcohol and Drug Services; and Julia Carr from Capital & Coast District Health Board, Primary and Community Care.

In the afternoon, the workshop divided into smaller groups to discuss key issues, and identify opportunities to develop good practices and improve collaboration.

Following the workshop, the Drug Foundation will continue to work with participants in the workshop, many others who were unable to attend, and other researchers, service providers and consumer advocates, to get an evidence-based approach to prison health on the political and public policy agenda.

Key themes of the workshop

- Use and abuse of alcohol and other drugs makes a significant contribution to New Zealand crime rates - as much as 80 percent of crime is alcohol and drug-related, and the majority of prison inmates have some alcohol or drug dependency.
- Drug use in prison, especially intravenous use (IVU), is a major contributor to the development and spread of dangerous infectious diseases such as hepatitis C and HIV/AIDS; while New Zealand currently has a lower rate of intravenous drug use than other countries such as Australia we still face risks that need to be managed.
- New Zealand has a high rate of imprisonment compared to comparable countries, and imprisonment costs New Zealand about \$55,000 per inmate per year.
- The effects of imprisonment have impacts on the families/whānau of prisoners and contribute to inter-generational criminal activity, as well as to other problems for them.
- The benefits of treating alcohol and other drugs problems outweigh the costs.
- New Zealand has a national *Strategy to Reduce Drug & Alcohol Use by Offenders* and a number of initiatives to reduce the supply of drug in prisons, reduce the demand for drugs by those in prisons, and minimise the harms from alcohol and drug use.
- Work is being done to clarify the responsibilities of the health sector (district health boards and the Ministry of Health) and of the Department of Corrections, in providing assessment and treatment services.
- More can be done to ensure to prevent and treat inmate AOD problems: treatment services in prisons are not consistent around the country, and inmates often have waiting lists for treatment.
- The point where a person leaves prison is a critical time if they are to maintain the benefits of treatment - at present there are gaps in service provision and support.
- We need to increase the community's understanding of how treating alcohol and other drugs problems can contribute to lower crime rates, and reduced effects of crime for all New Zealanders.

Opening speeches

Barry Matthews, the Chief Executive of the Department of Corrections, opened the workshop. He acknowledged the high incidence of drug dependency and abuse among prisoners, noting that in 1998, research carried out for the Department of Corrections found that 89 percent of serious offenders were under the influence of alcohol or drugs in the period leading up to their offence. Eighty-three percent of all prisoners have had past problems with alcohol or drugs, compared to only 32 percent of the general population.

Drugs continue to be used within prisons. Some inmates use stand-over tactics, assaults and pressuring visitors in an effort to maintain their drug taking. Cannabis is the predominant illicit drug of choice in prison, although amphetamine use is increasing.

Random drug testing is a major part of the Department's efforts to reduce drug use within prison, and results show a 50 percent fall in positive drug tests since its introduction. Random drug testing is part of the 2005-2008 strategy to reduce drug and alcohol use, which has three main objectives; preventing and detecting the supply of drugs, reducing prisoner demand for drugs, and reducing the harm caused by drug use in prison. The new strategy builds on the previous strategy by extending the focus to include offenders on community-based sanctions.

Mr Matthews outlined some of Corrections' initiatives to target supply, including strengthening prison security (such as perimeter fences), improving information gathering, and maintaining strong links with governmental agencies to identify and stop organised crime groups supplying drugs to prisoners. The Department also supports harm reduction initiatives within prisons.

Mr Matthews concluded by noting that the Department of Corrections also aims to increase the number of offenders who start and complete alcohol and drug treatment programs.

Mark Jacobs, the Director of Public Health in the Ministry of Health, gave the second opening speech. He pointed out that one of the Ministry of Health's main priorities is "to minimise the harm resulting from drug and alcohol use". While abstinence is the most effective way to reduce harm, other harm minimisation strategies must be employed. Within the National Drug Policy priorities for action, prisons and community correction settings are a key environment for harm minimisation strategies.

Dr Jacobs pointed out that the Department of Corrections does not have sole responsibility for inmate health. The relationship between Corrections and Health is held together by an agreement that "health services for inmates should be of the same standard and availability as is made to the general public". Problem limitation, the third strategy of the National Drug Policy, is ensuring that treatment services are available for people affected by abuse.

Mark Jacobs concluded by recognising that pre-release training and aftercare services play an important role in treating offenders and reintegrating them back into the community upon release.

Keynote Address

Associate Professor Michael Levy
Acting Director of the Centre for Health Research in Criminal Justice
Justice Health, New South Wales

“Kind and Usual Treatment”

Associate Professor Michael Levy joined the Corrections Health Service in 1998. In 2004 he became the Acting Director of the Centre for Health Research in Criminal Justice. He was one of four founding members of the Australian Council for Prison Health Services in 1999, and was Convenor of the Council in 2003. He has carried out research, and visited prison health care facilities, in 20 jurisdictions around the world.

Michael Levy’s presentation focused on research into best practice for treating intravenous drug users, and was anchored around the principle that:

“No medication legally and appropriately prescribed in the community ought to be ceased solely on the grounds of incarceration”.

The presentation began with a look at the harsh reality of prisoner health status in Australia, especially the significant proportion of Aboriginal Australians. They are disproportionately represented in substance abuse statistics, with health consequences, including a high incidence of hepatitis C. Imprisonment often becomes multi-generational.

Focusing in on prison inmates who inject, Dr Levy outlined the characteristics of injecting prisoners, which included a resistance to treatment, poor health and stigmatisation. He noted that prison is a place of initiation for drugs - 10 percent of drug users start in prisons. In the services he has researched, death by overdose of prisoners or former prisoners is 19 times higher than of non-prisoner heroin users.

Dr Levy considered that treatment options for intravenous drug users should be based on the principles of human rights, and of professional clinical practice. Options include:

- methadone;
- detoxification;
- abstinence-based programmes;
- cognitive behavioural therapy;
- other pharmacotherapies (eg bupropion);
- harm minimisation strategies, such as bleach or condoms

When used in the community, methadone maintenance therapy (MMT) prevents deaths, illness and recidivism. The obvious suggestion is that these outcomes could be replicated in prison if injecting offenders are given MMT. However, MMT is not the first option for many prisons, which instead use detoxification, cognitive behavioural therapy, and other general harm minimisation strategies such as health kits and information.

Michael Levy briefly noted that detoxification must be done carefully to minimise suffering. The evidence for the effectiveness of abstinence-based programmes is weak, and people need high motivation.

There are several models for supporting intravenous drug users in prisons, including heroin prescribing and other heroin substitutes. In some places clean injecting equipment is available, although this has risks, and the other option is a safe or supervised injecting place inside prisons. Methadone maintenance therapy is used by several countries (such as Switzerland and Germany), with Spain having the highest number in MMT – 36 percent of their prison population. This is despite Spain having a tough prison system; contrary to what might be believed, having methadone maintenance in prisons does not go with being “soft on crime”

Results of studies on prison methadone maintenance therapy (MMT) programs show they reduce heroin and syringe sharing. A four-year follow up showed a significant difference in mortality rates and re-incarceration risk, and those with only short MMT had the highest risk of hepatitis C. Hepatitis C is extremely expensive to treat over a person’s lifetime, so programmes which can reduce the risk have major economic, as well as social, benefits. Studies have found it costs \$AU3234 a year to maintain a prisoner on methadone, which could be offset by 20 days of reincarceration.

Introducing an MMT program for prisoners involves buy-in from both the custodial service and clinicians, and there need to be tight policies and procedures in place, as well as guarantees of ongoing care, to ensure people can continue MMT when released.

Dr. Levy concluded by stating that oral methadone was the best treatment option for opiate- dependent prison inmates when compared to other pharmacotherapy, options and reiterated the underlying principle that should guide decisions.

Discussion following Michael Levy’s presentation:

What is the value of psychosocial support?

It has an important role; there are a number of such initiatives being trialled by New South Wales Corrections.

How does the use of drugs in prison relate to contributing environmental factors, such as overcrowding and the lack of recreational activity for prisoners?

It was agreed that research needs to be done to see how changing the environment may affect drug-taking.

Morning Panel Presentations

Phil McCarthy
General Manager of the Public Prisons Service
Department of Corrections

Department of Corrections
2005-2008 Strategy to Reduce Drug & Alcohol Use by Offenders

The 2005-2008 strategy is part of a series, the first being in 1988. The goal of the strategy is to reduce re-offending through reducing alcohol and drug use, both in prison and upon release. “Drugs” covers all illicit drugs, abuse of prescription drugs, and alcohol, but excludes tobacco.

The strategy is underpinned by five principles:

- achieve a balance between initiatives to control supply of drugs and those that reduce demand for drugs;
- harm minimisation;
- community involvement and responsiveness;

- interventions based on best practice;
- staff attitudes and actions are critical to success.

The first key objective to the strategy, **enhancing efforts to reduce the supply of drugs**, includes increasing the number of dog detection teams, urinalysis, and random searching. Random searches have decreased positive drug tests by approximately 18 percent since 1998. There have also been changes to visitor management systems. Prisons have developed procedures to administer prescription medicine, to reduce the potential for diversion.

The second key objective, **strengthening efforts to reduce the demand for drugs** involves providing prisoners with a comprehensive assessment of their drug and alcohol problems; setting up Drug Treatment Units within prisons (such as the Kowhai Drug Treatment Unit); 100-hour “criminogenic programmes”; referrals to community programmes where they are available; and providing AA and NA (Narcotics Anonymous) programmes in prison. In particular, there are new programmes for women prisoners, recognising that most have multiple problems, including a history of abuse and alcohol and other drugs issues.

Lastly, the Department of Corrections is focussing on **minimising the harm caused by drug and alcohol use**. This includes collaboration with the Ministry of Health on the methadone withdrawal protocol (currently only remand or short-sentence prisoners, or those with specific medical conditions, receive MMT); and the pilot programs run in 2003. The six-month pilot programmes gave prisoners information about disease and a health kit.

Future plans include a review of intravenous drug user programmes, clarifying the responsibilities of the Ministry of Health and the Department of Corrections - including reviewing the current Prison Opioid Detoxification protocol - and evaluating current treatment programmes, such as the Kowhai Drug Treatment Unit.

Tim Harding
Chief Executive of Care NZ
Chair of the National Collective of Treatment Providers

Tim Harding began by asserting that because we know that treatment reduces alcohol and other drugs problems, which in turn reduces offending, the real debate is about *how* we effectively treat these problems in the prison population.

Tim Harding’s experience is that the Department of Corrections is committed to addressing problems in the system.

He noted there has been no real evaluation of the effect of *not* treating alcohol and other drugs problems. Community stigmatisation of both prisoners and addicts is fairly strong, and there must be much more understanding of addiction within our communities. We need to increase community’s understanding of the value of treatment *to* the community.

Treatment should encompass not only drug and alcohol, but all areas of a client’s problems - including their behavioural and mental health problems. Problems compound each other, but at the moment are often treated separately. Treatment providers need to collaborate with each other on an individual client basis, so that one area is not left out. Providers are moving towards collaboration, but are still a long way from it; for instance, it’s not clear who has responsibility for people with behavioural disorders, Corrections, Health, or both.

The key to successful “after-care” for people who have received alcohol and other drugs treatment in prisons is accommodation. People in treatment need a safe place to maintain being drug-free, away from other people with addictions or dependencies.

Tim Harding reviewed evidence that individualised treatment and motivational approaches are keys to reducing drug use and abuse among prisoners. A recent National Addiction Centre study of motivational interviewing has shown evidence of its effectiveness, and there should be research on the effectiveness of “brief intervention” in prisons settings.

A recent study of methadone has also been empirically supported, although New Zealand has slightly less opiate-dependent people in prison than Australia. Methadone maintenance should be undertaken in conjunction with a comprehensive treatment plan, and with full knowledge and acceptance of the client. Methadone maintenance therapy needs to be really thrashed out between Health and Corrections on the basis of the evidence.

The work that Care NZ is doing includes two prison-based “therapeutic communities”. They have found that therapeutic communities are effective where people taking part are motivated. Care NZ is also putting in a training programme for new Corrections staff in awareness of alcohol and other drugs problems and effective strategies.

Tim Harding concluded by presenting some key findings from the National Treatment Outcome research study.

Kayleen Katene
Acting Manager for Māori mental health
Mental Health Directorate, Ministry of Health

***Te Tāhuhu – Improving Mental Health 2005-2015:
The Second New Zealand Mental Health and Addiction Plan***

Ms Katene began by outlining the Mental Health Directorate’s responsibilities in the implementation of *Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan*. The plan was released the week before the workshop.

She then introduced two current projects of the Ministry of Health and the Department of Corrections. The first project involves identifying effective assessment needs and barriers to assessment in the general population, then analysing the difference with regard to assessing offenders. The second project looks at treatment services across the country, how these might be improved for the general population and again analyses the differences with treatment services for offenders.

There are a range of problems and issues with treatment services for both the community and for offenders. Due to the high degree of co-morbid disorders among clients, assessment in both addiction services and mental health services must test for co-existing problems.

Although the majority of people with addiction-related disorders do not seek formal help, those who do are faced with vast differences in service delivery across the country, and may have to go on a waiting list. Similarly, in prisons, there are limited resources for drug and alcohol treatment, with many prisoners simply not able to access treatment. To address these, the Ministry of Health will work towards implementing the alcohol and other drugs workforce plan developed by the National Addiction Centre in Christchurch.

Best practice for drug and alcohol treatment involves practitioners taking a multi-model approach. For inmate populations, the most effective treatment appears to be intensive, and addressing a wide range of issues aimed at preparing the prisoner for release.

The Second Mental Health and Addiction Plan aims to ensure that all New Zealanders have the confidence they can access high quality mental health and addiction services. The plan sets out some challenges to the government, one of which is around addiction. The challenge is to improve the availability of, and access to, quality addiction services, and to strengthen the alignment between addiction services and mental health services. There is an immediate focus on broadening the range of services funded for substance abuse problems, gambling services and on building on the expertise of addiction and mental health providers.

Discussion following morning presentations

The issue of switching drugs to avoid detection by urine testing was raised. The Department of Corrections responded that they were not concerned that this was happening in New Zealand prisons.

The discussion moved to the question of where the responsibility of health services in prisons falls; either the Department of Corrections, or the Ministry of Health. The health sector - the Ministry of Health and the DHBs - has the primary responsibility for ensuring that prisoners receive health care, including addiction treatment. However, regardless of ultimate responsibility, this involves Corrections and Health talking to each other, particularly when it's a matter of people "just swapping their beds from treatment to prison cell."

From Corrections point of view, their goals are clear: they aim to reduce re-offending, and their success is measured on this outcome. Despite some very good alcohol and drug treatment services within prisons, some people re-offend very quickly upon release.

Although treatment reduces re-offending, this cannot be the focus for treatment providers; they are there to deal with the drug and alcohol issues not the offending.

The question of harm reduction measures around injecting was brought up. Although Corrections are supportive of harm reduction strategies, and have piloted health kits focussed at educating inmates, there is no indication that needle exchanges will be offered in prisons in the future.

It was asserted that due to the swing back to a punishment model, there are too many people in New Zealand prisons. There needs to be more discussion around the use of incarceration, particularly for drug use. Drug users are people already at risk, who enter a potentially high-risk situation, and often don't have access to the treatment they require.

The final comment returned to the issue of responsibility and resourcing, with the department Corrections emphasising that they are not health providers, and while they are able to provide primary health care there should be no issue about someone receiving health care whether they are in prison or in the community.

Afternoon Panel Presentations

**Anthony Pompallier, Team Leader
Rapai Te Hau, Community Mental Health Worker
Inner City Project, Wellington**

Anthony began by talking about his experience working with youth justice centres in Melbourne in the 1990s, and how this could relate to New Zealand's experience with identification of needs and services for youth offenders. Successes in Melbourne were attributed to ongoing collaboration between the young offender, their key worker, their case manager, and other agencies that could provide the services the young person needed.

Rapai explained that the Inner City Project was the result of identifying a need to fill the gaps current services were failing to meet. The Inner City Project is a collaboration between nine community organisations, and provides a coordinated service for mental health consumers. This includes people recently released from prison who may have difficulty finding accommodation and accessing services.

The project's three focus areas are:

- helping people to access services;
- promoting interagency collaboration, and identifying;
- addressing unmet needs in the community for those with mental health issues.

Having worked with clients to identify their most important needs, they work alongside other organisations to fill these gaps. The Inner City Project provides specific support for problems including physical and mental health, accommodation, finance, debt and benefit issues, misuse and dependence of substances, employment advocacy, and recreation.

One of the most valuable aspects of the Inner City Project's work is their ability and desire to work with people "unconditionally". This means that the clients don't have to have a formal diagnosis, nor do workers need to know the person's history. This is a frustrating part of accessing treatment for clients – the need to tell their story over and over again. Anthony and Rapai agreed that this problem could be solved by collaboration between agencies who deal with the same person.

For the prison population, the emphasis was on providing community support for released inmates well *before* they arrived back into their community.

**Rhonda Robertson
Consumer Advisor, Alcohol and Drug Services
Bay of Plenty DHB**

Access to alcohol and other drugs (AOD) treatment in a prison setting: A consumer perspective

Rhonda's presentation started with two principles:

- that inmates who present with alcohol and other drug problems should have the same level of access to treatment as inmates with physical health needs;
- that consumer perspectives are valid and should be taken into account.

She noted that health consumers' rights to participation are underpinned by legislation, including the Code of Health and Disability Services Consumers' Rights 1996; Alcohol & Other Drug Treatment Sector Standards 2003; and the Health & Disability Sector Standards 2001, which provide for consumer involvement "in the planning, implementation and evaluation at every level of the service to ensure services are responsive to the needs of individuals.

Rhonda Robertson emphasised that the needs of *all* inmates should be met - both sentenced prisoners and remand prisoners, as well as those who prior to their incarceration had not sought treatment. To meet health needs, she argued for:

- wider access to AOD comprehensive assessment;
- greater access to existing specialist treatment programmes;
- full access to opioid substitution treatment (OST).

All inmates who present with alcohol and other drugs (AOD) problems should have a specialist assessment, including mental health, and if needed access to specialised AOD treatment. Currently this is only available at a few centres. To get services many inmates are transferred to another prison, often resulting in them being transferred away from their home town and the support of family and friends.

Rhonda was concerned about the present restrictive opioid substitution treatment (OST) protocol, which provides that OST is only available to:

- inmates with sentences less than three months;
- pregnant inmates;
- inmates who are HIV-positive or receiving interferon;
- inmates given leave to apply for home detention.

Rhonda argued that withdrawal from a methadone maintenance therapy program may constitute "punishing the offender twice". For example, an inmate with diabetes would not be denied their medicine, and a comparison can be drawn with inmates who suffer from alcohol and other drugs problems.

The Corrections system provides an excellent opportunity to actively offer a range of treatment initiatives, such as those offered by Care NZ, as well as providing comprehensive assessments for access to OST programmes such as methadone maintenance therapy (and possibly other therapeutics such as buprenorphine in the future). Rhonda Robertson concluded that the need to provide comprehensive AOD treatment initiatives in the New Zealand prison system is paramount.

Dr Julia Carr
Portfolio Manager, Primary and Community Care
Capital & Coast District Health Board

***Reducing re-offending through best practice in alcohol & drug treatment in prisons:
public health perspectives***

Julia Carr began by giving some pertinent statistics on the current prison population (2003) and the reincarceration rates for offenders. She cited evidence on the extent of alcohol and other drugs problems among prisoners, including:

- drugs offences are the major offence for 18 percent of sentenced females and 9 percent of males;
- the National Study of Psychiatric Morbidity in NZ Prisons (1999) showed that 89.4 percent of inmates have current substance dependence or abuse;

- New Zealand studies show that imprisonment is a significant risk factor for hepatitis C (similar to the findings discussed by Michael Levy)

She noted that an Inmate Health Survey is under way. It should provide more information, but findings are not yet available.

Julia Carr reiterated that we should focus on developing a model of “best practice” for New Zealand. Reducing re-offending is a performance expectation of the Department of Corrections, and alcohol and other drugs problems are a major contributor to reoffending. Focussing on best practice around AOD treatment helps to reduce re-offending by reducing substance misuse, and can also reduce intergenerational effects. There is also increasing recognition of the unmet need, not only for health services, but for the special expertise in managing drugs in prisons and the associated issues and risks.

The current environment offers a number of opportunities. In the health sector these include Government’s growing interest in “managing for outcomes”, and the focus on population health gain and reducing disparities (set out in the *New Zealand Health Strategy* and the public health document *Achieving Health for All*); the new mental health strategy presented by Kayleen Katene; and a Memorandum of Understanding between the Ministry of Health and the Department of Corrections. The Department of Corrections has developed its *Drug and Alcohol Strategy* (discussed by Barry Matthews and Phil McCarthy) carried out a Prison Health Service Review (2002), and appointed a National Clinical Leader for prison health.

Other agencies have increased their involvement in related issues, such as the Ministry of Justice with their Crime Prevention Unit Action Plan, and there is more interest from the Department of Courts, the Ministry of Social Development and ACC. But there needs to be coordinated action to recognise and overcome the barriers to making needed change. While there is rhetoric about a “whole of government approach”, in practice this is hard work for agencies.

There must be a number of conceptual shifts:

- from a punitive focus to a strengths-based/outcome focus;
- from focus on motivated/self aware/compliant clients to recognising the benefits of also treating those with complex needs;
- away from the model of “deserving” versus “non-deserving”;
- seeing equal access to health care as a norm, not a privilege;
- from seeing substance abuse as a moral issue, to seeing addiction as a health problem;
- from a view of offending as an individual responsibility, to working with offending in its context;
- a critical shift to recognise and support early intervention, which means increased focus on short-stay inmates, not only those with high “criminogenic need.”

Discussion following afternoon presentations

The suggestion was made to give clients ownership of their story and history - to carry their records with them. This would increase patient trust with service providers and the belief that they are valued. This idea has been discussed among service providers, but not yet implemented.

Aftercare for prisoners, and specifically accommodation needs was discussed. Corrections reiterated that they were not funded to provide this kind of service, noting that in the 2005 Budget there was a small amount of funding available to trial accommodation, but only for very high risk offenders.

Other ways to help those who need accommodation and reintegration after prison include reducing the stigma surrounding offenders. Best practice should also include recognising the importance of whānau/families and the role they can play in supporting the person, both in prison and upon release.

Discussions

After presentations, the workshop spilt into discussion groups. Each group had a facilitator, and a recorder to take notes for reporting back.

Questions given for discussion:

- What are the key issues the group has identified from the morning's presentations and discussion?
- What opportunities do members of the group see can come out of this workshop to develop or use good practices?
- What opportunities are there to develop collaborations to address issues? (eg. support once person has left prison; sharing research findings)

Discussion group outcomes

The discussion groups reported back on what they considered key actions to be taken. The discussion groups found a number of common themes:

The need to consider drug law reform

- the present legislative system imprisons addicts - but dependence or addiction can and should also be seen as a health issue.
- given the lack of research, it's not clear whether inmates with alcohol and other drug problems are committing serious crimes or minor ones, nor the extent to which their AOD problem may be contributing to their offending or just co-existing - this points to the need for New Zealand-specific research (see below).

The importance of improving collaboration between agencies;

- collaboration between agencies should be a priority, as the first step to achieving other goals - in particular bringing the DHBs into a collaboration on "best practice" health services in prisons.
- there are opportunities for information sharing on sharing on best practice (such as e-mail networks) to bring treatment workers, policy makers and researchers together.
- there should be more opportunity for community and service providers to participate in future policy development.
- the critical time when a prisoner is released – the current focus is on stopping re-offending, not on the person's health.

The need for systematic research to create evidence showing what works in New Zealand

- research has not been funded so far - perhaps because government has not identified it as a priority for research funders - and as a result, New Zealand knows relatively little about effective interventions.
- one possibility is to carry out a case study; for example, target one prison for changes and conduct research on the outcomes, and perhaps compare outcomes between sites.

The need to destigmatise addiction and change community views

- there are two problems - the stigma attached to having a conviction and being imprisoned, and the stigma of alcohol or drug dependence - the combination of the two makes it extremely hard for a person to rehabilitate into the community.
- the public holds contradictory views about prisoners' rights; for instance, apparently liberal people have draconian views about offenders such as serial drink-drivers.
- politicians make stigmatisation worse, as shown in recent political campaigns - is there a way to make them see the cost-effectiveness of alcohol and other drugs treatment for prisoners, and the benefits to their constituencies from treating problems?
- public perception needs to change, and the media has a role to play - several speakers cited the "Like Minds, Like Mine" campaign to destigmatise mental illness as a possible model.

- one key strategy is to reframe the debate – why are these people in prison and not in treatment services? (as people with health problems are barred from driving).

Other issues raised which were not discussed in detail given the time available included:

- short term sentences do not provide opportunities for treatment programs - this particular affects women as the majority of women prisoners are on short sentences, but (as shown in statistics) many have multiple sentences.
- how can we improve the management of people with complex needs? The obvious example is inmates with co-existing dependence and mental health problems, but there are also people with behavioural disorders, intellectual disabilities, not to mention people who are multiple drug users.
- workforce development, both in Corrections and developing skills needed in health providers
- home detention – is it a good access point for assessing and treating people while keeping links to the community? No-one was aware on any research being done on this.
- “best practice” guidelines would need to meet the needs of particular groups in society, for instance Māori and Pacific peoples.

The presenters were asked for their thoughts on the outcomes, and the floor was opened for general discussion.

Discussion on the outcomes

Julia Carr supported the importance of the health sector taking leadership of the provision of health services, and the need to create some cross-DHB action. She mentioned Arohata Prison as an example of innovation and visionary leadership in dealing with alcohol and drug issues in the context of the inmates, and suggested that in the short term we should try and really make it work in a few sites, instead of sprinkling good ideas around the country.

Debbie Gell, National Clinical Leader for the Department of Corrections, noted the need to be clear about what we mean by “best practice”. She supported the need to destigmatise addictions and dependence. She also agreed that treatment is too fragmented, and while it is becoming established that alcohol and other drugs are a health issue, policy makers and service developers can work together better than at present. Debbie Gell welcomed the possibility of collaborative research.

Tim Harding considered that the key over-riding point was the need for drug law reform, as many people are in crime solely because of their dependency issues. Because politicians reflect the messages they receive from the community, destigmatisation must start with the community. There also needs to be a closer look at co-morbidity and complex needs.

Rhonda Robertson restated the importance of consumer participation in the development and evaluation of services - consumers who have been there have a lot of wisdom about what does and doesn't work.

Issues raised in the general discussion

Prison is often not an ideal place to manage many crimes, and decisions about appropriate responses to crime should consider risks and benefits like family upheaval (for example, a significant number of women are in jail for drink driving - is the value of the deterrent sentence outweighed by the effect of imprisonment on their children?).

While imprisonment deprives people of a number of their rights, under law, and conventions to which New Zealand is a party, prisoners have the same rights as the general public to have their health needs met.

There was general support of the value of a campaign to destigmatise dependence and addiction, which in turn might support changes in attitudes the value or support and treatment for people with alcohol and other drugs problems who commit crimes.

Michael Levy's closing commentary

Michael Levy closed by reviewing what he saw as some of the main points raised during discussion, and suggesting some principles for future action.

1) Deprivation of liberty should be a punishment of last resort

There should be an affirmation that deprivation of liberty – going to prison - should be a punishment of last resort. That understanding has been lost. This is manifested in country after country increasing the incarceration of citizens, and disproportionately incarcerating subsections of the community - particularly its indigenous and minority populations.

There needs to be law change about what is criminalised. One ramification of the present system is there are too many prisoners inside; prisons are cluttered. The result is that, if there are people worthy of having their liberty deprived for the safety of the community, they're not receiving the effective programs needed to reduce their offending

Too many people are being swept up by the downstream generational effects of incarceration - for instance, increasing numbers of children having to visit their parents in jail. In Australia, 4 percent of Australian children visit a parent in jail before 16, and 25 percent of the prison population is Aboriginal. The number of prisoners must be reduced, so that those who need programmes can be targeted effectively.

2) Refocus attention on AOD

It is essential to refocus and reapportion responsibilities between the justice and health sectors. For too long in New Zealand, the Department of Corrections has been “carrying the can” for what is an exceedingly complex health area of responsibility. Compassion and therapy is needed, and while Corrections services don't do this well, they're not there to do it well - this should be a health role.

Michael Levy contended that one issue which will refocus society in this dilemma of health and justice is hepatitis C. The epidemic is out of control, primarily because it is so silent. - it is very difficult to identify in the early stage, as there is no specific sero-conversion illness. New Zealand doesn't yet have high rates of hepatitis C, but it will come. In five to eight years, there will be a very rapid demand for treatment services, which will confront the health system. The prisons are the attributed powerhouse of that epidemic.

3) Communicate better what “harm reduction” is

Lastly, Michael Levy noted a repeated theme of the discussions, that the language of the drug and alcohol criminal justice interchange isn't understood by the community. Communities don't understand what “harm minimisation” is and read it as code for something that's very fearful. There must be urgent thought on how to communicate the messages to get the best response and the best outcomes.

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