T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 4 September 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Mark Gepp
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Ms Jan Noblett, executive director, Justice Health, and
Assistant Commissioner Melissa Westin, Corrections Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We will continue on with the hearing of the Law Reform, Road and Community Safety Committee this afternoon. We are hearing from Jan Noblett from Justice Health and Melissa Westin from Corrections Victoria, so we welcome you both. As you would understand, we have been looking at a broad range of issues associated with drugs, drug law reform and drug treatment over a period of time now. Clearly there are a number of issues that have been raised with us that relate to prisons and issues of drugs in prisons, so we are pleased to have you along today to be able to follow up on some of those issues and have some discussions with you.

You would be aware that we have got Hansard recording the discussion that we have this afternoon. After a couple of weeks a transcript of that discussion will come to you for technical corrections, and then it will be part of the public domain after that. In the time that we have got, it looks like you have got a presentation to run through with us.

Ms NOBLETT — Yes.

The CHAIR — That will be helpful, and then we will follow up with questions and some discussion from there.

Visual presentation.

Ms NOBLETT — Melissa and I will variably present on some of the issues that have been raised with us that might be of importance to the committee. So in terms of alcohol and drug services, I thought we would commence by giving you an overview of what is provided in the prison system. Firstly, orientation to all alcohol and drug programs and services is available at each prison. If you do not mind me referring to it as AOD — makes it a bit quicker — AOD providers are required to offer a prison-related harm reduction session, and it is offered to 100 per cent of new prisoners. That provides information about harms associated with substance use in the prisons, it outlines the prison drug strategy, it provides information about pharmacological drug maintenance options in the prison and it provides an overview of the programs available at their location.

In addition to that, 100 per cent of new prisoners receive general health and mental health assessments on reception into the prison, and health service providers are therefore able to make references or referrals to the drug treatment providers within the prison system and detect or discuss any drug and alcohol problems that the prisoner has.

Ms PATTEN — Can I just confirm that they are tested for hepatitis at that point, at that health assessment?

Ms NOBLETT — The screening of hepatitis is a voluntary arrangement, and I can go into —

Ms WESTIN — It is offered.

Ms NOBLETT — It is offered to all, yes.

Upon transfer between prisons — so there is a deal of movement of prisoners between various prisons — again AOD providers are required to deliver that orientation session for all prisoners transferring to different prisons. It is an introduction to the prison to which they have been transferred and a reinforcement of the prison-related harm reduction sessions. Again further health assessments and mental health assessments occur on transfer, so every time a prisoner is received into a prison, a new prison or a transfer prison, they receive a medical assessment.

While in prison prisoners can receive two types of AOD programs. They are loosely called health and criminogenic programs. In terms of the health stream programs, they range in hour or intensity between six, 12, 14 and 24-hour programs. They are psycho-educational in nature to assist participants to identify and manage their AOD concerns. They are designed to increase knowledge of the physical, psychological, neurobiological and social impacts of their AOD use, both short and long term, and they include psychological strategies for managing and coping with withdrawal, self-management strategies and relapse prevention strategies. It is designed to increase motivation to change problematic use, and this is available to both remandees and sentenced prisoners at all prisons. It is probably worth saying at this point that in the 2017–18 budget we received additional funding to increase the number of health stream places by 263 places, again in recognition of the increasing remand numbers.

If I can go to the criminogenic stream, the alcohol and drug criminogenic stream of programs targets the link between drug use and offending behaviour and is designed to reduce the risk of reoffending. This is an important point because that is why remandees are not referred to this program. By its nature it requires the participant to discuss their offending behaviour, which prior to sentence is never advisable from a legal practitioner's point of view.

The criminogenic programs aim to instil participants with knowledge and encourage them to actively address their substance use and offending behaviour. It goes to thinking patterns, belief systems and behaviours that maintain their offending lifestyle. These vary in duration and intensity from 40 to 130 hours, and that is based on what is known of the intensity and targeting the intensity to meet the individual needs. As I said, they are only available to eligible sentenced prisoners who have no outstanding legal matters.

Ms PATTEN — So are all sentenced prisoners eligible?

Ms NOBLETT — Eligibility? Yes, it will be targeted on risk-need-responsivity. So this is about the 'what works' literature that, when it comes to rehabilitation of offenders, has some prominent principles, and we call those the risk-need-responsivity set of principles. There is also an integrity principle beyond that. So programs are more effective when the intensity of the program is matched to the level of risk of reoffending. In shorthand, you do not give your most intensive program to a low-risk offender.

Ms WESTIN — It might actually increase their risk of reoffending.

Ms NOBLETT — So it seems counterintuitive, but when it comes to the literature and what works, it is one of the prominent features of rehabilitation programs for offenders.

Need, which is the second principle, is a focus of rehabilitation effort on what we call dynamic risk factors. We often talk about dynamic risk factors and static risk factors. Dynamic risk factors are those that you have some capacity to change. In criminogenic needs that relationship between substance use and offending is considered to be a dynamic risk factor.

Responsivity, which goes to your question about everybody's eligibility, is about matching program need to match the client's need. Often there is work to be done with offenders prior to commencement of a program to increase their responsivity, and responsivity is about their capacity to participate in a program and their readiness to change. Often you might need to do some work prior to inviting them into a program because they may not have the slightest intention of changing their behaviour. Again eligibility and suitability are not always the same dimension.

Then the integrity principle is about program integrity, which refers to the extent to which the intervention design is matched by the delivery. You might have a lovely program manual, but how well are facilitators keeping to that manual, which is about program integrity? In shorthand — I am giving a very loose description of what is extensive 'what works' literature.

The other range of programs offered — comorbidity stream; again comorbidity is about one or more mental health conditions co-occurring with AOD issues. Individual counselling is offered to those prisoners who are unable to do or are unsuitable for group-based programs. There are some prisoners who would find it very difficult to be in a group, and matching those things is a role of the facilitator — to ensure that they have the most efficacious group that they can run. Individual counselling is often an option in those circumstances or in high-security units where high-security prisoners are unable to mix with other prisoners because of their risk rating or their classification rating.

The IDU reviews, as they are known — identified drug user reviews — where a person has been identified as a drug user, there is a requirement for there to be an IDU review conducted within five days of referral from Corrections Victoria.

Ms WESTIN — That is drug use within prison.

Ms PATTEN — Okay, right, because most of them identify as drug users when they go into prison.

Ms WESTIN — Yes, around 80 per cent.

Ms PATTEN — That's right, yes.

Ms NOBLETT — It is a classification within the prison system — sorry, I will be at risk of using acronyms loosely.

In this case it is the provision of information about the drug-free incentive program and the treatment options available. It is a way of capturing those who are identified as drug users within the system. We also run peer educator programs where they are selected and trained to support delivery of harm minimisation, infection control and treatment options.

Prior to release, all prisoners are eligible for a prerelease-related harm reduction session. Again this one aims to reduce potential harms associated with AOD use following release from prison. It discusses harm minimisation strategies and the AOD support options post-release. We also have prisoners on OSTP — and I have now gone blank.

Ms WESTIN — Opioid substitution therapy program.

Ms NOBLETT — That is right. This is your methadone, yes? They are given a discharge plan, and a referral is made to a pharmacy for OST in the community. Eligible prisoners are funded for 30 days worth of OSTP medication post-release. So the pharmacy sends us the invoices for the OSTP medication.

Ms PATTEN — Do you have data on how well that is —

Ms NOBLETT — I was just thinking about that. I did see some data on the uptake, and I would be speculating on it at the moment. I did see some data but I cannot recall.

Ms PATTEN — Could we maybe get that —

Ms WESTIN — We can take that on notice.

Ms NOBLETT — Take that on notice — so data on the uptake of the OSTP.

Ms PATTEN — Yes.

Ms WESTIN — The post-release OSTP.

Ms NOBLETT — The post-release OSTP. And monitoring of performance — the performance of providers of the AOD treatment is monitored and evaluated through this suite of things. There is contract management, performance measures; there is monthly and quarterly reporting; and there is an audit program run by Justice Health, which is auditing of the performance of the providers against the Justice Health Quality Framework for alcohol and drug treatment provision. That happens twice per year at every public prison site and quarterly at private prisons. That is on the ground, so that is a review of files and delivery of the programs. There are evaluation obligations under the contract arrangements. The providers are asked to provide evaluations of the programs, and we have recently created an alcohol and drug programs assessment panel and we commission evaluations periodically.

In terms of the accreditation of the AOD programs, Justice Health has established, as I mentioned, an AOD program and assessment panel, which reviews criminogenics AOD treatment programs delivered and intended to be delivered in the Victorian prison system. We established that in November 2016, and it provides expert advice to Justice Health to improve the quality of the programs. Our immediate focus, since its establishment, was reviewing the AOD programs for the new correctional centre at Ravenhall as well as the AOD programs run in the other private prisons. The panel will progressively review the AOD programs across all prisons in Victoria.

Ms WESTIN — Corrections Victoria's role in drug management essentially extends to both prisons and community corrections. Our approach is guided by the *Corrections Alcohol and Drug Strategy 2015*. It also includes a lot of elements that we do in conjunction with Justice Health that we have just heard about from Jan Noblett. The focus is essentially on maintaining safe and secure correctional environments and making sure that we get the harm minimisation message and good rehabilitation available to people. The strategy is a blueprint, and the overarching principles are around controlling the supply, reducing demand — which is some of what

we have just heard about — reducing harm and then monitoring the results and innovating going forward. That is broadly what the strategy is about.

At an operational level it is translated into several policies — how we treat the prisoners, how we treat visitors, the programs that we have available and then what we actually do when we have drug-related incidents in our facilities. It broadly goes into how we manage contraband and controlled items, how we do our searching, how we preserve evidence when we find particular contraband in our facilities and drug detection and testing regimes as well, which I will go into some more detail on.

Each prison, including both public and private prisons, is allocated a random general benchmark, and that is a benchmark set by which there are a maximum number of random general tests that can return a positive result to illicit substances. A prison's performance is monitored against those things, and we produce a monthly drugs in prisons report, which is available publicly on our website.

In addition to the broad *Corrections Alcohol and Drug Strategy 2015*, on a needs basis different prisons will actually develop their own local drug strategy to combat the different elements of the broader strategy around controlling supply and demand. Corrections Victoria has also seen a new law, or something introduced into the Corrections Act in August this year in relation to the control of unmanned aerial vehicles, or drones as they are commonly known, to prevent the introduction of contraband into our facilities, and that has also been extended to youth justice facilities.

Drug management in prisons — and this is probably where I will spend most of my time — has a broad range of impacts on how we manage offenders within our facilities. Problems associated with alcohol and drug use can often be exacerbated in our environment, and they relate to the altered behaviours that we can see with people who use drugs in our facilities but also the infection risk, overdose risk and of course the impact on their ability to address their offending behaviour whilst they are in custody if they then go on and continue offending through drug use.

In terms of prisoner management, there are obviously the negative impacts of intoxication, erratic behaviours, violence and the risk of physical assaults within our facilities. We do experience pressure placed on visitors to traffic contraband into our facilities. That is another really important element for us — controlling the supply of drugs into the facilities to remove that pressure on visitors to traffic drugs. It can lead to violence, to standover tactics between prisoners — which is a safety risk not just for the prisoners themselves but also for the staff who manage the prisoners — and to the accumulation of prison drug debts, which again are a risk in terms of violence within our correctional facilities.

Then there are also the risks around unsafe drug use methods — the sharing of needles and those sorts of things, needlestick injuries for staff and of course relapse. A period of incarceration is an opportunity for change, and if people cannot actually remove themselves from that behaviour, then they are at increased risk of reoffending and also increased risk of overdose when they go back out into the community.

Some of the current measures that we use to reduce the supply of drugs into the facility include physical searching of our prisoners and visitors. We also search our staff. We do vehicle searches within our car parks. We have got drug detection dogs. We have also got ion scanning devices in the gatehouses of some of our facilities, camera surveillance footage, intelligence, breath testing and the extensive drug testing that I mentioned earlier. Each of these measures is not necessarily the most effective in its own right. It is the combination of all of these things that helps us address the supply into prisons. When it comes to searching prisoners and visitors, physical searches are an important way of us controlling the supply into our facilities. We conduct searches as part of our barrier control, but we also conduct searches in our car parks and inside our facilities. We use drug detection dogs within our facilities also. They are also capable of detecting tobacco and buprenorphine, which is one of the opioid substitution therapies that we mentioned earlier.

Visitors who are found on prison property with drugs or drug and alcohol related paraphernalia can be subject to bans of up to 12 months. Prisoners can be subject to referral to Victoria Police for criminal matters, or they can also — we call them charges — be held accountable under regulation 50 of the Corrections Regulations. We have both fixed and walk-through ion detection devices in our facilities — fixed in only some, but portable ion detection scanners in all of our facilities. They have the ability to detect both illicit substances — or drugs — but also explosives. Our drug-testing regime within Corrections Victoria involves the testing of 1.25 per cent of our entire prisoner population every week, and the results are measured against the benchmarks that are set for

each individual facility. Those benchmarks are set based on the profile of the prison — you know, its security rating but also the types of prisoners that we have in the facility, like sentenced, remand and so on.

We also do targeted testing of those who we suspect to be actively engaging in drug use. We use a lot of intelligence-led searching and information to target those particular searches. We mentioned the identified drug user program earlier — the IDU. That is for prisoners who have previously tested positive for drugs within a correctional facility. We test 5 per cent of prisoners with an IDU status within our facilities each week. We also do additional testing for those prisoners. When a prisoner has been identified as having an IDU, they are referred to a voluntary program called the drug-free incentive program, where they can expedite the resolution of some of the consequences of their drug use. For example, they lose access to contact visits for different periods of time depending on how many times they have used drugs and which drugs they have used. They can actually, if they participate in the drug-free incentive program, get more regular urine testing and also get themselves involved in some of the AOD programs. They can expedite the resolution of those things.

Ms PATTEN — With the drug-free incentive program, are they allowed to access methadone?

Ms WESTIN — Yes, absolutely.

Ms PATTEN — So they do not have to be drug free?

Ms WESTIN — No. We count that as medication. It is not a positive; it is medication. We may also do additional drug testing of newly recepted prisoners just to get a bit of a baseline for whether it is new use or substances that are still within their system. We also undertake drug testing on parolees based on the orders set by the board and through the case managers. The drug-free incentive program, as I mentioned, is voluntary, and it is basically the prisoner consenting to more random drug tests but also participation in the AOD programs. It essentially means that if they successfully complete that, they can get their contact visits back within a four-week period instead of being subject to bans of up to — it depends on what the substance is — 12 months. It depends on how many times they have been caught using drugs within prison as to how significant the consequences are.

A prisoner may be charged with a prison offence, as I mentioned earlier, under regulation 50 and subject to disciplinary action, which can range from a reprimand through to a full loss of privileges, separation to a management unit, or they can be fined under the Corrections Act as well. Prisoners can be subject to those sanctions if they test positive to an illicit substance but also if they refuse or are unable to produce a sample to be tested.

As I mentioned, the drug testing regime for parolees is actually determined by the adult parole board and managed through community correctional services. The outcome of that can result in further conditions or cancellation of parole. There is a range of sanctions that can be imposed by the board. The same sorts of consequences can also arise if there has been an adulteration of a substance. If our test has come through as inconclusive and we think that the offender has potentially adulterated their sample, then they can be subject to the same sorts of sanctions and, as it says there, in extreme cases the cancellation of their parole.

The CHAIR — Thank you very much for that. In hearing the presentation you have made, you would think that you would have picked up on anybody who was likely to want to bring drugs into jail and you would be unlikely to have drugs in jails, but clearly we have been hearing, you might not be surprised to hear, from a number of people who have presented to the inquiry saying that despite all of these things, drugs are rife, or there is still a significant drug presence in the prison system. This morning we heard from someone from Hepatitis Victoria talking about it. On a number of other occasions we have had presentations about potential needle and syringe programs that should be offered in prisons. I am trying to get a sense of the reality of somebody who comes into prison who is an addict and how they can be supported through the system. There are a number of programs, but they are obviously voluntary, so I presume a number of them would simply either play a bit of a game with some of these programs and not treat them seriously or simply not take part in any of those programs. How do we work our way through a reality-based system in the prisons, or how do you deal with the realities of those people who are clearly addicted coming into the system? You do not have compulsory drug tests when they come into the prison system — is that the way? And why is that?

Ms WESTIN — There is no sanction for somebody who comes into custody with drugs in their system, because we acknowledge that they have potentially been using in the community. What we actually do is say,

'Here are the programs available, and this is how we can help you address these things', rather than trying to catch them out on the way in the door, I suppose.

The CHAIR — But you do not have a compulsory drug-testing system, in which case you would pick up on people who might be ones to watch out for to try and get in the direction of treatment?

Ms WESTIN — No. We absolutely do. The drug-testing program that I spoke about before is not voluntary. Participation in AOD is voluntary, but if somebody is identified either on the random general list or as a target that we have identified is engaging in risky behaviour or engaging in drug-taking behaviour, we can target and it is not voluntary.

The CHAIR — We hear that there are a lot of drugs still getting into prison and a lot of prisoners who are continuing to inject drugs. How is it that we think that they are getting into the prisons for one, and how is it that it is continuing to happen?

Ms WESTIN — You can probably tell by where we direct our efforts as to where we think the drugs are coming into. We will probably never reach a point where there will be — —

I say it like this: prisons are a reflection of the broader community. We see drugs available in the broader community. We will always see people seeking to get access to drugs within our prison environment, so that is why we target our visitors, it is why we search our staff and it is why we do our barrier control exercises and use our intelligence to target that. Of the thousands of drug tests that we do every year, the five-year average is that 4.92 per cent of those are positive to illicit substances.

Ms PATTEN — That is great. Can I extrapolate? I am trying to get my head around those figures. I was just looking at one of the drug reports online, and that one said that 11 per cent of the tests were positive. I am looking at May. It was 12 per cent of the tests, but I do note that there is this other number of 5 per cent. Can you just explain why on monthly reporting you are reporting 12 per cent positive for tests? Yes, I appreciate that we also got the figure that the percentage of random positive tests is 4.2.

Ms WESTIN — Without knowing exactly what you are looking at, I suspect you are looking at percentage positives for targeted testing. For targeted testing we actually consider a high return rate a positive thing —

Ms PATTEN — Absolutely.

Ms WESTIN — because it means that we are actually catching the right individuals, that our intelligence is leading us to test the right individuals.

Ms PATTEN — I appreciate that. I was actually looking at your urinalysis results.

Ms WESTIN — Random general or targeted?

Ms PATTEN — It says random general positive rate — sorry, targeted positive rate.

Ms WESTIN — Yes. Okay. Does my explanation of that targeted — —

Ms PATTEN — Yes, it does. That is completely clear now. Thank you.

Ms WESTIN — The higher that figure, the better.

Ms PATTEN — That is right. I appreciate that. I think the Ombudsman said that 75 per cent of men and 83 per cent of women reported previous illicit drug use. I know the testing that is done is showing quite high recent drug use. What percentage of prisoners, sentenced and on remand, are on opioid replacement therapy?

Ms WESTIN — I do not know off the top of my head.

Ms PATTEN — You do not know? Would anyone be refused it?

Ms NOBLETT — The guidelines are available online — the *Victorian Prison Opioid Substitution Therapy Program Guidelines*. They are designed to mirror community guidelines, so it is anticipated that there is a level of compliance with the eligibility around that. I could try and find some of those —

Ms WESTIN — There have been circumstances where people have been removed for non-compliance, similar to those people in the community who are not compliant with the conditions of being on the program.

Ms NOBLETT — Correct. That does not mean they are removed forever, because it is just about the compliance with the program as per a community equivalent.

Ms PATTEN — Yes. We would not remove someone from a methadone program even though —

Ms NOBLETT — In the community?

Ms PATTEN — In the community.

Ms NOBLETT — It is my understanding that people will be removed for routine and regular non-compliance — that is, and I am not entirely sure, the use of drugs alongside OSTP. I am sure there will be dialogue about it, but there is a point at which it is not possible to continue those.

Ms WESTIN — In a prison context it is more if they are found to repetitively not actually use their dose and sell it.

Ms NOBLETT — And divert it.

Ms PATTEN — Yes, a diversion — understandable.

Ms NOBLETT — So your question was —

Ms PATTEN — I was just interested in what percentage, because I know when I was out at Dame Phyllis Frost there was quite a line-up for —

Mr THOMPSON — Visiting —

Ms PATTEN — Yes, Murray.

The CHAIR — He is always helpful.

Ms NOBLETT — We do have the number of people on OSTP.

Ms PATTEN — Thank you for correcting that, Murray. When I was visiting Dame Phyllis Frost I noticed that there seemed to be a significant number of people.

Ms NOBLETT — So you are after the number?

Ms PATTEN — Yes, I am interested in the number that are on OTSP treatment.

Ms WESTIN — Yes, we can get that number.

Mr GEPP — I have a question if I can, Chair, about the needle and syringe program. We heard from Hep. Vic. this morning, who were very clear. They put forward a number of recommendations to the committee, and one of the recommendations was for needle and syringe program introduction to prisons here in Victoria. I note in your submissions that the framework that currently operates is not conducive to that sort of recommendation. Can you walk us through that a little bit?

Ms WESTIN — A needle and syringe program within Corrections Victoria is not something that is being considered or has been considered, essentially because it has the potential to compromise a safe and secure corrections system. Probably one of the broader reasons for that is in relation to the introduction of a potential weapon into an otherwise sterile environment. I know your next question will be, 'But you find syringes in jail, don't you?'.

Mr GEPP — That was going to be two questions. I will give you that.

Ms WESTIN — It is about not further putting the safe and secure operation of the prison at risk, and it really goes against the rehabilitative framework that we have walked through today. So there is no current policy nor is there in any Australian correctional jurisdiction, from what we understand. There were discussions of a trial

of an injecting room at the Alexander Maconochie Centre in the ACT, which was moved away from in January 2017, and other jurisdictions were watching that one. Since that has been moved away from within the ACT, no other Australian jurisdiction has moved in that direction.

Mr GEPP — This morning they referred to a couple of examples, one in Spain and I forget where the other was.

Ms PATTEN — Switzerland.

Mr GEPP — Switzerland. Are you aware of those programs?

Ms WESTIN — I am not aware of those.

Mr TILLEY — Just briefly, you turn up, you have been sentenced, commence your lagging and go through the process, and in the prison population — putting aside opioid dependence or a range of other things, pharmaceuticals — they turn up with a Webster-pak full of fruit salad. How is that dealt with in the first instance?

Ms NOBLETT — Are you talking about the management of prescription drugs?

Mr TILLEY — Yes.

Ms NOBLETT — That would be one for me. There are controls in place for the management of prescription drugs. In particular we have the justice health quality framework, which requires that there is a safe and accurate supply, storage and administration of medications to prisoners within the system. There are controls in place that follow the Drugs, Poisons and Controlled Substances Act, and each of those providers is to comply with that act and seek a permit for the administration of those drugs, particularly what we call schedule 8 and 11 medications. They are the ones that have the dependency potential and a risk of illicit diversion and misuse. I am not going to go through the names of those.

Mr TILLEY — That is all right.

Ms NOBLETT — Prisoners must attend a medical centre or designated medication dispensing point to receive those medications. They are not necessarily just administered in the same ways, and they must be administered by a registered nurse. Medication registers are kept to ensure that stock is accounted for against an individual prisoner medication prescription, and all providers must have their own medicines advisory and safety committee into which they would report — and to us — any medication errors or any kind of medication issues that arise out of that. So they are well protected in terms of medication dispensing and control.

Mr TILLEY — This is on the premise that prior to sentence they have got a number of prescriptions, and from my own personal observations there seem to be often a significant number of things prescribed. So how, from the time coming into the sentence, are they referred to a medical professional as to whether they actually need those particular prescriptions?

Ms NOBLETT — All prisoners receive a medical assessment within 24 hours. There is quite a lot of discussion with our providers around the use of some of those medications, and often they will be seeking substitutions for those. Typically we get some complaints from prisoners where some of the material that was available to them in the community is not as readily available in the prison as it might have been previously.

Mr TILLEY — Thanks for that. I have a couple of observations. Thank you so much for giving your time. I understand that you are employees of the Crown, but did this submission have to go before the Minister for Corrections before appearing before this committee today?

Ms NOBLETT — It did not have to.

Mr TILLEY — But did it?

Ms NOBLETT — I showed them what I was going to talk to in broad terms, but it was not submitted for endorsement.

Mr TILLEY — Thank you. That will do for now. Over to you, Murray.

Ms NOBLETT — I voluntarily did that, by the way.

The CHAIR — Murray, did you have another question?

Mr TILLEY — I will make another observation. Are the staff in the gallery from corrections or are they —

Ms NOBLETT — Justice health.

Mr TILLEY — They are your staff?

Ms NOBLETT — Yes. They were interested. I hope that is okay. They came out of interest.

Mr TILLEY — Good to hear.

Ms NOBLETT — I just wanted to qualify that it was the minister's advisers I spoke with. When you asked me whether I had had to seek permission for the responses, I had spoken to the minister's advisers about what I was providing.

Mr TILLEY — About what you were providing to the committee?

Ms NOBLETT — Yes. I just did not want you to think it was the minister that I went to. So you were asking about waitlists?

The CHAIR — Yes, that is right. Noting that you do have a range of programs to help people deal with drug problems, I am wondering whether there is a waiting list.

Ms NOBLETT — The providers themselves create what they call a priority list, but it does not equate to a waitlist because it is not related to the Corrections Victoria system, so they are inaccurate in that they have people who have left the prison, so they are not related to the programs, to automatically show who comes, who goes, who transfers. So it is their priority list, and I do not believe they are accurate waitlists, and nor do I have any faith in them to treat them as waitlists. We have introduced a new system in about April of this year called CVIMS, which is the Corrections Victoria intervention management system, and that I think will afford us better access to timeliness of referral and treatment. So at this point I cannot give you a solid answer on wait times for programs.

Ms PATTEN — I suppose that leads onto some of the evaluations like how you evaluate the success of a program. I am assuming — well, not for Ravenhall yet — that recidivism is one of those assessment —

Ms NOBLETT — In terms of the evaluation of the programs, we do a range of things, some of which I mentioned a little bit earlier in terms of the audit program. The audit program will assist us to observe programs against the standards — the justice health quality framework standards — so it goes to both the integrity of the program and its delivery.

Ms PATTEN — Because we will probably not get a chance to go through your manuals, can you give me an idea of what that means?

Ms NOBLETT — The justice health quality framework sets out the standards for service delivery, so that is part 1. Let me just qualify what I am saying. Part 1 goes to the AOD programs and services and what we have provided, which is what I gave you in the first slides around the orientation and the prison-related harm reduction program. It goes to the standards for that delivery, and then it goes, in part 3, to the measurement or performance framework for that. So that is how we monitor the delivery of the programs.

We also have a requirement in the contracts of the providers to provide us with evaluations on an annual basis. Often that will use pre and post testing for those evaluations. We also have the accreditation program itself up-front to deliver on what the program —

Ms PATTEN — When you said 'pre and post testing', what does that mean?

Ms NOBLETT — Often that will go to their criminal thinking, their reliance on drug use and how they have changed that belief system post —

The CHAIR — So a survey or a discussion that is written into the —

Ms WESTIN — It is a clinical assessment.

Ms NOBLETT — It is a clinical assessment, and I think that —

Ms PATTEN — A clinical assessment, yes; it is not an actual drug test.

Ms NOBLETT — No. That will be by program. We have not required the providers to look at recidivism. The recidivism would be a test post release and require follow-up over a period of time, so recidivism is generally two years for re-incarceration. We have not required that of the program providers in terms of evaluation. Recidivism will go to many things. Drugs and alcohol will be but one part of that.

Ms PATTEN — So to know that a program works in a prison we are relying on the self-assessment of the programs. They assess themselves?

Ms NOBLETT — No, it is psychometric testing, I believe, from the providers who will do that testing, because these programs are provided by clinicians, so they will do testing before the commencement of the program and post the program. That is a model of testing for rehabilitation programs that is well-known. In terms of your question about recidivism and the efficacy post release, that would require follow-up research and follow-up with all of those providers post release.

Ms PATTEN — Yes, and that is not —

Ms NOBLETT — Not routinely done.

Ms PATTEN — Yes. I believe everyone is in agreement that drug use is strongly linked to recidivism. I guess I assume that that would be one of the key targets of these programs — to reduce drug use post release, because that would reduce recidivism. But we do not —

Ms NOBLETT — We can commission evaluations that would pick up that broader research. It is a broader research piece.

Ms PATTEN — So I guess it is hard to know what the success of the program is if not using drugs is not one of the KPIs.

Ms NOBLETT — We start with the efficacy of the program and whether it is an evidence-based program that has been validated or in some part accredited in some way. That is why we have the AOD program and assessment panel. The first position is 'Do these follow the evidence of what works?', and what works is about not any program but a well evidenced alcohol and drug treatment program that has probably been validated against other data — not our data, but other data. That is the first position. Then the second question is around the providers providing us with an evaluation of the programs that they deliver, and then lastly we would look at the efficacy of how it is run and how it is delivered. So, no, we do not at this juncture do the recidivism research that you are talking to.

Ms WESTIN — And, as you mentioned, as a measure in and of itself, recidivism is caused by so many things — it is not just the AOD component — so to use that as a measure may not necessarily be indicative of the efficacy of the programs.

Ms PATTEN — Yes, I suppose it would be interesting to note how many prisoners who ended up back in the system had been through the program. To me looking from the outside it would seem like a really evident way of seeing the success of a program was that people did not go back to jail or did not go back to using drugs when they were released.

Ms NOBLETT — Yes, and I think there are multiple interventions for prisoners in the system. They may well also go through the offender behaviour program. They may also do alcohol and drug treatment. They may also have individual counselling. So how to segregate the effect of each of those is complicated. For example, has it been attributed to the offender behaviour program, which is about violence or sexual assault; is it about their alcohol and drug treatment; is it about the case management; is it about their parole supervision and how effective that has been on the ground; or have they got a job?

Ms PATTEN — But if they got a job probably their recidivism rate is probably right down there.

Ms NOBLETT — Or have they got accommodation? So our transition planning goes to seven key critical domains.

Ms PATTEN — When we talk about Ravenhall — and I know we will be paying a private company to provide that service for us — obviously one way of thinking is, 'Well, they don't care about recidivism because they're going to be paid for every prisoner that they take'. Presumably we would prefer that we had a successful rehabilitative program within our jails.

Ms WESTIN — Without being able to speak to the specifics of Ravenhall, they do have a results-based contract, but I do not know how that is being measured.

Ms PATTEN — No, right. Fair enough.

Ms NOBLETT — That is true, and they have a post-release transition centre, so they have a number of variables attached to what they are delivering that is slightly different to the current environment.

Mr TILLEY — As of roughly today's date, do you have available figures on the prisoner population on remand and the prisoner population in the state of Victoria sentenced?

Ms NOBLETT — We do.

Mr TILLEY — I want to lead onto something else.

Ms PATTEN — Some of us have a pedometer on our phones, but you have got to press the counter.

Ms NOBLETT — I have got prisoner stats.

Ms WESTIN — We have got different data on our phones. Just give me a moment. I get a daily email. I have just got to filter through hundreds to find them.

Mr TILLEY — If you can get that back to the committee, just a rough one for today's date, that would be helpful. Where I want to get to is: of the in global prisoner population, how many of those would be currently in the state of Victoria Aboriginal and Torres Strait Islander?

Ms WESTIN — That I would not be able to give you straight off the bat.

Ms NOBLETT — Prisoner population, remand versus sentenced, was it?

Mr TILLEY — Yes.

Ms NOBLETT — And Aboriginal and Torres Strait Islanders.

Mr TILLEY — So remand population, sentenced population and Aboriginal and Torres Strait Islanders.

Ms NOBLETT — Yes.

Ms WESTIN — This is taking a long time to refresh.

Mr TILLEY — Because specifically the question relates to, when it comes to Aboriginal and Torres Strait Islanders here, the committee looking at and certainly part of it being: is there any specific program for Aboriginal and Torres Strait Islanders in the state of Victoria, if there are programs specifically that —

Ms NOBLETT — So all AOD programs, firstly, are open to Aboriginal and Torres Strait Islanders. In 2016 an Aboriginal-focused criminogenic AOD program was piloted in the public prisons, and that program was designed to be delivered by a clinician and an Aboriginal co-facilitator. The program has been reviewed by the Justice Health AOD panel, but the panel recommended that it be reviewed through a cultural lens, and so it has been referred for that further evaluation. We are now looking at rolling out that program more broadly, and the additional funding provided for AOD programs in 2017–18 will enable us to do that.

A couple of other things go to the supports afforded to Aboriginal offenders in prison. One is a pilot program of particular note called the Aboriginal continuity of care pilot. The pilot is designed to strengthen both health and discharge planning for Aboriginal prisoners in recognition of the significant risks facing ex-prisoners, particularly Aboriginal prisoners, on release. That is being piloted in three sites: in DPFC, through Ngwala Willumbong; Dhurringile; through Rumbalara; and GEGAC is doing Fulham. What that program does is prerelease planning, and the prerelease planning is designed to attend the usual discharge appointments — they are in there two days a week per site — and then post release, to support them to get to the Aboriginal-controlled organisations for health support.

So the hope is that we will use the ACCHOs, or the VACCHO network to create a safer and more culturally safe transition from prison to community, because we know that even though we provide discharge summaries and we do discharge planning, some prisoners will bin that on the way out and not take it with them. So then we will be required to provide it post release. We also want to make sure that they get to those appointments.

Justice Health provides cultural safety training to all the health service providers. To date we have provided cultural safety training to 129 health provider staff and 196 mental health staff, again in this territory around ensuring that is culturally safe. I talked about the audit work that Justice Health does. That is done through clinical standards and review officers, and we are looking to trial the appointment of an Aboriginal clinical standards review officer for two reasons: one, to kind of establish what might be culturally safe standards of delivery, an audit tool, and then audit against that tool.

Ms WESTIN — There are 7128 prisoners in custody today: 2226 of those are on remand; 4902 are sentenced.

Mr TILLEY — Thank you. Is there a breakdown for the Aboriginal and Torres Strait?

Ms WESTIN — Not in what I have got here. We can get it.

Mr TILLEY — Thank you.

The CHAIR — I would also be interested to be provided with a figure that says how many are on an opioid replacement program, for example.

Ms NOBLETT — Yes, we have noted that.

Ms WESTIN — We will follow that up.

Ms NOBLETT — Did you want the Aboriginal breakdown? You have asked for the number on OSTP.

The CHAIR — Whether it is broken down or not —

Mr TILLEY — If you are able to, yes, that is helpful.

Ms NOBLETT — I do not know if we have that.

The CHAIR — Just to get a bit of a sense of what percentage of the prison population would be on it.

Mr TILLEY — Of the prison population — and you made mention before of those that have no intent to change their behaviour — have you got any indication of those that have absolutely no intent, when they return to the community after sentence, to correct or participate in any programs, to correct those behaviours?

Ms WESTIN — I could not put a figure on that.

Mr TILLEY — Just indicatively?

Ms WESTIN — It would be pure speculation.

Mr TILLEY — All right; of course. We have to throw it out there. This committee, as you will probably appreciate, will come up with a number of findings and recommendations. Certainly no-one has the monopoly on the good ideas. What do you think this committee would be assisted with? What could be a reasonable

recommendation to make our corrections systems work better when it comes to these matters of drug and alcohol treatment?

Ms NOBLETT — That was a question we had not contemplated.

Ms WESTIN — No.

The CHAIR — In two weeks time can you provide us with a full written answer!

Mr TILLEY — You are at the coalface. Obviously as a statutory body you deal with that with the government of the day, but is there something we can recommend to the government from the exhaustive research?

Ms NOBLETT — I think administratively we are doing everything that you would anticipate and would expect to see and do.

The CHAIR — Is there a funding issue, for example? I presume in terms of running any of the drug-related programs, funding is —

Ms WESTIN — It is probably not related to the D and A space. If you look at the seven factors of our reintegration framework, it is having all seven of those things right in a person's life when they transition back into the community that gives them the best possible chance of not reoffending, and that is around housing, employment and education and social supports and all of those things being right for a person.

Ms NOBLETT — Which is probably what the alcohol and drug treatment community would say to you as well — that AOD is one —

Ms WESTIN — It is one piece of the reintegration puzzle.

The CHAIR — Can I check too, in regard to opioid replacement treatment, is it offered to remand prisoners as well?

Ms WESTIN — Yes.

Ms NOBLETT — It is agnostic of sentence. All of the health services are offered to remandees and sentenced prisoners.

Ms SULEYMAN — Just to probably add to what you have just said in relation to when prisoners are released — the support services — through these hearings we have heard a lot of submissions in relation to there being a real lack of support services in particular in terms of dealing with those prisoners on some form of drugs. So what would be, I suppose, your view? You have just spoken about the seven pillars. I have heard so many submissions talk about how it is a bit of a circle: a prisoner is released and they just find themselves very isolated; there is a lack of housing, lack of support for their addiction; and then they probably reoffend and then are back in very quickly.

Ms NOBLETT — To tell you what is attempted, which is prerelease, there are not too many controls beyond the wall in respect of that, but there is a reintegration pathway through Corrections Victoria, and that is a program to improve the way prisoners return to the community. It has a number of elements. As we mentioned, there are seven critical domains that are attempted to be addressed through that program, and they include exactly what we said: housing, drug and alcohol, mental health, community and family connectedness, education and training, employment and independent living skills. So for complex people, that is quite a suite of things to try to resolve inside the wall.

There are three areas of program delivery. There is a prerelease program called ReGroup, which can be accessed by all sentenced prisoners, so it is available to all, and in that there are information sessions about leaving prison —

Ms PATTEN — Do you know what percentage take you up on that?

Ms NOBLETT — Not offhand. There are numbers, but we can —

Ms WESTIN — We can get them.

Ms PATTEN — It would be interesting.

Ms NOBLETT — So that is available to all. That is the first position. That is also about community correctional services — health, mental health, alcohol and drugs, release-related harm — so it is broad in its scope. For some prisoners, remember, it is a long time since they have been out in the community, so this affords them the kind of information that they would need on release. So it is broad and it is available to all. How many take it up is a separate question.

Direct support can be provided if additional transitional needs are identified in that program. Sometimes it could be day-of-release travel. It could be community engagement and referrals, disability engagement and referrals or state trustees — things of that kind can be run through that program — referrals to legal support and all of the suite that you would imagine. For those who require more intensive support following the ReGroup participation, there is another program called ReLink. There is actually ReLink 1 and ReLink 2. ReLink 1 is an 8-hour program that is delivered by VACRO. Are you familiar with VACRO?

Ms WESTIN — The Victorian Association for the Care and Resettlement of Offenders.

Ms NOBLETT — I do not do acronyms very well, I am afraid, sorry. That is an 8-hour program by people who are providing support in the community. VACRO, I should say, are also part of a ReConnect program, which is the post-release support. ReLink 2 is a 4-hour individual transition support program delivered by VACRO. That is more tailored again, and then there is the post-release program called ReConnect. This is for those who require highly individualised transition planning to address very complex needs. The workers provide inreach support six weeks prior to release. They are trying to engage with the person. That can involve case conferencing with community correctional services; it can involve connecting them to other services. The targeted reintegration stream can provide up to four weeks of assertive outreach post release, and the extended reintegration program can provide up to 12 months of assertive outreach and practical support. So this is very much the hand-holding.

We know that they have picked up prisoners at the gate and have transitioned them to their accommodation. They will actively work on what the first set of priorities are post release that they need to do. It is not available to everybody at this stage, but it does try to target those who need it. In 2017–18 there was additional budget provided over four years. I understand it will provide over 2000 additional places by 2019–20 to support prisoners exiting.

Ms SULEYMAN — Sorry, how many was that? How many places?

Ms NOBLETT — Two thousand.

Ms WESTIN — A further 2000.

Ms SULEYMAN — Can I just very quickly ask: who is it available to? What are the criteria?

Ms NOBLETT — Sentenced prisoners.

Ms SULEYMAN — So is it optional, or is it something that just —

Ms NOBLETT — The first program is available to all, and I think through assessments they identify those who require more intensive support.

Ms PATTEN — Is it available to all but it is voluntary?

Ms WESTIN — The level of intensity is, again, based on risk and need. Those assessed as lower risk and need will get the one that is available to everybody, but the more elements of the reintegration puzzle that they need, the more likely they are to progress into getting the intensive support packages.

Ms SULEYMAN — And is the current funding meeting the need?

Ms NOBLETT — I do not know.

Ms SULEYMAN — I would be interested to know.

Ms WESTIN — I cannot answer that either.

Ms PATTEN — VACRO would say no.

Ms NOBLETT — I also talked about the continuity of the healthcare pilot that we are running. That is also targeted at those people in the Aboriginal community to try and make that more seamless transition. About the OSTP, that is another arm to that transition space. It is worth saying that for exiting prisoners, while they are in prison they will have a discharge summary provided. The health provider will, as far as possible, try and find a GP to refer to. That is not always possible. In the community we will fund those people who are on OSTP for up to 30 days post release. So, again, that is another arm of that transition.

The other thing we are also working on with DHHS is a forensic AOD service delivery model, which is how we might better target those offenders who are on community corrections orders and how we can better target their treatment and the efficacy of their treatment. The vast majority are receiving counselling. Our aim is to try and create a group program and a more intensive program for those who are at high risk of AOD need and at a high risk of reoffending, and moderate as well. We are working with DHHS in the service delivery, and the treatment providers are working with us on that particular project. And by doing so we are hoping to create more of a seamless transition. The ATCs co-ordinate the reintegration programs — the transition coordinators — can make referrals at any time to ACSO. Are you familiar with ACSO? Do I have to go through that acronym?

Ms WESTIN — I do not know the ACSO —

Ms NOBLETT — ACSO COATS it is called. I will get that for you before I walk out the door, but ACSO is the referral pathway for offenders to treatment providers. So prerelease either the transition coordinator or the treatment provider or the health provider can refer to ACSO. ACSO operates as one door, and they do the referral pathway to the treatment providers. So that is a relatively good pathway because in all other respects they have to go into different areas. If we did not have ACSO as a referral pathway, then we would have to go to each treatment area to make a referral.

Ms PATTEN — I just had one quick question. We are rolling out naloxone in a much broader way in Victoria, and there has been significant funding into that program. Is naloxone part of a release program?

Ms NOBLETT — Not currently, and we have been exploring naloxone for a while. I need to find my notes, but my understanding is that the current dispensing of naloxone is with a minijet, and that represents some risk at this point in time. In fact we have subsequently been advised by DHHS that the minijet is not being manufactured any further. They are also describing to us some developments in its dispensing via a nasal spray, so we are watching that particular area, but it is not currently being delivered or rolled out.

The CHAIR — Thank you, Jan and Melissa.

Ms NOBLETT — We have got your requests. I will just go through them: post-release OST update and results; you have got the prison population; it was just the Aboriginal and Torres Strait Islander —

The CHAIR — Yes, and it was also not just post-release OST —

Ms WESTIN — It was the actual numbers of prisoners on OST.

Ms NOBLETT — Oh, yes. Sorry, you are right.

Ms PATTEN — Actual numbers within prisons, yes. And also the uptake of the prerelease integration program.

Ms WESTIN — I have written that down. The uptake of ReGroup?

Ms PATTEN — Yes, of ReGroup.

Ms NOBLETT — Thank you.

The CHAIR — Then Bill's is a two-pager on all the things we need to do.

Ms WESTIN — All the problems we would like you to fix?

Ms PATTEN — It may put them out of a job!

Witnesses withdrew.