LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 17 February 2014

Members

Mr B. Carroll
Mr T. McCurdy
Mr S. Ramsay
Mr J. Scheffer
Mr D. Southwick

Chair: Mr S. Ramsay
Deputy Chair: Mr J. Scheffer

Staff

Executive Officer: Ms S. Cook
Senior Legal Research Officer: Mr P. Johnston
Committee Administrative Officer: Ms K. Martinow

Witnesses

Ms J. Shuard, Commissioner, Corrections Victoria.

Mr L. Tucker, Acting General Manager, Community Correctional Services, Gippsland region, Corrections Victoria.

Mr J. Insana, General Manager, Community Correctional Services, South-east Metropolitan Region, Corrections Victoria.

Ms M. Wood, Assistant Director, Community Correctional Services, Corrections Victoria.

The CHAIR — I welcome you all to this public inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. I am sure you are well aware of the reference, so I will not background you on it. This is a joint parliamentary committee of the Victorian Parliament, the Law Reform, Drugs and Crime Prevention Committee. We were given this inquiry to report back to Parliament in August with a list of recommendations for the government to respond to. We appreciate your time. Firstly, I will get the pronunciations right. Is it Ms Jan Shuard, commissioner?

Ms SHUARD — That is right.

The CHAIR — Is it Mr Luke Tucker, acting general manager, community correctional services, Gippsland region?

Mr TUCKER — That is correct.

The CHAIR — Also Mr John Insana, general manager, community correctional services, south-eastern metropolitan region, and Ms Michelle Wood, assistant director, community correctional services, and you are all from Corrections Victoria. I am not sure of the format. I know that Sandy sometimes provides a list of questions, but I am not sure if you have been given them.

Ms SHUARD — No, we do not have the questions.

The CHAIR — Is there an opening introductory statement you would like to make?

Ms SHUARD — We did prepare a presentation that we thought might give some structure to give some context around community correctional services, but it is only fairly short as we do understand that you wanted mostly to talk to the front-line service delivery people about this issue. If you like, we could go through our presentation and you could stop us whenever you like. It gives a bit of context about the numbers and set-up of our service system. We have focused on community corrections services. You will know that Corrections Victoria has one part of its business that is around prisons and then the other part is the supervision of people in the community. Given the terms of reference for this inquiry, the focus of our presentation today is around community corrections. But if there are other questions that you wish to ask us or ask me, I will do my best to answer them in context.

The CHAIR — Thank you.

Ms SHUARD — Does everybody have a copy of that? Everybody is ready to go? Is it all right to do it like that? On the structure, I will give you a very quick overview of our framework for operations within Corrections Victoria.

The CHAIR — Sorry, Jan, I do have to read you the conditions under which you are presenting or everything you say from here on will be compromised, so please allow me to do this for a minute. Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including the effective repetition of what you said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees?

Ms SHUARD — Yes, I have.

The CHAIR — There is affirmation all around. It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence that they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate.

Ms SHUARD — As I said, I will give you a quick overview of the framework within which we operate at Corrections Victoria, and then Michelle, as the assistant director of community corrections, will talk to you about the community corrections aspect of our business. Then both John and Luke will talk about service delivery on the ground in both the south-east region and the Gippsland region with a particular focus on drug-taking offenders we are asked to supervise.

The first slide goes to our statutory framework. We operate, as you will know, under legislation — the Corrections Act, the Sentencing Act and the regulations. The Serious Sex Offenders (Detention and Supervision) Act, the Mental Health Act and the Disability Act all apply to us in one form or another. Then we have a set of procedures and guidelines that guide our practice.

I guess how that translates on the ground is that we issue the commissioner's requirements and the deputy commissioner's instructions, which will then go out to our service delivery areas that will interpret those in terms of the way that they supervise offenders and manage compliance with the conditions of the orders that are set by the court or the adult parole board. Everybody under community corrections supervision is either on a parole order, on a community corrections order that is issued by the court or on a community work order, which again are only issued by the court or the sheriffs.

The next slide is our service delivery model, which shows our end-to-end service system. We start sat the front end with providing court advice. When an offender is to be sentenced, the court will often ask our staff for advice on the suitability of a community corrections order and more particularly what conditions should be on that order, and they are related to the nature of the person's offending and the sorts of things that led to them being on the order. We have dedicated teams that provide that advice to the court.

Then we have two types of orders for community corrections, being the community work or the fine default orders. We would call those the orders where people get assigned or contracted to a community work site and do community work hours to pay off their hours of work that are required by the court. Then we have the supervised community corrections orders, and Michelle will go through the sorts of conditions in a bit more detail that are related to the individual's risk, need and the order they are on. Then we have remand prisoners — sentenced prisoners — and the next group are the people on parole. Parole supervision is another group again, and it is supervised by Community Correctional Services. That is people who have done the prison part of their sentence and have then been released into the community. The last part is our post-sentence supervision scheme for serious sex offenders.

That is the service system. The policy framework that goes with that is that we operate under an evidence-based offender management framework, and that outlines to our staff the set of practice principles that guide the consistent, system-wide approach to offender management. What those principles basically ensure is that we maintain system integrity, and by that I mean that whatever interventions we provide are based on evidence and are assigned to the person's level of risk and need. We make sure that we are not overintervening in people's lives if they do not need it and that people are getting the services they need to reduce their risk of reoffending.

Our other principle is that we increase self-responsibility — that is, for those people who come to us our job is to teach them how to access services in the community so that support and services can be ongoing even after their statutory obligation has been completed with community corrections.

The last one is that we create the environment so that offenders will participate in treatment programs — that is, we provide good case management and an environment that encourages their participation in treatment, which will reduce their risk of reoffending.

The next slide, if you turn over, is about Community Correctional Services, not about our prison services. You will see the role of community corrections orders. It is, firstly, our statutory responsibility to ensure that offenders acquit their obligations to court. We enforce those orders of the court and manage and facilitate the completion of the sanctions offenders might get, including parole.

If people do not acquit the obligations the court has set for them, then we have to take those matters back to court or back to the adult parole board to take action. Our staff facilitate that process, including by prosecution in court or by providing reports to the adult parole board so that it can then make its own independent decision on whether an offender stays in the community, whether they go back into custody, or, in the case of somebody on a community corrections order, whether or not the court rehears their matter and gives an alternative sanction if they are not able or not willing to comply with the conditions of the order that they have been given.

Our services include our assessments, case management, reducing reoffending programs, and drug and alcohol treatment and testing, although I need to make it clear that we do not provide the drug and alcohol treatment and testing. That is a subcontracted service, both in community corrections and in prisons. We say that we look after the statutory responsibilities of an order. We do the case management. We set the environment so that people will participate in those treatment programs, and then we send them off to the experts to provide the treatment according to their level of risk and need.

Our system overview — there are about 50 community corrections offices around Victoria, organised within an eight-region structure. There are around 9200 offenders under community corrections supervision at the minute, and about 1200 of those are on parole. The rest are on community correction orders or on community-work-only orders. Just over 600 staff work within a community corrections service, and they do both community correction orders, as I said before, and supervise parole.

The parole has the conditions set by the adult parole board, and the new single community correction orders set a range of conditions on it, such as supervision, which is that the offender has to participate in the case management process with our staff. They often have to do community work as part of the reparation or punishment element of the order. They can have curfews and no-go zones. They can be subject to electronic monitoring. They have restrictions on who they can associate with, and they have to participate in treatment aligned to the causes of their offending. That can be drug and alcohol treatment, violence treatment, sex offending treatment and the like.

Michelle is going to give you some more details. There is a map that shows you all of our community corrections offices across Victoria. Not all of our offices are full-time. We run full-time offices in many places — in the 50 places — and then we have other places where we provide advice, to the court or allow offenders to report so that they are not disadvantaged because they are living in a rural community and cannot get to a community corrections office.

If you look at the breakdown of our statistics, it will show you that of the 9200-odd offenders we have, nearly 80 per cent are on supervised orders, with about 14 per cent of that group being on parole, 82 per cent are men and 18 per cent are women. That is a little bit different than our prison population. If you look at our prison population, only 7 per cent are women, so women are twice as likely to get a community correction order than get imprisonment. That 7 per cent population in prison is about consistent with the number nationally as well, so it is not lower in Victoria. Six per cent are Aboriginal offenders, and 22 per cent are less than 25 years of age. The largest category of offences are those against the person, property offences and traffic offences, for people on community correction orders supervision.

Mr SCHEFFER — Can I just ask you: are they the only population breakdowns you have? Do you do it, for example, for religion or language groups or any other subset?

Ms SHUARD — In the community?

Mr SCHEFFER — Yes, because you have gender, Indigenous people, and then you have page — —

Ms SHUARD — No, we do not have the data on people's religion when they are in the community. We do when they come to prison because we provide pastoral care to people in prison, so we have to know how many are identifying as Christian, Buddhist or whatever to provide those services to them. In the community it would be up to them to access those services

through their normal network, so we do not have that. We would have a breakdown on the numbers per region, though, and I am sure John and Luke will talk about the numbers for their particular regions.

Mr SCHEFFER — Thank you.

Ms WOOD — As you will see here, slide 10 indicates to you the numbers of offenders we have that have both community correction orders and parole orders and how commonly we see this condition around drug or alcohol treatment occurring. Of the over 6500 offenders on a community correction order, around 55 per cent currently have a drug treatment or rehabilitation condition, and for alcohol, that is around 46 per cent. You will notice here that of the 1220-odd offenders on parole, the proportion is higher. It is around 90 per cent, but that is also because the way that condition is framed on parole orders currently includes drug treatment, alcohol treatment and psychological, psychiatric and medical treatment, so it is a very broad, far-reaching assessment and treatment condition. That is why that figure is so high for parole and why that condition is being attached to parole orders.

Notwithstanding that, we are very much aware that there is a very high proportion of offenders coming into the prison system with a history, particularly of illicit drug use alongside alcohol abuse. The Victorian Auditor-General's October 2013 report the *Prevention and Management of Drug Use in Prisons* reported that around 70 per cent of prisoners in the system self-reported to have used drugs in the 12 months prior to their entry into the prison system, and of that number 44 per cent were reported to have been involved in injecting drug use. We know that a quite high proportion of those 1220 require drug and alcohol treatment.

Ms SHUARD — I think it is important to point out that the conditions, as they are worded in the order, are for us to get assessment and treatment as required. So our job is to refer people for assessment to the drug and alcohol providers, and then they will determine what sort of treatment is suitable for the individual. That is because they have the expertise, not us. It is not for us or the court to say, 'You require this level of treatment or this dose of treatment'. That is determined by the drug and alcohol service providers. Certainly the parole order will often have on it assessment and treatment, and that will mean we keep an eye on the person and, if needs be, we send them off for assessment to make sure they are keeping on track for testing.

Ms WOOD — I will now take a second to run you through the service framework for offenders with a substance abuse issue. This is quite a busy slide, so if you would like a bigger version, I have it here on an A3 sheet. I will pass those along for you. Basically the best overall summary of this framework is that community corrections has a statewide protocol — a model of referral for assessment and treatment — and we work in conjunction ACSO, the Australian Community Support Organisation, through its COATS program, which is the Community Offenders Advice and Treatment Service. We refer to this as the ACSO COATS program.

It is ACSO that actually undertakes all offender alcohol and drug assessments upon referral from community corrections. It is the ACSO assessors who develop individual treatment plans and broker appropriate services with treatment agencies in the community. The service agreements and brokerage funding between ACSO and community treatment agencies are managed by the Department of Health. This service framework is very much a partnership between the Department of Justice and the Department of Health, between community corrections and the ACSO COATS program.

I can step you through the flowchart in particular, but effectively what happens is that once the court makes an order with a condition around requiring assessment and treatment, then it is the responsibility of the CCS case manager to refer that offender to the ACSO COATS program. We rely on their drug and alcohol assessment staff to make those individual assessments and develop a treatment plan. Having been a practitioner in CCS many years ago, before those statewide protocols existed, I know firsthand how difficult it was as a case manager to scout around local community agencies to access services for an offender and then try to make sure that we had the right kind of services for the needs of that offender. Effectively that is a statewide protocol, which is in place now. It takes responsibility away from the case manager to individually formulate what

that person needs and has someone who is trained in drug and alcohol assessment actually formulate a treatment plan. Centrally, Community Correctional Services works closely with the Department of Health around making sure the protocol that exists between community corrections and ACSO is regularly updated and maintained so that it can deal with issues that emerge over time.

In terms of the responsibility for our staff once someone is engaged in treatment, we do have a direct engagement with the treatment providers along that journey. There is a dialogue that flows back from the treatment agencies to the individual case manager to say, 'Yes, this person is attending', 'Yes, they are participating' or 'No, they are not', and then there is an indication of the point in time at which that person is to be exited from that service, if they are not compliant or when they have completed an episode of treatment.

While the COATS program is there to identify what the service needs to be and then broker a treatment, it is actually the dialogue that runs between the treatment agency and community corrections that needs to continue to run. As I indicated, if there are any offenders who are not complying with those treatment requirements — if they are not attending or are shirking their responsibilities — then that advice will flow back to the APB or the courts, as required, depending on the nature of the offenders' circumstances.

Mr CARROLL — Just on that, Michelle, is all the information updated to a central database?

Ms WOOD — ACSO does maintain a central database, and it reports to us quarterly, or the Department of Health reports to us quarterly, in terms of the number of assessments and a range of other data requirements.

Mr CARROLL — Thank you.

Ms WOOD — In summary, as I have indicated already, this is a highly valued protocol and service model that exists at the moment. We do not provide drug and alcohol treatments in house, as the commissioner said before, and our workforce profile currently does not accommodate this. So effectively our case managers have a very broad job description. As the commissioner has indicated, they have to enforce a broad range of conditions. On that basis, requiring them to have specific drug and alcohol expertise would be a lot to expect of them, but we ensure that they have adequate training in terms of understanding drug and alcohol issues. It is part of our centralised training program, but we also offer opportunities at different times for them to reacquaint themselves with emerging drug and alcohol issues as they come to light. It is part of our arrangement with the ACSO COATS program, that we involve their staff at times in information, presentation and training sessions for our staff around contemporary drug and alcohol issues.

Just as a sideline, I have mentioned in the slides one of the additional features that has been brought into the ACSO COATS program, and this is the introduction of the RAPIDS program. I have put it here to indicate how the arrangement we have has continued to evolve and develop over time. This came into play in January 2012, and it was because we identified issues that were emerging with the gap in time between when an offender was in court and was given an order requiring them to participate in treatment, and the time they actually attended at the CCS location, could get referred for an assessment and then end up in treatment. So there could be quite a gap. Even in a best-case scenario, it could still be a couple of weeks. This was put in place to deal with those offenders who were demonstrating the highest risk behaviours, both to themselves and others, to ensure that COATS was engaging with them on the same day as their court assessment and providing bridging support until they could get into treatment. Again this is just an indicator for us that this has been a very effective partnership between community corrections and ACSO COATS.

Just reflecting on what we know about ice in the CCS offender population, this is drawing from data that is provided to us by ACSO COATS. On slide 13 you can see that ACSO COATS conducted over 6900 individual offender assessments last financial year. In terms of what they were able to report back around a principal drug of concern, we can see that 12.9 per cent were reported in the last quarter of the last financial year as having had ice or methamphetamine as their

principal drug of concern. Putting that in context, we can see that has now surpassed heroin in terms of a principal drug of concern, and while we understand it is growing, there is still an obvious issue with alcohol in terms of the impact that alcohol is having on people's offending behaviour. That is not to say people are not using more than one of these substances, this is just being reported as the principal drug of concern and we know that polydrug use and the combination of drugs and alcohol are obviously very prevalent.

The regions have prepared some information for you in terms of their local observations.

Mr TUCKER — Yes, we have. Thanks, Michelle. I am currently responsible for the Gippsland region as the acting general manager, and we have four justice service centres located across the region, and that is at Morwell, Korumburra, Sale and Bairnsdale. We also have reporting centres, which the commissioner referred to before, and they are at Orbost, Wonthaggi and Warragul. That allows for those offenders who live in the pockets to access our services locally. In terms of offender numbers, we have just over 500 offenders on court orders in the region, and we currently have just under 60 offenders who are subject to parole. We have a profile of Indigenous offenders, particularly down in Bairnsdale and Morwell. The breakdown of the numbers is provided on the slides, but they are certainly concentrated in both East and West Gippsland.

The Gippsland region completed approximately 10 per cent of the state's risk assessments for CCS offenders for both those on parole and those on court orders between the dates of 1 July last year and 31 December. Analysis of that data can be broken down, and I will just summarise it. Thirty-eight per cent of those assessments indicate that the offenders identified some current drug use, and that is across all drug types. Just over 15 per cent had concerns relating to polydrug use where there are three or more drug types they are currently using, and 47 per cent, or just under 50 per cent, of assessments indicated that amphetamine was a drug that was used by the offender. The risk assessment tool that we have does not distinguish between methamphetamine and amphetamine, so I will be referring to amphetamine due to the nature of the risk assessment.

What we do know as well from the data is that just under 80 per cent of the offenders had used amphetamines in the previous 12 months, 60 per cent had used in the month prior to being arrested, just under 30 per cent were using daily and approximately 20 per cent were using weekly. Seventy-five per cent of users indicated their offending was related to amphetamine use.

Mr SCHEFFER — They are not mutually exclusive? So one of the 75.6 per cent could say they were also using alcohol or cannabis?

Mr TUCKER — That is correct. In relation to the delivery or method of use, 39 per cent indicated that they were smoking amphetamine and 36 per cent indicated that they were injecting. Some of the challenges that the region is — —

Mr SCHEFFER — Just before you go on from that, while we are on these statistics, that is the offending, but is this just the offending in relation to possession or does it also relate to offences that they may have committed because of the use of an illegal substance — for example, robbery?

Mr TUCKER — The assessments that are completed are a broad assessment that looks at the psychosocial history of the offender, and where it indicates the offending is related to amphetamine use, it could be for a broad range of reasons. The data is not — —

Mr INSANA — It 'could be'.

Ms SHUARD — This is not related to drug offences. It is related to all offences, and then the offender indicates — so if they have done a robbery, they will indicate to the staff that they have used drugs in the last 12 months, how they used them and what they have used. It is a question that is asked as part of our risk assessment, so we then know what it is we need to do. Offending is a pathway if you like; it is not just an event. We have to know the things that led to the robbery, and that is where we will get that information.

Mr SCHEFFER — Yes, understood, but what I am asking is: do you keep data on that?

Ms SHUARD — This is the data on that.

Mr SCHEFFER — I know, but unless you can point me to it, I cannot see where it says that. The issue we are interested in is the use of the drug and the offence relating to the drug and the connection between that and other offences. I instanced robbery as an example. I understand that it is interrelated and it is a pathway, but I am wondering how that is expressed and how we would find that expressed in the data here or elsewhere. Am I being clear?

Ms SHUARD — If you use some offences, whether you can say it is more related to robbery offences than it is to some other sorts of offences?

Mr SCHEFFER — Yes, robbery or assault.

Ms SHUARD — I do not think we have that data.

Mr SCHEFFER — Perhaps I will leave that on notice and we will move on.

Mr TUCKER — Some of the challenges that the case management staff in the Gippsland region have indicated anecdotally are that there has been an increase in the use of methamphetamine across the offender population, and that has coincided with a drop in the reported use of speed, if you like, or amphetamine, and ecstasy. As indicated before, cannabis and alcohol use remains prevalent across that cohort. Case managers also observed that there has been an increase in methamphetamine being indicated as an antecedent to offender behaviour, in particular there have been observational increases of violent offences where methamphetamine is indicated and they have observed increases in the offender's level of criminality where they have entered the criminal justice system at a pretty significant rate. So it is not just for a minor offence, it might be for a more serious offence, whether it be a serious violent offence or otherwise. They are just observations that the staff have made daily across the region.

Some other challenges that the staff on the front line face are challenges in supervising offenders when they have indicated methamphetamine use. There could be an acute response where the offender attends at a location under the influence of methamphetamine. Depending on the nature of that interaction it could result in various referrals to either area mental health services, ambulance or police if the matter is that acute. There are also situations where offenders are presenting in crisis — they have had a breakdown in relationship, there could be family violence issues and further police contact, with a subsequent breach of their parole or court orders. Another challenge is the reduction in the executive functioning of the offender population. They are using methamphetamines so their ability to remember appointments at the most basic level can be compromised, which can also then result in compliance issues across the court orders or parole orders and subsequent re-entrenchment into the criminal justice system.

Some of the local strategies that we currently have in place to address some of the concerns are we work closely with the Regional Aboriginal Justice Advisory Committee. There is an executive officer in each of the regions who primarily deals with indigenous concerns relating to justice. We work closely with the executive officer in the Gippsland region. We attend regular meetings with her and also the RAJAC committee. We have local justice reference groups that assist with the planning of ice workshops in the region. They have located these justice groups in both the east and central regions of Gippsland and they are currently coordinating some ice workshops strategically located at different locations across the region. There have already been some of those workshops coordinated by other agencies, particularly in Warragul, I believe, and Traralgon.

We have the youth, support and advocacy service director attending and running three workshops across the region. That is occurring before March of this year. Our staff and managers attend regular meetings with local police, and that includes the intelligence units, so we are able to get briefings on any current crime trends and any other analysis that might be helpful and beneficial for the case management of our offenders. We also have regular attendance at meetings with all our support agencies, and that is really to encourage a collaborative, I suppose, wraparound approach to the management of our offenders. That concludes my presentation. It is across to John.

Mr INSANA — Just to give you a little bit of information around the south-east metro profile, we have eight locations in the south-east region, including Victoria's only drug court. On the east side that includes Lilydale, Ringwood and Box Hill and on the south side Moorabbin, Dandenong, Frankston and Rosebud. Collectively we have 2900 offenders reporting. Dandenong is a very big location with 1200 offenders, and Moorabbin, Frankston and Ringwood all have 400-plus offenders reporting to those locations.

In terms of the profile of young and Indigenous offenders we have around 3.2 per cent of offenders who are Indigenous. That equates to around 95. Our young offenders are pretty consistent with what is happening with the rest of the state at around 22 per cent or around 630.

Luke indicated some of the indicators of the prevalence of ice in terms of our risk assessments, and we conducted 1480. Again some of these are similar to the Gippsland experience, so 10 per cent of the region's offenders are current polydrug users using three or more drug types, 24 per cent reported current drug use, with 48 per cent reporting amphetamines as their preferred drug type. Staff identified 68 per cent had reported drug use in the month before arrest; 33 per cent reported daily use and 21 per cent weekly use. This is consistent with statewide data or percentages. In terms of preference of ice usage, 51 per cent reported smoking as their preferred method, 24 per cent injecting, 18 per cent oral use and 7 per cent nasal ingestion, while 76 per cent of identified users reported their offending is related to amphetamine use.

We have looked at the challenges for managing offenders on ice in our region in three areas based on our experiences with drug and alcohol agencies, our experiences and what our front-line staff are reporting, and also from our involvement in various committees. The first one is as an ongoing challenge which relates to sourcing detox programs that will accommodate regular amphetamine use due to them not having a post-management plan. We have also had a number of alcohol and drug providers in the area — and in particular the Peninsula area — that have advised of an increase in presentations of younger clients or offenders using methamphetamine. Most of these are reporting their preferred method of using amphetamine is to smoke it. Some of these young clients and offenders have had no previous drug history. The same alcohol and drug provider has given an indication that the number of clients accessing forensic alcohol and drug services has increased by 61 per cent, so that is fairly significant. There has also been an increase of 56 per cent in the number of clients who have committed a violent offence prior to accessing forensic alcohol and drug services.

In terms of the front-line staff or our case managers who are on the ground supervising offenders on various dispositions, they have reported an increase in the number of offenders who are attending their order obligations. That could be for supervision. It could be to attend community work or it could be to attend some other program that is being run at the location to address their offence-specific needs. During supervision we have seen an increase in the number of offenders who are self-reporting an increase in the availability of ice. They are starting off with little use, and then it is escalating to problematic use and in many cases daily use. They are also reporting that they are using ice in conjunction with other drugs. At the Dandenong location in particular, or the Dandenong government service office, we have had a number of offenders report to supervision who have appeared disorientated. That has become very evident when we are trying to conduct supervision, so in those cases we have had to ring other specialist services such as the ambulance and provide a monitoring role in terms of their health, wellbeing and ensuring that they are safe.

We have also had a number of self-reports from staff that indicate a number of offenders, in particular young offenders, are contravening their orders earlier on. They are forgetting appointments or they might be hard to track down. In terms of our case-management plan, it is imperative for us to get on the front foot and ensure there is timely follow-up. When they miss appointments we try to follow up in a timely manner.

On some of the broader challenges for our region in the management of offenders on ice, there is increasing evidence that the availability of ice across young peer networks poses a significant barrier to those young offenders remaining abstinent, especially post-withdrawal. We have local alcohol and drug forensic service providers that are often taking daily referrals for those involved

in methamphetamine use and trafficking, and feedback from these agencies suggests that manufacturing is occurring within the region. In terms of accessibility, it is very easy to get ice.

We are part of a number of committees. One of those is the integrated family violence partnership, which we have been involved in for a number of years. A number of members of that committee are reporting that when the perpetrator is using methamphetamine there is an increase in aggression, an increase in deaths, an increase in criminal activity involved in the recovery of the debt and an increase in drug-induced psychosis and self-harm behaviour as well.

In terms of linking some of the challenges and strategies in the region, some of these are in the early formative stages. Luke has mentioned some of the collaborative work between the Regional Aboriginal Justice Advisory Committee and our staff to provide culturally appropriate referrals. Again, it is about linking up with Koori workers and Koori organisations so Koori offenders can receive appropriate cultural drug and alcohol counselling. We have had one of our forums facilitated by a Koori elder. We had 60 community members attend in the Healesville area and that was supported by Anex and Eastern Health. Again that is around collaboration, raising awareness and having a look at some place-based initiatives for Koori offenders who are currently using amphetamines.

We have a local alcohol and drug provider who will be attending one of our next management meetings to start to talk about the progress of Matrix, which is a pilot cognitive behavioural therapy program, and again that is in its infancy stages. This is with offenders or participants who are using ice. It is at the Drug Court of Victoria. We have initiated collaborative meetings between our staff and some of the youth services, such as YSAS in Dandenong and Frankston, and we have invited YSAS to spend a day or two working at the location trying to look at opportunities to work better with those offenders, in this case particularly young offenders. We have also instigated regular meetings with Victoria Police senior management to try to gather more intel around the manufacturing of amphetamines.

The CHAIR — Thank you. I might just ask a couple of questions, one of Luke and one of yourself, and I will do the best I can given the conditions under which we are operating this afternoon — my brain is not acting as well as it should because it must be nearly 90 degrees in this room!

Mr INSANA — Yes, it is a bit warm.

The CHAIR — So I apologise. I do not know why a government building cannot provide adequate air conditioning, but that is a challenge we always face in this building.

I just want to get a picture, Luke. We had evidence down in Traralgon that suggested there was quite a lot of trafficking going on in the prison down there, and according to the statistics about 70 per cent of those presenting to a correctional facility are on drugs or have used drugs, as distinct from those out on orders or on parole — I am talking about those in the system itself. They are going in there with a history of drug use.

Ms SHUARD — That is right

The CHAIR — So you could only assume that it is a melting pot of drug trades through the system itself. I understand there is no real work going on within the prison itself in relation to trying to reduce drug dependency apart from the fact that they cannot get access to it unless it is illegally coming through the system. So you spit them out at the other end on parole or on orders and then they go through a number of programs that you have outlined here. From our point of view our inquiry is looking at supply and what recommendations we can look at in relation to law enforcement on that side as against the harm minimisation or reduction at the other end and where in the prison system we can try to reduce access or trade going into the system whereby the work that is needed to be done outside the system can be reduced. It was suggested to us that it actually trades quite fairly in the correctional prison systems. You would expect that given the high percentage of drug-related prisoners. Can you suggest a means by which to reduce access flow into the system and out?

Mr TUCKER — That is probably a question better directed to the commissioner given that my responsibility as a general manager is with community corrections and ends there.

Ms SHUARD — Yes, you are right, 70 per cent of people reported having used drugs in the last 12 months before they came to prison and 44 per cent of those had injected drugs before they came to prison. You are right, there is that. We are dealing with a very high drug-taking group of the population, but then we know that and we have a drug strategy to deal with it across the system. Just because somebody comes into prison, it does not mean that their desire for drugs reduces. We have to work to make that desire for drugs reduce.

The first thing is that we have a range of strategies. One is managing supply, so we make sure that we have good intelligence systems to know if drugs are getting in, how they might be getting in and the like; so an intelligence system. We have targeted searching. We have really strong barrier control with a range of technologies that identify if people are coming through the gate with drugs, and we have a range of searching. So managing the supply is the first part of it.

We have a very extensive drug testing program. Around 26 000 random general drug tests were conducted in 2012–13, and of those around 5 per cent came back positive, so it is quite a low rate when you consider that you are dealing with a population of which 70 per cent reported to have used drugs before they came into our system.

We have another range of tests. Those are not the only tests that we undertake. That is random general, and we have a random general number of tests every single week where names are virtually computer-generated that will get drug tested across the system. No-one knows who it is going to be or where it is going to be, but that number is across every prison, and that is the random general test, which is 26 000.

And then we conduct targeted tests, so if there are any indications that somebody might be using drugs, and there can be a whole range of indications — it can be their behaviour, it can be intelligence-led, it can be testing or it can simply be a group in a unit that seems to be doing a lot of swapping of property and the like — then we will target test that group of people as well.

That is the first arm of our strategy. The second arm is managing demand, if you like, creating a healthy-person environment where people will have other activities, rather than concentrating on using drugs. What you are trying to do is develop in the offender group awareness that there are other things that you can do to control your drug taking. That is about treatment. It is about assessment and it is about going to treatment — we contract out our treatment services in the prison. We also run the opiates substitution program for those people who are addicted to particular sorts of drugs, and so that is another part of it.

We run different levels of treatment, depending on the person's level of addiction or need for drugs across our prison system. That can be the full criminogenic programs that we run at Marngoneet prison to have people come off drugs or the other programs, such as the educational programs that we run across all our prisons.

Aside from that, we also have harm reduction programs. We teach people about the harm that will be caused through using drugs, and how it led to their offending behaviour and the like. There is a whole range of activities to reduce the use of drugs, the supply of drugs and the harm caused by drugs within the prison system.

For people who use drugs in the prison system there are pretty severe consequences. We have what is called the Identified Drug User program, and if you bring about dirty urine in the prison system, and we know that you have used drugs, you become what is known as an Identified Drug User status prisoner, and you lose your contact visits. So you are then not able to have the normal contact visits with your family; you have to have a box visit. They are legally entitled to a visit, but it is a box visit behind a barrier. Those people are tested more frequently than other prisoners, and they are offered treatments. So it is not just a punitive approach, it is also a treatment approach. If over time their tests come back without showing any evidence of drugs, they can earn back some of those things like contact visits. They cannot move to, or should be able to get shifted from, our

open camps if they use drugs. There are all of those things across the system, and many more, to reduce the amount of drugs that come in.

The CHAIR — That will probably lead to another question from my colleagues. Before you go, Jan, I am not sure whether this is where you were heading before, but you were giving us data about those on court orders who are affected by drugs. I am trying to relate that to the actual crime. How many are drug-related crimes? We have the stats around meth drugs, but what about the crimes themselves? How many are related to the drug? You have identified drug users, but we have not got the connection with the crime, or did I miss that bit?

Ms SHUARD — We will only know that if the prisoner tells us. People are not often charged with using drugs. When they come in, what they will tell us is what their offence pathway is. One of the things you explore in treatment is the offender's offence pathway. You assume people do not wake up one morning and decide to do some heinous crime — rob a bank or the like. You assume there is a pathway in their life that they go through and it ultimately results in them breaking the law in a serious way. It is through that information that we know it is related to drugs. Perhaps they will tell us they started using drugs socially — —

Mr SCHEFFER — Sorry to interrupt you — I am conscious of the time — but just to pursue this: I think we understand the narrative, but the question is whether that is available in summary form, a tabulation statistic or some kind of cut of that so that it can be pictured properly? I am asking that question completely naively because I do not know how this would be presented.

Ms WOOD — Are you asking whether we are able to provide information on drug offences? How many offenders are on orders for drug offences as opposed to — —

Mr SCHEFFER — No, we are interested in that link between the pathways; as the commissioner said, how a person ends up using or is using, and the interconnections between that at various points in that pathway with criminal offences.

Mr INSANA — The types of offences.

Mr SCHEFFER — People have come to this hearing and we have heard them say that a relative, a friend or a son was involved in drugs and then they started stealing, started doing jobs, vicious assaults and stand-overs — they interact. What we are trying to elucidate is what that looks like in a form that we can understand, what the patterns are. That is all we are asking.

Ms SHUARD — And the types of offences? Are you asking whether it is particularly related to violent offences, stealing offences or offences against the person?

Mr SCHEFFER — Yes, exactly.

The CHAIR — We have heard plenty of evidence that crystal meth is cheap, accessible, traded and profitable, and that there consequences of its ongoing use. We would like to know how that is related to violence and armed robbery, which is a means to raise money for the payment of the drugs. We are trying to work out the connection between the crime itself and the history of the person committing the crime. We know they are on drugs. They are now committing a crime that because of crystal meth is more violent in nature, or more specifically, in relation to armed robbery, will create the means of generating cash for more drugs, as against the traditional heroin users and cannabis smokers who might not engage in that sort of activity. Perhaps we will say in our report that the increase and prevalence of crystal meth in our communities actually lead to an increase in crime, which shows more violent behaviour, more armed robberies or more family violence and so on. That is where I was heading. I am not sure if that is where Johan was going.

Ms SHUARD — I am not aware of any research that has been done around that area, but Michelle might be.

Ms WOOD — No, I am not aware of it. We might need to explore whether we can look at a couple of our data sources and lay them across each other and see the clarity of the picture that emerges from that. Now I think we understand what you are asking for, so we will need to explore

whether our two separate streams of data can potentially cross. They may not be able to, but we will explore that.

Ms SHUARD — I think what we will have difficulty doing is identifying a particular sort of drug related to a crime. Like I said before, we can say that 70 per cent of people who come through our system report using drugs. I suspect we would be able to say what percentage of drugs are related to their offending. Whether you can granulate it down to it being methamphetamine that is related to it or it is alcohol or the like will be the difficult bit.

Mr SCHEFFER — That pattern would at least give a kind of associative relationship if not a causal link.

Ms SHUARD — Yes. I will look at what research is available.

Mr SCHEFFER — My question relates to your presentation, John, and it is to do with Indigenous services. We have heard from other witnesses, relating not only to what is going on in Victoria particularly but nationwide probably, that there is a lack of targeting, a lack of responsiveness, a lack of resourcing — you have mentioned the lack of detox services — and a failure to really connect with an Aboriginal perspective and experience, and you talked about culturally appropriate strategies. We understand that it is going on but the evidence that we are getting on the other side is that it is not working. I am wondering if you could point towards a service that is specifically engaged with the Aboriginal community that, in the eyes of the users of that service, is doing a good job, that we could perhaps talk to?

Mr INSANA — Again from our experience in the south-east, there is probably one agency that you may want to engage with. It is based in St Kilda and deals predominantly with Koori clients and Koori offenders. That would probably be the agency most suited to answer some of those questions. I am happy to provide the details of that agency. They provide one on one and also provide detoxification for Koori clients. They work on some of that post-treatment plan. What I am not able to tell you is whether there is a pattern or treatment pathway that distinguishes between various drug usage. That is something that I would have to take on notice and follow up. They are definitely well equipped to deal with Koori offenders and Koori clients who, as part of their treatment plan, require some kind of intervention. They are situated in St Kilda, and we refer a number of our Koori clients to that organisation.

Mr SCHEFFER — When we run our eyes over the statistics, it is clear that we are not getting it right when it comes to Indigenous communities. That is the signalling we are getting. It is very difficult to work out where you go next and what the non-Indigenous community and service providers are not able to understand about service delivery. That is the struggle.

Mr INSANA — Again, through our initial workshop that we had at Healesville, there was some acknowledgement of that. Part of that forum was around raising or increasing the awareness of the prevalence of ice usage and then the next part of that is to find ways or a mechanism to work together potentially where we can have some services across all the organisations including the drug and alcohol organisations because I think there are some shortcomings if organisations are working on this with a solo mentality. The work required is to collaborate and work together. I can provide you with details of that organisation, and I am happy to do that.

Mr McCURDY — You seem to have really good data. By the time they become your clients they probably have limited options. When we have listened to the ambos, and even right through the hospital system, they cannot tell us what they are on. They know they are on drugs. I am grappling with this voluntary rehabilitation that they can choose or the involuntary rehabilitation. Now you are going down that path. I suppose I am looking for some middle ground. Are you aware of anywhere, even in other places in the world, where people do not have to get to that phase? We have had ice users tell us that they were pleased to get to jail, that it was their opportunity to get off it. Are there any thoughts of a middle ground before they get to corrections? Obviously there is voluntary rehabilitation and then there is when they get to you guys.

Ms SHUARD — I think some things like CISP — the courts integrated services program — are somewhere in the middle. They are before the court actually delivers a disposition, and people can be encouraged in a way to go and access treatment or go to a drug withdrawal centre and the like.

Mr McCURDY — As in the Dandenong Drug Court?

Mr INSANA — The Magistrates Court. But a CISP operates from a number of courts, including Melbourne, Sunshine, Dandenong and Latrobe.

Ms SHUARD — I guess there is some lever there that encourages the offender, because if they do well and go in there and can go back to the court and demonstrate that they have withdrawn or had treatment or have come off the drugs, then that can often be viewed favourably by the court. They still get sentenced for their offence, but it can sometimes be the difference between getting a community corrections order, which means you stay in the community and are supervised and maintain that contact with the treatment provider, and the alternative of going to prison. If you are still in a state of crisis and are not giving much confidence to the court that you can do something about it unless you are in an environment where there are no drugs available to you.

There is a paper I have here that might be helpful regarding the relationship between drug offending and the types of drugs used. It is from the Australian Institute of Criminology. It is titled 'Drug use among police detainees: a comparative analysis of DUMA and the US arrestee drug monitoring program'. It was done in 2012. It suggests that as many as 52 per cent of criminal charges may be attributable to substance abuse, and then it breaks down the sorts of drugs they are talking about. That might provide some information in relation to what you were saying about the absolute connection between the use of drugs and what they are getting picked up for.

The CHAIR — Thank you, commissioner. The AIC are helping us with this inquiry. We were up there on the weekend in Canberra. I did not pose that question to them, but given there is a paper, I probably will.

Mr CARROLL — Thank you for your presentation. It was really good evidence. Since the Auditor-General handed down the report last year looking at drugs in prisons there has been a bit of debate in the media and in the Parliament about the benefits of a needle and syringe program, given the existence of blood-borne viruses and the rates of hepatitis C in prisons. Do you think a trial would be worthwhile? Have you seen any evidence from interstate or overseas that suggests an NSP could have some benefits above and beyond what is happening at the moment? I know you do bleaching, and there are all sorts of options available in prison. Are we getting to the stage where these high rates of blood-borne viruses are needing a stronger program?

Ms SHUARD — It is a difficult one for a prison environment, because on one level you would say the introduction of a needle exchange program in prisons is in some way endorsing the use of drugs within a prison environment. That is a difficult one for us because we have a no-tolerance approach to the use of drugs in prison. That is not a punitive approach. The use of drugs in prison creates a whole range of other issues for us to manage, quite apart from the matter of addiction. There will never be enough drugs to go around. If 70 per cent are users before they come in, you would never have enough to go around. Therefore you have things like a hierarchy, standover men and people controlling your drug trade and controlling other people within the prison environment. Much of our activity is about maintaining a safe and orderly environment so that people are not stood over or assaulted and so that other things are not traded in exchange for drugs. My thing about introducing a needle exchange program is that in some ways it endorses that, and then you are endorsing all those other illegal activities that have to occur to get drugs in prison. That is one part of it.

The second part of it will always be an emotive issue with prison staff because of their safety and because of the search procedures they are required to do to keep it safe. They worry about needle-stick injuries and the like. I know that it can be argued that needlestick injuries can be a possibility in a prison in any case if people get needles in, but we are talking about maintaining that at the smallest possible level. It is a very difficult public policy issue. I would much prefer to have

health programs that teach people about harm minimisation, that address blood-borne diseases and the like and that encourage people to live lives without having to use illicit drugs and have a needle exchange program.

The CHAIR — Do you think the judiciary sees better value in putting a person who has committed a crime that is drug-related on an order outside the system rather than jailing and interning them for a lengthy period? We might ask, if you do not mind, a question on notice outside this hearing to you about services within the prison system. I am not saying that you can speak on behalf of the judiciary, and I would not ask you to do so, but there seems to be a view from some of our witnesses that they have gone a bit soft on drug-related crimes and drug-related activities. I am just wondering if maybe the judiciary sees better value in keeping them outside the system in those programs that are available, on orders or parole, rather than getting them into the mishmash of prison life and all the things that it has to offer.

Ms SHUARD — Our job is to make sure that the judiciary is well aware of what services and programs we provide, both in the community and in the prison environment. I think the judiciary will sentence based on the nature of the offence and whether or not it warrants imprisonment or staying in the community. They are two very different levels. If you can keep somebody in the community, then all of those other things — like further breakdown in family relationships, loss of job, not being able to get a job in the future — are not impacts on somebody's life. But if the crime is such that they deserve a term of imprisonment, that is what the judiciary gives them.

Our job is to make sure that people get access to the right services and the right programs, and that when it comes time for the adult parole board to consider whether or not they should be released that they have done all those programs and they have been given the best chance to transition back into the community safely, and have learnt something from being in prison, have learnt a whole range of things and have better skills to be able to survive. I suppose my answer is no, I do not think of it in that way.

The CHAIR — On behalf of the committee I thank all of you very much for your time this afternoon. We appreciate it.

Witnesses withdrew.