



Drugs in prisons

Principal findings

- ◆ Prison inmates continue to use drugs. The drugs are smuggled into the prisons by visitors, who pass them to inmates during contact, usually while kissing. As noted in the *Australian Illicit Drug Report 1997–98*, drugs and syringes are detected in greater numbers inside prisons than at the visitor barrier.
- ◆ The available data on searches and urinalysis show that pharmaceuticals and cannabis remain the most detected forms of contraband. There was a decline in the amount of cannabis detected in 1998–99, but the amount of heroin, amphetamines and pharmaceuticals detected increased.

Background

This chapter incorporates responses to questionnaires from the following public and private prison providers:

- the New South Wales Department of Corrective Services
- the Office of the Correctional Services Commissioner, Victoria
- the Public Correctional Enterprise
- Australasian Correctional Management (Fulham Correctional Centre)
- Group 4 Correction Services (Port Phillip Prison)
- the Corrections Corporation of Australia (Metropolitan Women’s Correction Centre)
- the Queensland Corrective Services Commission
- the Ministry of Justice, Western Australia
- the Department for Correctional Services, South Australia
- Northern Territory Correctional Services
- the Department of Corrective Services, Tasmania.

All references to responses from ‘jurisdictions’ refer to responses from these various correctional services, not responses from police services.

The statistics provided in this chapter are supplied by the jurisdictions. In some cases this data was unavailable in the format requested and there may be double counting given that private correctional providers are asked to supply data which may have already been included in the jurisdictional response.

The Australian prison population

Table 8.1 shows there were 20 504 prisoners in Australia in the quarter to June 1999. Of these, 19 257 (94 per cent) were male. New South Wales held 35 per cent of the national prisoner population (7127) and the Northern Territory has the highest imprisonment rate, at 476 per 100 000 adults—76 per cent of the Territory’s prisoners to June 1999 were Indigenous Australians.

The Australian Bureau of Statistics provides a breakdown of the prison population by type of offence—see Table 8.2. The data record the most serious offence rather than all offences, so the categories do not show all drug-related offences. People are gaoled for criminal offences, and it is not surprising that criminal behaviours such as drug use and trafficking occur in prison. Inmates use drugs out of habit or to alleviate stress or boredom.

The use of drugs in prison affects people on either side of the prison walls and compromises the security of the facility and the safety and integrity of staff. It prevents the rehabilitation of inmates by reinforcing criminal behaviour and increases the risk of spreading hepatitis C and HIV. Family and friends are compelled to finance, purchase or smuggle drugs and inmates risk becoming a source of infection to the wider community on their release.

Trafficking in prisons

All respondents to the Bureau’s 1998–99 prisons questionnaire reported drug trafficking in their facilities. New South Wales estimated that 80 per cent of inmates were either in custody for drug-related offences or were drug affected or drug dependent at the time they committed their crime. South Australia reported that random urinalysis ‘consistently indicates that approximately 30 per cent have used drugs in prisons’ (Department for Correctional Services 1998, p. 9). The demand for drugs is high inside prisons.

Production of drugs in prisons occurs on a very minor scale. New South Wales reported some cannabis plants grown at facilities surrounded by bushland or where the plants can be concealed in tall grass. The Public Correctional Enterprise (CORE)¹, Group 4 Correctional Services (Group 4), the Corrections Corporation of Australia, and South Australian and Northern Territory authorities reported incidents of ‘home-brew’ (alcohol) manufacture. Australasian Correctional Management, Western Australia and Tasmania reported no instances of drug manufacture or production.²

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

Most respondents reported that drugs are paid for through bank and TAB accounts. An agreed amount of money is transferred into a designated account in return for drugs being supplied to an inmate. No corrective service has legislation allowing it to scrutinise private bank accounts and so monitor this activity. New South Wales, CORE, Australasian Correctional Management, Group 4, the Corrections Corporation of Australia, Western Australia, South Australia and Tasmania can refer their suspicions to police to make further inquiries into bank accounts.

Organised trafficking in prison

Most corrective services reported some level of organisation for drug trafficking in prison by individuals and groups. The groups most commonly identified were Vietnamese, Indigenous Australian and Middle Eastern groups. South Australia reported that trafficking was normally organised by small groups, but that no particular group had been identified. The Corrections Corporation of Australia reported that trafficking appears to be organised in a random manner. CORE reported that trafficking was not restricted to any particular ethnic group or any particular gang. Tasmania reported that most trafficking is organised through friends and families of inmates; similarly, Western Australia found no evidence of gang involvement.

Table 8.1: The Australian prison population, 1993-94 to 1997-98

Year	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99
Number	16944	17428	18193	19082	19906	20504

Source: ABS (1999).

Table 8.2: Type of drug-related offence leading to imprisonment, 1993-94 to 1997-98

	1993-94	1994-95	1995-96	1996-97	1997-98
Other	88.5	88.9	89.7	90.2	90.8
Possess/use drugs	1	1	1	1	1
Deal/traffick drugs	9.1	8.8	8	7.6	7
Manufacture/grow drugs	1.4	1.3	1.3	1.2	1.2

Source: ABS (1996, 1997, 1998, 1999).

Note: Victorian figures are the combined results of CORE, ACM, Group 4 and CCA Data for New South Wales is unavailable.

The Information and Intelligence Sharing and the Infrastructure and Prisoner Management Workshops were held in Brisbane in December 1998. The Gangs Project Team of the New South Wales Corrections Intelligence Group presented the results of a study into ‘gaol-based gangs’. It concluded that ‘there was sufficient intelligence to suggest that “gaol-based gangs” do exist’ (Department of Corrective Services 1998, p. 4).

The study divided gangs into two types: security risk groups and gangs. Security risk groups, which are ethnically based, pose a management dilemma for corrective services. They form partnerships that affect the security of a facility and they fight between themselves over power and drugs. This can result in assaults on inmates and staff and can sometimes spill over into the wider community. Attempts by prison authorities to deal with problems on a group basis run the risk of being labelled racially discriminatory.

Members of external gangs—for example, outlaw motor cycle gangs, Asian-based gangs such as the Vietnamese 5T, and Middle Eastern, Colombian and Romanian drug cartels—have an established framework for continuing illegal activity inside prison. These gangs, known to act covertly, can use contacts outside gaol to intimidate inmates’ families into bringing drugs into prison.

The study concluded that effective management of gangs depends on timely information sharing between prisons and external agencies, to identify gang members upon entry to gaol or as close to reception as possible. This gives prison management time for contingency planning. The study also concluded, ‘Much of the current unrest in NSW gaols has a direct link to ethnic tension caused by friction between different factions within the system. The common factor in much of this tension is drugs and the battle for control, sale and distribution within Correctional Centres’ (Department of Corrective Services 1998, p. 14).

It may be that the role of external gangs in the prison drug trade is underestimated because of the gangs’ covert practices. This may account for their limited mention in the responses to the Bureau’s 1998–99 questionnaire. ‘[Gang members] have an implied status upon incarceration because of their external associations and are known to be covert in their activities’ (Department of Corrective Services 1998, p. 11).

Detection

All respondents reported using a variety of methods to detect drugs—random and targeted searches of visitors, inmates, cells and facilities; drug-detector dogs; urinalysis; mail screening; and

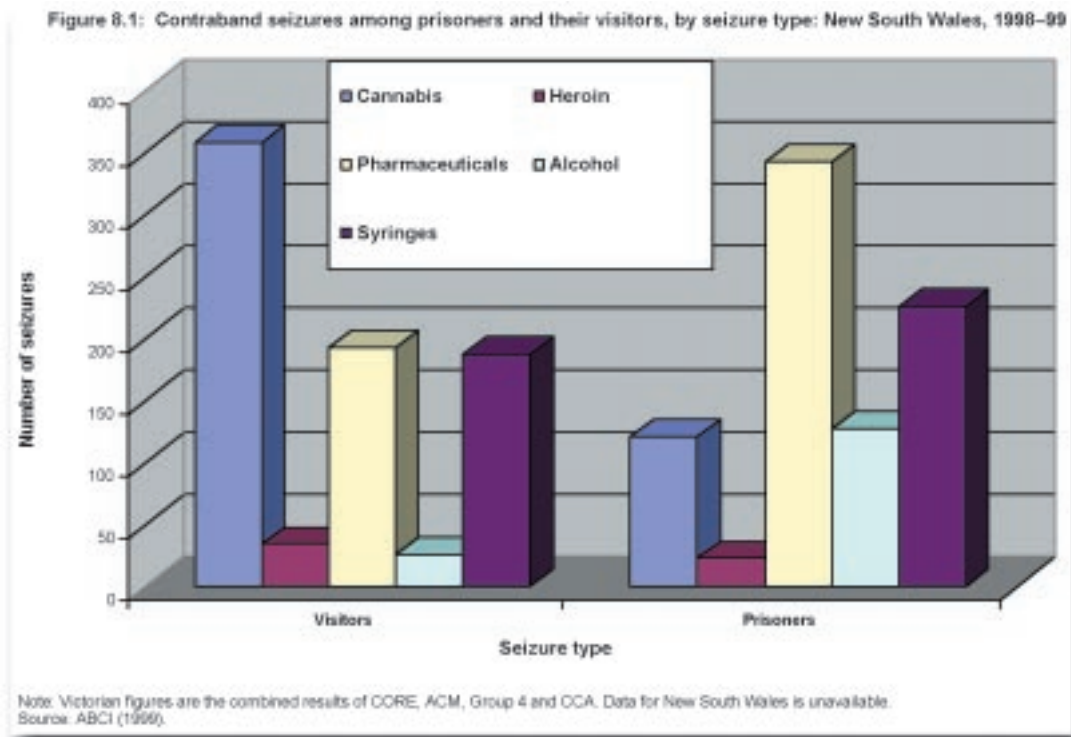
intelligence activity (targeted searches use intelligence and other information to focus on people suspected of trafficking contraband). South Australia has deployed an ‘Itemiser N’ narcotics detector to the drug-dog squad to detect trace amounts of narcotics on surfaces, clothing and skin. At Port Phillip Prison Group 4 monitors incoming mail using X-ray equipment. With the exception of the Northern Territory, telephone monitoring is common. Most respondents found drug-detector dogs and targeted searches to be the most successful detection methods.

Searches of visitors and inmates

In 1998–99 New South Wales authorities intercepted 153 visitors trafficking contraband; this compares with 167 in 1997–98. The figures for prisoners found in possession of contraband are 263 in 1998–99 and 302 in 1997–98. CORE estimated that two-thirds of visitors found smuggling were women; it detected 446 prisoners in possession of contraband in 1998–99. Queensland prison officers detected 95 visitors attempting to smuggle drugs in 1998–99 (compared with 21 in 1997–98) and 247 prisoners in possession of drugs (compared with 54 in 1997–98). Western Australian authorities intercepted 54 visitors in 1998–99 (compared with 18 in 1997–98) and 320 prisoners were found with contraband. Australasian Correctional Management found 33 visitors and 73 prisoners in possession of contraband; the 1997–98 figure for prisoners was 95. Corrections Corporation of Australia staff detected 14 visitors bringing drugs into prison (compared with four in 1997–98) and 50 prisoners in possession of drugs (compared with 27 in 1997–98).

With the exception of Queensland and the Corrections Corporation of Australia, most respondents reported that more women than men were detected smuggling contraband at the visitor barrier. This may be because males comprise 94 per cent of prisoners in Australia and are mainly visited by their female partners. The Corrections Corporation of Australia administers the Metropolitan Women’s Correction Centre in Victoria, which may explain why more men (13) than women (one) were detected smuggling contraband at this facility.

More inmates than visitors were found in possession of contraband. This is most probably because prisons have authority to search prisoners more thoroughly than visitors, but it also suggests that contraband is entering prisons undetected through the visitor barrier or by other avenues. Figure 8.1 shows contraband seizures among New South Wales prisoners and their visitors, by seizure type, in 1998–99. Figure 8.2 provides similar information for Victoria, Queensland, Western Australia, South Australia and Tasmania.



In New South Wales 358 grams of cannabis were seized at the visitor barrier in 1998–99 (compared with 852 grams in 1997–98) and 121 grams were seized inside prison (compared with 624 grams in 1997–98). This general decrease, in conjunction with more cannabis being seized at the barrier than in prison, suggests that less cannabis is entering prison. Urinalysis data by drug type are, however, unavailable for New South Wales so it is not possible to develop this hypothesis further.

Penalties for trafficking

All respondents reported that they detained and handed offending visitors to police for charging. In most cases prisons can impose bans of up to 12 months on visitors found in possession of contraband. Fifty-one visitors were banned from South Australian institutions in 1998–99.

Prisoners found in possession of contraband are referred to police for investigation and charging in most jurisdictions. In cases not referred to police, prisons can penalise inmates with the loss of amenities and privileges, reclassification, or transfer to another facility. Most respondents suspended contact visits for a specified period, in keeping with the quantity involved and the number of times the prisoner had offended.

Urinalysis

All respondents use random and targeted urinalysis to monitor drug use in prison. Random urine samples are often taken from inmates to provide a statistical measure of general drug use in prisons. Group 4 reported that random testing provided the opportunity to test inmates not targeted. Targeted samples are taken from inmates thought to be taking drugs; this was commonly reported to be more successful than random sampling.

Urinalysis is an effective deterrent when a positive sample incurs sanctions; such as loss of privileges, fines, reclassification, or transfer to another facility. CORE reported that prisoners often seek to mask their samples by taking medication and drinking bleach. New South Wales authorities reported 33 adulterated

samples, while Australasian Correctional Management reported five such samples. The Corrections Corporation of Australia reported that female inmates were able to interfere with urinalysis by swapping samples, despite testing times being random and unannounced.

New South Wales reported that 13.74 per cent of all urinalysis tests in 1998–99 were positive. Of these, 71.06 per cent led to prosecution. The Victorian Office of the Corrective Services Commissioner reported that drugs were detected in 4.8 per cent of samples in 1998–99. South Australia, which conducted targeted urinalysis only from July 1998 to June 1999, reported that 55.28 per cent of samples were positive. The Northern Territory recorded 18.18 per cent of all urinalysis tests as positive.

Figure 8.3 shows the number of positive urinalysis results for selected jurisdictions in 1998–99. To ensure consistency urinalysis statistics for random and targeted testing have been combined to provide the total number of positive samples. Please note that targeted testing will produce a higher number of positive samples and therefore may result in greater than actual increases in urinalysis results. Figure 8.4 shows urinalysis results for random and targeted tests in selected jurisdictions in 1998–99.

The conclusions drawn from the seizure and urinalysis data are based on the assumption that levels of drug detection have remained constant since 1997–98. The outcome of two national 'Drugs in Prisons' conferences and facilitation of a third in November 1999 show that corrective services are committed to reducing the amounts of drugs in prison and the related harm they cause. The majority of jurisdictions support a policy of total prohibition.

Cannabis

Figure 8.3 shows that THC (delta-9-tetrahydrocannabinol) is the substance most detected by urinalysis. THC stays in the body longer than other drugs, thus increasing the chance of passing a positive sample. For this reason Tasmanian authorities reported that urinalysis tended to emphasise cannabis use while understating the use of other drugs.

A concern raised in the *Australian Illicit Drug Report 1997–98* was that urinalysis may encourage inmates to change from cannabis to more harmful drugs because these drugs remain in the body for a shorter time and so there is a better chance of providing a negative urine sample. In Western Australia the Select Committee into the Misuse of Drugs Act of 1981 found that ‘some very harmful substance abuse (e.g. sniffing solvents, alcohol bingeing) which is directly related to offending may not be detected through urinalysis, whereas cannabis use is easily detected. This raises the prospect of participants being influenced towards the use of less detectable though more harmful drugs’ (1997, p. 234). In South Australia the Department of Correctional Services (1998) recommended that targeted urinalysis focus on detecting those drugs with the greatest potential to cause harm—intravenous drugs, alcohol, and other drugs that cause aggression.

Victorian prisons made a total of 96 cannabis seizures from visitors (compared with 109 in 1997–98) and 142 seizures from prisoners (compared with 187 in 1997–98). Authorities recorded 827 positive urinalysis samples for cannabis; this compares with 833 in 1997–98. The general decrease in seizures and positive urinalysis results suggests that the amount of cannabis entering and used in prison has dropped. Nonetheless, more cannabis continued to be detected in prison than at the visitor barrier, which suggests that cannabis is passing the barrier undetected or entering prison by other means.

The *Australian Illicit Drug Report 1997–98* noted a significant increase in positive cannabis samples in Victoria but that it was not possible to determine whether this was a result of more effective testing or whether it was a sign of increased cannabis use. Figure 8.4 shows that Victoria—which is reported by the Australian Bureau of Statistics as holding 14 per cent of the Australian prison population—collected 16 527 samples in 1998–99: this level of testing may explain the increase in positive samples noted previously as well as in the current reporting period.

Queensland prison authorities made 36 cannabis seizures from visitors (compared with 35 in 1997–98) and 96 from prisoners (compared with 77 in 1997–98). They reported 1163 positive

urinalysis samples in total; this compares with 941 in 1997–98. More cannabis was seized from prisoners than from visitors, which suggests that cannabis is passing the barrier undetected or entering prison by other means.

South Australian authorities seized 156.1 grams of cannabis in prison (compared with 417.4 grams in 1997–98) and reported 572 positive urinalysis samples for cannabis (compared with 480 in 1997–98). They seized less cannabis but detected more positive samples, which suggests that cannabis is entering prison undetected and that its use in prison may have increased.

Western Australian officers made 74 cannabis seizures from visitors and 124 seizures from inmates; 1176 positive urinalysis samples were recorded (compared with 965 in 1997–98). More cannabis was seized in prison than at the visitor barrier, suggesting that cannabis is passing the visitor barrier undetected or entering prison by other means. The increase in the number of positive samples suggests that cannabis use may have risen in 1998–99.

Northern Territory authorities reported that two males were intercepted attempting to smuggle cannabis into prison and that 49 positive urinalysis samples were recorded (compared with 16 in 1997–98). More cannabis was detected in prison than at the visitor barrier, which again suggests that it is passing the barrier undetected or entering prison by other means. The increase in the number of positive samples suggests that cannabis use has increased in Northern Territory prisons.

Tasmanian officers seized cannabis from one visitor and 14 prisoners, yet recorded 106 positive urinalysis samples for cannabis use. Thus, once again, more cannabis was detected in prison than at the visitor barrier, suggesting that it is passing through the barrier undetected or entering prison by other means.

Heroin

Heroin was the third most detected drug in 1998–99, coming after pharmaceuticals and cannabis. The data suggest that the overall amount of heroin detected was greater than in previous years.

Figure 8.2: Contraband seizures among prisoners and their visitors, by seizure type: selected jurisdictions, 1998-99

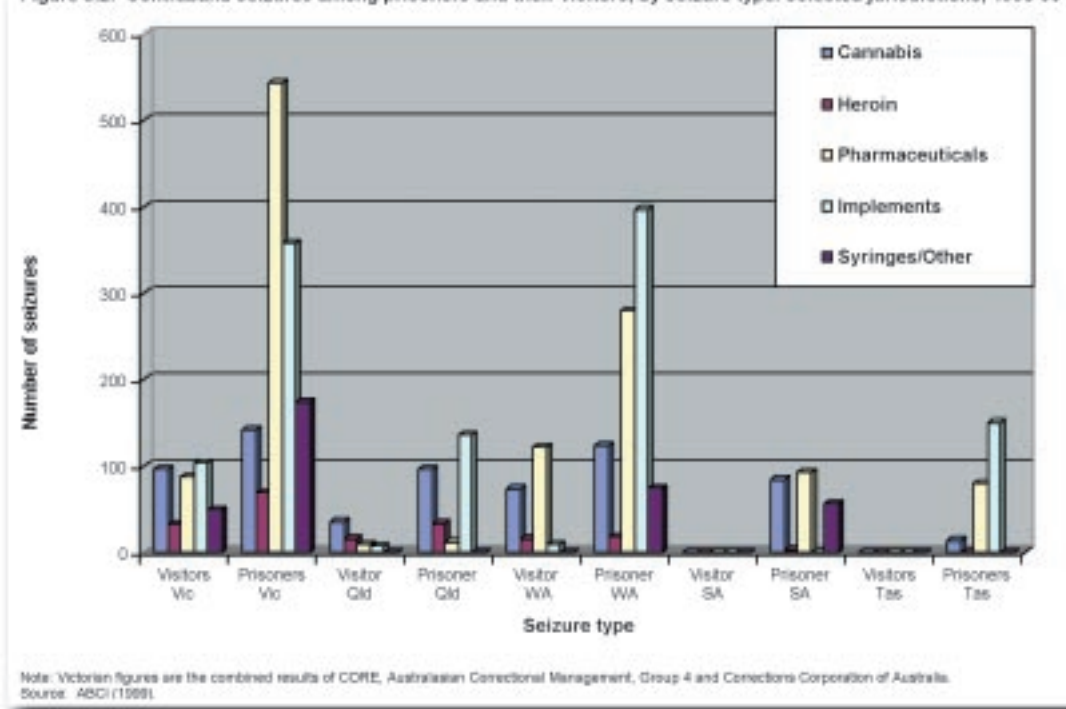
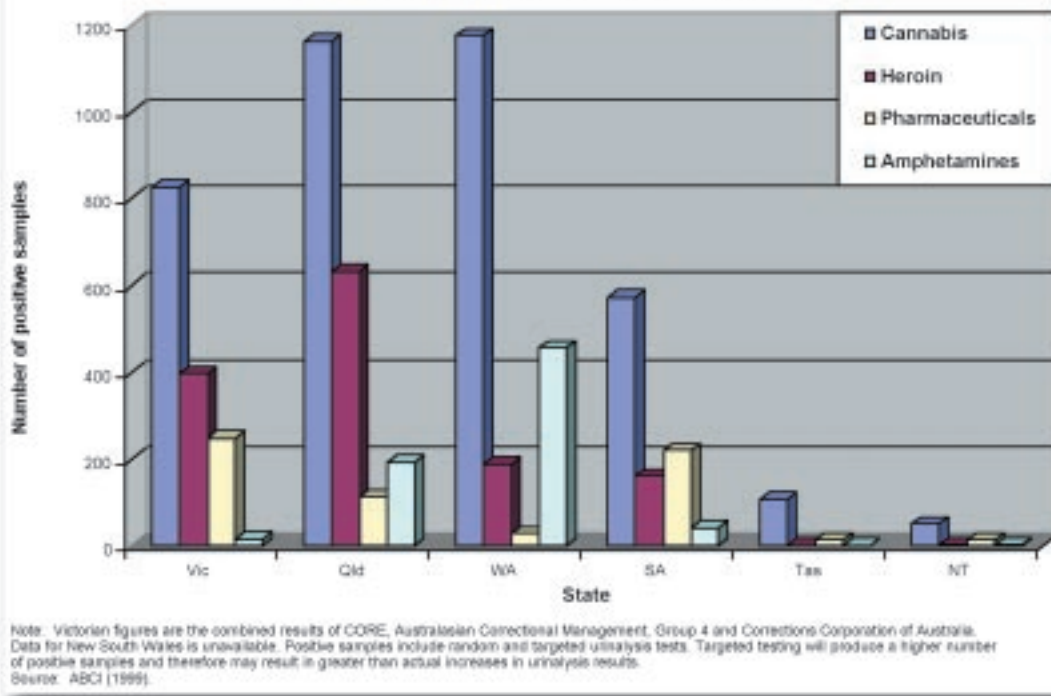


Figure 8.3: Positive urinalysis: selected jurisdictions, 1998-99



The New South Wales Department of Corrective Services seized 34.5 grams of heroin at the visitor barrier (compared with 16.5 grams in 1997-98) and 22.9 grams in prison (compared with 21.4 grams in 1997-98). More heroin was seized at the visitor barrier than in prison, which suggests that less heroin is entering prison. As noted, however, urinalysis data by drug type are unavailable for New South Wales so it is not possible to develop this hypothesis further.

Victorian authorities made 33 heroin seizures at the visitor barrier (compared with 10 in 1997-98) and 67 seizures from prisoners (compared with 41 in 1997-98). Figure 8.3 shows that Victoria recorded 396 positive urinalysis heroin samples; this compares with 242 in 1997-98. The increase in positive samples and heroin seizures suggests that more heroin is entering Victorian prisons. Increased urinalysis may also be a reason for the increase in positive samples for 1998-99.

The Queensland Corrective Services Commission made 16 heroin seizures from visitors (compared with eight in 1997-98) and 34 seizures from prisoners (compared with 14 in 1997-98). Authorities recorded 631 positive urinalysis samples for heroin; this compares with 309 in 1997-98. The increase in seizures could mean a rise in the amount of heroin being trafficked. More heroin was seized in prison than at the visitor barrier, which suggests that the heroin is passing the barrier undetected or entering prison by other means. The increase in positive samples suggests that heroin use may have increased in 1998-99.

In South Australia the Department for Correctional Services seized 0.19 grams of heroin in prison (compared with 0.2 grams in 1997-98). Authorities also reported 160 positive urinalysis samples; this compares with 117 in 1997-98. The increase occurred despite only minor seizures of heroin, which suggests that heroin is entering prison undetected and that its use in prison has increased.

In Western Australia heroin was seized from 16 visitors and 18 prisoners. Authorities recorded 188 positive urinalysis samples;

this compares with 127 in 1997-98. More heroin was seized from inmates than from visitors, suggesting that the drug is passing the barrier undetected or entering prison by other means. The increase in positive samples suggests that heroin use may have increased in 1998-99.

Tasmania's Department of Corrective Services reported no seizures of heroin and no positive urinalysis samples for heroin in 1998-99.

Northern Territory seizure data are unavailable, but one positive urinalysis sample was recorded for heroin in 1998-99; this compares with two in 1997-98. The fact that heroin is detected in prison in the absence of seizure data suggests that heroin is entering prison undetected.

Pharmaceuticals

Pharmaceuticals were the type of drug most commonly seized in the majority of jurisdictions in 1998-99, and there appeared to be a general increase in the number of seizures.

Figure 8.1 shows that New South Wales prison officers seized 193 pharmaceutical tablets at the visitor barrier in 1998-99 (compared with 265 in 1997-98) and 343 tablets in prison (compared with 946 in 1997-98). Urinalysis data are unavailable, but the seizure data suggest that, while the amount of pharmaceuticals in prison may have decreased, pharmaceuticals continue to pass the barrier undetected or enter prison by other means.

Figure 8.2 shows that Victorian officers made 87 pharmaceutical seizures from visitors in 1998-99 (compared with 71 in 1997-98) and 544 from inmates (compared with 293 in 1997-98). Victorian authorities also recorded 248 positive urinalysis samples; this compares with 242 samples in 1997-98. This increase in seizures and positive samples could indicate that there were more pharmaceuticals in Victorian prisons in 1998-99 than in 1997-98. Like the cannabis and heroin results, though, this increase may also be attributed to a greater number of urinalysis tests performed in Victoria.

Queensland authorities made nine pharmaceutical seizures from visitors (compared with two in 1997–98) and 12 from inmates (compared with four in 1997–98). Queensland recorded 112 positive urinalysis samples; this compares with 62 in 1997–98. The increase in seizures suggests that more pharmaceuticals were being trafficked in 1998–99, and the increase in positive samples may indicate a rise in pharmaceutical use in prison. More pharmaceuticals were detected in prison than at the visitor barrier, which suggests that these drugs were passing through the barrier undetected or entering prison by other means.

In South Australia 10 tablets of Rohypnol and/or Rivotril were seized (compared with seven in 1997–98) and 526.5 ‘other’ tablets were seized (compared with 792 in 1997–98). South Australia also recorded 219 positive urinalysis samples for benzodiazepines; this compares with 200 in 1997–98. The decrease in the number of tablets confiscated suggests that there was less trafficking in pharmaceuticals detected in 1998–99, but the increase in positive samples suggests that pharmaceutical use in prison may have increased.

In Western Australia in 1998–99 there were 122 pharmaceutical seizures from visitors and 280 from prisoners. Authorities recorded 456 positive urinalysis samples; this compares with 334 in 1997–98. The fact that more seizures were made in prison than at the barrier suggests that pharmaceuticals are passing the barrier undetected or entering prison by other means. The increase in positive samples suggests that pharmaceutical use in prison may have increased.

Tasmania’s Department of Corrective Services reported no seizures of pharmaceuticals from visitors, but officers made 80 pharmaceutical seizures from prisoners. There were no reported positive urinalysis samples for pharmaceuticals. Pharmaceutical are thus entering prison undetected.

The Northern Territory recorded 12 positive samples—a marginal increase on the 10 reported for 1997–98.

Amphetamines

Overall, in 1998–99 there were minimal amphetamine seizures and fewer positive samples for amphetamines than for cannabis, heroin or pharmaceuticals, which continues the trend noted in the *Australian Illicit Drug Report 1997–98*. This consistently low result suggests that demand for amphetamines is weaker than that for other forms of contraband or that amphetamine use is better concealed in prison.

In New South Wales 17.5 grams of amphetamines were seized from visitors but there was no record of any seizures from prisoners. This suggests either that no amphetamines are entering prison or that their use in prison is going undetected.

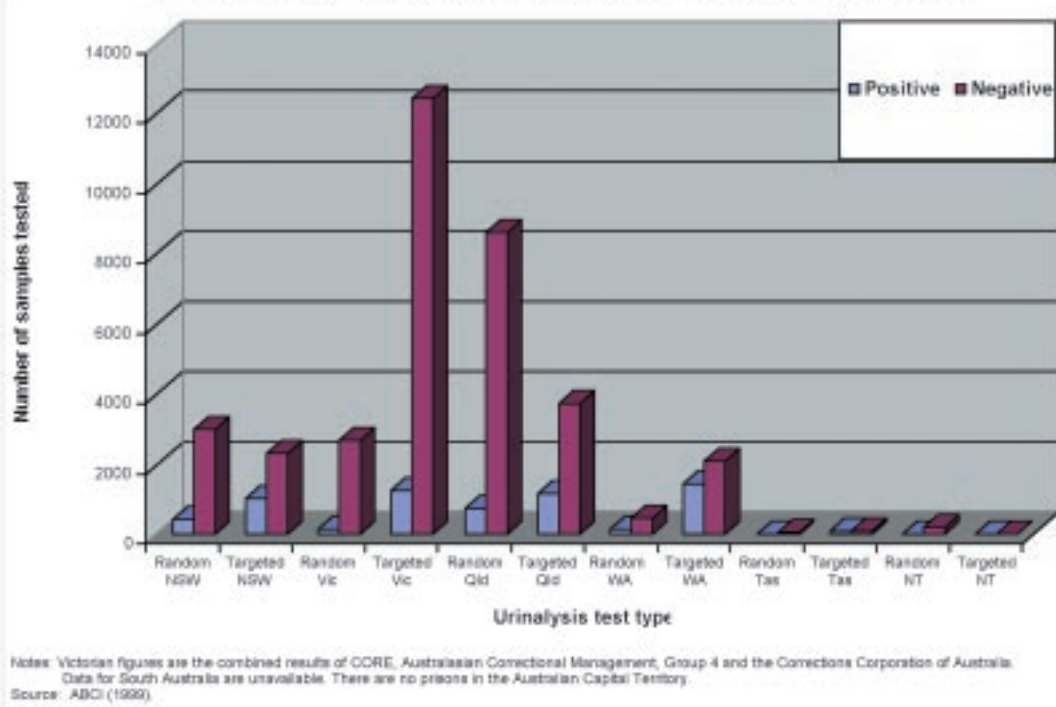
Victorian authorities made three amphetamine seizures from visitors and three from prisoners; they recorded 14 urinalysis samples positive for amphetamines. This suggests that amphetamines are passing the barrier undetected or entering prison by other means. CORE reports, however, that all seizures of white powder were assumed to be heroin because ‘prisons do not test every seized drug’.

Queensland prisons made six amphetamine seizures from visitors (compared with four in 1997–98) and nine from prisoners (compared with six). Prisons recorded a total of 192 positive urinalysis samples; this compares with 17 in 1997–98. These increases in seizures may not reflect an increase in amphetamine use in Queensland prisons, but the big increase in positive urinalysis results suggests that amphetamine use rose in 1998–99.

No seizure data were available for South Australia, yet 40 positive urinalysis samples were recorded (compared with 12 in 1997–98). Amphetamines are therefore entering prison undetected and their use may have increased.

Western Australian prisons reported no amphetamine seizures but 27 positive urinalysis samples (compared with 13 in 1997–98). This suggests that the amount of amphetamines entering prison undetected may have increased.

Figure 8.4: Random versus targeted urinalysis results: selected jurisdictions, 1998-99



Tasmania's Department of Corrective Services reported no amphetamine seizures and no urinalysis samples that tested positive for amphetamines.

In the Northern Territory one positive urinalysis sample was recorded for amphetamines—the same as in 1997–98. In the absence of seizure data, this suggests that amphetamines, albeit minor amounts, are entering prison undetected.

Syringes

The majority of jurisdictions reported that more syringes were seized in prison than at the barrier. This suggests that syringes are passing the visitor barrier undetected or entering prison by other means.

New South Wales authorities seized 188 syringes (compared with 154 in 1997–98)—making syringes the third most common contraband intercepted at the visitor barrier—and seized 226 in prison (compared with 250 in 1997–98). Victorian prisons made 50 seizures of syringes from visitors and 174 from prisoners; 260 were seized from prisoners in 1997–98. South Australian officers seized 56 syringes; this compares with 146 seized in 1997–98. Western Australian officers seized 54 syringes in prison (compared with 28 in 1997–98). Tasmanian officers did not seize any syringes or implements from prisoners.

South Australia's Corrections Intelligence Unit reports the re-emergence of a 1995 trend, whereby 'mini' or cut-off syringes, hidden in the mouths of visitors, are passed to inmates during access visits. These syringes, which are covered in plastic to prevent self-injection during smuggling, contain a pre-mixed load of heroin.

Telephone monitoring

All respondents except the Northern Territory reported using the Arunta Controlled Telephone System (ACTS).³ Telephone monitoring is widely recognised as a valuable source of information and intelligence on matters such as drug detection, previous and planned assaults, and suspicious financial transactions. In fact, South Australia reported that the use of TAB accounts for drug smuggling had declined as a result of telephone monitoring.

Other initiatives to prevent, detect and discourage drug use in prisons

The Metropolitan Remand and Reception Centre in Sydney has adopted 'smart card' technology. Prisoners use the cards to operate vending machines at the canteen and to make telephone calls. The cards also provide access to permitted areas and are used together with closed-circuit television to monitor inmates' movements. Visitor access is controlled by biometric security systems and, when inside the facility, visitors are subjected to rigorous surveillance, to the extent that 'ongoing visual and physical checks are exhaustive. Everyone's details are recorded to permit entry and facilitate exit' (Dolahenty 1998, p. 39). Such intensive monitoring does limit visitors' and inmates' opportunities to traffic.

The Victorian Office of the Correctional Services Commissioner reports the use of X-ray machines and biometric hand identification machines.

South Australia's Department for Correctional Services is assessing the application of the PharmChek™ sweat patch—a skin patch that captures sweat elements that contain drug residue and can be used to detect cocaine, opiates, amphetamines, PCP and cannabis. The samples are collected and analysed in a similar manner to urinalysis. One of the reported advantages of this method is that it can capture drug use over a seven-day period; urinalysis, on the other hand, is limited by the body's retention of drug residue for shorter periods.

The Western Australian Ministry of Justice reported that it is assessing sweat-patch detection methods similar to that used in South Australia. It reported that joint operations could be initiated with metropolitan and regional police to search all visitors and vehicles entering Ministry of Justice property.

Australasian Correctional Management is considering the purchase of a narcotic detection system similar to the technology used by the Australian Customs Service, the South Australian Department for Correctional Services, and some prisons in Queensland. The machine detects minute particles of contraband that have been transferred to surfaces, clothing and skin during handling.

Group 4 is investigating the use of 'Cozart RapiScan' to screen for cannabis, opiates, benzodiazepines, amphetamines, alcohol, methadone and cocaine in a saliva sample. It reports that the method is quick and non-intrusive and that it is 'near impossible' to adulterate the sample. RapiScan displays its results 'within 10 minutes' and can give a more accurate reading of an inmate's drug use at the time of testing.

Initiatives, health and treatment

Determining the likelihood of recidivism

In conjunction with the University of Western Australia, the Western Australian Ministry of Justice has developed a computer model to identify offenders most likely to re-offend.

The system, based on a US risk-assessment model, uses actuarial analysis of offender characteristics to develop a risk inventory: 'The WA model has sought to identify 8–10 key characteristics which would reliably predict re-offending risk to at least 95 per cent accuracy' (Ministry of Justice 1998, p. 17). It draws on arrest, conviction and custody data and provides a common database for more than 600 000 offender records. Identification of recidivistic offenders allows management to direct resources to greatest effect. From a drugs-in-prisons perspective, reduced recidivism means fewer offenders are re-entering prison for drug related offences, fewer inmates are drug dependent, and the prison drug culture becomes diminished. This model is currently in use in community based services.

Drug courts and diversion programs

Most jurisdictional programs aim to detect and reduce the supply of drugs in prisons. Another approach is to reduce the number of drug-dependent offenders entering prison by diverting them from prison during sentencing. The South Australian Drug Assessment and Aid Panel was established in 1985 to divert from court proceedings entirely people who are charged with possessing illicit drugs for personal use. Unless people are deemed unsuitable, or breach Panel requirements, their offences are never referred to a court. More recently the New South Wales Government established the first drug court, which has the power to suspend a custodial sentence in favour of referral to a treatment program (see Chapter 10). The New South Wales Drug Summit in 1999 recommended that the Department of Corrective Services divert greater numbers of drug-affected offenders to home detention, to increase their access to the supervision of government and non-government agencies (Drug Summit Communiqué 1999).

Testing for blood-borne viruses

Prisons in New South Wales, Victoria, South Australia and Western Australia medically assess inmates at reception for risk behaviours that may lead to HIV, hepatitis and STD infection and offer voluntary testing. Tasmania tests for HIV and hepatitis C on request,

but hepatitis testing is not routinely carried out. The Northern Territory tests all prisoners at reception, three and six months after reception and then annually until release.

Most jurisdictions do not segregate prisoners testing positive for blood-borne viruses unless a medical necessity exists. The Northern Territory may segregate a prisoner for their own protection and that of other prisoners. In Tasmania, despite the integration policy, most infected prisoners ask to remain in the prison hospital because they fear for their safety in the general prison population.

Hepatitis C and HIV infection

There is a strong correlation between injecting drug use and hepatitis C infection rates, particularly in prison. The Western Australian Select Committee into the Misuse of Drugs Act found that those 'at particular risk are people who have been incarcerated and have a history of injecting drug use' (1998, p. 385). As noted in the *Australian Illicit Drug Report 1997–98*, a significant proportion of the prison population is infected with hepatitis C and, given evidence of continued drug use and the seizure of illicit syringes, the situation may deteriorate. Most respondents are unable to determine whether infection occurred before or after reception, so the data are insufficient to elaborate on this trend.

It is not known how many, if any, prisoners contracted HIV or hepatitis while in New South Wales, Victorian and Western Australian prisons. South Australia recorded 29 males with newly acquired hepatitis C in 1998–99 (compared with 14 inmates in 1997–98) but added that it is not known if the infection occurred in prison. Tasmania reported four HIV-positive inmates being recorded on reception since 1987 but none in 1998–99. The Northern Territory did not report any cases of either HIV or hepatitis infection contracted in prison.

Harm minimisation

Correctional services were unanimous in their support for a total prohibition on drugs in prison. In general, however, more drugs continue to be seized in prison than at the visitor barrier. If supply cannot be stopped, then the level of harm associated with drug use—harm to inmates, custodial staff and the broader community—must be limited.

The harm-minimisation philosophy recognises that total prohibition produces high-risk behaviours that affect the drug user and ultimately the community. It minimises risk through the provision of condoms, methadone-maintenance treatment, education services, needle and syringe programs and bleach to ensure that drug use remains relatively hygienic.

When implementing harm-minimisation measures prison administrators must balance security concerns against health concerns. This is discussed later in this chapter, under 'The health-corrections interface'.

Methadone-treatment programs in prison

Methadone is a synthetic opioid that is used as a treatment for heroin dependence. One of the benefits of methadone-treatment programs is that the drug is generally provided as syrup prescribed for oral administration under medical supervision; it is not registered for use by injection in Australia. There is also a tablet form of methadone, called physeptone, but it is used to treat heroin dependence only in exceptional circumstances. Because methadone is a mood-altering drug, it becomes a valued commodity among drug-using inmates and may be diverted from therapeutic use.

The New South Wales Department of Corrective Services provides methadone at 14 centres, plus an additional two if required. Victoria provides methadone to five of its 13 prisons and recorded 116 prisoners in a methadone program in 1998–99. South Australia reported that 151 male and 35 female prisoners were on a methadone program. Tasmania reported eight inmates receiving methadone treatment. Western Australia provides a limited reduction program, which is under review by health services staff. The Northern Territory reported that rapid detoxification programs are provided for inmates requiring intervention but that the Northern Territory Government opposed methadone maintenance.

The National Policy on Methadone Treatment

The National Policy on Methadone Treatment states,

... Methadone treatment may be appropriate for certain prisoners. These include:

- Those who continue unsanctioned use of opioids in prison in a manner which constitutes a significant risk of harm (for example, infection with HIV or hepatitis B or C);
- Those assessed with a high probability of returning to dependent opioid use upon release because they are at significant risk of overdose due to their reduced tolerance to opioids developed during imprisonment;
- Those on a methadone maintenance program at the time of imprisonment, particularly if they are pregnant or HIV/hepatitis C antibody positive or hepatitis B antigen positive; and
- Those who are opioid dependent at the time of imprisonment and not receiving methadone treatment. The milieu of prison is significantly different from that in the community. Hence, criteria used to assess prisoners for methadone programs may differ from those used in community programs. Specific written criteria should be developed regarding the use of methadone in prisons. Detoxification treatment should be available for those individuals who are opioid dependent when they enter prison and do not want methadone treatment and for those who want to withdraw from methadone before they leave prison.

Close liaison should exist between prison methadone programs and community methadone programs so that methadone treatment is not interrupted for those clients on methadone when entering or leaving prison.

Confidentiality of medical records of prisoners on methadone should receive special consideration so that these records are not used for custodial purposes. No prisoner should be forced to accept methadone treatment or be recommended for methadone treatment for disciplinary reasons ... (Department of Health and Family Services 1998, p. 20)

Education

All respondents confirmed that they offered drug education to prisoners. Northern Territory and New South Wales prisons used peer education programs to inform inmates about health concerns and high-risk behaviours associated with drug use. The Aboriginal Family Supervision Program is conducted in Western Australia and assigns 'mentors' to Aboriginal offenders for three months. The State's main recidivism-reduction program involves education and vocational training: the Ministry of Justice claims, 'It is well proven that an offender who can find and hold a job after release from prison is less likely to re-offend' (1998, p. 20).

Needle and syringe programs

There are no needle and syringe programs available in Australian correctional institutions. Overseas, needle and syringe programs in prisons involve the provision of needles to inmates on request, anonymously through the use of distribution machines, or by medical staff. The programs seek to replace the illicit needles and syringes currently in circulation, which deteriorate rapidly and more often than not are shared without adequate sterilisation. Needle and syringe programs target that most fundamental of high-risk behaviours—sharing contaminated injecting equipment.

Australian correctional services remain unanimously opposed to these programs. Their chief concern is the risk of needlestick injury to custodial staff and the perception that the programs' implementation represents a softening of drug policy or encourages drug use. According to Dutney, 'Correctional staff can be genuinely fearful for their safety when dealing with issues such as the transmission of disease such as HIV' (1999, p. 3). The growing number of studies from Swiss trials of the program may, however, challenge such reservations; for example, Nelles et al. found that 'the belief that dispensing sterile equipment encourages inmates to start or switch to intravenous drug use was not confirmed' (1999, p. 1).

More syringes are seized from inmates than at the visitor barrier, which suggests that, despite total prohibition, syringes continue to enter prison undetected and injecting drug use still occurs. This behaviour has strong links to hepatitis C infection. The Department of Health and Aged Care found that, 'of all hepatitis C infections, 80 per cent were acquired through injecting drugs' (1999, p. 50).

Mental health

The Public Health Association Conference, 'Minimising the Harm: health in prisons', which was held in Sydney from 14 to 16 February 1999, paid much attention to the mental health care of inmates. Dr. Andrew Coyle said, 'A significant number of men and women in prison suffer from some form of mental disorder' (1999, p. 22). This may well be relevant to the question of managing drugs in prisons, especially if prisoners 'self-medicate' to counter the effects of mental health problems. As Lewis and Hayes have noted, 'Chronic substance abuse may exacerbate psychological symptoms or, alternatively, some individuals may "manage" their mental health problems by the use of drugs and alcohol' (1997, p. 56). If treatment can alleviate these symptoms prisoners may lose the compulsion to self-medicate and reduce or cease their drug use.

Drug use and Indigenous inmates

Maxwell and Davey (1997) reported an increase in the use of amphetamines by juvenile Indigenous Australians. Larson et al. report that amphetamine is the drug most commonly injected by Indigenous Australians in Brisbane (1999). Seizure and urinalysis data suggest, however, that amphetamine use in prisons is low in comparison with use of other drugs. This trend in the community has not yet translated into an increase in amphetamine detection in prison, although it is also possible that people tend to change their drug preferences once in gaol.

Larson et al. noted that in the wider community 'cultural identity and environment combined to reinforce unsafe behaviour' (1999, p. 60), and it has been observed that inmates tend to gravitate towards groups of similar ethnicity. Syringes are still being detected, suggesting injecting drug use is continuing: 'Participants [Indigenous Australians] who had been in prison indicated that they shared some or most of the time but also that they were "always" or "most times"

able to clean the needle with bleach between uses' (p. 59). The *Australian Illicit Drug Report 1997–98* noted that there was some doubt about the efficacy of bleach in destroying hepatitis. It is plain that the perpetuation of unsafe injecting behaviour will exacerbate the problems of hepatitis infection.

One conclusion to draw from the study by Larson et al. is that there may be Indigenous Australians entering prison who are predisposed towards unsafe injecting drug use. This may be significant given that the Northern Territory, Western Australia and Queensland have the three highest proportions of Aboriginal prisoners in their prisons.

The health–corrections interface

Prison administrators face a growing number of challenges delivering the services expected of today's correctional facilities. The health–corrections interface balances duty-of-care obligations to prisoners against the security, safety and good order of the institution. It has been described as the distinction between therapeutic and punitive establishments or between medical and custodial staff.

The management and staff of correctional institutions are concerned that some harm-minimisation measures operating in the community directly affect the security and occupational health and safety of prison staff. This is exemplified by the debate surrounding needle and syringe programs. As the New South Wales Department of Corrective Services noted, 'From a medical point of view there would be support for [the needle and syringe program] while there are real security and industrial issues of custodial staff.'

The *Australian Illicit Drug Report 1997–98* reported a mixed response to suggestions that a conflict of interest existed between custodial and medical staff in relation to the implementation of some harm-minimisation measures. In 1998–99 there was one reported incident of conflict over plans to expand prisoners' access to condoms in Western Australian prisons.

Another point of contention is the need for information-sharing procedures between medical and custodial staff. Any threat to confidentiality for prisoners will reduce the efficacy of medical treatment, while failure to disclose relevant health information may hinder staff in providing adequate care—particularly in connection with suicide prevention and mental disorders. Dalton (1999) recorded that seven inmates committed suicide by overdose between 1980 and 1998. Dutney summarises the health–corrections interface: 'In a prison context the issue of confidentiality may need to be balanced with the ultimate duty of care of preserving the life of a person in custody' (1999, p. 6).

Conclusion

Drugs continue to enter Australian prisons. Visitors conceal them internally and pass them to inmates during contact visits. Inmates exchange them for commodities and for money, which is transferred through private bank and TAB accounts.

In 1998–99 more pharmaceuticals than any other type of drug were seized during searches of visitors and inmates, while urinalysis most frequently detected cannabis. The available data show that less cannabis was detected in 1998–99 than in 1997–98, but that more heroin, pharmaceuticals and amphetamines were detected in 1998–99. In general, more contraband was seized inside prison than at the visitor barrier, which suggests it is passing through visitor reception areas undetected or entering prison by other means.

A number of initiatives have been introduced in an attempt to reduce the demand for drugs by referring drug-dependent people into

treatment programs rather than prison. Research to date remains inconclusive about the initiatives' success. Independent evaluation is needed to determine their effectiveness.

Harm minimisation in the prison context is problematic and often brings tension to the health–corrections interface. Although there was only one report of a conflict of interest between medical and custodial staff in 1998–99, the questions of needle and syringe programs and medical confidentiality remain contentious in the prison setting.

Outlook

Jurisdictions consistently report minimal, if any, drug production or manufacturing in prisons. The level of security and surveillance means this will remain the case, forcing inmates to rely on contacts outside prison to import contraband. The *Australian Illicit Drug Report 1997–98* reported that cannabis and pharmaceuticals were the most commonly detected drugs; this trend continued in 1998–99 and is expected to continue in future.

Inmates and their associates have taken, and will continue to take, advantage of legislative limitations that facilitate drug trafficking. Unless other means of detection are devised or legislation relating to visitor searches is broadened, contraband will continue to pass through the visitor barrier undetected or enter prison by other avenues, or both. Private bank and TAB accounts will continue to be used for monetary payment for drugs in prison.

In view of the findings of recent studies of prison-based gangs and the reported levels of organisation of drugs in prison, the Bureau expects that gangs will become more prominent—including 'standing over' inmates and intimidating inmates and their families into smuggling contraband—in the organised trafficking of drugs.

Confusion about whether inmates are infected before or after reception makes it hard to quantify hepatitis infection rates in prison. Research shows that unsafe injecting drug use is still occurring, illicit syringes are still being seized in prison, and the majority of corrective services have minimal provisions available to sterilise the syringes, so there remains a strong likelihood that hepatitis C infection rates will rise.

Notes

- ¹ The Public Correctional Enterprise (CORE) runs the publicly owned prisons in Victoria.
- ² There are three private prisons providers in Australia. Australasian Correctional Management operates Arthur Gorrie (Queensland), Junee (New South Wales) and Fulham (Victoria); the Corrections Corporation of Australia operates Borallan (Queensland) and the Metropolitan Women's Correctional Centre (Victoria); and Group 4 operates Mount Gambier (South Australia) and Port Phillip (Victoria).
- ³ The Arunta Controlled Telephone System is fully automated. It logs, monitors and, if required, records telephone calls. The prisoner enters either a 'smart card' or a PIN and when identification is verified he or she is given access to a list of predetermined telephone numbers. Once a number is selected, the number is auto-dialled. All facets of the activity—prisoner identification, the time and duration of the call, and the telephone number—are recorded on a database. This allows for closer monitoring. The use of analytical software has revealed previously unknown networks between prisoners and outside connections.

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