REVIEW OF THE OPIOID REPLACEMENT TREATMENT PROGRAM AT THE ALEXANDER MACONOCHIE CENTRE

REPORT OF THE ACT HEALTH SERVICES COMMISSIONER

MARCH 2018

ACT HUMAN RIGHTS COMMISSION
Australian Capital Territory

Authors

Karen Toohey, ACT Health Services Commissioner

Gabrielle McKinnon, Principal researcher

Ingrid Osmond

ISBN 978-0-6482883-0-5

CONTENTS

TERMS OF REFERENCE

In his Report of the Independent Inquiry into the Treatment in Custody of Mr Steven

Freeman: So *Much Sadness in Our Lives* ('the Moss Report') Mr Philip Moss AM recommended:

> That the Health Services Commissioner (of the ACT Human Rights Commission) conduct an own-initiative investigation into the prescription of methadone to detainees at the AMC.[1]

Section 48 of the *Human Rights Commission Act 2005* provides that:

> (1) The commission may, on its own initiative, consider (by a commission-initiated consideration)—
>
> (a) an act or service that appears to the commission to be an act or service about which a person could make, but has not made, a complaint under this Act; or
>
> (b) any other matter related to the commission's functions.

As noted in the Government Response to the Moss Report, released on 16 February 2017, the Health Services Commissioner advised the ACT Government that she would conduct a commission-initiated consideration of matters relating to delivery of health services within the Alexander Maconochie Centre (AMC), including matters associated with methadone prescription.

This report concerns the issues of Opioid Replacement Treatment (ORT) at the AMC. While this review focuses on the prescription of methadone, it considers this in the broader context of the ORT program, including:

- The role of ORT in the prison context
- Assessment and prescription practice in the ORT program
- Induction onto methadone
- Dosing practice
- Managing the risk of diversion of methadone
- Throughcare and transition to ORT in the community

This commission-initiated consideration examines current practice at the AMC as at October 2017 with regard to the provision of methadone, to assess whether it is consistent with relevant legislation, policy and applicable standards. It does not focus on historical practice, nor the details of the tragic deaths in custody of Mr Steven Freeman or Mr Mark O'Connor, as these issues are the subject of current Coronial inquests.

[1] Report of the Independent Inquiry into the Treatment in Custody of Mr Steven Freeman: So *Much Sadness in Our Lives* November 2016 Recommendation 7.

EXECUTIVE SUMMARY

The use of methadone for opioid replacement treatment is a recognised evidence-based approach to minimise harm associated with opioid addiction. It is appropriate that ORT be available in the AMC as a treatment for detainees who are opioid dependent, to meet human rights requirements of equivalence in relation to health care available in the community, and to reduce serious risks associated with illicit drug use in prison. The use of ORT has also been shown to reduce recidivism rates and to assist rehabilitation of detainees, provided that the treatment is continued in the community after release.

While methadone is a sound and evidence-based treatment option for opioid addiction, it carries a range of risks, and it is vital that any ORT regime operates in accordance with legislative requirements and adheres to applicable clinical standards and guidelines. To ensure effectiveness of ORT in assisting rehabilitation of detainees, the treatment must be provided as part of a broader approach that includes counselling and throughcare to ensure continuity of treatment on release.

This review was conducted to address concerns raised in previous reports, including the Moss Report, regarding the operation of the ORT program at the AMC, and in particular, stakeholder concerns about the assessment process for eligibility for methadone treatment. The review focused on the current practice and operation of the ORT program at the AMC, noting that a number of changes have been implemented in relation to assessment, dosing and monitoring following the tragic death of Mr Steven Freeman at the AMC.

The review included an assessment of policies and procedures, review of detainee clinical files and other documentation, observation of dosing practice and interviews with health and corrections staff and detainees. I am grateful for the generous assistance and co-operation of ACT Health and Corrective Services in conducting the review.

The level of prescribing of methadone at the AMC, with around 30% of detainees receiving methadone, is substantially higher than in other jurisdictions, although comparisons were difficult due to arbitrary restrictions and caps imposed in other ORT programs. Interviews with detainees and staff suggested that there is a culture of drug-seeking amongst detainees, where access to ORT was sometimes sought for recreational and other reasons, and that detainees perceived that it was relatively easy to be placed on methadone at the AMC.

However, the review found that revised ORT Clinical Procedure and associated changes to practice at the Hume Health Centre (including standardised forms and electronic record keeping) have significantly tightened and improved the process of assessment of detainees for eligibility for ORT, and that the current assessment process is generally consistent with ACT and National Guidelines. In particular, the inclusion of a preliminary assessment by a drug and alcohol nurse, and the implementation of a Clinical Meeting has increased consistency and rigour of assessment decisions. It is important that these improvements are maintained and built on, and to that end I have made recommendations to further strengthen the assessment process, including a regular file review by an AOD specialist practitioner from the Wruwallin clinic.

One area of the assessment and treatment process which requires further attention is the need for specialised case planning and health care to meet the needs of Aboriginal and Torres Strait Islander detainees, in accordance with the ACT Guidelines.

This review considered the processes in place for induction and monitoring and noted the reduction in the standard starting dose for induction onto methadone from 30mg to 20mg, which brings practice in the ACT in line with other jurisdictions, and reduces risk of overdose from prescribed methadone. Changes have been made to ensure systematic monitoring of detainees during the induction phase and to improve information sharing with Corrective Services. I have recommended that naloxone be available to be administered by appropriate staff at the AMC, and that detainees be given information about symptoms of overdose and how to respond in an emergency.

During the period of this review, the Hume Health Centre moved to the use of electronic dosing of methadone in some areas of the prison, with the implementation of an idose system which uses iris scanning technology to ensure accurate identification of detainees receiving ORT. This transition was generally implemented smoothly, and I am satisfied that the use of idose should reduce risk of human error and double dosing. However, following a serious overdose incident occurring in February 2018 it has become apparent that risk of dosing error may be increased where staff do not use the idose machine during machine down-times and instead manually dispense doses. I have recommended that idose be rolled out to all areas of the AMC and be used consistently, and that additional safeguards be put in place to address heightened risk associated with manual dosing.

Prevention of, and response to, the diversion of methadone is important in managing risks posed by an ORT program. Our observations indicate that procedures to prevent diversion are not being implemented consistently by Corrective Services and I have recommended that this be rectified. Where a detainee persists in diverting methadone and places others at risk, it may be necessary to consider involuntary withdrawal from ORT treatment, however this must be done in a way that is consistent with clinical standards and human rights. I have recommended that the Clinical Procedure be amended to reflect this obligation.

The review considered throughcare arrangements for continuation of ORT in the community. A key issue identified was the lack of data available on the number of former detainees who continue to receive ORT in the community following their release from custody. It is vital that this data is collated and monitored to allow effective intervention to reduce apparently high rates of attrition from community based ORT programs.

This review also briefly examines context of the ORT program, which must be coupled with counselling and rehabilitation programs. Such programs are available at the AMC but take up has apparently diminished over the last year. The review notes the importance of a structured day within the prison, to reduce boredom and drug seeking behaviours. The availability of a needle syringe exchange program would also reduce risks of harm from illicit drug use in the prison.

The Commissioner thanks the executive and staff of ACT Corrective Services and ACT Health, in particular staff of Hume Health Service for their assistance with this investigation.

RECOMMENDATIONS

Assessment

1. That Justice Health Services improve its process for assessment of eligibility for the ORT program at the AMC by:

    a) Requiring relevant collateral information to be obtained to assist to verify information provided by detainees, where there is not clear objective evidence of opioid dependence.

    b) Encouraging prescribing doctors to make use of confidential urine screening where appropriate to provide additional support for decision making.

    c) Requiring prescribing doctors to refer matters to the ORT Clinical Meeting for review where there is a lack of objective evidence to corroborate information provided by the detainee regarding opioid use and dependency.

    d) Ensuring that the ORT Clinical Meeting is conducted as envisaged by the Methadone Management Review Report and that all parties are invited to attend each meeting, including an addiction medicine specialist from the Wruwallin Clinic, and a representative from Justice Health Forensic Mental Health Services.

    e) Capturing accurate data of outcomes of all applications in relation to ORT to allow appropriate benchmarking against practice in the community and in other jurisdictions.

2. That Justice Health ensures that an individual case plan is prepared for all vulnerable detainees being inducted onto the ORT program, as required by the ACT Guidelines, including Aboriginal and Torres Strait Islander detainees.

3. That all Aboriginal and Torres Strait Islander detainees be offered annual Aboriginal Health Assessments, and that ACT Health continue to seek an exemption to allow a Medicare rebate for these assessments occurring at the AMC. In the meantime, funding for these assessments should be considered in arrangements made between ACT Health and Winnunga Nimmityjah Aboriginal Health Service to implement recommendation 5 of the Moss Report.

4. That ACT Health establish a process for a periodic file review (at least once each year) of Hume Health Centre ORT assessment decisions, to be conducted by addiction medicine specialists from the Wruwallin clinic, to assist in maintaining consistency, appropriate record keeping and equivalence with assessment practice in the community.

Induction and Monitoring

5. That Justice Health staff provide training to Corrective Services staff to observe signs of intoxication and overdose.

6. That ACT Health and Corrective Services make arrangements for Naloxone to be available at the AMC and ensure that it is able to be administered in an emergency situation, including an emergency occurring after-hours.

7. That Justice Health provide readily available, accessible information to detainees about signs of intoxication and overdose to enable detainees to identify and assist other detainees in emergency situations.

8. That Corrective Services routinely share information with Justice Health Services regarding the detection of illicit drug use or relevant contraband held by a detainee on the ORT program, to allow Justice Health to monitor and review dosing, and to educate detainees about risks of combining illicit drugs and prescribed methadone.

Dosing

9. That ACT Health ensure that:

   (a) As far as possible, idose is used for all methadone dosing at the AMC to address risks of identification errors, and that ACT Health and Corrective Services work together to upgrade dosing areas to allow idose machines to be installed or used in each area where methadone dosing occurs.

   (b) Additional procedural safeguards are immediately developed and implemented within Justice Health to ensure safety and accuracy of dosing in situations where the idose machine is not operable and methadone is required to be dispensed manually.

   (c) The Clinical Procedure for Opioid Replacement Treatment is amended to include a requirement to inform Corrective Services immediately of any detainee overdose, to ensure that the detainee can be adequately monitored and supported.

Preventing and Responding to Diversion

10. That Corrective Services immediately implement the procedures for prevention of diversion of methadone stipulated in the *Corrections Management (Management of Medication) Procedure 2011*.

11. That Corrective Services provide staff with refresher training regarding policy and procedures for searching and observation of detainees who are dosed with methadone.

12. That Justice Health revise its Clinical Procedure for ORT to provide further guidance to clinicians about considerations for involuntary withdrawal, consistent with practices in the community, including detainee rights to procedural fairness and humane treatment.

Throughcare

13. That ACT Health establish systems to accurately track and monitor the percentage of detainees inducted onto methadone at the AMC who continue methadone treatment in the ACT community after their release, both in the short term and longer term.

14. That ACT Health increase support and aftercare for detainees to continue to access methadone in the community to address the apparently high level of detainees who discontinue ORT on release.

15. That ACT Health consider a pilot program for detainees who are stable on methadone at the AMC to transition directly to dosing at a community pharmacy rather than Building 7 to address reported barriers of distance and unwanted associations.

Other issues

16. That the Justice and Community Safety Directorate, Corrective Services and ACT Health undertake further work to progress the implementation of the ACT Government policy of a needle syringe program in the AMC, consistent with services available in the ACT community, to reduce risks of blood borne virus transmission.

REVIEW METHODOLOGY

The review was conducted by the Health Services Commissioner and a small team of experienced staff within the Commission, with a combination of legal policy and clinical expertise.

The review was informed by a range of sources including primary documents and data requested from ACT Health and ACT Corrective Services; observation of practice; review of clinical files and health records and in-depth interviews. ACT Health and ACT Corrective Services have been helpful and co-operative in accommodating requests made by the Commission, and have actively assisted and facilitated interviews, file reviews and visits.

During the course of the Audit, the review team observed a medication round and dosing of methadone in a number of settings within the AMC, before and after the introduction of 'idose' and also observed methadone dosing in the community at the Wruwallin Clinic in Building 7 at the Canberra Hospital. The team had the opportunity to speak in depth with an addiction medicine specialist and staff at the Wruwallin clinic, to provide a comparative perspective between the operation of the ORT program in the AMC and in the community.

The team interviewed five current detainees at the AMC, including detainees who had been inducted onto the ORT program at the AMC and detainees who were found not to be eligible for the program. They conducted interviews with eight staff members (including the Clinical Director, Assistant Director of Nursing, prescribing doctors, policy officer and nursing staff who administer methadone) at Hume Health Centre and with two senior Corrective Services officers. The Commissioner also met regularly with senior staff of ACT Health and Corrective Services and with key stakeholders regarding the progress and interim findings of the review. The team also met with management and clinical staff of Winnunga Nimmityjah Aboriginal Health service.

The team conducted a detailed review and assessment of twenty clinical files and records of detainees who had been inducted onto the ORT program between April and October 2017. The Commission has an ongoing oversight role in relation to the AMC, and the Health Services Commissioner attends bi-monthly oversight meetings at the prison. The Health Services Commissioner also handles enquiries from detainees and investigates individual complaints relating to health services provided within the AMC. The information and insights obtained through these individual matters have also informed the Commissioner's review.

RELEVANT STANDARDS

In conducting this review, the Commissioner assessed current practice in the ORT Program at the Hume Health Centre, AMC, against applicable standards for the provision of ORT services within the prison environment, including human rights standards, regulatory requirements and clinical guidelines. Key standards are set out below.

HUMAN RIGHTS STANDARDS

The *Human Rights Act 2004* provides legislative protection for human rights of all people in the ACT. These rights must be considered in formulating policy for the AMC and in decision making and actions by public authorities. Relevant human rights include the right to equality (s 8), the right to life (s 9), the right to be free from torture and cruel, inhuman and degrading treatment, or medical treatment without consent (s 10), the right to privacy (s 12) and humane treatment when deprived of liberty (s 19). The distinct cultural rights of Aboriginal and Torres Strait Islander peoples protected in s 27(2) are also significant in relation to the health care provided to Aboriginal and Torres Strait Islander detainees.

In interpreting these rights, s 31 provides that international law, and the judgments of foreign and international courts and tribunals, relevant to a human right may be considered.

The key international human rights standard on humane treatment in prison is the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), which were revised in 2015. The Mandela Rules set out a range of minimum requirements regarding health care in prison, including Rule 24 which enshrines principles of equivalence with community standards and continuity of care:

1. The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

2. Health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence.

The *Corrections Management Act 2007* also contains minimum requirements regarding health services for detainees in the AMC. Section 53 provides that the Director General (of the Justice and Community Safety Directorate) must ensure that detainees have a standard of health care equivalent to that available to other people in the ACT; and timely treatment where necessary, particularly in urgent circumstances; and, as far as practicable, necessary health care programs, including rehabilitation programs.

The United Nations Declaration on the Rights of Indigenous Peoples is also relevant to the health care provided to Aboriginal and Torres Strait Islander detainees. Article 23 provides that Indigenous

peoples have the right to be actively involved in developing and determining health programs affecting them and, as far as possible, to administer such programs through their own institutions.

CLINICAL STANDARDS

MEDICINES, POISONS AND THERAPEUTIC GOODS ACT 2008 AND REGULATION

The prescribing and supply of controlled medicines including methadone and buprenorphine used for ORT is governed by the *Medicines, Poisons and Therapeutic Goods Act 2008* and *Medicines, Poisons and Therapeutic Goods Regulation 2008*.

Methadone and buprenorphine are Schedule 8 controlled medicines under the Commonwealth Poisons Standard, as they are associated with an increased risk of abuse, dependency or diversion. The Poisons Standard is adopted by the *Medicines Poisons and Therapeutic Goods Act* and Regulation, which impose additional approval requirements for the prescribing and supply of ORT.

Section 557 of the Regulation provides standing interim approval for doctors at a correctional centre to prescribe buprenorphine or methadone for a detainee in accordance with approved guidelines for treatment of opioid dependency in the ACT (the ACT Opioid Maintenance Treatment Guidelines). Prescribing doctors must make an application to the Chief Health Officer under s 560 of the Regulation within 72 hours for ongoing approval for each individual patient who is prescribed ORT. Under s 561 the application for approval to prescribe ORT to a patient must specify whether in the designated prescriber's opinion, based on reasonable grounds, the patient is a drug-dependent person in relation to a controlled medicine or prohibited substance.

ACT OPIOID MAINTENANCE TREATMENT GUIDELINES

The ACT Opioid Maintenance Treatment Guidelines have been approved under s 630 of the *Medicines, Poisons and Therapeutic Goods Regulation 2008*, as guidelines for treatment of opioid dependency in the ACT.[2] The ACT Guidelines provide specific guidance to ACT Health employees and other practitioners in the ACT context. They provide guidance regarding authority to prescribe and dispense ORT; the information that should be provided to patients being inducted onto an ORT program and the consent required from patients for information sharing. It also makes provision for special population groups, including people who identify as Aboriginal or Torres Strait Islander and detainees being released from prison. A revised version of the ACT Guidelines was released by ACT Health as this report was being finalised in late February 2018. [3] The revised Guidelines include expanded and updated content and are consistent with the National Guidelines. However the approach of the ACT Guidelines remains consistent. References in this report to the ACT Guidelines are to the version current during the investigation period.

[2] *Medicines, Poisons and Therapeutic Goods (Guidelines for treatment of opioid dependency) Approval 2010 (No 1).*

[3] Opioid Maintenance Treatment in the ACT: Local Policies and Procedures available at http://www.health.act.gov.au/sites/default/files/Opioid%20Maintenance%20Treatment%20in%20the%20ACT%20-%20Local%20Policies%20and%20Procedures%202018.pdf.

NATIONAL GUIDELINES FOR MEDICATION-ASSISTED TREATMENT OF OPIOID DEPENDENCE

The National Guidelines for Medication-Assisted Treatment of Opioid Dependence, dated April 2014 ('National Guidelines') have been approved by an Intergovernmental Committee on Drugs as part of the National Drug Strategy. These consolidated guidelines update and replaces previously separate clinical guidelines for use of methadone, buprenorphine and naltrexone.

The National Guidelines provide a broad policy context and a framework for medication assisted treatment of opioid dependence. They seek to establish national consistency in approach whilst acknowledging jurisdictional responsibility for health care and legislative requirements in relation to controlled substances.[4] The National Guidelines also provide detailed clinical guidance on issues such as assessment and induction.

CLINICAL PROCEDURE FOR OPIOID REPLACEMENT TREATMENT – JUSTICE HEALTH SERVICES 2017.

The operation of the ORT program at the AMC has been guided by the Standard Operating Procedure of Justice Health Services on *Management of adult patients receiving Opioid Replacement Treatment (Methadone (Biodone ©), and Buprenorphine + Naloxone (Suboxone ©) at the Alexander Maconochie Centre and Periodic Detention Centre.* During the course of this review, a new *Clinical Procedure for Opioid Replacement Treatment – Justice Health Service* was drafted and approved, which sets out more detailed requirements for assessment, diversion, dosing and discharge planning. A number of changes required in the new Clinical Procedure have already been introduced in practice.

OTHER POLICIES AND PROCEDURES

There are also a number of related policies and procedures relevant to the ORT program at the AMC which have been considered in this review. In particular, the *Corrections Management (Management of Medication) Procedure 2011* provides guidance on the role of correctional officers in relation to the observation and prevention of diversion of medications including ORT.

THE ROLE OF OPIOD REPLACEMENT TREATMENT IN PRISON

The National Guidelines recognise that the health, social and economic costs to the individual and the community associated with the use of illicit drugs, including opioids, are substantial and include premature mortality, reduced quality of life and productivity and drug related crime. Dependent opioid users are at most risk of overdose and other health harms and are more likely to be criminally active.[5] Opioid dependency is regarded as a chronic, relapsing condition, and it is recognised that for people who are opioid dependent, abstinence is not easily achieved or maintained.[6]

[4] National Guidelines p 6.

[5] National Guidelines p 64.

[6] National Guidelines p 2-3.

The broad goal of treatment for opioid dependence is to improve health outcomes and promote wellness.[7] ORT is a well-established, evidence-based medical treatment for opioid dependency, which seeks to minimise the harm to an individual and community associated with the ongoing use of illicit or prescription opioids. It achieves this by substituting a regular and monitored dose of a long-acting opioid (methadone or buprenorphine) for the opioid on which the client has developed a dependency. This treatment aims to provide stability for the client, to reduce risks of overdose and other health and social harms, and encourage positive lifestyle changes which may eventually allow a client to successfully achieve abstinence from opioid use.

The ACT Guidelines recognise that ORT is an important part of treatment for many individuals, but needs to be part of a holistic program:

> Treatment for opioid dependence is guided by the principles of harm minimisation. Opioid maintenance treatment for opioid dependence should be part of a comprehensive program with access to counseling and other health services available for all individuals.[8]

The National Guidelines also note that best outcomes for opioid dependence are achieved with treatment that combines medication and behavioural interventions.[9]

In accordance with the human rights standard of equivalence, health care available for opioid dependence in the community should also be available within prison settings. The National Guidelines note that:

> Pharmacological treatment of opioid dependence should be accessible to all those in need, including those in prison and other closed settings.[10]

Accessible treatment for opioid dependence is particularly important in the prison context, as the prison population has a higher rate of opioid use than the general community, and treatment for drug dependence can assist rehabilitation, as well as reducing risks of harm.

Prisoners in Australia report significantly higher rates of opioid and injecting drug use than the general community on entry to prison.[11] Lifetime heroin use is up to 10 times higher in the prison population and prisoners are 20 times more likely to inject drugs than the general population.[12] In the 2016 ACT Detainee Health and Wellbeing Survey conducted at the AMC, 55% of detainees surveyed reported having ever used heroin, and 32% having ever used other opiates.[13] Approximately one-third of respondents (35%) reported injecting illicit drugs once a day or more often in the month prior to their current incarceration. In the survey 29% reported having used

[7] ACT Guidelines p 3.

[8] ACT Guidelines.

[9] National Guidelines p2-3.

[10] National Guidelines p 4.

[11] Australian Institute of Health and Welfare: The Health of Australia's Prisoners 2015.

[12] The Burnet Institute Report - External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre 2011 p 43.

[13] ACT Detainee Health and Wellbeing Survey 2016 p 41.

heroin while in prison, and 19% reported having used other opiates while in prison. The survey also found that 19% of respondents reported having injected drugs during their current period of incarceration.[14]

While there has been a decline in the use of heroin in the Australian community since 2010, in favour of drugs such as methamphetamine (ice),[15] this has been counterbalanced by increasing rates of addiction to prescription opioids such as oxycontin, tramadol and endone, reflecting significant shifts in practice in the use of opioids for pain relief. Australian opioid dispensing episodes increased from 500,000 prescriptions in 1992 to 7.5 million prescriptions in 2012 and it is now apparent that the ongoing use of these medications can lead to dependency and misuse.[16] There is a higher prevalence of misuse of prescription medication amongst female prisoners, with just over one-quarter of women in prison reporting misuse of analgesics/painkillers (27% of women compared with 11% of men).[17]

Prisoners are more likely than others in the community to be opioid dependent, and face greater risks of harm from their addictions, both inside prison and on release. While drug use is generally reduced in prison due to limited supply, many injecting drug users will continue to inject in prison and the use that occurs within prison is typically more risky, carrying a greater risk of blood borne virus transmission and other harms as a result of sharing needles.[18] Prisoners who are opioid dependent may incur debts to other prisoners in order to maintain their habit, and may be subject to violence and stand-over demands as a result. Prisoners with a history of opioid dependence who cease use in prison also have a high risk of relapse on release from prison, and are at increased risk of overdose on release, due to reduced opioid tolerance while in prison.[19]

There is substantial evidence that for prisoners who are opioid dependent, ORT is effective in reducing harms, and assisting rehabilitation, particularly where that treatment is continued in the community.[20] A longitudinal study following NSW prisoners over a ten-year period, found a 20% reduction in re-incarceration and a decrease in mortality for those who left prison on methadone and remained on it after release.[21]

Accordingly, to be consistent with human rights principles of equivalence, and to maximise prospects of successful rehabilitation, ORT should be accessible in prison to detainees who are opioid dependent and for whom this treatment is determined to be clinically appropriate, without a

[14]ACT Detainee Health and Wellbeing Survey 2016 p 42 - 43.

[15] Australian Institute of Health and Welfare: Alcohol and other drug treatment services in Australia 2014–15 p29.

[16] Currow D, Phillips J, Clark K. Using opioids in general practice for chronic non-cancer pain: An overview of current evidence. Med J Aust 2016; 204(8):305–09.

[17] Australian Institute of Health and Welfare: The Health of Australia's Prisoners 2015.

[18] Ibid.

[19] National Guidelines p148.

[20] Rich, Josiah D et al. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomised, open-label trial The Lancet , Volume 386 , Issue 9991 , 350 – 359.

[21]Larney S, Toson B, Burns L, Dolan K: Effect of prison-based opioid substitution treatment and post-release retention in treatment on risk of re-incarceration. *Addiction*. 2012 Feb;107(2):372-80.

'cap' on numbers in the program, or other arbitrary restrictions. Continuity of treatment on release is essential to realise the full benefits of ORT.

However, it is important to note that while ORT is a key evidence-based treatment for opioid dependency, it involves risks that must be addressed in accordance with regulation, clinical standards and human rights obligations. As discussed further below, ORT is only appropriate (and may only be legally prescribed) for detainees with an established opioid dependency, as it can cause addiction, the very harm it is intended to treat, if prescribed for detainees who do not have a history of opioid dependence.

Methadone is more difficult to transition off than buprenorphine, and carries a greater risk of overdose,[22] but is generally preferred in the prison context because it is less easily diverted. Accordingly, because of the serious consequences of induction onto the ORT program, a thorough assessment process is vital to determine eligibility for ORT. This is particularly important in the prison context, where there are a range of factors including stress or trauma, boredom, financial motivation or pressure from other detainees, which might lead detainees who are not actually opioid dependent to seek ORT while in prison.

The right to life also imposes a positive duty on prison and health authorities to protect all detainees from risks of harm arising from the ORT program within the prison. Risks associated with induction onto ORT, of incorrect dosing and overdose, of 'topping up' with illicit drugs and diversion to other detainees (who may not be opioid tolerant) must be addressed and minimised.

ORT PROGRAM AT THE AMC

The AMC is the ACT's only adult prison and accommodates both male and female detainees, including those on remand and those who are serving a sentence, at all levels of classification.

Primary health care services within the AMC, including the ORT program, are provided by Justice Health Services, a division of Mental Health, Justice Health and Alcohol & Drug Services (MHJHAD) within the ACT Health Directorate. Health services are structurally separate from the operational aspects of the prison which are managed by ACT Corrective Services, but corrective services staff play an important role in supporting medication rounds, including observing detainees being dosed with methadone and taking steps to prevent diversion.

ORT services are provided from the Hume Health Centre which is situated inside the prison. The Hume Health Centre is based on a community health centre model, with a hierarchy of care, with nurses offering first point of contact for detainees and general practitioners providing the secondary level of care. There is currently no AOD specialist practitioner within the Hume Health Centre and general practitioners make the assessment regarding a detainee's eligibility for induction onto ORT. Advice can be sought by AMC doctors from the AOD specialists at the Wruwallin Clinic. A Clinical Meeting has also recently been established which has already met several times at the AMC.

[22] National Guidelines p 21.

Methadone (in the form of biodone) is the preferred medication for ORT at the Hume Health Centre. Buprenorphine (in the form of suboxone) is only available for limited periods to manage withdrawal on entry and shortly before release to reduce risk of overdose in the community. A short trial of suboxone maintenance was conducted at the AMC but was ceased due to allegations of widespread diversion.

ORT (methadone) has been provided through the Hume Health Centre since the prison commenced operations in 2009. Since that time the prison population at AMC has expanded rapidly, from 158 detainees in July 2009 to 441 in 2016 and the prison has increased its capacity from approximately 270 to 539 through the addition of new accommodation units. [23] However, the Hume Health Centre facility has not been expanded since commencement, placing strain on health services and facilities which were not designed for the current number of detainees.

Since the opening of the AMC, the proportion of detainees receiving methadone has remained relatively constant, at around 30% of all detainees, but as the actual number of detainees prescribed methadone has grown, this has increased the time and resources required for induction, review and daily dosing.[24]

EARLIER REPORTS

A number of earlier reports have examined the provision of health services at the AMC and have considered the operation of the ORT program. The finding of these reports are discussed in further detail where relevant to particular aspects of this review.

KNOWLEDGE CONSULTING REPORT 2011

Knowledge Consulting, led by Keith Hamburger, was engaged in 2010 to conduct an independent review of operations at the Alexander Maconochie Centre. This fulfilled a government commitment to conduct a review of the AMC after 12 months of operation. The wide-ranging review provided detailed recommendations in relation to all aspects of operations, including health services.

This report made recommendations for improvements to clinical record keeping in the Hume Health Centre. As discussed below, the report also made a recommendation, which was subsequently implemented, regarding a review of the medication policy and increasing the period for which a detainee is separated from others following dosing with methadone.

BURNET INSTITUTE REPORT 2011

The Burnet Institute was engaged to independently evaluate drug policies and services at the AMC. Their 2011 Final Report: *External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre*, raised a range of concerns about the ORT program at AMC, in particular:

[23] Australian Bureau of Statistics: Prisoners in Australia, 2016 table 14; Moss Report p 22.

[24] Justice Health Services, Methadone Management Review Report 2017, p 2.

- Delays in getting on to opioid pharmacotherapy if not on a program in the community
- No access to buprenorphine
- Some diversion of opioid pharmacotherapy and other medications occurring
- Perceived pressure to go on methadone for those not currently on a program
- Irregular dosing times experienced by prisoners
- Lack of advice and consultation for prisoners regarding reduction schedules
- Lack of support experienced by prisoners wanting to cease opioid pharmacotherapy following a reduction schedule
- Throughcare may be inadequate to ensure program retention post-release
- Further exploration of reasons for program cessation post-release is needed [25]

The Burnet report made a number of recommendations regarding these issues – discussed further below. A final status report in 2013 indicated that the implementation of agreed recommendations had been completed,[26] although many of the same concerns have continued to be raised by stakeholders in subsequent reviews.

HUMAN RIGHTS COMMISSION AUDIT OF CONDITIONS OF DETENTION OF WOMEN AT THE AMC 2014

This audit was initiated by the then Human Rights and Discrimination Commissioner to assess the conditions of detention of women detainees at the AMC, as a small minority of the prison population. The Commissioner examined women's access to a range of services and programs including healthcare. The report did not make specific findings regarding the ORT program but noted concerns raised by some detainees about the program, including waiting periods before commencing on methadone, detainees being put on methadone where this may not have been necessary and lack of access to buprenorphine.

THE AUDITOR-GENERAL REPORT ON THE REHABILITATION OF MALE DETAINEES AT THE AMC 2015

The Auditor-General's report examined the adequacy of programs and services for the rehabilitation of male detainees. This report did not consider the operation of health services, including the ORT program, but did report concerns raised by stakeholders that methadone was provided to detainees who did not require it; and that methadone doses were increased with little consideration.[27]

[25] Burnet Institute Report 2011

[26] ACT Health: Final Status Report - Implementation of supported recommendations from the ACT Government's Final Government Response to the Burnet Report. <http://www.health.act.gov.au/datapublications/reports/alcohol-tobacco-and-other-drugs/burnet-institute-report>.

[27] ACT Auditor General: The Rehabilitation of Male Detainees at the Alexander Maconochie Centre. Report No. 2/2015, p128-129.

MOSS INQUIRY REPORT: SO MUCH SADNESS IN OUR LIVES 2016

The Moss Inquiry examined the treatment in custody of Mr Steven Freeman, an Aboriginal man who died at the AMC on 27 May 2016. The Inquiry considered a range of aspects of Mr Freeman's treatment in custody including the accessibility and appropriateness of health and other support services within the AMC for Steven Freeman and the extent of the consideration given to Aboriginal culture, traditions and beliefs in the management, care and custody of Steven Freeman.

The Inquiry did not consider issues surrounding the cause of death of Mr Freeman, as this is the subject of the Coronial Inquest, but noted the concerns of Mr Freeman's family about his induction onto methadone, and uncertainty about the use of methadone at the AMC.[28]

JUSTICE HEALTH SERVICES METHADONE MANAGEMENT REVIEW REPORT 2017

During the course of the Commissioner's review, Justice Health Services conducted an internal review of the methadone program at the AMC and the Commission was provided with a draft and final report of this internal review. Justice Health Services staff visited interstate correctional centres in Wellington and Nowra in NSW and Metropolitan Remand Centre and Port Phillip Prison in Victoria, to compare the Hume Health Centre programs with ORT programs run in these prisons. This internal review also involved consideration of current procedures and forms. The review recommended revisions to the assessment, induction and dosing procedure to reflect best practice in other jurisdictions. Many of these changes have already been implemented.

CORONIAL INQUESTS – ONGOING

The Commissioner is aware that assessment and prescribing of methadone at the AMC has also been the subject of detailed evidence in the Coronial Inquest into the death of Mr Steven Freeman, and that specific recommendations may be made by the Coroner in relation to these issues. The Commission has been informed by the extensive evidence provided to the Coronial Inquest, however, this review is concerned with current rather than historical practice and does not examine the specific circumstances that are the subject of that Coronial Inquest. The Commission is also aware of a Coronial Inquest into the death of detainee Mr Mark O'Connor at the AMC. This review does not examine the circumstances that are the subject of that ongoing Coronial Inquest.

[28] Moss Report p 64.

ASSESSMENT AND PRESCRIBING PRACTICE AT AMC

A key focus of this review is to examine the process of assessment of suitability of detainees for induction onto the ORT program at the AMC, to address uncertainty about these issues noted in a number of previous reports.

The Justice Health Services Methadone Management Review states that: "At any given time approximately 30% of the AMC detainee population is participating in the JHS ORT program. This percentage has been consistent from the initial commissioning of the AMC (200 detainees) to 450."[29]

The proportion of detainees prescribed methadone at the AMC at around 30% is the highest of all Australian jurisdictions, with the Australian Institute of Health and Welfare reporting a national average of 6% of detainees on methadone at discharge in 2015, excluding NSW which did not provide data.[30]

However, this figure masks a wide variation in levels among States and Territories, as the Northern Territory and Tasmania provide for continuation of methadone treatment for detainees who were prescribed methadone in the community, but do not provide induction onto ORT in prison, and Queensland provides ORT only for female detainees.[31] NSW and Victoria have the second and third highest percentage of detainees prescribed methadone at around 12%[32] but programs in these jurisdictions are also subject to an artificial cap on numbers, so that not all eligible detainees are able to access ORT on request.

A number of earlier reports have touched upon ORT assessment and prescribing practices at the Hume Health Centre, and have reported a range of stakeholder concerns. A consistent theme of these reports is the perception of some stakeholders that ORT (and in particular, methadone) is being prescribed for some detainees in circumstances where it may not be clinically indicated.

The Burnet Institute Report noted in 2011 that:

> Some prisoners, ex-prisoners, community service providers and correctives services staff were concerned that prisoners experienced undue influence from health staff to commence methadone, especially after they had detoxed from other drugs.[33]

The ACT Human Rights Commission's Audit on the conditions of detention of women at the Alexander Maconochie Centre noted mixed views, but reported the account of a female detainee who was placed on methadone at her own request after having been clean for 6 months, and later regretted this treatment:

---

[29] Justice Health Services, Methadone Management Review Report 2017, p 2.

[30] Australian Institute of Health and Welfare: The Health of Australia's Prisoners 2015 p 105.

[31] Ibid 2015 p 104.

[32] Australian Institute of Health And Welfare: National opioid pharmacotherapy statistics (NOPSAD) 2016; The Canberra Times: Figures show ACT has almost three times the rate of prisoners taking methadone, 9 December 2017.

[33] Burnet Institute Report p 107.

> I didn't have no habit, nothing, it just seemed like a really good idea at the time… And I just said to the doctor 'I feel like using' and bang, methadone.[34]

The Auditor-General, in her report on the rehabilitation of male detainees at the Alexander Maconochie Centre noted that:

> A number of stakeholders reported concerns about the provision of methadone to detainees: that methadone was provided to detainees who did not require it; and that methadone doses were increased with little consideration.[35]

The Moss Review concluded that "there is uncertainty about the use of methadone at the AMC" and noted that Mr Steven Freeman's case "has again brought this uncertainty to attention."[36]

Although these reports have highlighted stakeholder concerns, these reports did not specifically examine the clinical decision making in the ORT program and did not make findings or recommendations regarding assessment and prescription of methadone at the AMC.

STANDARDS FOR ASSESSMENT

As specified in the Regulation and ACT Guidelines, approval to prescribe ORT for a client requires a diagnosis by the prescribing doctor that the client is opioid dependent. The National Guidelines note that:

> Establishing a diagnosis of opioid dependence is a requirement for opioid substitution treatment |R|. The International Classification of Diseases (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) provide widely accepted definitions of dependence.

The ICD definition provides that:

> Opioid dependence is defined by the presence of three or more of the following features present simultaneously at any one time in the preceding year:
>
> - a strong desire or sense of compulsion to take opioids;
> - difficulties in controlling opioid use;
> - a physiological withdrawal state;
> - tolerance;
> - progressive neglect of alternative pleasures or interests because of opioid use;
> - persisting with opioid use despite clear evidence of overtly harmful consequences. [37]

The DSM IV criteria for opioid dependence are very similar:

---

[34] ACT Human Rights Commission: Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre 2014, p 127.

[35] ACT Auditor General: The Rehabilitation of Male Detainees at the Alexander Maconochie Centre, p 128-129.

[36] Moss Report p 64.

[37] International Classification of Diseases, 10th edition (ICD-10).

A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by three or more of the following occurring at any time in the same 12 month period:

- Tolerance as defined by either of the following:
  - A need for markedly increased amounts of opioids to achieve intoxication or desired effect;
  - Markedly diminished effect with continued use of the same amount of opioids.
- Withdrawal as manifested by either of the following:
  - The characteristic withdrawal syndrome for opioids.
  - Opioids or a closely related substance are taken to relieve or avoid withdrawal symptoms.
- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful attempts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain opioids, use opioids, or recover from their effects.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- The opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

The updated DSM V no longer includes a specific diagnosis of opioid dependence but replaces separate diagnoses with a broader diagnosis of substance abuse disorder, with different degrees of severity. It also adds a criteria of craving, which is now recognised as one of the fundamental criteria of substance use disorders, and as a feature that may persist during remission.

In determining whether a client is opioid dependent and whether they are suitable for ORT, the National Guidelines provide that a comprehensive assessment should be undertaken, including taking a detailed substance use history, conducting a physical and mental state examination and an assessment of intoxication and withdrawal. It notes that collateral information should be incorporated where appropriate:

> Initial assessment of a person using opioid drugs should follow standard practice for assessment of a complex clinical condition and incorporate collateral information where appropriate |S|. Collateral information might be obtained from other health care providers, family members, partners and carers as well as regulatory and prescription monitoring systems, according to usual standards of privacy and confidentiality.

The National Guidelines indicate that urine drug screening may assist where there is some uncertainty about the history provided by the client, and can corroborate accounts of recent opioid use:

> Urine drug screening is useful to corroborate patient history and establish recent opioid and other substance use. However delays in obtaining results should not delay treatment initiation where the diagnosis can be clearly established |C|.[38]

[38] National Guidelines, p 11.

The National Guidelines also recognise that in some circumstances ORT may be appropriate where a client has a history of opioid dependence but has not recently used opioids, and thus may not have opioid tolerance or symptoms of withdrawal, due to circumstances such as detoxification, incarceration or hospitalisation. It states that:

> Some patients may not have recently used opioid drugs, but nevertheless have a history of opioid dependence and a high risk of returning to opioid use (e.g. following release from prison). It may be appropriate to offer substitution treatment with methadone or buprenorphine even when neuroadaptation is not evident, after consultation with specialist services |S|.

We understand that methadone has been prescribed to detainees at the AMC in some cases for relief of chronic pain rather than opioid dependence. The Moss Report stated that "ACT Health told the Inquiry methadone is not only prescribed as an opiate substitution for heroin use, it is also prescribed for chronic pain management."[39]

While some detainees who are opioid dependent may also have chronic pain issues (and may have developed an addiction to other opioids originally prescribed for pain management), Biodone liquid (the form of methadone used in the ORT program at AMC) is registered only for the management of opioid dependence, not for pain management.

The revised Clinical Procedure notes that:

> the long-term use (greater than 4 weeks) of opiates is associated with reduced benefits because of the development of tolerance to the analgesic properties. For non-cancer chronic pain there is little evidence for benefit of long term use, more than 3-4 months (Medicinewise, 2015). [40]

In our view, it is not appropriate for detainees with chronic pain, but without an existing opioid dependence, to be inducted onto the ORT program solely for pain management, unless this is done with the support and advice of a pain specialist.

CURRENT PRACTICE OF ASSESSMENT AT AMC

In considering current practice at the AMC, the review team examined the relevant procedures, evidence of clinical files and information provided in interviews.

REVISED PROCEDURE

The Justice Health Services Methadone Management Review identified a need for a revised Clinical Procedure. The Review noted that:

[39] Moss Report p 63.
[40] Canberra Hospital and Health Services Clinical Procedure: Opioid Replacement Treatment – Justice Health service, p 14.

> [The existing procedure] was developed when the prison population was less than 200 and issued in 2014. Since this time, the procedure has not been reviewed against new ORT trends and amended to reflect the increased number of detainees in the prison.
>
> At the time of this review JHS were not using any standardised forms for assessment of suitability onto the ORT program. There were also no forms used for the formal collection of observations prior to dosing clients for the first days of ORT induction.
>
> A review of clinical written documentation of clients that were commenced on methadone showed an inconsistency in the information that was documented in the clients' clinical record. It is important to acknowledge that the while the review does not indicate that the questions were not asked, it does indicate that there is an inconsistency in the information that is documented. [41]

In 2017, a revised Clinical Procedure was developed. This procedure was initially provided to the Commission in draft form, but aspects of the procedure were being implemented during the period of the review. A final version was subsequently provided. This revised procedure provides that:

> Induction is indicated for clients who
>
> - Are opioid dependent and at the time of entering a secure setting are not on an ORTP
> - Continue using opioids (licit or illicit) in a secure setting in a manner which constitutes a significant risk of harm
> - Are at significant risk of using opioids in a secure setting or on discharge.

While previously all aspects of assessment were conducted by a medical officer, the new procedure introduces a three-phase approach to determine a detainee's suitability for ORT. This brings the assessment process in the ACT more closely into line with the process followed in the Wruwallin clinic in the community and with prisons in Victoria and NSW.

Under the new procedure, requests by detainees to go onto the ORT program are first triaged by a registered nurse, who determines whether they fall within a priority category, which includes pregnant women, Aboriginal and Torres Strait Islander detainees, detainees with HIV or hepatitis B and detainees with significant co-morbid conditions (mental or general health). Detainees in the priority category are scheduled for assessment as soon as possible rather than waiting for routine assessment appointments.

Phase two for all applicants is a Drug & Alcohol nursing assessment. This includes the taking of a history of drug use and treatment, provision of information about risks and benefits of ORT and clinical procedures such as an ECG scan. The Drug & Alcohol nurse may decide that a detainee is not eligible for ORT, but these decisions are reviewed by the ORT Clinical meeting.

The function and composition of the ORT Clinical Meeting is described in the internal review report as follows:

[41] Methadone Management Review p3.

> The aim of an ORT clinical meeting is for ORT clinical decisions to be peer reviewed and to allow open discussion regarding complex ORT clients residing in a secure health setting. The membership of this meeting will include and is not limited to:
>
> - Justice Health Services Primary Health
> - o Assistant Director of Nursing
> - o Medical Director
> - o Clinical Nurse Consultant
> - o AOD nurse
> - o General Practitioners
> - Justice Health Services Forensic Mental Health Services
> - o Clinical Nurse Consultant
> - Justice Health Services Dhulwa Mental Health Unit
> - o AOD nurse
> - Pharmacy
> - ADS Addiction Specialist

However, as discussed below, since these meetings have commenced, we understand the membership of the meetings has been more limited, comprising only Justice Health Services primary health staff and a representative of Forensic Mental Health Services. Justice Health have informed us that an Aboriginal Liaison Officer has also attended this meeting. However, the ADS addiction specialist and other external members have not been invited to attend these meetings.

Phase three is an assessment by the medical officer. The procedure notes that:

> To minimise concerns about clients commencing ORT without a history of opioid dependence, the medical officer will consider all assessment information compiled by the JHS team before completing the medical assessment
>
> --
>
> The decision to commence a client on ORT is the responsibility of the medical officer, however, all collateral information should be considered prior to the commencement of treatment. The medical officer must clearly demonstrate the potential benefits to the client's health and well-being and confirm that benefits outweigh the potential risks of a client commencing ORT.

As discussed below, the revised procedure incorporates a number of measures to improve the consistency of clinical decision making and use of collateral evidence to verify opioid addiction, to be more consistent with the National Guidelines. This review recommends some further measures to improve the assessment process.

REVIEW OF CLINICAL RECORDS

The review team conducted an analysis of the clinical records of assessment of detainees inducted onto the ORT program at the AMC over the period from April to October 2017. The team had also requested to review files where an assessment had been conducted but had *not* resulted in

induction onto the ORT program, but the data kept at the Hume Health Centre did not allow these files to be readily identified.

The Hume Health Centre has, until very recently, used a paper based file system rather than an electronic record management system. This form of record keeping had serious limitations in terms of the legibility of clinical notes, effective use of forms (eg through drop down menus), lack of electronic reminders for follow ups and tests, and the ability to share information easily. It also meant that parts of the file such as medication charts might be taken on medication rounds and were thus not available for review in the paper file. The Health Services Commissioner raised concerns with Justice Health Services during this review about the reliance on a paper based filing system. An electronic record management system has now been developed by ACT Health and commenced implementation in the Hume Health Centre from October 2017.

It was evident from our file review that some changes to procedure recommended by the internal review, such as new consent forms to be signed by detainees, were being put into place, although the procedure itself had not yet been finalised. The latest assessment records were generally more detailed and thorough than historical assessments on the files, some of which had insufficient detail.

In most cases the files contained detailed notes describing the assessment and findings of the medical officer which were clear and easily understood. All assessments included a history of the detainee's drug use including reports of opiate use, a physical examination and an assessment of withdrawal symptoms, although forms recording scores on clinical scales such as the COWs were not used consistently. Each file contained records of the medical screening undertaken on entry to the AMC which included detainee's accounts of drug use in the community and ratings of withdrawal symptoms on induction to the prison.

The majority of assessment decisions appeared to be relatively straightforward as many detainees had been in prison on previous occasions and had a documented history of multiple episodes of opioid use, evidence of withdrawals on induction to AMC, and previous periods of participation in the ORT program in prison or in the community.

The review did not find any instances in this period where methadone in liquid form was prescribed for the treatment of chronic pain rather than opioid dependence.

However, a small number of files reviewed did not indicate an externally corroborated history of opioid use but appeared to rely on subjective history given by the detainee of opioid use within prison and largely subjective accounts of withdrawal symptoms. These accounts were not confirmed by physical evidence such as track marks, as the detainees reported smoking heroin or misusing prescription opioids including buprenorphine within the prison.

In one such case, a second opinion had been sought from the Clinical Director and a decision made to induct the client onto ORT following this review. In another case a detainee was initially not diagnosed as opioid dependent, and was twice determined not to be eligible for the ORT program, due to doubts about the veracity of his account of opioid use and lack of objective evidence. However, following a further request, the detainee had an appointment with a different medical officer and was inducted onto the program.

There were no records of the use of urine drug screening as part of the assessment in the files reviewed. In particular, urine drug screening was not sought to corroborate the accounts of detainees regarding recent opioid use where there was little objective evidence of opioid dependence.

The review team found limited evidence of health records being sought from other treating practitioners in the community to corroborate a history of opioid dependence. There was no evidence of medical officers seeking information from family or partners (which would of course require the consent of the detainee). There is also no evidence that medical officers have access to corrective services records regarding detection of illicit drug use.

There was no evidence in these files of individual case plans for Aboriginal and Torres Strait Islander detainees as required by the ACT Guidelines, or of culturally based supports being sought for Aboriginal or Torres Strait Islander detainees. It did not appear that requests were regularly being made to Winnunga Nimmityjah Aboriginal health service for details of their records regarding Aboriginal or Torres Strait Islander detainees who may have been clients of that service.

Discussions with clinical staff at Winnunga suggested that their client records are rarely requested by the Hume Health Centre, even though many detainees are clients of Winnunga and this service has extensive records that would provide a more detailed picture of clients' health and background. Winnunga staff emphasised that they have processes in place for sharing records (with client consent) and could provide these records with minimal delay if requested.

The team also reviewed brief minutes of several ORT Clinical Meetings that had been held since the commencement of the new procedure. Participants were limited to Justice Health Primary care staff and it did not appear that external participants had been invited to attend. The meetings focused on reviewing clients assessed as ineligible for the ORT program by the drug & alcohol nurse. In most cases this initial assessment was confirmed, and the client was not admitted to the program. It did not appear that prescribing doctors were bringing complex cases to the meeting for discussion, but this may be because the drug and alcohol nurse assessment was effective in identifying these clients.

PERCEPTIONS OF STAKEHOLDERS

Health staff

Justice Health staff interviewed considered that the clinical decision making in relation to assessment for the ORT program at the AMC had always been consistent with the National Guidelines, but agreed that the internal review had been helpful in improving documentation and ensuring consistency of decision making.

One prescribing doctor explained that there is 'no foolproof objective test' to determine opioid addiction, particularly as urine drug screening could be manipulated by detainees and could give both false positives (through the deliberate taking of painkillers with codeine) and false negatives (due to the short time that opioids can be detected in urine). It was noted that the urine screening available is not effective in detecting buprenorphine, which is an opioid that is known to be used

illicitly by detainees at the AMC. This doctor re-iterated that assessment is an area of clinical judgment that relies on a combination of subjective and objective evidence.

Staff were well aware that detainees might be motivated to seek methadone when they were not actually addicted to opioids, and reported rejecting many applications where detainees presented inconsistent or unconvincing accounts of opioid use. However, they felt that it was not always possible to prevent a detainee who is very knowledgeable and convincing 'gaming the system'. They noted that an approach that relied solely on objective evidence of addiction would necessarily exclude some detainees who genuinely required treatment but could not provide this evidence.

Nevertheless, there was agreement amongst health staff that the availability of additional evidence and background information could help inform clinical decision making. The involvement of a drug and alcohol nurse in the assessment process was viewed as positive development, and it was noted that a number of detainees who had been assessed by the drug and alcohol nurse were found to be ineligible for the ORT program. These assessments were further considered by the Clinical Meeting, which had generally endorsed the nurse's assessment.

Health staff who participated in the Clinical Meeting found this a useful opportunity to discuss the approach to assessment and did not see the need for the involvement of an external specialist in this meeting. However, staff were generally comfortable with the suggestion of a periodic audit of assessment documentation by specialist staff at the Wruwallin clinic.

Detainees

Interviews conducted by the review team with detainees at the AMC suggest that there is a perception that methadone is easy to obtain at AMC, and that there is a culture of sharing information about how to get onto the ORT program.

One detainee noted his experience of being encouraged to seek methadone when he was using drugs recreationally in prison but was not necessarily opioid dependent:

> Other boys said to me that it makes time go easier and lets you sleep as much as you want. They said that time flies when you are on methadone and you don't have to pay for your drugs.

A number of detainees indicated concerns about methadone being prescribed when it was not necessarily required:

> They need to be more vigilant about who gets on it. Some boys just go on it to get high, and so they can sleep during the day. The doctors should be able to tell if someone has a drug history. If they aren't using a lot, why create an ongoing problem by making them dependent on methadone?

> The medical staff do need to tighten their ropes a bit when it comes to the methadone. They don't do urine testing on entry so they can't tell if a detainee is using when they come in. Then a boy can say he was using on the outside and they can't tell any different.

> Some people just choose to get on it for kicks. People get bored in here and don't have the motivation to do anything. You need to get people the right treatment. They should check what their outside GP had them on.

However, another detainee noted that he had sought to be placed on the methadone program but had not been assessed to be eligible:

> It is hard to get in to see the GP. I asked to be put on methadone. Put in my form with the nurse and had to wait seven weeks for an appointment. I'd been using some bupe [buprenorphine] in the prison about twice a week and was costing me a bit of money. When I saw the doctor I only got to see them for about 10 minutes. They asked me about how much I was using and how I was using. They did a urine test. The doctor felt that I wasn't in withdrawal and refused to put me on it.

The detainee noted that looking back he is glad he didn't get on it as "I won't have the hassle of getting off it and the stigma of being a druggie." The detainee is now studying and reported that he doesn't feel the desire for methadone or illicit drugs any more.

Correctional staff

Corrections staff interviewed noted concerns about detainees being placed on ORT in circumstances where, in their view, this is not warranted:

> I have personally seen detainees who were not on drugs get signed onto methadone. Others have been put on it for pain relief. Then they all keep upping the dose, and they just want to sleep all day and not participate in programs or education. It gives them dental problems and gives them an addiction. They are just going on it as an easy way to get through their sentence, most of them don't really have an addiction.

Winnunga Nimmityjah

Clinical staff at Winnunga Nimmityjah Aboriginal Health Service also expressed concerns about Aboriginal and Torres Strait Islander detainees being put on methadone in the absence of a holistic program to address issues of intergenerational trauma and other complex social needs. They noted that the trauma of incarceration can lead Aboriginal and Torres Strait Islander clients to seek methadone while in prison when they may not have been addicted to opioids in the community. Winnunga staff noted that clients may not fully appreciate the consequences of becoming dependent on methadone and how difficult it is to come off this treatment compared with other medication such as buprenorphine. They noted that while methadone can be a valuable and vital treatment for clients with opioid dependency, it poses particular difficulties for Aboriginal and Torres Strait Islander people and places restrictions on their life and opportunities. Many Aboriginal and Torres Strait Islander people in Canberra have family interstate, and Winnunga staff often need to make complex arrangements so that clients can obtain their methadone when required to travel at short notice for family and cultural reasons. There is a real risk that these clients may turn to illegal opioids where methadone is seen as too restrictive.

Winnunga staff stressed the importance of culturally appropriate care and of Aboriginal and Torres Strait Islander detainees having access to Aboriginal Health Assessments which are offered on an annual basis for Aboriginal and Torres Strait Islander clients in the community. These assessments address particular health risks and vulnerabilities of Indigenous clients as part of the strategy to Close the Gap on Indigenous Health outcomes.

CONCLUSIONS

The Commissioner is satisfied that there have been significant improvements in policy and practice of assessment for induction onto the ORT program at the Hume Health Centre since the tragic death of Steven Freeman and the findings of the Moss Review.

The new Clinical Procedure, which is informed by the National Guidelines, introduces a further screening process drawing on the expertise of a drug & alcohol nurse and provides for the collection and review of collateral information to support decision making. It also introduces standard forms for assessments which will help to ensure thoroughness in assessment and consistency of information obtained.

The Commissioner is satisfied that this new Procedure is being implemented and is having some impact in improving the consistency of assessments.

Nevertheless, the relatively high percentage of detainees prescribed methadone at the AMC, together with evidence of drug-seeking behaviours among detainees, indicates that further safeguards are required to ensure that this change in practice is sustained over time, and that detainees are not inducted onto methadone in the AMC when they are not opioid dependent. It is clearly inimical to the aims of rehabilitation to enable detainees who are not opioid dependent to become dependent on methadone while in prison.

We note that the revised clinical guidelines do not make reference to the use of urine drug screening to corroborate a detainee's account of opioid use. While the Commissioner is aware of the limitations of urine screening (which will only detect very recent opioid use and do not detect all forms of opioids), it remains a useful tool to provide additional information for medical officers to assist in decision making and use for this purpose is supported by the National Guidelines.

The Commissioner considers that to provide greater assurance of consistency with assessment practice in the community, that in all cases where there is a lack of objective evidence to corroborate opioid dependence, decisions should be referred to the ORT Clinical Meeting for review.

The Commissioner is concerned that while the internal review indicated that an addiction medicine specialist from the Wruwallin Clinic would attend the Clinical Meetings, this has not happened in practice. The meeting has also not included representatives from Forensic Mental Health Services, Dhulwa Secure mental health unit or Pharmacy as envisaged. While it may not be possible or necessary for all members to attend each meeting, the broader membership of the meeting is important, as a mechanism to ensure consistency with assessment practice in the community, and to sustain the changes to assessment practice and culture at the AMC that have occurred since the death of Steven Freeman. The Commissioner considers that the meeting should take place as

envisaged in the internal review report, and that a specialist from the Wruwallin Clinic be invited to attend this review meeting to provide guidance and input on a regular basis.

The Commissioner also considers that to embed good practice and to maintain consistency with community standards, an addiction medicine specialist from the Wruwallin Clinic should conduct a periodic review of a sample of documentation of assessment decisions regarding applications for the ORT program at the Hume Health Centre.

The Commissioner is concerned about a lack of specific case planning for Aboriginal and Torres Strait Islander detainees in respect of induction onto ORT. Such case plans are required by the ACT Guidelines. Aboriginal and Torres Strait Islander peoples are vastly overrepresented in the prison population in the ACT, and to assist in addressing this disturbing inequality it is vital that all aspects of treatment of Aboriginal and Torres Strait Islander detainees meet their cultural needs and support their rehabilitation.

It is also important that all Aboriginal and Torres Strait Islander detainees be offered annual Aboriginal Health Assessments as part of their broader health care at the AMC to ensure equivalence with community health care. These assessments have been developed to meet the specific needs and identified health risks of Aboriginal and Torres Strait Islander peoples, in order to close the gap in health outcomes between non-indigenous and Indigenous people in Australia.

Annual Aboriginal Health Assessments are covered by Medicare in the community: (Medicare Benefit Schedule (MBS) item 715), but currently, under s 19(2) of the *Health Insurance Act 1973* (Cth) Medicare benefits are not payable in respect of health services provided within correctional facilities. We understand that ACT Health is pursuing an exemption with the Commonwealth Government to allow Medicare funding for this particular item for Aboriginal and Torres Strait Islander detainees at the AMC. In the meantime, we consider that these assessments should be funded by the ACT Government in the same way as other health treatments provided at the AMC.

The Commissioner understands that progress is being made in negotiating arrangements for Winninunga Nimmityjah Aboriginal Health Services to provide holistic, culturally appropriate services for Aboriginal and Torres Strait Islander detainees within the AMC, including Aboriginal Health Assessments, which would achieve greater equivalence with care available to Aboriginal and Torres Strait Islander peoples in the Canberra community. Until these arrangements are finalised, where Aboriginal and Torres Strait Islander clients are treated by Justice Health Services, client records and assistance should be sought (with client consent) from Winnunga as a matter of course for these detainees.

RECOMMENDATIONS

1. **That Justice Health Services improve its process for assessment of eligibility for the ORT program at the AMC by:**

    a) **Requiring relevant collateral information to be obtained to assist to verify information provided by detainees, where there is not clear objective evidence of opioid dependence.**

b) **Encouraging prescribing doctors to make use of confidential urine screening where appropriate to provide additional support for decision making.**

c) **Requiring prescribing doctors to refer matters to the ORT Clinical Meeting for review where there is a lack of objective evidence to corroborate information provided by the detainee regarding opioid use and dependency.**

d) **Ensuring that the ORT Clinical Meeting is conducted as envisaged by the Methadone Management Review Report and that all parties are invited to attend each meeting, including an addiction medicine specialist from the Wruwallin Clinic, and a representative from Justice Health Forensic Mental Health Services.**

e) **Capturing accurate data of outcomes of all applications in relation to ORT to allow appropriate benchmarking against practice in the community and in other jurisdictions.**

2. **That Justice Health ensures that an individual case plan is prepared for all vulnerable detainees being inducted onto the ORT program, as required by the ACT Guidelines, including Aboriginal and Torres Strait Islander detainees.**

3. **That all Aboriginal and Torres Strait Islander detainees be offered annual Aboriginal Health Assessments, and that ACT Health continue to seek an exemption to allow a Medicare rebate for these assessments occurring at the AMC. In the meantime, funding for these assessments should be considered in arrangements made between ACT Health and Winnunga Nimmityjah Aboriginal Health Service to implement recommendation 5 of the Moss Report.**

4. **That ACT Health establish a process for a periodic file review (at least once each year) of Hume Health Centre ORT assessment decisions, to be conducted by addiction medicine specialists from the Wruwallin clinic, to assist in maintaining consistency, appropriate record keeping and equivalence with assessment practice in the community.**

INDUCTION AND MONITORING

The period of induction of a detainee onto methadone is a time of heightened risk, as methadone has a delayed and cumulative effect over a period of days during induction, and overdose may occur during this period where the dose exceeds a client's opioid tolerance. Methadone can also interact with other licit or illicit drugs (particularly other opiates or sedatives) with adverse consequences. Accordingly, induction is subject of detailed clinical guidance in the National Guidelines. Changes have been made to the practice of induction at the AMC following the death of Steven Freeman, including changes to the starting dose and monitoring, and the new regime is assessed against the National Guidelines in this section.

STANDARDS FOR INDUCTION AND MONITORING

The National Guidelines confirm that the goal of the first month of methadone treatment is to safely achieve an adequate dose of medication, stabilise the patient's opioid use, and to address co-

existing conditions.[42] They note that methadone has a delayed onset of action – with peak effects achieved two to four hours after dosing, and accumulates in a client's bloodstream during induction, and increases in effect until it reaches stability on a dose after approximately 4-7 days.

The National Guidelines require that:

> … Patients should be assessed two to three hours after a dose to observe the peak effects of methadone (assessing for intoxication), and 24 hours after a dose to assess the extent to which methadone dose is preventing withdrawal.

The Guidelines provide that all doses of methadone should be supervised, where possible, during induction and a clinician (which includes a nurse) should review the patient daily during the first week of treatment, corresponding to the greatest risk period for methadone-related overdose. This review provides an opportunity to assess intoxication or withdrawal symptoms, side effects, other substance use and general well-being of the client.[43]

The Guidelines provide that an appropriate starting dose is 20 – 30mg of methadone, and that:

> lower doses (e.g. 20mg or less) are suited to those with low or uncertain levels of opioid dependence, with high risk polydrug use (alcohol, benzodiazepines) or with severe other medical complications. Higher doses (30-40mg) should be considered with caution if clinically indicated, at the discretion of the prescriber. Consultation with a specialist is recommended before commencing patients at doses greater than 40mg because of the risk of overdose.

Although lower doses of methadone are safer and present less risk of overdose, there is a balance to be struck, as very low doses may be insufficient to prevent withdrawal symptoms, and there is a risk that this may lead detainees to take illicit drugs in addition to their prescribed methadone and that the combination of prescribed and illicit drugs may lead to an overdose. The Guidelines note that:

> While initial doses of methadone which are too high can result in toxicity and death, inadequate commencement doses may cause patients experiencing withdrawal symptoms to "top up" the prescribed dose of methadone with benzodiazepines or other opioid drugs. This can also have potentially lethal consequences.

The Guidelines state that prescribers should consider specialist advice or referral for patients with an unclear level of opioid tolerance, high-risk polydrug use, concomitant physical conditions or use of other medications that may affect the metabolism of methadone.

The Guidelines further provide that the dose should be gradually increased in order to achieve cessation (or marked reduction) in unsanctioned opioid use, and alleviation of cravings and opioid withdrawal features between doses, whilst minimising methadone side effects.

[42] National Guidelines, p 22.

[43] National Guidelines p 23.

REVIEW AND REVISED PROCEDURE

The Methadone Management Review confirms that the standard starting dose of methadone at the AMC had been 30mg daily. While this is within the starting dose range recommended in the National Guidelines, the Guidelines stipulate that lower doses are recommended where tolerance is low or uncertain. Comparative figures indicate that the 30mg starting dose was higher than starting doses in NSW, Victoria and New Zealand prisons, which ranged from 10-20mg.

The revised Justice Health Service Clinical Procedure for Opioid Replacement Treatment imposes a requirement that an induction dose generally be no higher than 20mg daily:

> Clients will commence on a methadone dose of no higher than 20mg daily. There may be situations where the medical officer deems it clinically indicated to commence the client on a starting dose of 10-15mg daily. For clients with uncertain or low opiate tolerance commencement on a methadone >20mg daily requires consultation with the Clinical Director. This discussion is to be documented in the client's clinical record.

The revised procedure also provides new safeguards for the induction period requiring that doses occur prior to 2pm and that detainees are assessed by nursing staff post dosing for the first five days:

> Clients new to ORT will be assessed for intoxication (using the ORT Monitoring form) prior to dose administration by the dosing nurses for the first 10 days of treatment. Clients will also be assessed 3-4 hours post dose for the first 5 days of induction.

This change ensures that the peak effect of a methadone dose occurs during daytime hours when nursing staff are available to observe detainees on afternoon mediation rounds and immediate medical assistance is available if intoxication or overdose occurs.

The procedure recognises the importance of the environment for induction dosing to enable nursing staff to properly assess intoxication levels:

> During induction to ORT, clients will be administered their first dose in the health centre prior to 2pm. All subsequent doses will be administered in a therapeutic environment that provides JHS nurses the ability to assess the client for intoxication. This is assessed on a case by case basis.

The procedure also introduces a new requirement to inform ACT Corrective Services in writing when a client commences induction onto methadone, and makes it a condition of entry into the ORT program that detainees consent to this information being shared with Corrective Services.

IMPLEMENTATION OF THE NEW PROCEDURE

A review of clinical records confirmed that starting doses have been reduced to 20mg per day on induction, and that notifications are made consistently to corrective services when a detainee is inducted onto methadone.

On our observation of the methadone medication rounds, nursing staff conducted checks of intoxication prior to dosing and undertook post-dose assessments of detainees who had received induction doses that morning. This was generally done by bringing a detainee partially into the dosing station, rather than making an assessment through the medication hatch.

Clinical records confirmed that these assessments were documented appropriately by nursing staff pre and post-dose as required by the new procedure.

Interviews with corrections officers suggested that while corrections staff were being notified of a detainee commencing methadone, information regarding illicit drug use or contraband detected by corrective services was not necessarily being shared with health staff to assist with monitoring and treatment of detainees on the ORT program.

Interviews also indicated there had not been adequate training for corrections staff regarding the symptoms of intoxication and overdose and how to conduct effective observations on detainees during the induction period. The Commissioner was informed that some detainees have participated in first aid training as part of their rehabilitation program, but there is not any broader provision of health information and education to detainees about detecting and responding to overdose.

The Commissioner was surprised that naloxone (a medication which blocks the effects of opioids to reverse overdose and is available for peer use in the community) is not available to be administered in the event of an overdose. We understand that currently, if an overdose occurs after-hours, when health staff are not onsite, naloxone could not be administered until paramedics arrive at the AMC to treat a detainee who has overdosed.

CONCLUSIONS

The Commissioner is satisfied that significant changes have been made to methadone induction procedure and practice at the AMC since the death of detainee Steven Freeman.

A reduction in the general starting dose of methadone from 30mg to 20mg, combined with more systematic observation and assessment during the induction period better aligns practice at the Hume Health Centre with the National Guidelines. The procedure allows prescribing doctors some flexibility to prescribe a higher dose to address withdrawals and reduce risk of 'top ups', with the approval of the Clinical Director, which is consistent with the Guidelines.

The notification of ACT Corrective Services when a detainee commences induction on methadone is also an important safeguard. While this requirement imposes a limitation on a detainee's right to privacy in relation to their health records, the Commissioner considers that this limitation is

reasonable as it serves an important purpose in enabling Corrections Officers to monitor detainees' health during the high-risk period of induction, and thus to discharge their duty of care to detainees. This is particularly relevant overnight when health staff are not present to observe detainees.

Conversely, the Commissioner considers that information collected by Corrective Services regarding the detection of relevant contraband or illicit drug use by detainees who are receiving ORT should be routinely shared with Justice Health Services. This information may be important to the monitoring of detainees on ORT, particularly during the induction period. Notification regarding illicit drug use would be helpful for therapeutic rather than punitive reasons, and could appropriately trigger a review by Justice Health to ensure that the detainee's dosing is appropriate to control withdrawals and that the detainee properly understands the risks of topping up ORT with illicit drugs.

To ensure that Corrections Staff are able to assist in monitoring the health of detainees during the induction period, training should be provided on the symptoms of intoxication and overdose, and procedure to be followed in relation to observations.

Other detainees will often be the first responders in an overdose situation, particularly where this occurs overnight within a shared cell. It is important that they are also given the knowledge and skills to identify intoxication and overdose, to provide first aid responses where necessary and to obtain immediate assistance from staff.

The Commissioner considers that naloxone should be made available at the AMC and that ACT Health and Corrective Services should make arrangements to ensure that naloxone is able to be administered as soon as possible in an emergency situation occurring after hours.

Recommendations

5. **That Justice Health staff provide training to Corrective Services staff to observe signs of intoxication and overdose.**

6. **That ACT Health and Corrective Services make arrangements for Naloxone to be available at the AMC and ensure that it is able to be administered in an emergency situation, including an emergency occurring after-hours.**

7. **That Justice Health provide readily available, accessible information to detainees about signs of intoxication and overdose to enable detainees to identify and assist other detainees in emergency situations.**

8. **That Corrective Services routinely share information with Justice Health Services regarding the detection of illicit drug use or relevant contraband held by a detainee on the ORT program, to allow Justice Health to monitor and review dosing, and to educate detainees about risks of combining illicit drugs and prescribed methadone.**

DOSING AND IDENTIFICATION

The accurate dosing of methadone as prescribed is a critical issue, as incorrect dosing may result in overdose and serious harm. Identification of detainees during dosing can introduce errors, particularly where detainees have similar names, are being observed through a hatch in a busy dosing environment and may in some cases deliberately seek to mislead clinical staff to obtain additional doses.

The Knowledge Consulting report noting that in the first year of operation there were two cases of double-dosing of methadone where a detainee was able to convince the nurse that he had not received his dose. [44]

Records provided to this review by Justice Health show that mis-identification and inaccurate dosing has been an ongoing issue at the AMC. Since 2012 there have been 22 reported incidents involving methadone dosing, and 8 of these were classified as overdoses. In 2016 a detainee was accidentally provided with the wrong dose, being 95mg of methadone when the prescribed does was 67.5mg. In the same year a detainee was mistakenly given another detainee's dose of methadone which was an overdose amount. In 2017 a near-miss incident was reported, with a detainee almost given two doses of 100mg instead of a single dose. In each case the mistake was reported immediately and responded to effectively, but the potential for overdose due to mistaken identity or double dosing remains a concern.

The Methadone Management Review identified concerns with mis-identification and states that "To decrease clinical risk of double dosing clients and increase safety surrounding identification of clients the implementation of an electronic methadone dosing machine is imperative. "

To reduce human error, a new dispensing and dosing system (idose) which uses iris recognition technology has been implemented at the AMC and commenced in August 2017. This system was already being used successfully in the Wruwallin Clinic at the Canberra Hospital and in several pharmacies in the ACT.

CURRENT PRACTICE

Methadone dosing occurs in the Hume Health Centre for detainees receiving their first induction dose and on an ongoing basis for some detainee cohorts, but most dosing occurs in the accommodation units in a dedicated morning medication round. Nursing staff take a trolley to a secure dispensing area within the accommodation unit and dispense methadone doses and water through a hatch to the waiting detainees, who are supervised by corrections staff.

We observed nursing staff carefully following protocols, with one clinician reading out names and prescription details while the other double-checked details. Prior to idose, detainees were required to present their prisoner identification card for verification before receiving their methadone dose.

[44] Knowledge Consulting report p 218.

Nevertheless, in those early rounds we observed, some detainees presented and received their dose without their card, as staff were apparently familiar with them. We observed that the process of identification (matching a detainee to their card and prescription) could be difficult, as the view of the detainee was in some cases obscured through scratches or tinting on the perspex window, and there was often a lot of noise and activity occurring during the dispensing process which made it difficult to hear names accurately. A number of detainees share surnames with others, adding to the confusion, and some detainees presented with clothing partially covering their faces.

The idose system was implemented in AMC from August 2017, following training and preparation of staff for the transition. Currently, there are two portable idose machines which are attached to custom designed trolleys. As at October 2017 idose was being used in the Hume Health Centre, Assisted Care Unit and Special Care Centre, with plans to roll it out fully to the Sentenced and Remand Units. We understand that it is not currently able to be fully rolled out to the cottages or management unit due to the configuration of the dispensing rooms in those areas. In particular, the dispensing hatch in the cottage area (formerly the women's cottages) opens to an outdoor space which is open to the elements and is not able to be fitted with an iris scanner.

Detainees are enrolled onto the idose database through an iris scan which is matched with their details and prescription. Detainees are then able to present for a scan and the machine automatically dispenses their prescribed dose, following a checking and authorising process conducted by the attending nursing staff. Staff report that the identification process has worked well, although a small number of detainees who had been enrolled on the idose database externally (at the Wruwallin Clinic) were not immediately recognised by the iris scanner. However this difficulty was able to be immediately rectified.

Once a detainee has received their prescribed dose from any idose machine, the idose software records this and prevents that detainee from receiving any further doses that day. An alert for renewal of methadone prescription is also automatically generated by the idose system before the prescription expires.

Where idose is not able to be used directly, a procedure has been developed where nursing staff will dispense methadone from the idose machine in the Health Centre into individual labelled bottles in accordance with prescriptions (although this process was still being finalised when we observed). These doses will then be taken to the accommodation units and dosing will proceed in the usual way, which continues to require nursing staff to identify detainees and match them with prescribed methadone doses.

As this report was being finalised a new concern emerged. In February 2018 a serious methadone overdose incident occurred at the AMC. A detainee who had missed the usual dosing round due to illness sought methadone later in the afternoon. We understand that the idose machine at the Hume Health Centre had been turned off. Thus instead of using the idose machine, clinical staff dispensed a dose of methadone using a manual pump. Due to what appears to have been a misunderstanding about the concentration level of the methadone suspension, the detainee was given a dose significantly greater than prescribed. We understand the error was immediately realised and the detainee was treated by Hume Health clinical staff for overdose.

This significant error is cause for concern, and highlights a new risk where methadone is manually dispensed by Hume Health staff rather than being dispensed by a pharmacist or through the idose machine.

CONCLUSION

The move to an idose system is an important step in addressing concerns about inaccurate dosing of methadone at the AMC and the real risks of overdose as a result of human error. The adoption of this system is consistent with the identification system which is already in use in the community and which has been shown to reduce human error in dosing.

The Commissioner is satisfied that the idose system is working effectively in the areas in which it has been rolled out at the AMC, and that the use of this system will greatly reduce opportunities for mis-identification and double dosing.

The Commissioner remains concerned about the potential for mis-identification and error in dosing conducted in the cottage areas and management unit. While an idose machine will be used to dispense methadone for detainees in these areas, it is proposed that the iris scan function will not be used in these areas to identify detainees. Our observations indicate that these dosing environments and current practice are not conducive to accurate identification of detainees and that continuing to rely on the existing system will mean ongoing risks of overdose and potential limitation to detainees' right to life.

Further, the overdose occurring in February 2018 indicates an area of heightened risk, where the idose machine is not available (we understand in this case it was due to it being offline for recalibration) and doses are dispensed manually. In my view this incident underscores the importance of the roll-out of the idose machine in all areas of the prison to reduce the possibility of human error, and to ensure that the idose is available and used wherever possible. However, it is also important that staff are able to safely dispense manual doses where the machine (for whatever reason) is not available. I consider that specific procedural safeguards must be urgently developed and implemented immediately by Justice Health to address this risk, and all staff who may be involved in the dispensing of methadone given regular training to ensure that they are able to safely dispense methadone in this situation.

Recommendation

9. That ACT Health ensure that:

(a) As far as possible, idose is used for all methadone dosing at the AMC to address risks of identification errors, and that ACT Health and Corrective Services work together to upgrade dosing areas to allow idose machines to be installed or used in each area where methadone dosing occurs.

(b) Additional procedural safeguards are immediately developed and implemented within Justice Health to ensure safety and accuracy of dosing in situations where the idose machine is not operable and methadone is required to be dispensed manually.

(c) The Clinical Procedure for Opioid Replacement Treatment is amended to include a specific requirement to inform Corrective Services immediately of any detainee overdose, to ensure that the detainee can be adequately monitored and supported.

PREVENTING AND RESPONDING TO DIVERSION

The procedure for dosing must also minimise opportunities for diversion of prescribed methadone by detainees. In the prison environment diverted methadone is a tradeable commodity and the illicit supply of diverted methadone can place other detainees at real risk of harm and overdose. Where diversion is not effectively prevented, some detainees may be subject to 'standover' tactics and be pressured to seek methadone for others. Preventing and detecting diversion during and after dosing is generally the responsibility of Corrective Services rather than Justice Health Services.

The Knowledge Consulting report raised concerns about the period of separation and monitoring of detainees following methadone dosing noting that:

> When there are such short time frames for separation after receiving a dose, the likelihood that a diversion of methadone could take place is high. This is concerning because if the detainee receiving the diverted dose is unaccustomed to methadone, the potential for an overdose is high and the consequential risk of serious injury or death is also high. (p218)

The Report made the following findings:

- That due to the location and time constraints relating to the administration of medication in the AMC, the time that detainees spend in a separate area following methadone administration is as little as five minutes; (finding 13)
- That some jurisdictions have procedures in relation to methadone administration that specify 20 minutes after the last detainee has been dosed as the acceptable minimum time for separation of methadone recipients from other detainees (finding 14)

At that time, the management of medication policy provided that "the detainee must wait a minimum of 5 minutes to prevent the misuse or diversion of methadone, after which the detainee leaves the Medical Centre."

That report recommended:

> That … ACT Corrective Services examines the location of methadone administration and the period of time spent in isolation following the dose in conjunction with the AMC management team.

In response to this recommendation, the Procedure which sets out requirements for monitoring of methadone administration by corrections staff was reviewed and reissued, to require that detainees remain in the designated area for 15 minutes, or if housed in the Crisis Support Unit, for 30 minutes. The formula for methadone was also changed to incorporate Biodone to minimise the possibility of

diversion.[45] However, as discussed below, the Procedure is no longer consistently followed and the situation has been complicated by a subsequent General Manager's instruction.

While Corrections are responsible for the prevention and detection of diversion, Justice Health may also play a role in responding to ongoing diversion of methadone by a detainee on the ORT program. In some cases this may mean that a detainee ceases to be eligible to continue on the program because of the risks posed to other detainees. However, it is important that any steps taken by Justice Health are reasonable and consistent with the human rights of detainees and the therapeutic role of health services in the AMC.

RELEVANT STANDARDS

PREVENTION OF DIVERSION

The current Procedure, the *Corrections Management (Management of Medication) Procedure 2011* notes that it is mandatory that the administration of medication be monitored by a corrections officer to reduce the incidents of trafficking medication within the prison facility. The Procedure provides a clear and specific regime of monitoring for methadone, as follows:

> Step 1
>
> The detainee will attend the medication issue area with their detainee identification card (PID) and be positively identified by the corrections officer, supervising the medication issued. The detainee is not to have anything else in their hand and is not to be smoking. Health staff can be expected to refuse to provide medication to a detainee who is smoking.
>
> Step 2
>
> A frisk search and mouth check must be performed on all detainees presenting for treatment, to prevent misuse and diversion of Biodone.
>
> Correction officers must ensure that the detainee:
>
> - has his/her sleeves rolled down;
> - has his/her pockets turned out;
> - is holding nothing except an accepted means of identification;
> - has open clothing around the neck to ensure that no plastic bags or similar items or containers are being secreted; and
> - has no foreign material secreted in the mouth.
>
> All searches are to be conducted in accordance with the *Searching Policy* and *Procedure*.

[45] ACTCS Progress Report The Knowledge Consulting Report, Independent Review of Operations of the Alexander Maconochie Centre March 2012
http://www.justice.act.gov.au/publication/view/1837/title/progress-report-implementation-of

Step 3

Detainees will present their PID card and be positively identified by the Justice Health Staff supervising the treatment. The detainee will be directed to give their name and PID number.

Step 4

Each dose must be accompanied by the detainee's signature indicating that he/she has received the dose.

Step 5

Biodone administered

Step 6

After receiving the Biodone the detainee will drink the water provided by Health staff. The detainee will open their mouth, raise their tongue and, using their index finger, run their finger around their mouth.

Step 7

The detainee will wait a minimum of 15 minutes in a designated area to prevent the misuse or diversion of Biodone. Detainees housed in the CSU are to remain in the designated area for a minimum of 30 min. After the allocated time and once the corrections officer is satisfied that the detainee has taken the Biodone, the detainee will leave the area. Where the corrections officer has any doubt as to whether the Biodone has been swallowed, the detainee will remain separated from other detainees until the corrections officer is satisfied that the Biodone has been swallowed.

However, an Instruction issued by the General Manager dated 14 August 2014 on the subject of Dispensing Biodone stated that "there have been some changes to the procedure for dispensing biodone…Please note particular changes to step 7." This instruction then specifies a new step 7:

7. Detainee remains in the designated area until the staff person is satisfied that the detainee has taken the Biodone. The staff member will:

- Complete a check of the inside of the detainee's mouth
- Speak with the detainee so that detainee will communicate in a manner that satisfies the officer there is nothing in the mouth.

This instruction thus apparently overrode the requirement in the Procedure which stipulated a minimum waiting time of 15 minutes following dosing, and does not substitute any minimum period for waiting or separation of detainees. However, it is notable that the Procedure itself was not amended by Corrective Services and remains in force as a Notifiable Instrument, creating a degree of inconsistency and confusion about the applicable standard. We have been informed that this Procedure is being reviewed by Corrective Services.

Research on available standards and practices in other Australian jurisdictions indicates that a period separation of at least 5 minutes post dosing is generally practiced to prevent diversion of methadone, and that a longer period is considered desirable where practicable. For example, in a Coronial case in Western Australia it was reported that the practice at Casuarina Prison is that:

> The prisoners attending for methadone are then escorted to the clinic. They line up and are individually searched and their identification is checked against their photograph. An individual prisoner is then allowed through the locked gate before his identification is checked again and his name is ticked off the list. The prisoner then attends a window with a grille where the treating nurse again checks his identification before the prisoner is shown a pre-pack of methadone with his name on the front and his dose of methadone in it. The nurse then breaks the seal and pours the liquid methadone into about 100 mls of water. The prisoner signs for and is given the dose, and is required to drink it and an additional glass of water. **The prisoner is then required to stand and wait for about 5 minutes before his mouth is checked by a prison officer**. He is then permitted to leave the area and return to his unit.[46]

This regime was found by the Coroner to be comprehensive and to strike an appropriate balance in seeking to prevent diversion of methadone and limiting intrusion on prisoners' rights to privacy.[47]

The Queensland Corrective Services Procedure – methadone treatment provides that: "If practicable, prisoners should remain separate from the mainstream for a period of around 10 minutes after dosing." [48]

The World Health Organisation Guidelines for ORT also note that rates of diversion of methadone in prison settings are generally low but "can be reduced further by diluting the methadone and by keeping methadone patients separate from other prisoners for 30 minutes after dosing." [49]

RESPONDING TO DIVERSION

The National Guidelines recognise that it is sometimes necessary to discharge a patient from treatment for the safety or well-being of the patient, other patients or staff, and that this may be as a result of repeated diversion of medication as well as other serious issues such as violence or drug dealing.[50] They provide that rules regarding involuntary discharge should form part of the contract of treatment and be explained prior to induction.

The Guidelines note that a decision of involuntary discharge is a serious matter should be considered carefully in light of the increased risk of death that this involves. The Guidelines provide that while a

[46] 'Record of Investigation into Death of Shane John Robinson' (10 February 2015), Western Australia Coroners Court, p15.
[47] Ibid, p 33.
[48] Queensland Corrective Services Procedure – methadone treatment (August 2006)
[49] World Health Organisation Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence (2009).
[50] National Guidelines p 43.

rapid cessation may be necessary in extreme cases, a gradual taper of medication is preferred where possible. Patients being discharged must be warned about the risks of opioid drug use, of possible reduced tolerance to heroin and subsequent risk of overdose, and informed of other treatment options.

More generally, the National Guidelines note that the most commonly used treatment approach for ceasing OST is to undertake an outpatient gradual taper of the medication over several months, enabling time for patients to adjust to the necessary physiological, behavioural and social changes that arise during this process. The Guidelines confirm that withdrawal severity tends to increase as the dose approaches zero, with peak withdrawal discomfort usually described in the 1 to 4 weeks after cessation of dosing, and low severity symptoms (poor sleep, mood disturbances, cravings) often persists for several months.

The Guidelines state that "Most patients will tolerate a 5-10% reduction of the current methadone dose every 1 to 4 weeks in the dose of their medication, with the rate of reduction varied according to the indications and timeframe for withdrawal."[51]

CURRENT PRACTICE OF PREVENTION OF AND RESPONSES TO DIVERSION

PREVENTING DIVERSION

In methadone rounds observed by Commission staff, it was apparent that the requirements of the Procedure were not being consistently followed by Corrections staff. While Corrections staff were professional, attentive and respectful in their relationships with nursing staff and detainees, they did not consistently follow procedural steps designed to minimise diversion.

We did not observe any period of delay between detainees taking their methadone dose and being allowed to return to their cells or to join other detainees and activities within the accommodation units. In many instances detainees walked immediately back to their cell after dosing. There is a period of separation enforced by default when detainees are dosed at the Hume Health Centre as detainees are required to wait to be escorted back to their units by a correctional officer when one becomes available. By contrast, for dosing of suboxone (a form of buprenorphine mixed with naloxone, which is generally available only on a reduction regime at the AMC rather than for maintenance), a period of separation and strict observation of detainees was consistently observed by Commission staff.

While the lack of an enforced waiting period may reflect the reduced supervision requirements introduced by the General Manager's 2014 instructions, practice regarding other preventative measures was also observed to be inconsistent.

In several rounds of dosing, across different units, we observed only one instance where a detainee was required by corrections staff to open their mouth for inspection before receiving a dose of methadone, and in this case the detainee appeared surprised and refused the request. The detainee was still permitted to receive their methadone dose. We did not observe detainees being routinely

[51] National Guidelines p 42.

asked to open their mouths or speak to corrections staff after consuming their methadone dose and water.

Detainees were sometimes (but not consistently) frisk searched before dosing, but were never asked to turn out their pockets or to roll sleeves down. Detainees presented for dosing in some cases wearing hoods or clothing up over their heads (which could potentially conceal a container) and were not asked to uncover their heads.

RESPONDING TO DIVERSION

The Revised Clinical Procedure for Opioid Replacement Treatment provides a detailed regime for responding to diversion of methadone at the AMC. The Procedure provides that reduction or withdrawal from ORT is a clinical decision made for the safety of the client and not a punitive decision. It provides that where diversion is suspected or proven that clinical staff will discuss the issue with the detainee, with a particular focus on investigating and assisting with any concerns about standover issues. A second incident triggers a further review, and potentially involuntary withdrawal from the program, although this is not a mandatory consequence. The Clinical Director may become involved in more complex cases.

The Procedure provides that in the case of involuntary withdrawal the reduction regimen for methadone will be completed within four weeks. Consultation with the Clinical Director regarding the ongoing management of the client must occur where shorter or more extended timeframes for involuntary withdrawal regimens are being considered by the medical officer.

Our file review did not include any instances of involuntary withdrawal from methadone, noting the review was focused on new inductions on to methadone, but through the Commissioner's complaint handling role, the Commission is aware of cases where detainees have claimed they have been subject to an involuntary withdrawal regime much shorter than that recommended in community settings.

CONCLUSIONS

PREVENTING DIVERSION

We consider that the procedural steps specified in the current *Corrections Management (Management of Medication) Procedure 2011* are appropriate to prevent diversion, and should be adhered to by correctional staff. The status of the General Manager's instruction in overriding the waiting period required in the Procedure is unclear, given that the Procedure itself has not been formally amended.

Any amendment to this Procedure should take account of the importance of a reasonable period of separation and observation of detainees following methadone dosing, as recommended by the Knowledge Consulting Review, and consistent with practice in other jurisdictions, to reduce the risk of diversion of methadone and the serious harms this can cause.

The lack of adherence by Correctional staff to the range of procedural requirements to prevent diversion indicates a need for training and leadership to reinforce the importance of diligently following these requirements.

RESPONDING TO DIVERSION

While the new Justice Health Clinical Procedure for ORT provides flexibility for clinical decision making in response to diversion, it does not explicitly protect detainee rights to procedural fairness, or ensure that decisions do not unreasonably limit detainees' right to humane treatment or (potentially) their right to life.

It is important that detainees are afforded procedural fairness in any decision-making about involuntary withdrawal (for example not being subject to this regime on the basis of suspicion of diversion rather than established misconduct), and that they have a right to a review of any decision by the Clinical Director.

The National Guidelines and human rights considerations require that involuntary withdrawal from the ORT program only be initiated if there is no reasonably practicable alternative that would be less restrictive of a detainee's human rights, for example more stringent supervision of dosing, or separating the detainee for a period of time after dosing.

It is also important that where involuntary withdrawal is considered to be the only appropriate response to repeated diversion, that the withdrawal regimen be conducted in a way that humane, and consistent with good clinical practice as far as possible.

It is clear that a 4 week period for complete withdrawal is a much faster rate of reduction than would otherwise be clinically recommended, particularly for detainees on a high dose, noting that the National Guidelines indicate that a reduction of more than 5-10% of the current methadone dose every 1 to 4 weeks may exceed patient tolerance.

Where the detainee does not pose a significant risk to staff or other detainees, a longer timeframe for withdrawal is more likely to minimise withdrawal symptoms and risks of harm.

RECOMMENDATIONS

10. **That Corrective Services immediately implement the procedures for prevention of diversion of methadone stipulated in the *Corrections Management (Management of Medication) Procedure 2011*.**

11. **That Corrective Services provide staff with refresher training regarding policy and procedures for searching and observation of detainees who are dosed with methadone.**

12. **That Justice Health revise its Clinical Procedure for ORT to provide further guidance to clinicians about considerations for involuntary withdrawal, consistent with practices in the community, including detainee rights to procedural fairness and humane treatment.**

THROUGHCARE

While this review focuses primarily on the practice of assessment and induction of detainees into the ORT program, the issue of throughcare is critically important in ensuring the full benefits of the ORT program.

As discussed above, there is substantial evidence that for prisoners who are opioid dependent, ORT is effective in reducing harms, and assisting rehabilitation, but only where treatment is continued in the community on release.[52] In the longitudinal study of prisoners in NSW, participation in ORT in prison was not of itself significantly associated with reduced re-incarcaration rates, but the average risk of re-incarceration was reduced by 20% while participants who had been on ORT in prison continued in treatment post-release.[53]

Accordingly, the full benefits of induction into the AMC ORT program in reducing recidivism and serious health risks are likely to be realised only if detainees continue to participate in methadone maintenance treatment upon release into the community, rather than returning to illicit drug use. The overarching aim of treatment is to provide stability for clients on release, to allow them to participate in employment and other activities and to minimise the legal, health and social harms associated with the use of illicit drugs.

STANDARDS

The National Guidelines note that:

> The post-release phase of the treatment process has been found to be of critical importance in reducing the risk of relapse and further criminal activity among prisoners with drug dependence problems. Several studies show that effective aftercare is essential to maintaining the gains made in prison-based treatment of drug dependence. In addition to drug dependence treatment needs, many ex-prisoners have housing and financial difficulties and in some instances psychiatric problems. They may be released to either poor family support or deeply dysfunctional families and friends. For this reason, aftercare cannot be limited to drug treatment but needs to include social support services. Appropriate liaison between correctional centres and health services needs to be undertaken to ensure continuity of treatment for those released from prison. [54]

THROUGHCARE IN PRACTICE

The AMC has a well-developed throughcare program for prisoners released after serving a sentence of imprisonment, which includes assistance in finding and maintaining accommodation, obtaining

[52] Rich, Josiah D et al. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomised, open-label trial. *The Lancet* , Volume 386 , Issue 9991 , 350 – 359.
[53] Larney S, Toson B, Burns L, Dolan K: Effect of prison-based opioid substitution treatment and post-release retention in treatment on risk of re-incarceration. *Addiction*. 2012 Feb;107(2):372-80.
[54] National Guidelines supporting materials p148.

social security and establishing links to social services. Less supports are available to those detainees held on remand but subsequently bailed or acquitted, although the prison will try to assist these clients where possible.

For detainees on ORT at the time of release, Justice Health provide structured referrals to the Wruwallin Clinic at Canberra Hospital to enable continuity of methadone dosing in the community. Once patients are considered to be stabilised they can transfer dosing to a pharmacy rather than continuing to dose at Building 7.

However, despite these provisions, it appears that there is a high attrition rate for participation in ORT on release into the community. Figures provided by Justice Health indicate that in 2016-17, 74% of detainees referred to building 7 on release took up that referral but that three months post release only 33% of this 74% were still receiving their opioid maintenance at Building 7. This is only a slight improvement from 2015-16 where 78% of released detainees commenced initially but only 21% of this group had continued in treatment at Building 7 after three months. It was not possible to obtain reliable data beyond three months post release.

Part of the difficulty in interpreting these figures is that some former detainees may have moved interstate and others may have transferred their methadone supervision to another prescribing doctor once stabilised. ACT Health report that they have not yet developed a system that can accurately track the numbers of former detainees who continue to receive ORT in the community over time.

These apparently low retention rates and difficulties in obtaining clear data are consistent with concerns raised in the Burnet report, which stated that:

> Many interviewees raised throughcare as an issue for opioid pharmacotherapy. While arrangements may be made to continue opioid pharmacotherapy after release, it was considered by some prisoners and ex-prisoners that attending community clinics was undesirable after release as this would result in unwanted contact with peers. This desire to avoid peers post-release was reported as contributing to some individuals undergoing fairly rapid reduction schedules so that they could be off methadone by release. 'I'm not going out to the Woden Clinic there because there are a lot of dropkicks who go out there and hang around out there. Just don't want to go out there and see them. It just leads back into the same old crowd and same old people' (key informant). The limitations of the quantitative data on opioid pharmacotherapy mean it is difficult to determine if throughcare is the only reason for poor retention in opioid pharmacotherapy following release. Further exploration of reasons for program cessation, including how the acceptability of the public clinic could be improved or how other dispensing arrangements could be accessed, is warranted. [55]

[55] Burnet Institute Report p 111.

While only a small sample, our review of detainee health files also indicated a concerning cycle of detainees being inducted onto ORT while in prison, dropping out of treatment in the community and then being inducted back onto ORT on return to prison. For these detainees, the ORT program was not providing a stabilising influence nor helping to reduce recidivism when released into the community.

Similar concerns about stigma, mixing with drug taking peers, and transportation difficulties in getting to building 7 were also raised by detainees interviewed by this review.

CONCLUSIONS

Given the importance of continuity of treatment to realise the benefits of the ORT Program, it is essential that ACT Health develops a reliable system for tracking the number of former detainees continuing ORT on release, to accurately determine rates of retention in treatment over time and to identify factors that may be contributing to attrition. We note that the Chief Health Officer and Chief Pharmacist have access to electronic tracking of prescriptions for controlled medications (through the ACT Drugs and Poisons Information Service) and it may be possible to utilise this source of data, with appropriate privacy protection, to better understand patterns of prescribing and dosing post release for detainees who remain in the ACT community after release.

Given the consistent messages from detainees over time regarding the range of barriers to accessing treatment at Building 7, it would be helpful for ACT Health to explore other options for detainees to continue treatment on release. It may be possible to establish a pilot program where detainees who are stable on ORT at the AMC could be released to the supervision of a local general practitioner and dose at a community pharmacy, rather than being referred to the Wruwallin clinic at Building 7.

It is a positive step that the new Clinical Procedure allows Aboriginal and Torres Strait Islander clients to commence supervision of their methadone with Winnunga Nimmityjah Aboriginal Health Service. It will be important for these transitions to be managed effectively in advance of release, as Winnunga do not dose methadone and will need to make arrangements with a local pharmacy.

Recommendations

13. **That ACT Health establish systems to accurately track and monitor the percentage of detainees inducted onto methadone at the AMC who continue methadone treatment in the ACT community after their release, both in the short term and longer term.**

14. **That ACT Health increase support and aftercare for detainees to continue to access methadone in the community to address the apparently high level of detainees who discontinue ORT on release.**

15. **That ACT Health consider a pilot program for detainees who are stable on methadone at the AMC to transition directly to dosing at a community pharmacy rather than Building 7 to address reported barriers of distance and unwanted associations.**

OTHER ISSUES

REHABILITATION PROGRAMS

The National and ACT Guidelines recognise that ORT should be part of a comprehensive rehabilitation program with access to counselling and other health services available for all individuals. Accordingly, the Commission sought data from ACT Health and Corrective services regarding drug and alcohol programs available at the AMC. Figures were provided as at November 2017.

In addition to the ORT Program offered at the AMC, both Corrective Services and ACT Health offer a range of drug and alcohol rehabilitation options for detainees as follows:

- The Solaris Therapeutic Community Program is a residential program which includes a one month preparation phase, a four month treatment phase and a two month consolidation phase, as well providing assistance with transitioning to the community. The Solaris program is available to remanded and sentenced male detainees, and as of 17 November, had been successfully completed by 22 detainees in 2017.

- The Self-Management and Recovery Training (SMART) Program is a 20 hour psycho-educational program assisting all detainees with an alcohol, drug, or other addiction. It has been completed by 36 detainees thus far in 2017, which is noted to be a significant reduction from the previous two years, being 84 in 2016 and 113 in 2015.

- First Steps Alcohol and Drug Course is a 12 hour drug educational program, available to all detainees with offending behaviour related (but not causally connected) to substance abuse. It has, to 17 November, been completed by 8 male detainees in 2017.

- A two hour Harm Minimisation session, facilitated by the Corrections Program Unit, discusses strategies to minimise harm associated with drug and alcohol use. This session has been accessed by 62 male detainees in 2017, a significant increase from the previous two years.

- The Sober Driving Program is available to all sentenced detainees who have been convicted of two drink driving offenses in the past five years, or a number over 10 years. It offers an 18 hour group education program designed to increase understanding of the legal, health and social impacts of drink or drug driving. Ten detainees completed this program in 2016, however this program has not been accessed in 2017.

- Alcohol and Drug Awareness and Harm Prevention Training (ADAPT) is run by Directions ACT and commenced in 2017. This is a six hour program available to all detainees with an alcohol or drug, or other addiction. To 17 November, this program has been completed by 90 male detainees in 2017.

- Think First – Alcohol and Other Drugs is group counselling offered by CPSS to detainees accommodated in the Special Care Centre. Nineteen detainees have taken part in this program in the last 12 months.

Individual drug and alcohol counselling is also offered within the AMC, with sessions provided by Directions ACT and ACT Health Alcohol and Drug Service. Combined, these agencies have booked 162 sessions in 2017, of which 112 were completed. This represents a significant reduction from previous years, with 417 sessions completed in 2016, and 294 sessions completed in 2015.

ACT Health note that the reduction in the drug and alcohol sessions provided for 2016/17 has been impacted by the availability of the Alcohol and Drug Services AMC Counsellors due to temporary vacancies and difficulties recruiting to the area.

In relation to the individual counselling offered, it is unknown how many of the detainees accessed multiple sessions. However ACT Health have provided information that from September 2016 – September 2017, 51 detainees accessed counselling provided by Alcohol and Drug Services at the AMC, which was 152 occasions of service.

In addition to the specific programs mentioned above, detainees can access the Schema Therapy and Stress Less programs, which address drug and alcohol issues as part of a broader counselling program.

It appears that female detainees had a much lower uptake of rehabilitation programs and services than male detainees (only 6 female participants across all programs 2017). ACT Health note that ADS Counselling service rarely receive referrals for women at the AMC. Predominately, female detainees are referred to Directions ACT (a non-government organisation) and ACT Women's Health Service.

It is our view that ACTCS and ACT Health offer adequate drug and alcohol rehabilitation options for detainees and that these options complement the ORT program. Low numbers of women participating in drug and alchohol programs may indicate a need for more targeted drug and alcohol programs for women to address their specific needs.

STRUCTURE AND ACTIVITY

While not the primary focus of this review, in the course of considering the ORT program at the AMC, a number of interviewees raised concerns with the Commissioner and staff about the impact of the lack of structured activity on detainees, and the connection with detainees' drug-seeking behaviour.

Several detainees stated that a key motivating factor for drug seeking while in prison was to alleviate the boredom of an unstructured day and to allow them to 'sleep through' their sentence:

> There is no point withdrawing people from methadone if they have nothing to do during the day. Drugs wouldn't be so popular if there were more things to do.

> The boys don't want to work because they haven't done it before but they need to set that norm for us. We are humans and we are adaptable - and we are in prison to get better. Make us wake up at 7am and get out of bed and do things. They boys will whinge about any change but it's what they need, and it's ok, at least they will be only whingeing in their spare time rather than sitting around all day doing it.
>
> They need to be more vigilant about who gets on methadone. Some boys just go on it to get high, and so they can sleep during the day.
>
> People get woken up at 8am for muster but you don't have to get up, just have to move so they can tell you are alive. Most people stay in bed until later. There is not much to do on the block except cards, table tennis and gym.

Difficulties in ensuring structured work and activities for detainees at the AMC have been an ongoing theme considered in many of the reports and reviews discussed above. It is clear that these challenges reflect the complexities of a single ACT prison with a rapidly expanding population, accommodating male and female detainees, remanded and sentenced detainees, and detainees at all levels of security classification.

Nevertheless, it is important that there be a continuing focus on increasing work and training opportunities for all detainees, to provide structure and to decrease patterns of boredom and oversleeping associated with drug seeking.

NEEDLE AND SYRINGE EXCHANGE PROGRAM

Another issue intimately connected with the ORT program at the AMC is the absence of a needle and syringe program (NSP) at the AMC. The aim of an NSP is to reduce risk of blood-borne virus transmission in the prison and provide equivalence with programs available in the community. Justice Health staff identify risks of detainees contracting serious blood-borne viruses through needle sharing, including HIV and Hepatitis C, and the absence of an NSP appears to be is an underlying factor in clinical decision-making regarding induction into an ORT program at the AMC.

The ACT Human Rights Commissioner, in her 2014 Human Rights Audit on the Conditions of Detention of Women at AMC, recommended that the ACT Government continue to advance the introduction of a Needle and Syringe exchange program at the AMC, noting that "The Commissioner remains of the view that the principle of equivalence in health care requires that detainees have access to the same health services, including needle exchanges, as are available in the community."[56]

[56] Human Rights Audit on the Conditions of Detention of Women at the Alexander Maconochie Centre, p130-131.

We understand that a working group had agreed upon a medically supervised injecting room as the preferred model for a NSP at the AMC, [57] but that in September 2016 corrections officers again voted against the implementation of an NSP.[58]

We acknowledge the work undertaken by the Hume Health Centre in conjunction with Hepatitis ACT to provide curative treatment for detainees infected with Hepatitis C. ACT Health have informed us that in 2010 approximately 30% of detainees at the AMC were Hepatitis C positive. In July 2017, with the support of Hepatitis C treatment made available through the Pharmaceutical Benefits Scheme (PBS) in 2016, those figures have reduced to less than 2 percent. This is a significant achievement that will improve the health and life expectancy of many detainees into the future.

Nevertheless, sharing needles continues to pose a risk of HIV and other blood borne virus transmission. It is important that the issue of an NSP continue to be progressed by the ACT Government to find a workable solution to reducing risks of blood borne virus transmission at the AMC.

16. **That the Justice and Community Safety Directorate, Corrective Services and ACT Health undertake further work to progress the implementation of the ACT Government policy of a needle syringe program in the AMC, consistent with services available in the ACT community, to reduce risks of blood borne virus transmission.**

CONCLUSION

This review analysed current practice and operation in the provision of ORT at the Hume Health Centre at the AMC.

While a number of concerns have been raised about the program over time, it is clear that significant improvements have been made to the ORT program at the AMC since the death of Mr Steven Freeman. The implementation of the revised Clinical Procedure and associated changes will strengthen the consistency and rigour of assessment decision making. Changes have been made to address risks associated with the induction period, including changes to dosing, increased monitoring and information sharing. The move to an idose system is an important improvement to reduce risks of human error and misidentification of detainees. However, this system needs to be implemented consistently across the prison and immediate attention must be given to ensuring that methadone can be safely dispensed where an idose machine is not able to be used.

This report identifies areas where further work is required to maintain these improvements and to continue to strengthen the ORT program at the AMC, and makes a number of recommendations to safeguard and consolidate these improvements.

[57] Shane Rattenbury MLA: Preferred model for Needle and Syringe Program at the AMC, Media Release 15 July 2016.

[58] ABC News: Needle exchange program rejected for Canberra's jail, 17 Sep 2016 http://www.abc.net.au/news/2016-09-17/needle-exchange-program-rejected-at-canberra-jail/7854290.

As Health Services Commissioner I am committed to working with ACT Health and Corrective Services to assist and monitor the implementation of these recommendations over time, to ensure that the ORT program adheres to legislative and human rights requirements and clinical standards, and is effective in contributing to the rehabilitation of detainees at the AMC.