What works.
Alcohol and other drug treatment in prisons.
In brief.

People with alcohol and other drug problems are over-represented in the criminal justice system and prisons provide a unique opportunity to address these problems.

The dynamics of the relationship between alcohol and other drug use and crime is complex and treatment in justice settings should reflect evidence-based practice, and target factors that are associated with criminal behaviour.

It is important to address the needs of subpopulations of prisoners, including women, Aboriginal and Torres Strait Islanders, young adults, individuals with low literacy, those from diverse cultural and language backgrounds, and prisoners with comorbid mental health issues or an acquired brain injury.

Evidence of effectiveness is strong for:
- Prison needle and syringe programs
- Tailored cognitive behavioural therapy programs (both short- and long-term)
- Individual counselling
- Opioid substitution therapy
- Therapeutic communities
- Exit preparation programs (including pre-release centres)

Evidence of effectiveness is moderate for:
- Motivational interviewing
- Therapeutic groups

Evidence of effectiveness is insufficient for:
- Peer educator programs
- Contingency management
- Twelve-step peer support groups, except as an adjunct to therapeutic interventions
- Mindfulness based relapse prevention over ‘traditional’ CBT
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The prevalence of alcohol and other drug (AOD) use among people involved in the criminal justice system is significantly higher than the general population.

Data from the 2015 National Prisoner Health Data Collection showed that 67 per cent of prisoners reported use of an illicit drug in the previous 12 months (Australian Institute of Health and Welfare 2015), compared to about sixteen per cent of the general population aged 14 years and over in 2016 (Australian Institute of Health and Welfare 2017).

**Drugs other than alcohol**

National data from the Drug Use Monitoring in Australia program (DUMA) showed that in 2014 nearly 73 per cent of police detainees tested positive to at least one drug that was not alcohol (Coghlan, Criminology et al. 2015). That finding was consistent with an earlier study which found one third reported using two or more drugs in the 30 days prior to being detained (Sweeney and Payne 2011).

In 2012, 70 per cent of Australian prison entrants had used any illicit drug in the past 12 months, most commonly cannabis (50%) or methamphetamine (37%), followed by heroin (15%), ecstasy (9%) and cocaine (8%). A further 17 per cent had used analgesics/pain killers, 16 per cent reported tranquiliser or sleeping pill use, and 13 per cent had used ‘other’ analgesics (Australian Institute of Health and Welfare 2013).

**People who use drugs by injection**

A 2013 survey found that 45 per cent of Australian prison entrants had injected drugs at some time in their lives, while 67 per cent of that group had used a drug by injection in the month prior to the survey (Butler, Callander et al. 2015).

According to the 2015 Health of Australian Prisoners Report, 10 per cent of a sample discharged from prison reported using illicit drugs whilst in prison, and six per cent reported using drugs by injection while in prison (Australian Institute of Health and Welfare 2015).

One study found that among a group of people who injected drugs and had a history of imprisonment, almost one-half had injected while in prison (Fetherston, Carruthers et al. 2013).
Alcohol use

Risky alcohol use is also highly prevalent among prison populations. In 2015, 39 per cent of Australian prison entrants reported consuming alcohol during the previous 12 months at levels that placed them at risk of alcohol-related harm (Australian Institute of Health and Welfare 2015).

Certain groups of prison entrants were more likely to drink at risky levels such as offenders who were Aboriginal (54% vs. 33% of non-Aboriginal prisoners) and male offenders (40% vs. 28% for females).

Relationship between substance use and offending

The dynamics of the relationship between drug use and crime is complex, and the topic has generated a considerable body of literature over many decades.

Substance use has been associated with a range of offences including those related directly to drug possession or sale; offences related to drug acquisition such as stealing; and offences related to lifestyle factors that predispose people who use drugs to engage in criminal activity (National Institute on Drug Abuse (NIDA) 2012).

While debates continue over whether AOD use is a causal factor in criminal activity, evidence does show a relationship between levels of drug use and involvement in criminal activity (Payne and Gaffney 2012).

Data from the DUMA program indicated that nearly half of all detainees surveyed in 2013 reported that use of alcohol and or drugs was a contributing factor to their most recent offending (Coghlan, Criminology et al. 2015), which is consistent with international findings (Bahr, Masters et al. 2012). Furthermore, continued AOD use, concurrent alcohol and drug use in particular, has been shown to be predictive of re-offending (Dowden and Brown 2002).

Evidence also shows that different patterns of use have varying relationships with offending. For example, a 2008 meta-analysis of thirty predominantly US-based studies found that the likelihood of offending was about three to four times greater for people who used drugs when compared to those who did not, and that the odds of offending varied across different substances used: six times higher for people who used ‘crack’ cocaine, three times higher for people who used heroin, and one and a half times higher for people who used cannabis (Bennett, Holloway et al. 2008).

Implications for AOD treatment

Around half of all Australian prisoners are likely to meet criteria for substance dependence (Casey and Day 2014).

Given the high prevalence of AOD problems among people in Australian
prisons and the relationship between AOD use and its potential influence on re-offending, the period of imprisonment represents an excellent opportunity to deliver evidence-based treatment, which is described in Section 2.

**Context of AOD treatment in prisons**

AOD treatment within criminal justice settings should not only be delivered in accordance with the evidence base for effectiveness among the general population, but should also target factors that are associated with criminal behaviour, particularly the attitudes and beliefs that contribute to offending (National Institute on Drug Abuse (NIDA) 2012).

**The risk-need-responsivity model**

In the criminal justice system, the main aim of any intervention is to stop the person from re-offending. The risk-need-responsivity model (RNR) is commonly applied, and relies on:

1. assessment of risk of re-offending;
2. assessment of the factors that are associated with criminal behaviour (‘criminogenic needs’); and
3. treatment being matched to the person’s assessed level of risk and needs that will result in the best positive outcomes (‘responsivity').

Criminogenic factors that are amenable to change - so called ‘dynamic risk factors’ - are targeted by a matched type and dose of intervention (Wooditch, Tang et al. 2014). People with a higher risk of re-offending generally receive higher intensity interventions.

**AOD interventions**

AOD use is one of a range of dynamic risk factors open to change through evidence based treatment. Other dynamic risk factors include offending-related attitudes, beliefs and values; impulsive behaviour; and poor problem-solving, self-regulation and coping skills.

The following section on what works examines AOD use outcomes (e.g. reduced AOD use, reduction of AOD-related harms, improved quality of life) as well as impact on re-offending which is relevant to the criminal justice setting.
Effective AOD interventions for prisoners.

Addressing alcohol and other drug use by people in prison has been the subject of considerable investigation by researchers over the past two decades, and a number of informative and high-quality systematic and non-systematic reviews have been published in the last ten years.

Evidence-based treatment models that have been tested in a tightly controlled research context are often delivered differently in routine clinical practice. Although there may be practical reasons why facilitators of AOD treatment programs adapt these effective treatments to suit a particular context or prisoner group, research shows that the most effective programs are those that are delivered as originally intended (Miller, Miller et al. 2013).

In this section, we summarise the current evidence supporting a range of AOD interventions for prisoners with alcohol and other drug use problems, including criminal justice (e.g. effects on recidivism) and AOD use outcomes.

Screening and assessment

Accurate screening and assessment are crucial components of effective AOD treatment in the community and also in custodial settings.

The purpose of screening is to identify the presence of an AOD use problem, and the results assist in determining if a detailed AOD assessment is warranted (Jenner and Lee 2013).

Screening tools that studies have found to be sufficiently sensitive to detect a specific problem, and able to detect a specific problem (e.g. alcohol, cannabis, methamphetamine) are frequently used. Conducting screening with validated tools may significantly decrease numbers of inappropriate referrals for
comprehensive assessment (Jenner and Lee 2013, Department of Health and Human Services 2015).

Screening tools may be clinician administered, while many are suitable for self-completion.

Best practice guidelines for AOD treatment with adults in the criminal justice system indicate that screening should be conducted as early as possible after the offenders enter into the justice system (Center for Substance Abuse Treatment 2005).

If AOD use problems are detected through screening, a comprehensive assessment to determine the nature and extent of an individual’s drug problems is then conducted.

Due to the high prevalence of mental health issues among people entering prison, mental health should also be addressed during AOD assessment at intake (National Institute on Drug Abuse (NIDA) 2012, Department of Health and Human Services 2015).

A key barrier to effective treatment matching is assessments that rely on broad definitions of ‘drug use problems’. The assessment should be comprehensive and allow prisoners to be appropriately matched with an AOD program that is likely to meet their needs.

Repeated screening and assessment is also recommended for offenders whose readiness for AOD treatment and level of fear related to disclosing AOD use is likely to change over time (Center for Substance Abuse Treatment 2005).

Harm reduction programs

Offenders in custody have disproportionately high rates of substance use disorders and prevalence of blood borne viruses such as Hepatitis C virus (HCV) (Jürgens, Lines et al. 2010, Australian Institute of Health and Welfare 2013).

Prison based AOD programs are designed to not only address substance use but promote improvements in health concerns that are commonly associated with alcohol and other drug use.

AOD treatment planning that includes strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis is considered by the U.S. National Institute on Drug Abuse (NIDA) to be a key principle of practice for working with substance using offenders (National Institute on Drug Abuse (NIDA) 2012).

Harm reduction strategies aim to directly reduce the harms associated with illicit drug use for individuals, families and communities, without necessarily reducing drug consumption.

These strategies can include harm reduction education; needle and syringe programs; blood-borne virus testing and hepatitis vaccinations; provision of condoms and dental dams, and access
to methadone treatment (Rodas, Bode et al. 2012).

Research has shown that harm reduction interventions can reduce the spread of infectious diseases by reducing high-risk behaviours like needle-sharing and unprotected sex (National Institute on Drug Abuse (NIDA) 2012).

**Needle and syringe programs**

Needle and syringe programs (NSPs) are an evidence-based harm reduction intervention in the community that provide at the minimum, sterile injecting equipment to people who inject drugs, which has been shown to effectively reduce injecting risk behaviours (Wodak and Cooney 2006) and reduce the spread of blood borne viruses (Kimber, Palmateer et al. 2010, Aspinall, Nambiar et al. 2014).

Strong evidence in Australia and internationally has shown that the use of non-sterile injecting equipment in prisons is associated with extensive HIV transmission (Jürgens, Lines et al. 2010). Prison-based NSPs have been provided in over 10 countries and have been the subject of extensive evaluation. They reduce the rate of blood-borne viral transmission among prisoners who inject drugs and improve referral to, and uptake of, appropriate treatment among prisoners with drug dependence (Rutter, Dolan et al. 2001, Dolan, Rutter et al. 2003, Stöver and Nelles 2003, Lines, Jürgens et al. 2004, Niveau 2005).

Models of delivery have included anonymous syringe dispensing machines, direct distribution by prison health staff and/or non-government organisation workers, and distribution by prisoners trained as peer outreach workers. Despite concerns, prison based NSPs have not resulted in serious, unintended negative consequences (Jürgens, Lines et al. 2010).

While the ACT has been the first state or territory to incorporate the potential for a prison-based NSP into Government policy, no prison-based NSPs are as yet operational in Australia.

**Peer educator programs**

Peer education programs in AOD treatment services utilise trained peers (i.e. people who have in the past, or currently use AOD), to provide targeted drug-related harm reduction and health promotion information relevant to the needs of a specific group. The aim of peer education is to actively share harm reduction information via a perceived credible source, as well as promote a culture within the drug-using community that promotes healthier behaviours.

There is limited research on the efficacy of prisoner peer education approaches specific to AOD use education or counselling, however peer-led HIV education in prisons are widely used and evidence confirms their effectiveness in
reducing sexual and drug taking risk behaviours post-release (Devilly, Sorbello et al. 2005, Bagnall, South et al. 2015).

Community based peer education delivering HIV related information has been demonstrated to effectively increase HIV knowledge and reduce equipment sharing among people who inject drugs (Medley, Kennedy et al. 2009). It also achieves positive outcomes for peer educators such as receiving training, gaining knowledge and enhancing self-esteem, and reducing their own risk behaviours in regard to injecting (Garfein, Golub et al. 2007).

A recent systematic review concluded in-prison peer education programs achieve similar results to those conducted on the community (Bagnall, South et al. 2015). The review found consistent evidence that peer education reduced sexual and drug taking risky behaviours, including not using a condom at first intercourse after release from prison, injecting drugs after release from prison; past month injection and sharing injection equipment after release from prison. Evidence was also consistent from a small number of studies that peer educators are as effective as professional educators in HIV prevention, and qualitative study findings showed that peer educators improved their own knowledge of health issues as a result of their training (Bagnall, South et al. 2015).

Relevant to prisoners with substance use problems, the review also highlighted a single study of peer mentoring, rather than peer education, which it found to have provided weak evidence that mentoring reduced AOD use and re-offending, and had positive effects on health behaviours and treatment adherence (Bagnall, South et al. 2015). The study involved a mentoring/case management program developed for incarcerated women with experience of mental health issues and AOD use, re-entering the community from jail and prison (Goldstein, Warner-Robbins et al. 2009).

Detailed examples of effective interventions may guide program development. In a trial of harm reduction peer education among incarcerated men (Braithwaite, Stephens et al. 2005), overall positive outcomes were observed in reductions in substance use, sexual risk taking and health self-efficacy across four interventions provided as part of a pre-release and community re-entry program: 1) an educational and skills
building program on HIV and substance abuse delivered by an ex-prisoner who is HIV-positive; 2) the program as delivered by an HIV-negative peer facilitator; 3) a non-peer facilitator; and 4) presentation of health promotion and disease prevention videos. However, peer education groups, particularly those led by an HIV-positive facilitator, showed more significant changes in AOD use at three-month follow-up post-release. All interventions were implemented in a 12-session curriculum, two groups per week over a period of six weeks. The peer education interventions included goal-setting, skills-building, role playing and discussion activities. Facilitators used their own personal experiences to demonstrate skills and information (Braithwaite, Stephens et al. 2005).

Appropriate length and intensity of training for peer educators programs vary greatly, and depend on factors such as the program content and mode of delivery (Devilly, Sorbello et al. 2005). In a community setting, a randomised controlled trial\(^1\) (RCT) demonstrated that a six-session, small-group, cognitive behavioural, skills-building intervention to teach peer education skills to young injecting drug users, effectively reduced the educators’ injection risk behaviours (Garfein, Golub et al. 2007).

In prison settings, HIV peer education programs with promising evaluation evidence of effectiveness have conducted training for peer educators as intensive courses, such as 40 hours over one week (Dolan, Bijl et al. 2004, Ross, Harzke et al. 2006).

**Opioid substitution therapy**

Opioid substitution therapy (OST) is associated with reductions in drug use and to some extent, criminal activity among offenders (Dolan, Shearer et al. 2005, Perry 2014, Perry, Neilson et al. 2015).

Furthermore, as the immediate post-release period is often a time of high risk for overdose among offenders whose tolerance to opioids has largely diminished (Merrall, Kariminia et al. 2010), OST has been shown to reduce mortality (Dolan, Shearer et al. 2005) or to be at least associated with reduced mortality among released Australian offenders (Larney, Toson et al. 2011).

Psychosocial interventions such as CBT and contingency management delivered concurrently can enhance the effectiveness of OST (Gowing, Ali et al.

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\(^{1}\) The National Health and Medical Research Council (NHMRC) developed criteria for assessing strength of evidence. Within the NHMRC framework, systematic reviews and meta-analyses are considered the strongest evidence when examining outcomes of treatments, followed by randomized-controlled trials. Case studies are considered the weakest evidence upon which to make decisions about applying treatments to groups of patients.
OST has been available in Victorian prisons since 2003 and the demand for treatment is reportedly high (Victorian Auditor-General 2013).

Findings from a NSW longitudinal cohort study found that for prisoners who left prison on methadone and remained in OST, there was a 20 per cent reduction in re-incarceration during the nine years observation period (Larney, Toson et al. 2012).

A broader systematic review of OST in prisons, which included experimental and observational studies, concluded that when OST commenced pre-release it was associated with reduced heroin use, reduced injecting and sharing of syringes when doses were adequate, and with increased treatment entry and retention after release (Hedrich, Alves et al. 2012).

Importantly, disruption of OST continuity, especially due to brief periods of imprisonment, was associated with very significant increases in incidence of HCV (Hedrich, Alves et al. 2012).

An analysis of 14 RCTs found that methadone, in particular, had no impact on recidivism outcomes (arrest, conviction, charges, re-incarceration), while treatment with antagonists (such as naltrexone) did reduce criminal activity (Perry, Neilson et al. 2015).

### Intensive interventions

**Behavioural and cognitive therapies**

Cognitive behavioural therapy (CBT) specifically targets unhelpful thinking and behaviours and is a cornerstone of evidence-based AOD treatment.

Cognitive behavioural approaches include self-monitoring, goal setting, interpersonal skills training, relapse prevention, and lifestyle modification. There is considerable evidence for the effectiveness of well-conducted CBT on reducing recidivism among offenders and general prison populations (Lipsey, Landenberger et al. 2007, McMurrnan 2007, Bahr, Masters et al. 2012).

A systematic review and meta-analysis conducted by Lipsey and colleagues in 2007 included 58 studies of CBT treatment with offenders (including 27 studies of treatment based in correctional institutions) (Lipsey, Landenberger et al. 2007). Results showed that CBT was as effective in reducing recidivism among offenders in prison (which the authors note is generally provided close to the end of their sentences) as it was for offenders in the community. CBT programs increased the likelihood that participants would not re-offend in the 12 months after discharge by 1.5 times when compared to controls, resulting in an overall reduction in recidivism of 25 per cent.

While the review included a range of CBT programs, not exclusively...
substance use focused treatment, it provided indicators of effective CBT treatment for offenders that appear generalizable to prisoners with AOD use problems.

Despite differences across CBT programs, with some programs delivered over 5-10 weeks and some delivered in the context of residential treatment for six months, Lipsey et al concluded that the CBT approach appeared to be responsible for the overall positive effects on recidivism, rather than any one specific CBT program.

The intensity of CBT programs (number of CBT program sessions and to a lesser extent the number of contact hours per week) rather than treatment duration was associated with greater effect size on recidivism outcomes. Notably, those at highest risk of re-offending received the greatest benefit.

To create a model of ‘best practice’ CBT for statistical analysis, Lipsey et al presented the ‘favourable’ scenario of moderately high-risk offenders receiving two sessions per week over 16 weeks (the median intensity and duration). They concluded that several key factors were related to the greatest effect sizes:

- inclusion of distinct anger control and cognitive restructuring components in the CBT program enhanced the effects, while victim impact components appeared to diminish effects;
- high quality implementation reflected by close monitoring of the quality and fidelity of treatment delivery (delivering the program as intended);
- adequate CBT training for the providers;
- the addition of individual therapy to group therapy.

A review of the literature on effective AOD treatment programs for offenders by Bahr and colleagues (Bahr, Masters et al. 2012) highlighted the efficacy of CBT in prison. The review identified two evaluation studies of CBT programs within intensive prison residential programs of at least six months’ duration and applying four hours of treatment programming each week day, which demonstrated greater reductions in drug use and recidivism among prisoners who had received CBT at between six- and 12-months post-release.

One of these U.S. studies (Hall, Prendergast et al. 2004) evaluated the ‘Forever Free’ six-month program for female prisoners that operated as a modified therapeutic community with a cognitive-behavioural curriculum and relapse prevention focus. Program elements included individual AOD counselling, educational seminars, 12-step programs, parole planning and individual and group sessions on issues specific to supporting women such as assertiveness training, relationships, trauma, and parenting skills.
The second of these studies (Pelissier, Wallace et al. 2001, Pelissier, Motivans et al. 2005) evaluated 20 residential unit-based AOD treatment programs, based on a cognitive-behavioural model with relapse prevention approach as a core element. Programs were delivered primarily as a ‘moderate’ intensity 500-hour treatment program over nine months, with one staff member for every one prisoner.

Three of the programs were ‘high’ intensity treatment units involving 1000 hours of treatment over 12 months and staff ratio of 1:12 prisoners (Pelissier, Wallace et al. 2001). Psycho-education and group process treatment was generally conducted for a half-day in two consecutive 2-hour sessions five days per week. Groups sessions generally involved 10 to 12 participants on topics such as cognitive skills building, relapse prevention, interpersonal skills building and criminal lifestyle examination, with some availability of individual counselling.

Incentives for participation ranged widely from small items such as pens up to reduced sentence length for non-violent offenders successfully completing the program (Pelissier, Motivans et al. 2005).

Efforts to standardise the program across prisons included written treatment manuals which prescribed content for 350 of the 500 required hours of treatment and lesson plans, on- and off-site training and approaches to staffing and program monitoring, whereby all program directors were doctoral level psychologists and standard criteria were applied for the hiring of AOD treatment specialists (Pelissier, Motivans et al. 2005).

Individuals who entered and completed in-prison residential drug and alcohol treatment were found to be less likely to experience new arrests and substance use in the first six months following release, which the evaluators noted reflects positive results across multiple sites of varied security levels and with both female and male prisoners, and the potential for replicating the CBT approach in other settings (Pelissier, Wallace et al. 2001).

**Australian CBT programs**

In Australian examples, an evaluation of intensive offender programs in three NSW custodial settings reflects the effectiveness of this model, with CBT components at the core of intensive residential treatment that ranged from three to 12 months duration (Kevin 2011). All programs implemented group-based CBT using either the ‘Pathways’
intensive program (100 hours) and/or ‘Getting SMART’ 12-session program. The evaluation found treatment program completers achieved relatively reduced rates of recidivism in the short-to medium term post-release (six to 12 months), rates of offences in custody declined among program completers, and program completers were half as likely as non-completers to be charged with a drug offence while in custody (Kevin 2011).

The ‘Pathways’ program, also known as ‘Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change – Pathways to Responsible Living’ is applied in various forms in prisons in Queensland, Western Australia, NSW, ACT and Tasmania (Commonwealth of Australia 2015). It is a high intensity CBT program that addresses the link between criminal behaviours and substance use, and in Australian programs generally involves at least 100 hours of treatment delivered over 16 to 21 weeks (e.g. three two-hour sessions per week) (Queensland Corrective Services 2009, Corrective Services New South Wales 2013, Commonwealth of Australia 2015).

From program evaluations conducted in Queensland and Western Australia, there is some indication that involvement in, and/or completion of programs utilising the ‘Pathway’ model can positively affect prisoner’s understanding of their criminal behaviours and ability to manage cravings (Heseltine, Day et al. 2011), and may be associated with reduced rates of recidivism (Government of Western Australia 2014).

However, researchers have observed that the Pathways outcomes studies were affected by methodological issues such as short-term follow-up and/or involving small samples of prisoners (Heseltine, Day et al. 2011, Government of Western Australia 2014).

**Shorter-term CBT programs**

Bahr’s review highlights that current evidence in community AOD treatment more widely also supports the effectiveness of shorter-term CBT programs. Studies of specific intervention programs ranging from eight to 16 weeks duration show positive substance use outcomes such as increased duration of abstinence (Bahr, Masters et al. 2012).

Program approaches that appear to be aligned with effective CBT treatment for substance use in general populations
include the ‘Getting SMART’ 12-session CBT group intervention (18-24 hours). The program is the most commonly delivered program in the NSW Corrections system and aims to reduce risk of re-offending by addressing AOD use (a ‘dynamic’ risk factor for recidivism) and motivate and facilitate involvement in ongoing SMART Recovery meetings (Kevin 2011, Aydin, Kevin et al. 2013). Findings from 39 Getting SMART programs across six NSW custodial sites in 2007-2008 showed high completion rates (83% of 355 participating prisoners), although offender motivation to complete the program was strongly linked to the knowledge that participation in programs could improve the likelihood of progress to parole (Aydin, Kevin et al. 2013).

Promising evidence for short-term, but intensive CBT interventions was provided by a 2013 study by Bahr et al (Bahr, Harris et al. 2013), which compared outcomes for prisoners who received an intensive, short-term CBT program – the OUT Program - with a matched sample who did not participate in the program. The OUT program focused on skills building, providing life-skills training, cognitive distortion awareness, and therapeutic interventions.

The 30-day intervention was delivered as an intensive reintegration preparation program and involved 100 hours of treatment, delivered five days per week over four weeks. The authors noted high intensity treatment has previously been categorised as programs with more than 3.3 hours per week (Bahr, Harris et al. 2013).

Followed-up at 14 months after release, treatment participants were found to be significantly less likely to have returned to jail or prison for more than 30 days (27% compared with 46%) and reported overall reduced rates of any re-arrest (49% compared to 63% of control group).

Mindfulness Based Relapse Prevention

Mindfulness based interventions for AOD problems comprise a range of treatments and approaches which have been developed to target relapse and improve AOD treatment outcomes. Mindfulness based interventions form part of the suite of cognitive and behavioural therapies. Mindfulness based interventions involve intentional and sustained focus of attention on present moment experiences, with an attitude of acceptance, non-judgment and curiosity (Zgierska, Rabago et al. 2009, Chiesa and Serretti 2014).

Mindfulness based interventions may be almost wholly based on principles of mindfulness and mindfulness meditation practice, such as mindfulness-based cognitive therapy (MBCT). Or, like dialectical behaviour therapy (DBT) and Acceptance and Commitment Therapy (ACT) combine mindfulness techniques with other therapeutic approaches (Chiesa and Serretti 2014).
Mindfulness based relapse prevention (MBRP) is informed by mindfulness-based stress reduction, mindfulness-based cognitive therapy and Marlatt’s relapse prevention protocol. MBRP integrates secular mindfulness meditation practices with traditional cognitive behavioural relapse prevention techniques such as identification of individual risk factors and triggers and improving coping skills. MBRP was designed, and is typically delivered as an outpatient, therapeutic group, aftercare program (Bowen, Chawla et al. 2011).

Studies of mindfulness based meditation approaches for AOD problems, including among incarcerated populations (Bowen, Witkiewitz et al. 2006, Zgierska, Rabago et al. 2009) and a number of randomized controlled trials into the effectiveness of MBRP for offenders (Lee, Bowen et al. 2011, Witkiewitz, Warner et al. 2014) provide promising evidence of its safety and efficacy. However, recent systematic reviews (Grant, Hempel et al. 2015, Grant, Colaiaco et al. 2017), which included two trials of MBRP in prison settings, found that there was limited high quality evidence available on the effects of MBRP and additional studies are required.

**Contingency Management**

Contingency management (CM) is a behavioural therapy that is underpinned by the premise that reinforcing ‘non-drug using’ or ‘desirable’ behaviours should decrease drug use (Prendergast, Podus et al. 2006). CM involves the provision of rewards to reinforce treatment goals such as attendance and participation in therapy and/or pharmacotherapy, and AOD abstinence. The approach commonly uses vouchers, prize draws, or program privileges such as take-away methadone doses as reinforcements.

A body of research supports CM as an effective approach to promoting abstinence and improves the ability of people to remain abstinent (Prendergast, Podus et al. 2006). CM appears compatible with strategies used in many criminal justice settings, in which reinforcers and sanctions are routinely used, and is beginning to be implemented to support AOD treatment and compliance goals in settings such as drug courts (Marlowe, Festinger et al. 2008) and probation agencies (Rudes, Taxman et al. 2012). The evidence-base for use in these settings is still developing and its effectiveness in prison AOD treatment programs is not clear, however ‘contingency contracting’ is considered an important element of the compulsory drug treatment program in NSW (Birgden and Grant 2010).

**Motivational interviewing**

Motivational Interviewing is an approach that emerged from a humanistic framework in response to traditional confrontational approaches commonly
used in AOD treatment (Miller and Rollnick 2002).

The approach is focused on engaging people in AOD treatment and increasing a person’s readiness to change. Strategies to increase motivation include exploring ambivalence about AOD use and highlighting discrepancy between current AOD use and the person’s goals for the future. A growing body of evidence supports the effectiveness of MI with a range of people who use AOD (Lundahl and Burke 2009).

A 2009 systematic review conducted by McMurran examined the effectiveness of motivational interviewing (MI) with offenders and though outcomes varied across studies, the author concluded that MI was associated with reduced offending, improved retention in treatment and enhanced motivation to change (McMurran 2009).

A more recent review (Kouyoumdjian, McIsaac et al. 2015) found MI had positive effects on AOD use outcomes among people convicted for the first time of driving under the influence of alcohol and in detention; incarcerated adolescents with depressed mood; and women with risky patterns of AOD use.

The latter study involved an in-reach alcohol screening and MI intervention with women in prison using the Alcohol Use Disorder Identification Test-Including Drugs tool (AUDIT-12) and provision of personalised feedback on screening results using a brief MI interview format (Begun, Rose et al. 2011). Significantly greater improvement in alcohol and other substance use screening results at two months’ post-release were evident among women randomly assigned to the intervention compared to treatment as usual groups.

Service types

**Therapeutic Groups**

Almost all prison based AOD programs are delivered in a group setting. A review of health interventions for prisoners found that psychotherapy group interventions achieved positive AOD use outcomes in studies of Acceptance and Commitment Therapy, group interventions for women prisoners, and in male and female prison-based modified therapeutic communities (Kouyoumdjian, McIsaac et al. 2015).
Group programs appear most effective when they are targeted towards single gender groups and are engaged in voluntarily (Mitchell, Wilson et al. 2012).

**Individual counselling**

Individual counselling has been shown to significantly improve the impact of CBT group-based rehabilitation programs on recidivism outcomes among the general offender population (Lipsey, Landenberger et al. 2007). It is likely that this finding is applicable to AOD specific CBT programs.

Systematic reviews of the evidence have identified ‘group counselling programs’ as interventions for offenders, which may also include individual counselling, as being effective in reducing offending (Mitchell, Wilson et al. 2012). As with group therapies, a number of effective approaches utilise combinations of modalities and include individual counselling with group CBT programs.

For example, the Canadian Offender Substance Abuse Pre-release Program (OSAPP) delivered 26 three-hour group sessions plus three individual counselling sessions to prisoners with ‘intermediate to severe’ AOD problems (McMurran 2007, Casey and Day 2014). The program demonstrated good completion rates (89%) and less recidivism among program completers; 42 per cent of completers were imprisoned again in the follow-up period compared with nearly 49 per cent of matched comparison offenders.

**Exit Preparation Programs**

Programs that prepare prisoners with AOD problems for transition into the community vary widely. A number of evidence-based approaches, such as CBT and MI, are delivered in prisons to support re-integration into the community, to facilitate engagement with treatment and reduce relapse to AOD use and/or reoffending.

An intensive 30-day CBT program for prisoners with AOD problems and short sentences was designed to prepare participants for re-integration into the community. OUT Program participants spent five hours per day in treatment, five days per week for four weeks, equating to 100 treatment hours. Results of an evaluation showed that the program was associated with significantly lower recidivism with 27 per cent of the treatment participants returned to jail or prison for more than 30 days, compared with 46 per cent of a matched comparison non-treatment group (Bahr, Harris et al. 2013).

A study among women with AOD problems examined the effect of a jail in-reach brief screening and feedback intervention, which included use of motivational interviewing for those with risky patterns of AOD use (Begun, Rose et al. 2011). Results showed positive outcomes, with significantly greater reduction in AUDIT scores at two-
months post-release among women randomly assigned to the intervention compared to those not receiving the intervention. Recidivism was not measured in the short follow-up period.

**Pre-release centres**

Pre-release centres may be considered a specialised form of exit preparation program. Pre-release centres operate in a number of states, including New South Wales (NSW), South Australia, Western Australia and the Australian Capital Territory (Heseltine, Day et al. 2011).

In NSW, female offenders with AOD problems who participated in the Bolwara Transitional Centre, a specially designated pre-release centre, showed consistently lower rates of recidivism compared to a matched control group at six, 12 and 24 months after release (Kevin 2011). Bolwara was separated from the main correctional complex, and provided support for women with histories of AOD use problems and included specialised services for Aboriginal participants provided on site and in the community, including a ‘Koori women’s group’. After controlling for other risk factors, the study reported Bolwara Transitional Centre participants were around 30 per cent less likely to re-offend and return to custody for a new offence (Kevin 2011).

**Therapeutic communities**

Prison-based therapeutic communities (TCs) are TCs that have been modified to the requirements of correctional settings and adapted to the needs of different prisoner populations.
There is a comparatively large evidence base for this treatment model. Although findings have been mixed, TCs are widely recognised as the most effective available treatment for prisoners with AOD problems, demonstrating relatively consistent reductions in recidivism and AOD use (Bahr, Masters et al. 2012, Mitchell, Wilson et al. 2012, Casey and Day 2014).

In a systematic review published in 2015, Galassi and colleagues (Galassi, Mpofu et al. 2015) reported on 14 studies focused solely on examining the effectiveness of TCs among populations of prisoners with AOD dependence at the time of initial imprisonment. Three-quarters of the studies showed TCs were effective in reducing rates of re-imprisonment; seven of the nine studies that examined AOD relapse found the intervention to be effective in reducing rates of relapse; and five of the nine studies examining re-arrest outcomes reported that TC participation reduced incidents of re-arrest. From four studies, including results at longer-term follow up periods of two or more years, overall results suggest that treatment gains may taper over the longer-term.

Overall, across three main outcome areas, TCs were shown to have produced the greatest effect on reducing re-imprisonment, reducing AOD relapse, and reducing rates of re-arrest than other treatment alternatives. These effects were irrespective of aftercare or type of TC applied, though the combination of TC with aftercare programs may increase reductions of re-imprisonment and drug use (Galassi, Mpofu et al. 2015).

In contrast, one RCT examined the effects of treatment modality (therapeutic groups vs. TC) on re-imprisonment rates among 604 prisoners over a three-year follow-up period (Welsh, Zajac et al. 2013). The study demonstrated that the superiority of prison TC to less intensive group counselling (total of 150 hours’ treatment) was not fully supported; TC resulted in significantly reduced likelihood of re-imprisonment, however differences between the interventions’ effects on reducing re-arrest and drug relapse were not significant. The investigators also explored the relationship between risk of reoffending characteristics and AOD program type and found that not all prisoners considered high risk responded positively to a TC environment. The authors concluded that the most intensive intervention may not always be the most appropriate for high risk offenders, and suggested that other factors that affect response to treatment must be considered including negative affect, cognitive limitations, interpersonal skills, and prior treatment when conducting treatment matching.
**Twelve-step peer support groups**

Twelve step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are often used to complement AOD interventions, but are not considered therapeutic treatments in their own right. Studies have shown that AA attendance is associated with reduced alcohol use and symptoms of dependence, and NA and Cocaine Anonymous attendance are associated with positive outcomes such as greater rates of abstinence (Humphreys, Wing et al. 2004, Kelly and Yeterian 2011).

Participation in these support groups, particularly after completing a treatment program, can significantly reduce relapse after treatment, result in longer periods of ongoing abstinence than treatment alone, and help improve social functioning of people who are focused on maintaining changes to their AOD use (Humphreys, Wing et al. 2004).

While many custodial settings provide access to 12-step groups, in particular AA and NA, there is limited research concerning its effectiveness in prison settings (Mitchell, Wilson et al. 2012). An earlier review and meta-analysis from 1999 concluded that while quality evaluations were lacking, 12-step groups were widely used as adjunct to other programs and were considered promising approaches for reducing recidivism for imprisoned offenders with AOD problems (Pearson and Lipton 1999).
Prisoners with specific needs.

Specific subpopulations of prisoners have particular needs that require attention during AOD treatment, and the evidence is examined in this section.

Women

The profile of women involved in the criminal justice system differs from their male counterparts. Women have complex needs related to exposure to victimisation, trauma and abuse; high rates of mental and physical health problems; primary parenting responsibilities; and issues with other relationships (Grella, Cochran et al. 2011). Women may also experience greater severity of AOD dependence than male offenders (Simpson and McNulty 2008). Australian studies have reported different substance use patterns, including greater use of heroin, analgesics and sedatives among women in prison compared to men in prison (Australian Institute of Health and Welfare 2013, Pollard and Kiehne 2015). In another Australian study, AOD use problems among women represented ‘an acute dynamic risk factor’ that had an immediate association with offending behaviours (Hsu, 2011).

While much is known about effective treatments for male offenders, interventions for women offenders has been subject to less investigation, and the variation in methodology among studies is a barrier to drawing firm conclusions about the effectiveness of these programs (Perry, Neilson et al. 2014). Nevertheless, effective AOD treatment can reduce women offenders’ involvement with the criminal justice system and decrease their risk of reoffending (Tripodi, Bledsoe et al. 2011, Kissin, Tang et al. 2014), and therefore facilitating women offenders’ entry into AOD treatment is crucial. One study (Tripodi, Bledsoe et al. 2011) found that women who participated in AOD treatment whilst in prison were less likely to reoffend than those who did not participate, and overall positive outcomes were found on measures of mental health and AOD use. Large effect sizes were linked to interventions that applied CBT, group trauma therapy and psychoeducation, and these interventions were found to reduce symptoms of anxiety, depression and trauma.

Researchers Hall et al. (Hall, Golder et al. 2013) recommended that interventions should comprehensively address psychological and social needs of women such as victimisation, AOD use
and other mental disorders to increase the effectiveness of standard AOD treatment programs (Hall, Golder et al. 2013). When evidence-based AOD treatment is also gender sensitive (for example, treatment encompassing women's experience of trauma, influences of their relationships, role and parenting responsibilities) in criminal justice settings it has been shown to reduce drug use and criminal behaviour (Sacks, McKendrick et al. 2012, Kissin, Tang et al. 2014). A recent Cochrane review also found gender responsive treatment, as well as TCs, to be associated with a reduction in re-imprisonment rates for women offenders with AOD problems (Perry, Neilson et al. 2014).

Studies have also shown that a longer duration of program is not always the best option. For example, a 2014 study with female prisoners experiencing co-occurring mental health and substance use disorders receiving prison based treatment reported greater ‘misconduct’ was associated with treatment over 90 days, and ‘misconduct’ further increased based on exposure to more than 180 days of treatment (Houser, Blasko et al. 2014). This finding is contrary to the general understanding that longer time in treatment is associated with better outcomes, and suggests optimal treatment time for some client groups may be shorter than expected.

Like their male counterparts, aftercare programs for women offenders post-release are important for maintaining treatment gains (Simpson and McNulty 2008). Aftercare is associated with reduced risk of recidivism, especially when combined with treatment that was initiated while women were in prison (Grella and Rodriguez 2011).

**Aboriginal and Torres Strait Islander People**

It is widely acknowledged that Aboriginal and Torres Strait Islander people are over-represented in Australian prisons and a key principle of the National Corrections Drug Strategy 2006–2009 was a focus on the needs of Aboriginal and Torres Strait Islander people (Ministerial Council on Drug Strategy 2008).

Aboriginal and Torres Strait Islander people are considered to have a number of culturally specific criminogenic needs that include: substance abuse and personal/emotional functioning; acculturation stress and de-culturation; separation from family, communities and land; physical and mental health problems; violence; discrimination; literacy and numeracy problems; generational unemployment; and significant and specific transitional and post-release needs (National Indigenous Drug Alcohol Committee 2013, Wilkes, Gray et al. 2014).
Reports from the National Indigenous Drug and Alcohol Committee summarise the extent of health and substance use issues experienced by incarcerated Aboriginal and Torres Strait Islander offenders. Key health risks include transmission of blood-borne viruses, and comorbidity of mental health and AOD use issues, which is a significant factor in Aboriginal and Torres Strait Islander offenders’ over-representation in the criminal justice system. Alcohol in particular is a common precursor to offending, and Aboriginal offenders are significantly more likely to report being under the influence of alcohol at the time of the offence or arrest than non-Aboriginal Australian offenders (Gray, Stearne et al. 2010, National Indigenous Drug Alcohol Committee 2013).

While imprisoned, issues such as separation from family and culture, and previous history of an undiagnosed or untreated health condition can increase risk of harms for Aboriginal offenders. However, involvement with the criminal justice system also provides opportunities for providing interventions to improve the general health of the person while imprisoned (National Indigenous Drug Alcohol Committee 2013, Dolan, Rodas et al. 2015).

Importantly, Aboriginal prisoners have been shown to be more likely to use health services when in prison than in the community, although access to in-prison treatment programs has been found to be particularly limited among Aboriginal and Torres Strait Islander prisoners. A study with Koori prisoners in Victoria found that barriers to accessing treatment included feelings of mistrust, lack of cross cultural awareness and stigma, in particular in relation to blood borne viruses and sexually transmitted infections (Dolan, Rodas et al. 2015).

Empirical research identifying effective treatment approaches specifically for Aboriginal and Torres Strait Islander offenders is lacking, however a range of studies and treatment manuals can inform the development and delivery of AOD treatment for Aboriginal and Torres Strait Islander more broadly. General recommendations commonly emphasise collaborative, culturally sensitive, strengths-based and family inclusive approaches for working with Aboriginal people with AOD problems, including involvement of trained Aboriginal workers and the use of culturally specific written materials (Gray, Stearne et al. 2010, Lee K 2012, National Indigenous Drug Alcohol Committee 2013, National...

Treatment delivery should be culturally specific, that is, delivered within a framework of *cultural competence*, in which respect for Aboriginal people’s culture is recognised, respected, and safeguarded; *cultural safety* that ensures an environment for Aboriginal people that is free from ‘assault, challenge, or denial of a person’s identity’; and *cultural security* in which cultural values are actively incorporated into the planning, delivery and evaluation of treatment practice (National Indigenous Drug and Alcohol Committee 2014).

Dolan and colleagues (Dolan, Rodas et al. 2015) noted that from the limited evidence available, culturally specific substance abuse treatment for marginalized populations are required to improve engagement with AOD treatment in both prison and the community; however there was a paucity of research available to guide the development of such programs. In 2009, there were seven Aboriginal specific programs provided by external organizations in four states (Dolan, Rodas et al. 2015).

An evaluation of three intensive AOD programs in NSW custodial centres found that Aboriginal and Torres Strait Islander participants showed higher completion rates than non-Aboriginal offenders (75% vs. 63%) (Kevin 2011). Program graduates showed a lower rate of in-prison AOD use than non-graduates, and improvements in health-enhancing attitudes and behaviours such as motivation to change. Two programs were delivered in designated wings. For example, the Bolwara Transitional Centre (BTC) was a separately located pre-release program for female offenders that included specialised services for Aboriginal participants provided on site and in the community, including a ‘Koori women’s group’ (Kevin 2011).

**People with comorbid mental health problems**

The prevalence of mental health problems among prisoners in Australia is high. In 2012, 21 per cent of Australian prison entrants were currently taking medication for a mental health disorder and 15 per cent reported very high levels of emotional distress (Australian Institute of Health and Welfare 2013).

International studies have found that compared to the wider community, prisoners were several times more likely to have psychosis or major depression, and ten times more likely to have an antisocial personality disorder (Perry, Neilson et al. 2015). In Australia it is estimated that about eight per cent of male prisoners and 14 per cent of female prisoners had a major mental disorder with psychotic features, compared to less than one per cent of the general population (Ogloff, Davis et al. 2007).
Little is known about evidence-based AOD treatment for prisoners with concurrent mental health problems. A recently updated Cochrane review of interventions for offenders with co-occurring AOD problems and mental illness assessed evidence of drug use and/or criminal activity outcomes, while mental health and wellbeing outcomes are intended to be included in future reviews (Perry, Neilson et al. 2014). The review concluded that two trials of TCs and aftercare showed promising results for reducing re-imprisonment among this group. However, as Perry et al concluded with only two studies available the wider applicability of the finding is somewhat limited. Furthermore, across studies, the TC model showed less success in reducing rates of re-arrest and limited or mixed findings in regard to reducing self-reported drug use.

While trials of TCs showed mixed findings, one RCT that involved a 12 month prison-based modified therapeutic community (MTC) with the option of six months voluntary residential aftercare reported a range of positive outcomes (Perry, Neilson et al. 2015). Compared with prisoners randomized to routine mental health treatment, participation in MTC was associated with greater reductions in alcohol and drug use at one year after release and significantly reduced rates of re-imprisonment (Perry, Neilson et al. 2015). All participants had both a serious mental disorder and an AOD use disorder (32% used drugs, 32% used alcohol).

MTCs commonly retain the key structures, elements and processes of a traditional TC approach and adapt the model to better address the needs of specific groups, and in this case those with co-occurring mental health and AOD disorders. Modifications can include less confrontational therapeutic styles, greater flexibility in treatment phases, more individualized treatment, and employment of more professional staff, including doctors, psychiatrists, and counsellors with postgraduate training (Dye, Ducharme et al. 2009, Sacks, Chaple et al. 2012). Other helpful modifications included incorporation a CBT curriculum that emphasized criminal thinking and behaviour and psycho-educational classes regarding the interrelationship of mental illness, AOD use, and criminality (Sacks, Chaple et al. 2012).

Although based on a single study, motivational interviewing among imprisoned adolescents with depressed mood and recent AOD use was shown to be effective in reducing marijuana use and to some degree alcohol use, compared with relaxation training (Stein, Clair et al. 2011, Kouyoumdjian, McIsaac et al. 2015).

Integrated dual diagnosis treatment programs following an in-custody treatment unit demonstrated increased
use of outpatient medication services and reduced average days of hospitalization over 18 months compared with treatment as usual on release from the unit, though no relevant drug or crime outcome measures over time were reported (Perry, Neilson et al. 2015).

For males with co-occurring amphetamine dependence and attention deficit hyperactivity disorder (ADHD), medication with osmotic release methylphenidate commenced two weeks prior to release from prison and continued in conjunction with outpatient CBT, showed greater reductions in ADHD symptoms and risk for AOD relapse than those not receiving medication (Kouyoumdjian, McIsaac et al. 2015).

Young adults comprise a significant part of the adult prison population. In Victoria, around half of all young offenders aged between 18 and 21 given a custodial sentence were sentenced to an adult prison (Victorian Ombudsman 2015).

Young offenders between 18 and 21 years are commonly given less severe sentences than adult offenders. It is recognised that their immaturity and inexperience may make them less culpable, and that rehabilitation should be the focus (Victorian Ombudsman 2015). However, there is limited specific evidence and programming for young adult offenders, with most research focused on juvenile and adolescent offender aged under 18 years.

Young people engaged with Victorian specialist AOD services in the community have been found to have extremely high levels of harmful AOD use and complex psychosocial needs, with two thirds of treatment clients having criminal justice involvement (Kutin, Bruun et al. 2014).

Prison entrant data collected in 2015 showed that prison entrants aged 18-24 years were the most likely to have used illicit drugs within the past 12 months (76%). The most common illicit drugs used were methamphetamine (59%) and cannabis (53%) (Australian Institute of Health and Welfare 2015).

Offenders in Victoria aged 25 years and under have an increased likelihood of recidivism, with earlier research indicating younger offenders may also have a shorter time to re-offending than
older counterparts (Sentencing Advisory Council 2013).

As with the literature for AOD use treatment more broadly, evaluation of AOD treatment programs for prisoners in the US (Miller, Miller et al. 2013) and Australia (Aydin, Kevin et al. 2013) have found that younger age is associated with treatment drop-out. The need to successfully engage younger prisoners in treatment and provide support for complex needs such as social skills and community integration, mental health and education, was emphasised by these authors.

Research into effective treatment for younger offenders is primarily focused on juvenile and adolescent populations. There is little quality evidence to guide treatment for young adults. However, more preparatory work and motivational approaches may be of benefit (Aydin, Kevin et al. 2013).

From the juvenile offender literature, which can extend to studies involving offenders aged 18-19 years, counselling interventions, provision of multiple services and skills building are effective approaches to decrease juvenile recidivism, while tailored treatment models that include family show promise for reducing AOD use (Janopaul-Naylor, Brown et al. 2014).

While not solely AOD focused, positive outcomes of a multi-service and tailored approach are evident from the evaluation of Victoria’s specialist 35-bed youth unit within Port Phillip Prison for prisoners aged 18 to 25 years. The unit provides youth specific programs and support covering education, offending behaviour, personal development, leisure and recreation and employment, and includes AOD programs. Prisoners placed in the unit for 60 days or more had lower recidivism rates compared to the comparison groups (32.5% vs 41%); was a safer environment; was viewed more positively by prisoners; and had a greater rehabilitation focus than two mainstream comparison groups (Victorian Ombudsman 2015).

Analysis by Lipsey found that with other variables statistically controlled, relatively few differences were found in the effectiveness of different types of therapeutic interventions for juvenile offenders (Lipsey 2009). Only three factors were found by Lipsey to be major correlates of program effectiveness:

- a “therapeutic” intervention philosophy,
- serving high risk offenders, and
- quality of implementation.

A meta-analysis showed that aftercare programs for young adult and juvenile offenders released from correctional institutions had a small effect on recidivism, with more intensive programs associated with lower rates of rearrests and reconvictions. Greater effect was found for aftercare programs that were well implemented (as opposed to those programs that described implementation
difficulties), consisted of individual rather than group treatment, and were aimed at older and ‘high-risk’ youth. Program initiation (pre- or post-release) and program duration showed no effects (James, Stams et al. 2013).

**People from culturally and linguistically diverse backgrounds**

In June 2014, Victoria had the highest proportion of prisoners born overseas (25%), with nearly 20 per cent having English as their second language (Department of Justice & Regulation 2015). Despite growing numbers of prisoners from diverse cultural and linguistic backgrounds, very little is known about what works in prison based AOD treatment for these populations.

In a survey on help seeking among prisoners in the United Kingdom, over half of all prisoners whose first language was not English reported they would not seek help for AOD problems; twice as many as native English speakers (Jaffe 2012). Language and other cultural factors are significant barriers for prisoners’ help seeking and treatment engagement (Jaffe 2012), suggesting that prison based AOD programs must be culturally informed, and use materials that can be read and understood by participants.

There is limited evidence to guide effective engagement and response strategies with prisoners from diverse cultural backgrounds, and mixed findings regarding efficacy of treatment across cultural groups, however some interventions such as counselling programs, have been shown to be effective in reducing re-offending across ethnic and racial groups (Mitchell, Wilson et al. 2012).

**People with acquired brain injury**

Acquired brain injury (ABI) among Australian prisoners is significant, with over one third of prison entrants at increased risk of ABI as indicated by whether they had ever received a blow to the head that resulted in a loss of consciousness (Australian Institute of Health and Welfare 2015).

In a cohort experiencing high rates of mental health and AOD use disorders, it is also expected that a significant minority of prisoners will have varying levels of alcohol related brain damage (ARBD) (Royal College of Psychiatrists 2014).

Information concerning the most effective AOD treatment response for this group is lacking, and importantly, treatment outcome studies on which best practice is based usually excludes participants with ABI due to impairment.

A recent report by the UK Royal College of Psychiatrists reviewed the literature relating to ARBD, including among prisoner populations. (Royal College of Psychiatrists 2014). The close association between ARBD and TBI was noted and screening for both was
recommended. The report indicated that for prisoners with ARBD, a considerable proportion of these individuals will improve through abstinence. It is recommended that alcohol misuse screening instruments are routinely used on admission to prison to identify people at risk of ARBD. Reassessments should then be made once individuals have settled into routine prison life, and are referred to appropriate external services on release.

The report found that prisoners who have significant deficits due to ARBD may be unable to engage well with CBT treatment programs, which could impede their progress towards gaining release (Royal College of Psychiatrists 2014). Recommendations for screening and management of ARBD within the UK prison service were:

- Alcohol withdrawal may need to be conducted under care of the local hospital.
- Primary and secondary screening should incorporate alcohol screening instruments.
- Individuals identified as having alcohol-related problems should be signposted to appropriate support facilities.
- People with alcohol-related problems should be reassessed prior to release from prison and referred to appropriate external agencies.
People with low literacy

Education levels among prisoner populations are commonly lower than in the general population. Higher levels of schooling are associated with a lower probability of arrest and imprisonment (Australian Institute of Health and Welfare 2015).

While it is clear that AOD treatment interventions need to be accessible and appropriate for a wide range of reading and comprehension levels, there is limited research about best practice AOD treatment specific to prisoners with low literacy.

A 2010 evaluation of the correctional centre in Canberra (Stoove and Kirwan 2010) highlighted concerns that treatment programs may not adequately cater to those with low literacy levels, and interventions requiring homework and reflection on ideas considered ‘text-book stuff’ could be a barrier to treatment engagement for some prisoners.

Participant criteria for the Getting SMART program, a widely used CBT-based intervention in NSW prisons, requires a ‘reading level 2’ and ‘writing level 1’ based on the Australian Core Skills Framework (ACSF) literacy level (Aydin, Kevin et al. 2013). Only three of the fifty-nine program participants who dropped out of the program reported doing so due to inadequate literacy (Aydin, Kevin et al. 2013).

The implications for AOD program practice are to assess the literacy levels of all participants and ensure that the reading materials and handouts are set at an appropriate literacy level. Prisoners that have low literacy can and should be encouraged to participate in AOD group programs, and group facilitators should check participants’ understanding of the materials at the end of each session and adjust as necessary. For some, it may require specially-developed handouts with graphics rather than words, or an additional individual session to explain the materials, especially when CBT practice tasks or ‘homework’ is required.
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