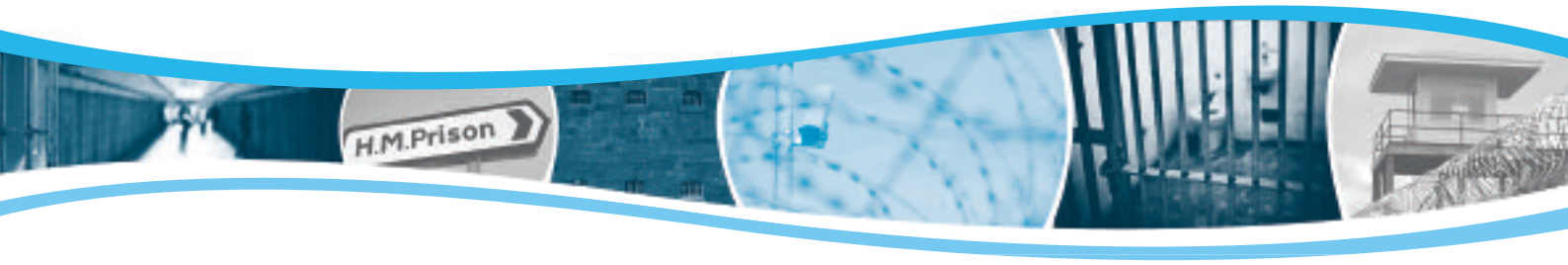

With conviction:

the case for controlled needle and syringe programs in Australian prisons

October 2010

anex

The Harm Minimisation in Prisons Committee has been established to provide advice and assistance to Anex on its policy directions and activities in regard to improving access to NSP services in custodial settings in Australia.

Anex is a leading national voice in the public health sector. Since our inception as independent, non-profit organisation in the 1990s, we have worked to increase understanding and improve responses to the problems arising from the use of illicit drugs and the misuse of pharmaceuticals and alcohol.

Anex does not condone drug use, but strives to protect people from drug-related harm when at their most vulnerable.

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Foreword

'Supply and demand reduction without harm reduction is harm creation.'

It is an indisputable fact that illicit drugs enter correctional facilities regardless of the level and sophistication of security measures. Drug injection occurs in prisons and the rates of unsterile needle sharing are extremely high, as shown in this paper.

For some years Anex has worked with lay people and experts to advance the case of introducing needle and syringe programs (NSPs) in some correctional settings as a means to reduce the risks of viral and other disease transmission.

We have had the support of Anex's distinguished Patrons and Board, all of whom believe protecting community health in Australia will be enhanced by extending mainstream health measures into prisons.

The Harm Minimisation in Prisons Committee includes distinguished Australians who are highly respected in their fields. I would like to thank the members of the Committee for volunteering their expertise to assist Anex prepare this paper. Any errors are the responsibility of Anex.

Implementing a prison NSP trial is going to save money and lives throughout the entire Australian community.

Mr John Ryan
Anex CEO

26th October 2010

The Harm Minimisation in Prisons Committee members are:

Professor Nick Crofts	Nossal Institute for Global Health
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Professor Michael Good	National Health and Medical Research Council
Professor Margaret Hamilton AO	University of Melbourne
Ms Annie Madden	AIVL (Australian Injecting and Illicit Drug Users League)
Ms Helen McNeil	Hepatitis Australia
Professor Chris Puplick AM	Former Chair of Australian National Council on AIDS, Hepatitis C and Related Diseases
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Summary

- The principles enshrined in Australian national drug strategies aim to improve the health, social and economic outcomes for individuals and the community. The principles recognise that Needle and Syringe Programs (NSPs) are a proven public health measure.

- Significant proportions of prison populations inject illicit drugs. Needle sharing among prisoners is institutionalised, unnecessarily making prisons potential incubators of blood borne infections, including HIV and hepatitis C.

- Prisoners return to their communities. The health risks posed by sharing injecting equipment in prisons are a broader public health issue.

- Prison staff have the right to a safe working environment. The risk of contracting a blood borne virus through accidental needle stick injury would be reduced by a regulated prison-based NSP.

- Harm minimisation includes three components: harm, supply and demand reduction. Currently, supply and demand reduction are institutionalised prison management practices; however, all Australian jurisdictions have, to date, failed to implement harm reduction measures in prisons.

- Australian prison systems need to offer the three pillars of harm minimisation measures to be consistent with the Australian National Drugs Strategy.

- Providing a regulated NSP to prisoners meets the State's obligation to ensure prison facilities are safe and secure for staff. Accordingly, the provision of NSPs to prisoners is compatible with the standard of care required by the State in fulfilling its duty of care towards the workforce. It also provides prison staff with greater control of their work environment.

- Prisoners are entitled to health services comparable to those available to the general community The scope of the State's legally enforceable duty of care to prisoners must include providing prisoners with access to sterile injecting equipment to prevent the spread of blood borne viruses – as is done in all Australian communities.

- Aboriginal and Torres Strait Islander communities are particularly vulnerable to infection with blood borne viruses due to the high rates of incarceration of their members.

- A prison-based NSP trial, which has been endorsed by the Australian HIV, hepatitis C and the Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections strategies and which have been agreed to by all State and Territory Health Ministers, is urgently needed in Australia.

- Prison-based NSPs should be integrated within the primary health care services, including health promotion, preventative care and drug treatment provided to prisoners.

Introduction

The financial efficiency and health effectiveness of Australian needle and syringe programs (NSPs) are well established (1). The effectiveness of NSPs in prisons has also been proven in numerous settings, particularly in Europe (2). Yet in Australian prisons, where the incidence of blood borne viruses is far higher than in the community, there has never been a needle and syringe exchange trial. The Australian Government recently issued HIV and hepatitis C virus (HCV) prevention strategies as well the National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. All three strategies recommend that State and Territory governments identify prisons for controlled NSP trials (3-5).

This paper by the Harm Minimisation in Prisons Committee (hereafter HMPC) outlines the main reasons why community health is threatened by the high rates of drug injecting and sharing of unsterile needles in prisons. It argues that Australians concerned with community health should support clinical trials of this important intervention. The purpose of the trial would be to examine how best to implement prison-based NSPs.

The HMPC is convened by the not-for-profit public health organization Anex, whose Chief Patron is Emeritus Professor Sir Gustav Nossal AC. The purpose of the HMPC is to support national health strategies that promote the commencement of at least one controlled prison-based NSP trial in Australia.

Prisoner health is community health

The health of prison populations, including staff, is not only a concern of those responsible for correctional settings. As the head of the Australian Capital Territory's Corrections Health, Professor Michael Levy, has pointed out: "health problems in prison move between the two sides of the wall" (6). The health of prisoners is therefore a broader community health issue (7). This is especially the case with regards to blood borne viruses, as infected prisoners may transmit infection within the broader community through their sexual and injecting networks (8-10).

Almost 30,000 Australians are in prison at any one time (11). The Health of Australia's Prisoners survey conducted in 2009 found that 71 per cent of prison entrants had used illicit drugs during the 12 months prior to incarceration (12). It is estimated that in 2007/2008 there were 50,405 episodes of prisoners being released back into the community (13). Although comprising only approximately 2.5 per cent of the Australian population, Aboriginal and Torres Strait Islanders comprise 25 per cent of the total prisoner population, meaning that the rate of imprisonment was 14 times higher than non-Indigenous prisoners as of 30 June 2009 (11). The Ministerial Council on Drug Strategy acknowledged that Aboriginal people incarcerated in prisons "need to be given better access to appropriate healthcare" (14).

Prisoners have complex health needs. The bulk of prisoners have overlapping issues that can include mental and physical illnesses as well as drug and/or alcohol addictions (15-17). Prisons are high risk environments for blood borne virus transmission through sharing injecting equipment (18-21). Many prisoners who had not previously injected drugs do so while in prison (22, 23), often as a means to cope (24). Upon release, they may practise this newly acquired risk behaviour within their social networks and the wider community (25).

Expensive supply and demand reduction

All Australian States and Territories support the harm minimisation approach to illicit drugs. Harm minimisation involves three pillars: reducing the supply of drugs, reducing the demand for drugs and reducing the harms associated with drug use (26). Of the three pillars, only supply reduction and, to a lesser extent, demand reduction are implemented in Australian prisons substantively (7).

Departments of Corrections go to great lengths focusing on supply reduction (27). Depending on the security level of the facility, state-of-the-art electronic drug detection systems, staff, prisoner and visitor searches, urinalysis and highly trained sniffer dogs are deployed in order to stop illicit drugs being trafficked into and within prison (7). Demand reduction in prisons includes drug treatment programs (7, 28).

Combined, the cost of supply and demand control steps deployed through corrections systems run into the tens of millions of dollars annually (7). However, the reality is that a wide range of drugs are smuggled into even maximum-security prisons, including by corrupt prison staff, and subsequently injected (18, 29, 30). In NSW, the 2009 Inmate Health Survey found that the proportion of prisoners who reported having ever used an illicit drug while in prison was 43 per cent, and almost half of those surveyed said it was

easy or very easy to get illicit drugs within corrections facilities (23). The study found that the most commonly injected drugs in prison were heroin and amphetamine-type stimulants.

As such, the need for the three pillars of harm minimisation to be implemented in prisons is clear. Former High Court Judge, Justice Michael Kirby, is a member of the United Nations Development Program Global Commission on HIV and the Law. In the words of Justice Kirby, "unless governments, and prison administrators can absolutely guarantee a totally drug-free environment, it is their plain duty to face up to the risks of the spread of HIV infection by the use of unsterile injecting equipment in prisons" (31).

The rates of sharing injecting equipment among prisoners are usually dramatically high (32, 33). For example, a 2003 research paper by the NSW Department of Corrective Services found that 21.3 per cent of male prisoners reported injecting while imprisoned, three quarters of whom had shared injecting equipment while in that period of custody (34). A 2003 NSW Inmate Health Survey found that among male injectors, 74 per cent reported using a new needle and syringe each time they injected in the month before they entered prison, but 67 per cent were sharing needles during their imprisonment (22).

The 2009 NSW Inmate Health Survey found just three per cent of those who injected in prison had not shared needles on their most recent occasion. Seventeen per cent reported that six or more people had shared the needle/syringe before they used it, while a quarter of men and a third of women did not know how many people had injected with the equipment before they had (23).

The fact that five State and Territory governments provide bleach within prisons so that inmates can clean syringes is de facto recognition that illicit injection needs to be addressed on health grounds (7, 35).[1] But the primary means of disease prevention – sterile needle and syringe access - remains untested in Australian prisons.

Prisons as incubators of disease

It is estimated that there were at least 280,000, and possibly as many as 348,000, Australians living with hepatitis C infection as of 2008 (36). Aboriginal and Torres Strait Islander people accounted for six per cent of the 11,303 hepatitis C infections diagnosed in 2008 (37). It has been estimated that the public health burden of hepatitis C virus infection upon the health care system was approximately $156 million in 2004/05 (38). Rates of hepatitis C infection are up to 60 times higher in correction facilities than in the general population (39). Hepatitis C antibody seroprevalence among injecting drug users was found to be 71 per cent in NSW prisons in 2007 (18).

A recent study led by Dolan examined risk behaviours and hepatitis C transmission among 120 male injecting drug users in NSW prisons (9). It found that 33.6 per cent continued to inject while in prison and, at 90 per cent, the rate of sharing injecting equipment was far higher in prison than when they were in the community.

A HIV-positive male who has spent almost half his life in prisons recently described the reality of sharing while in custody:

[1] While cleaning needles the correct way using bleach can reduce HIV transmission risks, it is less effective against hepatitis C transmission.

> "In the cell, you got your bottom bunk and top bunk. About four blokes would sit on the bottom bunk, and then you've got your toilet and a couple of blokes sitting around that area. Then you've got your table for your TV and stuff, people would be sitting on them waiting their turn. Once they have their taste they leave, and another one goes around – 'bang bang' with the same fit [needle]" (40).

Most notably, the 2010 study among NSW prisoners by Dolan found "HCV sero-incidence in prison was alarmingly high at 34.2 per 100 person years" (9). These findings mean that "one in three people injecting drugs in prisons contracted hepatitis C" while in prison (Dolan quoted in 41).

Disease prevention through programs in the community

The relatively low rates of needle sharing by illicit drug injectors within the community is largely due to the widespread provision of sterile equipment through government-funded and private sector needle and syringe programs (1, 42).

When first introduced in the mid-to-late 1980s, NSPs were criticised by some as being a de facto 'soft on drugs' strategy, or even condoning illicit drug injection (43). They are now mainstreamed and highly cost-effective health interventions that greatly reduce the number of blood borne infections annually. Analysis by the World Health Organisation has established that NSPs are effective and do not contribute to higher levels of drug use or serve as pathways into drug use (25).

In 2009, the National Centre in HIV Epidemiology and Research released health economics research into the results of the previous decade's experience of NSPs across all Australian States and Territories (1). The research found that provision of sterile injecting equipment and accompanying health promotion information had prevented 32,000 HIV and 96,600 hepatitis C infections. The study also found that for each dollar invested by government in the NSP programs, there was a $27 financial return to the community through health and other savings. In the 2009 NSW Inmate Health Survey half of the prisoners surveyed who had ever injected drugs had obtained needles and syringes from a NSP or pharmacy at least weekly in the month prior to incarceration (23).

All Australian police departments are supportive of harm reduction and do not regard it as compromising strict drug supply reduction policies or practices. Law enforcement officers have adapted work practices such as search techniques to reduce the risks of accidental needle stick injury.

Australia drags the chain on NSPs in prisons

Prison environments are extremely hierarchal. This is true for both prisoners and corrections staff. The internal pecking order can create environments which end up making HIV and hepatitis C a much greater risk. A former prisoner explained how wariness of other prisoners meant he felt unable to refuse a request by other inmates to 'stash' contraband in his cell when they suspected their cells were about to be searched. The prisoner's reward was an offer of drugs which he also felt too scared to refuse. Being a new inmate, he ranked low in the hierarchy and had to share a used needle. Unfortunately this episode resulted in hepatitis C infection:

> "They got ramped [searched] and the warders didn't find anything. Next day they came back and were grateful for that. I thought 'grouse, I got someone on my side'. They pulled me aside later and said 'We're gonna score [heroin] - we'll shout you a taste'. I thought 'oh shit, I don't' really want to', but then again I thought 'if I say no it's gonna look bad, they will want to know why. They could start getting paranoid, thinking I'm gonna lag them in or this or that'. So I gave in. But unfortunately I was the new guy and had to go last. It's just the rules. It was my first time in, so of course I've gotta go last. I'd say easily 10 people had used that needle, it was really blunt. It was cut down, not a proper syringe by then. When it got to me, it was pretty bloody useless. Bloody hurt that's for sure. And boom, I got hep C" (44).

That particular case is of a person who had routinely accessed NSPs in the community to avoid infection with blood borne viruses, including hepatitis C and HIV. However, in jail he had almost no choice but to take a life threatening risk in order to avoid other risks to his welfare.

Evidence from international experience

To avoid scenarios such as that quoted above, many countries have established a variety of carefully controlled programs that allow prisoners who inject drugs to access sterile needles (45). The first such program was established in Switzerland in 1992. NSPs have since been established in more than 50 prisons in 12 countries in Europe and in central Asia, including in Spain, Portugal and Germany where the programs are supported by trade unions (2, 46). In settings in which such arrangements have been made, it has not meant that government or prison authorities have become lax on drug supply reduction (2).

Lines et al (47) provide examples of how prison-based NSPs help to reduce blood borne virus transmission, noting that NSPs in prison have the following benefits for staff and prisoners:

- ✔ No observable increase in injecting or other forms of drug use;
- ✔ Reduced blood borne virus transmission;
- ✔ Reduced needle sharing and re-use;
- ✔ Reduced injecting-related health concerns such as abscesses;
- ✔ Reduction in needle-stick injuries for prisoners and staff;
- ✔ No instances recorded of needles being used as weapons;
- ✔ Acceptance by staff and prisoners.

Recently, it was reported in The Lancet that introducing NSPs remains compatible with the goal of reducing the supply of drugs in prisons, and that the provision of sterile needles "has not led to an increase in drug use" (2: 61). Needle syringe programs operate on a range of models and reviews have found that they have not jeopardised the occupational health and safety of prison staff (2).

In April 2010 the Australian Health Ministers Advisory Council (AHMAC) released the Third National Hepatitis C Strategy, the Sixth National HIV Strategy and the Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy. These strategies, which cover 2010-2013, were developed by the Australian Government in conjunction with State and Territory Health Departments, and were approved by all Health Ministers. The three strategies each state:

> "In view of the well-documented return on investment and effectiveness of Australian community-based needle and syringe programs, combined with the international evidence demonstrating the effectiveness of prison needle and syringe programs *it is appropriate throughout the life of this strategy for State and Territory Governments to identify opportunities for trialling the intervention in Australian custodial settings"* (3: 10, 4: 13, 5: 34, emphasis added).

As such, trialling prison-based needle and syringe programs is not a radical policy, but, rather, it is consistent with current mainstream national health strategies agreed to by all jurisdictions' Health Ministers.

Aligning prison health interventions with community NSPs

The trial of prison-based NSPs would also be consistent with established legal principles that state that prisoners access to health services be on a par with those available in the general community.

Passed in 1990, the UN General Assembly Resolution 45/111 concerning prisoners states:

> "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (48).

The 2004 revised *Standard Guidelines for Corrections in Australia* were co-produced by each State and Territory government. The national guidelines are not binding. Rather, they constitute a "statement of national intent", following from which each jurisdiction "must continue to develop its own range of relevant legislative, policy and performance standards" to reflect "best practice" and "community demands" (27: 2).

Clause 2.26 of the *Standard Guidelines for Corrections in Australia* states that:

> "Every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community" (27: 2).

That principle of comparable health service access was reiterated in the National Drug Corrections Strategy 2006-2009 (49). There is variation in the extent to which State and Territory jurisdictions operationalise the concept of "comparability" of (access to) health services (50). As discussed in the Case Study on page 9, Australian Capital Territory law asserts that prisoners should not be put at risk of infection, and that they must have access to health care "equivalent to other people in the ACT" (51).

Case Study

A trial in the Australian Capital Territory

The Australian Capital Territory government opened the Alexander Maconochie Centre (AMC) prison in March 2009. It caters for low, medium and high security prisoners. The AMC includes the most advanced drug detection systems yet deployed in Australia. The AMC operation is intended to comply with human rights legislation and principles.

In outlining the responsibilities of ACT Corrective Services, the ACT Corrections Management Act (s 53), 2007 states: "(1) The chief executive must ensure that –

(a) detainees have a standard of health care equivalent to that available to other people in the ACT; and

(b) arrangements are made to ensure the provision of appropriate health services for detainees; and

(c) conditions in detention promote the health and wellbeing of detainees; and

(d) as far as practicable, detainees are not exposed to risks of infection" (51, emphasis added).

It is noteworthy that the above-mentioned legislation did not become effective until 19th December 2009. In other words, at the time of its opening there was no legislative requirement that prison management provide access to "equivalent" health services. But there was from December 2009 onwards.

The ACT Government had initially proposed piloting a NSP in the new prison. The Government instead deferred the decision pending an evaluation of the first 18 months of its operations to establish whether or not drug trafficking into and/or drug use in the prison could be averted. The evaluation of the first 18 months of the AMC operation is due for release in December 2010.

According to Dolan, the findings from the NSW study of hepatitis C seroconversion among prisoners meant that:

> "We could say that one in three people injecting drugs in prisons contracted hepatitis C and the situation is likely to be similar in Canberra" (41).

It has been established that drugs have entered the AMC prison. ACT Health Minister, Hon. Ms Katy Gallagher, told the ACT Assembly's Budget Estimates Committee hearing on 17 May 2010 that among those prisoners tested to March 2010, "65 per cent had hepatitis C", including one prisoner who was the "first case where there is evidence to support transmission of hepatitis C while in the AMC" (59).

Of concern to political authorities everywhere in Australia is the possibility that media outlets would run a series of hostile coverage if a prison-based NSP was considered. However, coverage to date suggests that this may not be the case in the ACT. For example, in 2010 the Sunday Canberra Times newspaper ran an editorial calling for an exchange to be trialled in the ACT. The editorial stated that:

> "Prisoners do return to the community. Should we not do our utmost to ensure they do not reoffend? Should we not also prevent the spread of disease both within and outside the prison walls? The ACT Government set a benchmark with the AMC. A trial needle exchange program, in consultation with prison staff, would continue that spirit of reform" (60).

In May 2010, while speaking before a Parliamentary Budgets Estimates Committee, the ACT Health Minister described the health benefits of prison-based NSP as follows:

> "I have to say that, from a health point of view, I do not think you would find anyone interested in public health who would oppose it ... from a health point of view, it is a no-brainer, you would have a syringe program in the jail as soon as you can" (59).

Addressing health and safety concerns of prison officers

One of the largest barriers to trialling a prison-based NSP in Australia is the opposition from prison officers and the trade unions acting on their behalf (52). Officers are covered by State and Territory branches of the Community and Public Sector Union, all of whom currently oppose the introduction of NSP in prisons. A commonly voiced concern is a fear that a blood-filled syringe could be used as a weapon against prison staff. This can be traced back to an incident in NSW in 1990 in which a guard was stabbed with a syringe infected with the blood of a HIV-positive prisoner experiencing mental health issues. The guard later died from an AIDS-related illness, as did the prisoner.

However, the concern that needles provided under a controlled prison-based exchange would be used as weapons against staff is not supported by international evidence (2). In those prisons that have established needle and syringe programs, not a single instance of the use of needles as weapons has been reported (2, 47). In Germany, prison staff have come to support NSPs on occupational health and safety grounds (46, 53).

Nevertheless, the importance of occupational health and safety assurances for all correctional staff cannot be under-estimated (52, 54). For example, prison officers are already at risk of accidental needle stick injuries during cell and body searches (39, 55-57). Introduction of a controlled prison NSP reduces the likelihood that those needles circulating in prison would be infected with a virus, thereby reducing risks to prison staff (54).

As employers, correction facilities have a duty of care to protect the health and safety of prison employees, and it has been strongly argued that introducing a controlled prison-based NSP would in fact make the workplace safer. Corrections facilities management can follow the lead of law enforcement agencies by adapting existing risk reduction practices to cater for the introduction of controlled needle exchange (54), as has occurred successfully in other countries (46, 53, 58).

In considering this issue, Justice Michael Kirby has captured the way in which prison-based NSP must balance officer and prisoner health as part of a broader community health issue:

> "The infection of any prison officer by the isolated act of a prisoner is most unpalatable. It is criminal conduct and morally outrageous. The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is just as unpalatable. As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society" (31).

Any introduction of a NSP trial in prison would need to include concerted education programs with all prison staff and their unions to address their concerns by showing that such programs do not put their safety at risk (52). Prison-based NSPs could be integrated within the primary health care services, including health promotion, preventative care and drug treatment provided to prisoners.

In conclusion

Currently, Australia's harm minimisation approach fails to implement the harm reduction pillar in prisons. The absence of controlled sterile needle and syringe provision inside prisons is a glaring weak link in Australia's response to blood borne infection control, including HIV and viral hepatitis. There is irrefutable evidence that injecting drug use occurs within prisons and that the unnecessary transmission of blood borne viruses is occurring as a result of the institutionalised sharing of unsterile needles.

Prison-based NSPs would contribute to a stronger continuity of care by more closely aligning prison health services with those provided in the community. This would mean a significant reduction in risk-taking injecting behaviours, which as most prisoners return to the community, would have far reaching public health benefits.

There is no evidence that controlled needle and syringe provision in prison would threaten corrections staff safety. Rather, NSPs would make prisons safer workplaces for staff and, by extension, their families. It is time that at least one jurisdiction undertook a prison-based NSP clinical trial as recommended in the national HIV, hepatitis C and the Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections strategies.

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