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**THE PROPOSED NEEDLE SYRINGE PROGRAM
AT THE ALEXANDER MACONOCHIE CENTRE,
CANBERRA'S NEW PRISON**

An information paper on the evidence underlying the proposal

Commissioned by Directions ACT

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1. IN BRIEF ...

The ACT Government is constructing Canberra's first prison, the Alexander Maconochie Centre, due to become fully operational in the 2007-08 year. It will be state-of-the-art with respect to its facilities and programs, emphasising rehabilitation as well as incapacitation and punishment. The Government is considering a proposal from the Minister for Health, Simon Corbell MLA, to include a scientific trial of a needle syringe program (NSP) as part of the Centre's health services.¹

The need to improve Australia's response to the epidemic of high risk drug use in our prisons is absolutely clear, based upon the uncontested epidemiological evidence of the sharing of contaminated injecting equipment in prisons and the extent of hepatitis C and other blood-borne diseases among the prison population.

Many authorities argue that failing to provide to prison inmates a quality of health care at least as good as that found in the community, including access to sterile injecting equipment, contravenes our obligations under international law. It is clearly inconsistent with the Standard Guidelines for Corrections in Australia and a resolution of the General Assembly of the United Nations.

The Australian Correctional Ministers and Administrators are to be commended for moving some way towards adopting harm reduction strategies within Australian prisons, as demonstrated by the availability of treatment services, bleach and condoms in some institutions. These initiatives, however, are not sufficient to achieve important public health goals.

The evaluation research evidence as to the processes of introducing NSPs into prisons, and the impacts of the NSPs, is now well documented in peer-reviewed scientific journals. It has been assessed by independent, prestigious organisations including WHO and the Australian National Council on Drugs, and they have concluded that the evidence base is strong enough for prison NSPs to be provided far more widely.

The research findings from the NSPs in six nations where over 50 prisons are currently providing these interventions are remarkably consistent: positive on all variables assessed including those related to the health of inmates, their drug use, infectious disease transmission, impacts on prison drug treatment services and on the safety of prison staff and inmates. The diversity of situations in which these NSPs operate strongly suggests that we will have no real difficulty in finding one or more models that will work in Australia.

As one authority put it, 'Prison systems and governments can no longer avoid their responsibilities to provide for the health of prisoners by dismissing prison needle-exchange programmes as something new or untested. They are neither' (Lines 2005, p. 61). A trial of a prison NSP is needed in Australia, and the establishment of a world's best practice corrections health service at the Alexander Maconochie Centre, Canberra's new prison, provides an ideal opportunity to implement this important intervention, at least on a trial basis.

¹ This paper uses the term 'needle syringe programs' to cover what some others call 'needle exchange programs' or 'needle syringe exchange programs'. This reflects the dominant Australian approach in which providing the sterile injecting equipment to people who use illicit drugs is the main focus, rather than emphasising the 'exchange' aspect of the program with its implication of exchanging a used syringe for a new one on a one-for-one basis.

2. DRUGS AND PRISONS

This section presents a brief overview of drug use in prisons and drug-related harm in prisons.

Drug use in prison

Correctional authorities across the nation report that drug use, including injecting drug use, occurs frequently in Australian prisons. The position was summarised by the Australian Bureau of Criminal Intelligence (ABCI) in 2000

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

Production of drugs in prisons occurs on a very minor scale...

In the absence of significant drug manufacturing inside prison, it is reasonable to conclude that the majority of drugs detected come from outside. Contraband predominately enters prison through the visitor reception area (referred to as the visitor barrier), over or under the prison perimeter, or via vehicle and pedestrian gates. Prison inmates exchange drugs for commodities such as canteen goods, cigarettes, electronic equipment, expensive clothing and running shoes. Western Australia reported that inmates 'who are not "hard" drug users have been known to trade heroin for quantities of cannabis' (Australian Bureau of Criminal Intelligence 2000, p. 102).

The Executive Director of ACT Corrective Services, Mr James Ryan, advised a Public Forum in Canberra on 15 Nov 2005 that it would only be possible to keep illegal drugs out of prison by instituting a security regime that would have to be so harsh as to be unacceptable. He concluded that this means that, in reality, it is not possible to keep all illegal drugs out of Australian prisons.

The ABCI pointed out that urinalysis is a key technique used by corrections authorities to attempt to control the amount of drugs in prisons: inmates with 'dirty urines' are punished with the aims of general and specific deterrence. They expressed the concern that this enforcement regime has unintended adverse consequences quite contrary to the harm minimisation policy on drugs adopted by all Australian Governments. The ABCI wrote

...urinalysis may encourage inmates to change from cannabis to more harmful drugs because these drugs remain in the body for a shorter time and so there is a better chance of providing a negative urine sample. In Western Australia the Select Committee into the Misuse of Drugs Act of 1981 found that 'some very harmful substance abuse (e.g. sniffing solvents, alcohol bingeing) which is directly related to offending may not be detected through urinalysis, whereas cannabis use is easily detected. This raises the prospect of participants being influenced towards the use of less detectable though more harmful drugs'... In South Australia the Department of Correctional Services...recommended that targeted urinalysis focus on detecting those drugs with the greatest potential to cause harm-intravenous drugs, alcohol, and other drugs that cause aggression (Australian Bureau of Criminal Intelligence 2000, p. 105).

The 2001 NSW Inmate Health Survey reached a similar conclusion (Butler & Milner 2003, p. 123).

Prevalence of drug use in prison

The 2004 National Prison Entrants' Bloodborne Virus Survey revealed that '59% of prison entrants screened had a history of injecting drugs [and] 38% had injected in the month prior to reception into prison (National Centre in HIV Epidemiology and Clinical Research 2005, p. 6).

The 2004 National NSP Survey revealed that, of injecting drug users interviewed in community settings nationally, 18% stated that they had been in prison in the last year and that, of this group, 53% reported injecting in prison during the last year (National Centre in HIV Epidemiology and Clinical Research 2005, p. 11).

The 2001 New South Wales Inmate Health Survey also investigated drug use in that State's prisons (Butler & Milner 2003, pp. 119-26). The study showed that

- 57% of inmates report a history of injecting illegal drugs and 51% of that group report injecting while in prison
- 48% of inmates report using some type of illegal drug in prison (females 49%; males 48%)
- cannabis use in prison: females 40%; males 45%
- heroin use in prison: females 32%; males 23%
- amphetamines use in prison: females 20%; males 10%
- cocaine use in prison: females 15%; males 7%
- alcohol use in prison: females 14%; males 13%

Respondents to that survey also reported that illegal drugs are 'quite easy' or 'very easy' to obtain in prison, with 76% of the female inmates and 78% of the males responding in this manner (op. cit., p. 122).

Syringes in prisons

With 51% of the drug users in NSW prisons injecting, there is clearly a stock of injecting equipment in our prisons. How does it get there? Again, the national review conducted by the ABCI provides helpful information

The majority of jurisdictions reported that more syringes were seized in prison than at the barrier. This suggests that syringes are passing the visitor barrier undetected or entering prison by other means. New South Wales authorities seized 188 syringes (compared with 154 in 1997-98) -making syringes the third most common contraband intercepted at the visitor barrier -and seized 226 in prison (compared with 250 in 1997-98)...South Australia's Corrections Intelligence Unit reports the reemergence of a 1995 trend, whereby 'mini' or cut-off syringes, hidden in the mouths of visitors, are passed to inmates during access visits. These syringes, which are covered in plastic to prevent self-injection during smuggling, contain a pre-mixed load of heroin (Australian Bureau of Criminal Intelligence 2000, p. 108).

Drug-related harm in prison

Sharing injecting equipment

Because injecting equipment is currently considered contraband in Australian prisons, and the prevalence of injecting is high, the sharing of injecting equipment occurs frequently. This has been documented in a number of studies (Australian studies include Butler et al. 2004; Butler et al. 2003; Butler & Milner 2003; Crofts et al. 1995; Crofts et al. 1996; Dolan, K., Wodak & Hall 1999; Rutter 1995; Rutter et al. 2001).

The NSW Inmate Health Survey 2001 shows that, of the inmates with a history of injecting in prison, 72% of the females and 67% of the males had used the injecting equipment after someone else had done so. Furthermore, 31% of the women and 36% of the men stated that the needle had been used by five or more people prior to their own use. Importantly, in terms of the risk environment for the transmission of blood-borne diseases, inmates also reported frequently sharing other injecting paraphernalia including spoons, the drug mix, water, filters and tourniquets.

As the authors of the survey report point out, 'Prison injecting practices are in stark contrast to those occurring in the community with 75% of women injectors and 74% of men using a new needle and syringe every time they injected in the month before coming into prison' (Butler & Milner 2003, p. 121).

Prevalence and transmission of blood-borne viral diseases

Blood-borne diseases transmitted by contaminated injecting equipment and environments, with serious health consequences, include the viral diseases hepatitis C, hepatitis B and HIV/AIDS. A range of health problems are also caused by bacteria transmitted in the same ways.

In 2004, the prevalence of hepatitis C in people being received into Australian prisons nationally was 34% and among prison entrants who inject drugs, 56%. In NSW the prevalence was 69% among entrants who inject drugs. Only three inmates were HIV positive (Butler, Boonwaat & Hailstone 2005).

The 2001 NSW Inmate health survey showed the prevalence of infectious diseases in the inmate population

- HIV positive: one male inmate
- hepatitis A antibody: females 50%; males 46%
- hepatitis B core-antibody: females 31%; males 28%
- hepatitis C antibody: females 64%; males 40% (Butler & Milner 2003, pp. 73-4)

A recent study of NSW prisoners showed that a disturbingly high number actually contracted hepatitis C in prison, mostly through sharing contaminated injecting equipment (Butler et al. 2004). This confirms earlier evidence from Victoria (Crofts et al. 1995). Studies have also confirmed the transmission of HIV in Australian prisons (Dolan, K. A. & Wodak 1999) as also occurs abroad (World Health Organization, Regional Office for Europe 2005).

These high levels of infectious blood-borne diseases in prison, combined with the high prevalence of risk factors for the transmission of disease, particularly through sharing injecting equipment, along with the limitations of harm reduction programs that do not include needle syringe programs, highlight the urgency of responding to the recommendations of prestigious bodies such as the Australian National Council on Drugs that NSPs be trialled in Australian prisons (Australian National Council on Drugs 2002).

3. HUMAN RIGHTS AND LEGAL STANDARDS RELATING TO A PRISON NEEDLE SYRINGE PROGRAM

The principles underlying the establishment and operation of the Alexander Maconochie Centre

Alexander Maconochie was and remains to this day perhaps the greatest prison reformer that Australia has seen. His view was that cruelty debases both the victim and society and, as a result, punishment should not be vindictive but should aim at the reform of the offender (Barry 1958; Morris 2002). Maintaining the physical and mental health of the prisoner was part of his mission.

The Chief Minister, Jon Stanhope MLA, enlarged on this when explaining the selection of the name Alexander Maconochie Centre for Canberra's new prison

The ACT prison will be named the 'Alexander Maconochie Centre' after the nineteenth century penal reformer who was commandant of Norfolk Island from 1840 to 1844. Maconochie is famous for his contribution to penal reform and for introducing the humane management of prisoners and many innovations in penal practice, which were well ahead of their time. The naming of the ACT prison will not only honour his memory and the many humane reforms he introduced to a brutal prison system. It will also set the tone for the ACT prison - which will uphold human rights and focus strongly on prisoner welfare, rehabilitation and community safety (ACT Corrective Services nd).

Stanhope went on to explain that 'The Operating Philosophy of the Alexander Maconochie Centre is founded on the ACT Human Rights Act 2004 and also sits within the framework provided by the Canberra Plan and its constituent documents, the Social Plan, the Spatial Plan and the Economic White Paper' (loc. cit.).

The Centre will be state-of-the-art with respect to its facilities and programs, addressing the three goals of sentencing: retribution, deterrence and rehabilitation (Findlay, Odgers & Yeo 1994) and the three purposes for which prisons are used: custody, coercion and punishment (Morgan 1994).

The Standard Guidelines for Corrections in Australia

Providing health care services that are evidence based and are at least of the standard available to people in the community at large is accepted policy in all Australian correctional systems. The policy specifies that, with respect to prisoners' drug-related health problems, correctional services should provide a full range of services including those focusing on supply reduction, demand reduction and harm reduction. The concept of harm reduction includes taking action to minimise the harm experienced by drug users when, despite efforts aimed at prevention and desistance, they continue to use drugs in a manner that is harmful to themselves or to others (Ministerial Council on Drug Strategy 2004).

These national policies have been articulated as recently as 2004 in the Corrective Services Ministers' Conference and the Conference of Correctional Administrators revision of the *Standard Guidelines for Corrections in Australia*, where they state that

Prison systems should have a comprehensive and integrated drug strategy that seeks to prevent the supply of drugs into prison, reduce the demand for drugs and minimise the harm arising from drug use in prisons through education, treatment and enforcement

...

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. Notwithstanding the limitations of the local-community health service, prisoners are to have 24-hour access to health services. This service may be on an on-call or stand by basis (Corrective Services Ministers' Conference 2004).

The ACT Human Rights Act 2004

The Australian correctional standards flow from internationally-recognised human rights standards, many of which have been mandated in the ACT *Human Rights Act* 2004. Of particular relevance are the right to life (s. 9) and the right to protection from torture and cruel, inhuman or degrading treatment etc. (s. 10). As many commentators have pointed out, for far too many prisoners a sentence of imprisonment is a sentence of ill-health and even a sentence of death, considering that the prevalence and incidence of HIV and hepatitis C in prisons are so much greater than in the community (e.g. Davies 2004; Lancet 2005).

These underlying human rights principles also reflect what is perhaps the most important principle of penology, Sir Alexander Paterson's dictum that '[offenders] are sent to prison as a punishment, not *for* punishment' (cited in Morgan 1994, p. 894).

International instruments

Prisoners' rights are linked, furthermore, to a range of international human rights instruments. An extensive literature exists detailing these issues (e.g. Brown & Wilkie 2002; Havemann 1999; Lines et al. 2004).

International law

Many international laws are relevant to prisoner health and well-being and, by extension, to the provision of evidence-based preventive health services including prison NSPs. They include the following, as listed by Lines (2004) with respect to the global HIV/AIDS epidemic

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- African Charter on Human and Peoples' Rights
- American Convention on Human Rights
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights
- [European] Convention for the Protection of Human Rights and Fundamental Freedoms
- European Social Charter

Rules, guidelines, principles and standards

Based upon these instruments and the Universal Declaration of Human Rights from which many flow we find sets of international rules, guidelines, principles and standards which, although not having the force of law, set out the global consensus in this area. Again, many are linked to the prevention of communicable disease among prisoners generally and injecting prisoners specifically.

Among these instruments is the UN General Assembly resolution on the *Basic Principles for the Treatment of Prisoners* which includes, as Principle 9

Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation (General Assembly of the United Nations 1990).

Since NSPs are provided to the community at large by Australian State and Territory Governments (largely funded by the Australian Government Department of Health and Ageing), and have been found to be effective (Dolan, K., Topp & MacDonald 2000; World Health Organization 2004c) and cost-effective (Health Outcomes International 2002), the application of this Principle would include providing NSPs in Australian prisons.

World Health Organization and UNAIDS policies

The World Health Organization has gone further in detailing the crucial role of NSPs in the prevention of transmission of communicable diseases such as hepatitis B & C and HIV, and has pointed explicitly to the necessity of NSPs in prisons. The documents include the WHO *Status Paper on Prisons, Drugs and Harm Reduction* (World Health Organization, Regional Office for Europe 2005) which states

- All prison systems are urged to move as quickly as resources allow to introduce important additional harm reduction action.
- developing a planned and comprehensive clinical treatment programme for drug-dependent prisoners, including the use of opiate substitution maintenance therapy;
- developing a needle-exchange programme equivalent to that available in the community, especially if the local prevalence of HIV or hepatitis C is high or if injecting drug use is known to occur in the prison ... (p. 14).

Another contemporary WHO document summarising experience, research evidence and expert opinion urges member nations to introduce prison NSPs to address the many problems linked to injecting in prisons

The evidence shows that such programmes should include all the measures against HIV transmission which are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment. All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programmes (World Health Organization 2004b).

A scholarly review of the research evidence, produced with the financial support of AusAID and published by WHO, also stresses the evidence base for prison NSPs, recommending

Special populations of IDUs are of great public health significance in HIV control especially 'bridge populations' (such as IDUs who are also men who have sex with men or male or female commercial sex workers). In most countries, a large proportion of IDUs spend a considerable proportion of their drug-injecting careers behind bars while a large proportion of prison inmates have a history of drug injecting. Many inmates of correctional facilities continue to inject while they are incarcerated. The limited evidence available from evaluation of the few existing prison

NSPs suggests that their benefits are similar to community programmes, while there is no evidence to date that these programmes are inherently unsafe or counter-productive. On the available evidence, there is a strong case for establishing and expanding NSPs in correctional facilities in many countries (World Health Organization 2004c, p. 30).

These sentiments have been recently reinforced by UNAIDS in its Policy Position Paper on *Intensifying HIV Prevention* (UNAIDS: Joint United Nations Programme on HIV/AIDS 2005), among others.

Legislative issues

New legislation would need to be enacted by the ACT Legislative Assembly to allow a trial of the NSP to be implemented. There is nothing unusual about this. For example the ACT *Drugs of Dependence Act* 1989 includes Part 7: 'Supply of Syringes', authorising the Chief Health Officer to approve designated people to supply syringes for purposes of 'preventing the spread of disease' (s. 86) (McDonald 1989) and this approval could be extended to people working in correctional centres. Most if not all Australian States and Territories have removed the offence of possession of syringes for the purpose of self-administration of an illegal drug as a public health measure (Norberry 1997). In 2004 the Legislative Assembly passed the *Drugs of Dependence (Syringe Vending Machines) Amendment Act* to authorise a trial of syringe vending machines in Canberra. These are all examples of legislative changes made to facilitate access to sterile injecting equipment as a public health measure.

Acts and/or regulations covering the operation of the Alexander Maconochie Centre could also be amended to remove any barriers to the NSP, such as current offences relating to the possession and use of syringes. Other existing offences related to drugs would remain in force, including possession, cultivation, manufacture and supply. This mirrors the position in the Canberra community, where all these behaviours are criminal offences, unproblematically coinciding with an extensive community-based NSP.

Comment

For some time, international instruments, standards and policies stressed the rights of prisoners to high quality health services of a standard at least as sound as those available to people in the community. Sadly they have been largely ignored. In recent years, however, the research evidence of the appallingly high prevalence of communicable diseases (especially hepatitis C and HIV/AIDS) among prisoners, of how prisons are vectors for the transmission of these diseases, and of the effectiveness of prison NSPs as part of comprehensive prison health programs, has led international agencies to make specific recommendations on the necessity of implementing prison NSPs as a matter of urgency in the interests of the health of inmates, corrections staff and the broader community.

4. THE ACT ALCOHOL, TOBACCO AND OTHER DRUGS STRATEGY

In 2004 the ACT Government released its ACT Alcohol, Tobacco and Other Drug Strategy 2004 – 2008 (Australian Capital Territory Government 2004). Australia's National Drug Strategy is based on the principle of 'harm minimisation', and the ACT's is the same. The three components of harm minimisation are supply reduction, demand reduction and harm reduction. Although similar in their core elements, the ACT Strategy is superior to its national equivalent in that it is more sophisticated in its recognition of the social determinants of drug use and drug-related harm, is more soundly based on a vision of what type of society we want to build, and has a stronger emphasis on intersectorality. It also differs from the National Drug Strategy in that it includes an Action Plan and is silent on Strategy governance arrangements.²

In the *ACT Alcohol, Tobacco and Other Drug Strategy 2004 – 2008* we find an explicit statement of the rationale underlying its development, as follows

The ACT Alcohol, Tobacco and other Drug Strategy builds on the previous ACT Drug Strategy - From Harm to Hope (1999). The purpose of the Strategy is to provide a framework that offers direction for decision-making on issues associated with alcohol, tobacco and other drug use in our community. The Strategy provides a common vision for the ACT Community. It supports the development of a shared understanding of both the issues facing the ACT, including the changing needs of the population and those of the alcohol and other drug sector, and the directions identified to address these issues. This shared understanding will support the community in working together to address alcohol, tobacco and other drug issues in a co-ordinated and collaborative way (*op. cit.*, p. 7).

One of the strengths of the ACT Strategy is that it contains a detailed Action Plan to guide the Plan's implementation, including priority setting. Each of the identified actions is grouped under one of the three main categories of supply reduction, demand reduction or harm reduction, producing the following breakdown of actions by priority and goals:

	<i>Priority actions</i>	<i>Other actions</i>	<i>Total</i>
Supply reduction	3	2	5
Demand reduction	9	8	17
Harm reduction	19	26	45
Total	31	36	67

The predominance of proposed actions under 'harm reduction' (45 out of a total of 67) is noteworthy, particularly because this is the most highly contested area of drugs policy internationally (Erickson et al. 1997). A careful examination of what lies within each category, however, reveals that many of the items under 'harm reduction' would also fit under demand reduction. Examples are #33: improved primary health care services and #35: national programs to address community attitudes about alcohol. On this basis, one should not place too much weight on the categorisations used.

² This section draws upon McDonald, D 2004, *The ACT Alcohol, Tobacco and Other Drug Strategy 2004-2008: a background paper for the ACT Alcohol, Tobacco and Other Drug Strategy Evaluation Group*, ACT Health, Canberra, <http://www.health.act.gov.au/c/health?a=sp&pid=1057881447>. Comprehensive governance arrangements for the Strategy have been designed and implemented following the publication of the Strategy document.

ACT Health's Alcohol and Other Drug Policy Unit is responsible for implementing the Strategy, with the support of a broadly-based Implementation and Evaluation Group. Details are available online at <http://www.health.act.gov.au/c/health?a=sp&pid=1057881447>.

One element of the Strategy's Action Plan deals with 'Custodial Service Delivery' of alcohol, tobacco and other drug services. It states

Action: Provide full access to health services and treatments that are available to the community to prisoners, detainees, and remandees.

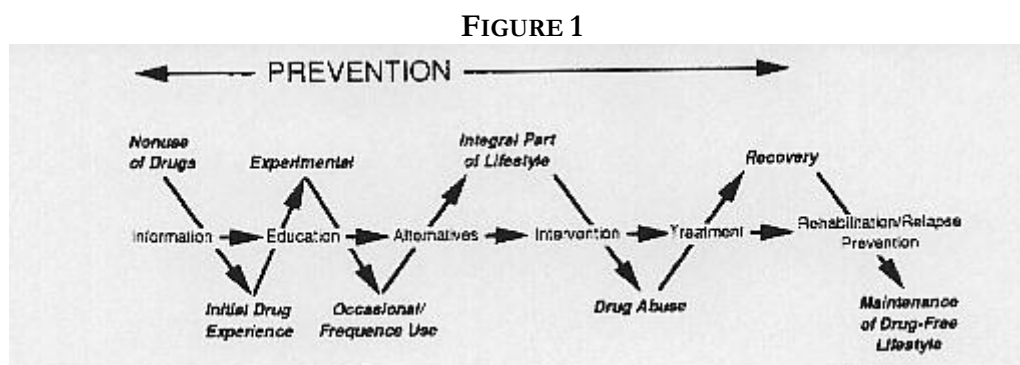
Rationale: The Draft Standard Guidelines for Corrections in Australia 2003 (revised) states that every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Restrictions on a person's liberty should not necessarily restrict their access to continuity of treatment options.

Consistent with Health Action Plan (Australian Capital Territory Government 2004, p. 46).

The Corrections Health Plan, currently being developed by the ACT Government, is the context for the implementation of this part of the Strategy as well as for consideration of the need for a NSP in the Alexander Maconochie Centre (Australian Capital Territory 2005).

Continuity of care

The ACT Strategy also emphasises the importance of continuity of care for people with alcohol, tobacco and other drug related problems, and flags this as one possible criterion for evaluating services to inmates of correctional facilities. The continuum of helping interventions covers a wide range, from prevention through early intervention, active treatment and post-treatment relapse prevention and rehabilitation or after-care. This is illustrated in Figure 1.



Source: (Bukoski, WJ 1991, cited in McDonald 2004b, pp. 4-5).

Two implications for the ACT's Corrections Health Strategy stand out from the continuum of services and care approach, namely

- (a) the need to provide to detainees and their families a comprehensive range of services and
- (b) the need for seamless integration of services from the community to the institution when a person is incarcerated and from the institution to the community upon release.

5. THE EVIDENCE BASE RELATING TO PRISON NEEDLE SYRINGE PROGRAMS

In this section we present the findings of the evaluations of prison NSPs that have been published to date. They are remarkably consistent, considering the diversity of contexts in which the NSPs have been initiated and implemented: very different types of prisons, in both poor nations and wealthy OECD nations, with many different types of prison populations and modes of operating the prison NSPs. The evaluation results have been summarised and assessed in a number of recent publications, particularly Dolan, Rutter & Wodak 2003; Hughes 2000; Lines et al. 2005; Lines et al. 2004; Nelles, Fuhrer & Hirsbrunner 1999; Niveau 2005; Rutter et al. 2001; and Stöver & Nelles 2003.

Approaches to implementing prison NSPs

The particular approach used in implementing a prison NSP should be sensitive to context, taking into account the local needs and opportunities. The approach taken will depend, in part, on the objectives of the program and how health staff interact with the drug-using inmates. Overall, however, across the more than 50 prison NSPs currently operating, some for over a decade, five broad models have been described (Stöver & Nelles 2003). They are

- syringe dispensing machines
- hand-to-hand provision of injecting equipment by corrections health staff
- hand-to-hand provision by the staff of external drug sector agencies
- distribution by peer leaders/educators
- various combinations of these

Syringe dispensing machines

This approach was used in some of the early trials and still operates. Typically the dispensing machines operate on a 'one in – one out' basis. Prisoners are given a wooden blank by prison health staff or peer educators to enable them to get from the machine their first sterile syringe. A modification of this approach that better reflects the way syringes are provided in the community is not to require one for one; rather, a sterile syringe is dispensed whenever the button is pressed, as with the public machine in the grounds of the Queanbeyan Hospital.

This approach has the advantage of privacy/confidentiality, especially when the machines are in relatively secluded locations, increasing their attractiveness to users. The machines operating on a one-for-one basis mean that prison staff can be assured that the stock of syringes in the institution is controlled, and that used syringes are safely removed from the system.

The disadvantages of this model include the risk of the disposal machine being vandalised by prison staff or inmates or malfunctioning, and the results of anonymously obtaining the syringes: opportunities for face-to-face interactions with correctional health staff are reduced.

Hand-to-hand provision by correctional health staff

This approach is particularly useful when the objective of the service includes correctional health staff gaining closer contact with the prison drug users, including those not previously known to be injectors, so as to offer them a range of health services in addition to sterile injecting equipment. They have succeeded well in this regard. Other advantages are the high degree of control over the amount of injecting equipment dispensed (it could be on a one-for-one basis) and the opportunities it provides to remove used syringes from the prison when staff distribute sterile syringes on a new-for-used basis.

The disadvantages include the loss of anonymity which, for some inmates, would be a barrier to participation.

Hand-to-hand provision by the staff of external drug sector agencies

This approach accords with a principle underlying a set of recommendations of the Royal Commission into Aboriginal Deaths in Custody that specialist services for prisoners can be outsourced to specialist agencies with skills and other resources not necessarily found among the correctional services staff. It entails community-based organisations that operate NSPs in the community coming into the institution and providing sterile injecting equipment on a hand-to-hand basis. A one-for-one, new-for-used, approach is possible.

This model links drug using inmates to the counselling services that the external agency can provide, removes from the corrections' staff the need to be involved in the prison NSP, controls access to syringes and provides incentives to participate on the part of injectors who are not known by the corrections staff to engage in this behaviour. Confidentiality is maintained.

Its disadvantages include the limited availability of sterile injecting equipment (only when the external agency's staff are on duty in the prison) and possible mistrust of the 'outsiders' by corrections' staff.

Distribution by peer leaders/educators

Australia's National Drug Strategy and National Hepatitis C Strategy both acknowledge the importance of involving the affected communities in dealing with drug problems, and peer education and support programs are acknowledged as crucial components of a comprehensive range of interventions (Department of Health and Ageing 2005; Ministerial Council on Drug Strategy 2004). Consistent with this policy, some overseas prison NSPs use the services of peer educators/leaders to distribute sterile injecting equipment and provide related educational and referral services, reflecting the approach taken in the broader community.

Peer-based prison NSPs have the advantage of a high level of acceptance by inmates, great confidentiality and syringe provision as part of a comprehensive peer education outreach program. Their disadvantages include limited control over distribution and the possibility that syringes can still be used as valued trade goods within the prison power hierarchy.

Storage and disposal of syringes

The storage of syringes provided through the prison NSP, and their subsequent safe disposal, are aspects of the program requiring careful attention. Decisions are best made collaboratively between the corrections health staff, prison officers, corrections management and inmate representatives. A number of models exist in the more than 50 prisons currently operating these programs. Importantly, in most programs it remains an offence for inmates to possess syringes not obtained through the prison NSP, and to store, in unauthorised ways, syringes obtained through the program.

Storage of syringes

- One option used is that inmates are required to store their syringes in rigid plastic containers ('fitpacks' or other sharps containers)
- Sometimes these are transparent containers, so that prison officers can visually check their contents
- In some programs, the syringes are required to be stored in a place where they are visible to inspecting officer, such as in a glass on a shelf over their sink. Concealing them is an offence.

Disposal of used syringes

- Discarding the fitpacks containing the used syringes and other injecting paraphernalia in specified disposal bins, sometimes located adjacent to dispensing machines or in other discreet locations
- Placing them in a one-for-one syringe exchange machine
- Handing them to a member of the correctional health team on a one-for-one basis

Recommendations made to date on implementation approaches in the Alexander Maconochie Centre

A Technical Report commissioned by ACT Corrective Services from the National Drug and Alcohol Research Centre recommended that an NSP trial be implemented in Australia and that syringes be distributed by vending machines, nursing staff or an outside agency-run 'injecting room' (Rutter et al. 2001, p. 40).

The ACT Legislative Assembly's Standing Committee on Health has recommended that the Alexander Maconochie Centre's NSP take the form of 'one-for-one vending machines and a clinic arrangement that offers education, counselling and equipment exchange' (Legislative Assembly for the Australian Capital Territory 2003, p. 29).

AIVL, the Australian Injecting and Illicit Drug Users' League, has published a comprehensive proposal for the design of an Australian prison NSP that is grounded in its members' experiences with NSPs in the community and intimate knowledge of the realities of life for people who use illegal drugs in Australian prisons. They have recommended a combination of syringe dispensing machines and hand-to-hand provision by the staff of external, community-based NGOs (Australian Injecting and Illicit Drug Users League (AIVL) nd).

Comment

This overview of models of providing sterile injecting equipment within prisons highlights the fact that a range of approaches are available. It is not a matter of ‘take-it-or-leave-it’, Instead, the task is to identify which model or blend of models is most suitable for trialling in a given context. Each of the models described, however, has been used for some years with considerable success.

The objections sometimes raised to introducing prison NSPs

The reality is that only six nations (three OECD and three non-OECD) currently operate prison NSPs. In some of those nations the number is increasing markedly because the correctional authorities have committed themselves to providing this service in all of their prisons in line with their international human rights obligations and the UN *Basic Principles for the Treatment of Prisoners* (Lines et al. 2005).

The objections raised to introducing this health service in many countries are too frequently based on people’s moral attitudes to prisoners (a feeling that prisoners are not entitled to quality care and that prison should be a place of suffering). Furthermore, they reveal ignorance of the research findings or, more disturbingly in a policy-making context, the rejection of them without providing any justification for doing so. A statement such as ‘I am not convinced by the body of research evidence’ takes us nowhere unless it is backed up by a solid body of scholarly evidence refuting the evaluation findings that unanimously support prison NSPs. That refutation simply does not exist.

In this section we summarise the results of the systematic scientific evaluations of prison NSPs that have been conducted abroad and published in the international peer-reviewed literature, focusing on the most common objections to introducing prison NSPs in Australia.

Safety

The safety of prison staff, volunteers and inmates is a primary consideration, reflecting the duty of care that correctional services owe to people in their institutions. On the face of it, providing sterile injecting equipment might increase the risk of syringes – including those containing contaminated blood – being used as weapons.

This understandable concern fails to acknowledge, however, that syringes are currently available in significant numbers in Australian prisons now and that there has been only one incident of a prison officer being stabbed with a syringe. That occurred in 1990 in a NSW prison (Norberry 1991).

Not one incident of syringes being used as weapons has been reported from the 50-plus European prisons with NSPs (Lines et al. 2004). Indeed, prison staff where these programs operate have advised that their institutions are actually safer following the introduction of the NSPs as the syringes are generally stored safely, greatly reducing the risk of officers incurring needle-stick injuries.

The World Health Organization has concluded

Programmes providing clean needles and syringes in prisons were satisfactory in all studies reported...No serious unintended negative consequences were reported...The use of needles or syringes as weapons was not reported, contrary to what had been feared. Staff attitudes were generally positive but response rates in surveys varied (World Health Organization 2004b).

Drug use and drug injecting

The objection is sometimes raised that making available sterile injecting equipment for use by drug-injecting inmates will increase the amount of drug use in prison, and/or increase the amount of injecting. This claim has no empirical support and does not reflect experience with NSPs in the community. Providing clean injecting equipment does not increase the amount of injecting or drug use (Australian National Council on Drugs 2002; Dolan, K., Topp & MacDonald 2000; World Health Organization 2004c).

The first published systematic study of the impact of prison NSPs on drug use in prison was undertaken in a small Swiss female prison (Nelles, Joachim et al. 1998; Nelles, J., Fuhrer & Hirsbrunner 1999). It concluded that

These findings suggest that drug intake in prison is influenced by the availability of drugs and money. It was evident that access to syringes did not increase drug use or injecting. There was no increase in drug use or injecting (Nelles, J., Fuhrer & Hirsbrunner 1999, p. 138).

This finding has been replicated in the subsequent evaluations in diverse settings: different types of prisons, different types of prisoners and different types of prison NSPs (Lines et al. 2005; Niveau 2005; Stöver & Nelles 2003). These are robust research findings and have been accepted by WHO as informing its global policy on the prevention of communicable diseases in correctional facilities (World Health Organization 2004b).

Impacts on treatment

Policy makers legitimately ask if providing NSPs in prisons has adverse impacts on prison drug treatment programs (Families and Friends for Drug Law Reform 2003, pp. 52-3). The answer is no. The many evaluations conducted to date show that sterile injecting equipment can be distributed in prisons with no adverse impacts on drug treatment programs. This reflects the position in the broader community (Dolan, K., Topp & MacDonald 2000; World Health Organization 2004c).

A full range of health services is needed in prisons to address drug problems, as in the community. These include drug education (including peer education and support), pharmacological and psycho-social treatment programs, drug free units and harm reduction measures such as the provision of bleach and sterile injecting equipment.³ They inter-relate to provide synergy, rather than compete (Lines et al. 2004, pp. 47-8).

³ The evidence base for disinfecting injecting equipment, including through the use of bleach, is weak. This presents a strong argument for interventions with proven effectiveness including prison NSPs (source: World Health Organization 2004, *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*, Evidence for action technical papers, World Health Organization, Geneva).

Indeed, an encouraging research finding is that prison NSPs, rather than detract from the effectiveness of in-prison drug treatment programs, can enhance their effectiveness

Ideally, needle exchange programs should be one component of a comprehensive drug service within prisons that includes abstinence-based programs, drug treatment, drug-free units, and harm-reduction measures. From this perspective, the availability of sterile needles does not undermine or impede the provision of other programs, but rather offers drug users more options for improving their health status, and a potentially greater interaction with the range of health and drug treatment options offered in a particular institution. In the case of the German pilot programs, the evaluator found that the needle exchange program actually *increased* the number of people accessing drug treatment services, demonstrating that needle exchange programs can serve as valuable points of contact and referral for a difficult-to reach drug-using population. This was also the experience in Spain... (op. cit., p. 47).

Context and transferability

In developing any new public health initiative attention needs to be given to the context in which it is planned to be implemented, and an assessment made of the transferability and generalisability of the evaluation research findings from other contexts. Nonetheless, it is somewhat surprising to hear, in Canberra, the argument that we should not trial a prison NSP in Australia because the correctional administrators of Canada, New Zealand and the UK, being nations with correctional systems similar to Australia's, do not as yet provide prison NSPs (Families and Friends for Drug Law Reform 2003, pp. 50-51).

As noted above, prison NSPs currently operate in three OECD nations and three poorer nations. Most significantly, in terms of generalising the findings of the evaluations of those programs to Australia, the evaluated programs show great diversity. They have led a range of authorities, including the Australian National Council on Drugs (2002), the National Drug and Alcohol Research Centre (Rutter et al. 2001) and WHO (World Health Organization 2004a, 2004b) to conclude that we should trial this public health intervention in Australia.⁴

The evidence base for implementation in diverse settings has been nicely summarised by the leading scholars in this field

Needle exchange has been available in some prisons for as long as ten years, and it is an approach that has been rigorously evaluated everywhere it has been enacted. Prison systems and governments can no longer avoid their responsibilities to provide for the health of prisoners by dismissing prison needle-exchange programmes as something new or untested. They are neither (Lines et al. 2005, p. 61).

It is also untrue that the Canberra proposal is out-of-touch with thinking in other English-speaking Commonwealth nations. A firm proposal to establish NSPs in Scottish prisons is currently being considered by the Scottish Prison Service (Scottish Prison Service 2005) and the Canadian correctional authorities are actively investigating the proposal

The tattoo program may be a sign of progressive steps to come. That's because the federal government is currently analysing whether to hand out clean needles to inmates who inject drugs. Correctional Service Canada and the Public Health Agency of Canada have signed an agreement to work together to analyse the risks and benefits of prison-based safe needle programs.

In September [2005], officials from the two agencies, along with representatives from the Union of Canadian Correctional Officers and the Professional Institute of the Public Service, toured prisons in Spain and Germany that have needle exchange programs. Needles are often shared by dozens of inmates, leading to the spread of blood-borne diseases (Weeks 2005).

⁴ Such a trial was also advocated by the current Australian Government Minister for Education, Science and Training, The Hon. Dr Brendan Nelson MP, in 1995 (source: Rutter (1995, p. 7))

The ACT Government implementing a trial of a prison NSP will not be out-of-step with others. Rather, it will be a case of the ACT acknowledging its responsibilities and the research evidence available to guide policy in this contested area.

Impacts on communicable diseases and other aspects of health

Concern has been raised that prison NSPs would have little impact on the health of prisoners and, by extension, on the community. The evidence, however, reveals the opposite: dramatic beneficial impacts in terms of reduced risk behaviour for drug use-related health problems and reduced incidence of transmissible disease infections. In particular, the evaluations of the prison NSPs in six countries revealed *no* cases of hepatitis C virus or HIV seroconversion, *no* overdose deaths and *no* increases in injecting. Needle sharing dropped dramatically. The prevalence of abscesses caused by injecting with contaminated equipment fell. A country-by-country summary of the epidemiological data is provided by Lines et al. (2004, 19-43).

These positive outcomes have been summarised by the World Health Organization in its recently-published Policy Brief

Programmes providing clean needles and syringes in prisons were satisfactory in all studies reported...Drug consumption by inmates participating in such programmes was stable or decreased over time. Reported sharing of needles and syringes declined dramatically and was virtually non-existent at the conclusion of most pilot studies.

No cases of inmates acquiring HIV, hepatitis B or hepatitis C were reported in any prison with a functioning needle and syringe programme. No serious unintended negative consequences were reported. There were no reported instances of initiation of injecting by inmates who did not inject before the introduction of a programme (World Health Organization 2004b, p. 2).

Considering the high levels of unsafe injecting in prisons without NSPs, the high prevalence of blood-borne viral and bacterial disease in the prison population, the fact that people initiate injecting in prison and become infected by blood-borne diseases there, and the relatively short median length of stay in Australian prisons, these are very positive findings with respect to the health and well-being of prisoners able to access prison NSPs, and for the people in the community with whom they interact upon release.

Common factors in effective programs

Although opponents of a trial in Canberra have pointed to the importance of context, implying that it is difficult to transfer learnings from other prisons systems to Australia's, researchers have determined that there are a number of factors common to the effective programs implemented and evaluated in diverse settings. They apply regardless of the actual implementation model adopted. These common factors provide a valuable guide in thinking about a Canberra prison NSP trial, both at the early policy-making stage and subsequently as detailed implementation planning is undertaken.

The studies have identified six core common features of effective programs (adapted from Lines et al. 2004, pp. 53-6)

- *The intervention needs to be designed taking into account the particular situation, including the needs of the inmates, the prison officers and the prison as a whole*
 - This highlights the need for the careful articulation of the prison health plan with other aspects of management of the institution
- *Leadership by the correctional service administration and the support of staff*
 - The trial needs to be supported by political leaders, the senior officers of the correctional service and corrections health service, and by prison officers. In particular, the prison officers need to be included in the design phase of the project from its inception as their roles in implementation are crucial
- *Confidentiality and trust*
 - The evaluations have demonstrated the importance to program success of confidentiality and trust: of inmates being confident that they can obtain sterile injecting equipment and dispose of it safely without their identities as program participants being revealed to the corrections authorities, and trust in the individuals managing the NSP. These features can be attained through careful planning of the program, e.g. with respect to the location of syringe dispensing machines or the use of peer distributors/educators.
 - In some programs, however, a considerable degree of trust has developed between the inmates and prison officers such that inmates do not need to conceal the fact that they obtain sterile injecting equipment through the program. In some of these programs the syringes are required to be stored in locations that can be visually checked by officers. Both prison officers and inmates have found the increased trust linked to this openness helpful in other aspects of prison operations.
- *Adequate access to sterile injecting equipment*
 - Evaluations of the impacts of NSPs in the community have taught us that, where they fail to achieve their aims of reducing the incidence of blood-borne diseases such as hepatitis B & C and HIV, it is usually because of inadequate availability of sterile injecting equipment, i.e. too few NSPs or too restricted opening hours (Ashton 2003b, 2003a). The same applies in prisons. The successful programs are those where sterile syringes are available when needed, rather than requiring drug users to fit in with the limited opening hours of a clinic, for example.

- *The NSP as part of a comprehensive harm reduction strategy which is, in turn, part of a broader prison health initiative*
 - Australia's National Drug Strategy and National hepatitis and HIV/AIDS strategies are practical, relatively effective and evidence-based approaches. They highlight the importance of contaminated injecting equipment and contaminated injecting environments as sources of infection. The response to this is Australia's three-pronged approach to illicit drugs: demand reduction, supply reduction and harm reduction.
 - Prison NSPs are harm reduction interventions, building on our extensive experience and evidence base in this area (Black, Dolan & Wodak 2004; Hunt 2003). Successful prison NSPs are part of a full range of harm reduction, supply reduction and demand reduction strategies, as recommended by WHO (their references here to HIV prevention apply equally to hepatitis C prevention)
 - The evidence shows that such programmes should include all the measures against HIV transmission which are carried out in the community outside prisons, including HIV/AIDS education, testing and counselling performed on a voluntary basis, the distribution of clean needles, syringes and condoms, and drug-dependence treatment, including substitution treatment.
 - All these interventions have proved effective in reducing the risk of HIV transmission in prisons. They have also been shown to have no unintended negative consequences. The available scientific evidence suggests that such interventions can be reliably expanded from pilot projects to nationwide programmes (World Health Organization 2004b, p.2).
- *Trialling the intervention so as to produce a sound evidence-base*
 - The sixth common features of the prison NSPs currently operating abroad is that, in all ten countries now using them, the interventions were developed initially as pilot programs and rapidly expanded. The evidence for program expansion quickly became clear. Indeed, following a brief pilot, Spain has adopted the policy that NSPs are to be available in all its prisons, and other correctional services (e.g. the Scottish Prison Service) are likely to do the same, in accordance with their international human rights obligations.
 - While introducing a prison NSP in Canberra on a trial basis, and carefully evaluating it, is desirable, it should be noted that research ethics include the requirement that, if a trial intervention is found to be effective before the trial is completed, the trial should be terminated and the intervention be made available to all who could benefit from it (National Health and Medical Research Council 1999). (Of course, the opposite also applies: if the intervention is found to be harmful, the trial should be stopped rather than complete its initially planned course.) This means that decision-makers need to think through the implications of conducting the trial.

Trial evaluation

Although strong evidence from well-conducted and evaluated trials of prison NSPs is available, supporting these programs' feasibility and effectiveness, it is desirable that a prison NSP be introduced in one or more Australian prisons in the form of a scientific trial.⁵ This reflects the (unlikely) possibility that there may be some contextual challenges in transferring learnings from abroad to the Australian setting, and the fact that some Australian opinion leaders are sceptical of research findings from abroad, requiring replication locally before they will place much store on the findings.

No serious impediments exist to designing and implementing a carefully evaluated trial of a prison NSP in Australia. We already have a cohort of expert researchers with international reputations in research on prisoner health, particularly as it relates to infectious disease and drug use. They are concentrated in NSW, and have sound working relationships with the NSW Department of Corrective Services. Most of the key researchers are located at the National Drug and Alcohol Research Centre at the University of NSW and at the Centre For Health Research in Criminal Justice, a body associated with NSW Justice Health operating under a memorandum of understanding with the University of Sydney.

A relatively powerful evaluation research design would entail introducing a NSP into one prison such as the Alexander Maconochie Centre in Canberra when it opens in 2007-08, and comparing process and outcome issues there with a NSW prison which does not have a NSP. This would be a quasi-experimental intervention study (Shadish, Cook & Campbell 2001).

The trial would be conducted in accordance with the NHMRC's (1999) *National statement on ethical conduct in research involving humans*. The *National Statement* does not include any provisions that would present ethical or privacy impediments to the trial. Coverage under the ACT *Epidemiological Studies (Confidentiality) Act* 1992 would be desirable, as well as coverage under the corresponding NSW act if a comparison prison were to be used in that State.

Work has already been done to identify the key issues in trial design, implementation and evaluation. In 1995 researchers from the National Drug and Alcohol Research Centre conducted a study that was published under the title 'Is syringe exchange feasible in a prison setting? An exploratory study of the issues' (Dolan, K. A. et al. 1996; Dolan, K. A., Wodak & Rutter 1996; Rutter 1995). The study included discussions with ten expert health and corrections researchers. They concluded that the trial is feasible, and provided guidance on how it could be conducted and evaluated. Details may be found in Rutter 1995 and Rutter 2001 and will not be repeated here. In summary, however, the researchers identified the following procedures required for the evaluation of a trial prison NSP in Australia

- a. Open-ended interviews should be conducted with staff and inmates on a monthly basis
- b. Structured interviews on drug use should be conducted at 6-month intervals
- c. Hair analysis of all participants should be conducted at 3-month intervals
- d. Marked syringes should be monitored to estimate circulation times

⁵ A scientific trial may be defined (in this context) as a study conducted to find out whether and to what extent an intervention which it is believed may improve people's health, social functioning, and/or attain other desirable goals, actually does so.

- e. Focus groups should be conducted with custodial staff, health staff and inmates after the first year
- f. Prison records should be reviewed for assaults and drug seizures in both wings at the conclusion of the study
- g. All participants should receive a clinical evaluation at the end of the pilot (Rutter et al. 2001)

They proposed a two-year study with pre- and post-intervention data collection, as well as throughout the intervention period. The recommended method of distribution of sterile injecting equipment was via a vending machine. Clinical evaluation of inmates would be needed to identify rates of communicable disease seroconversion.

Although the authors did not propose the research questions for the trial, they could be as follows

1. How feasible is it to implement an NSP in the Alexander Maconochie Centre?
2. What are the outcomes of the prison NSP in terms of the inmates' and prison staff's physical and mental health, inmate drug use and injecting behaviour, used syringe disposal, prison safety, prison discipline and compliance with regulations, relationships between detainees and staff, etc?
3. How strong is the evidence that the intervention (the NSP) actually created the observed outcomes?

6. CONCLUSIONS

The need to improve Australia's response to the epidemic of high risk drug use in our prisons is absolutely clear, based upon the uncontested epidemiological evidence of the sharing of contaminated injecting equipment in prisons and the prevalence and incidence of hepatitis C among the prison population. The relatively short median lengths of stay in Australian prisons (just 2.8 months for remandees and 24 months for sentenced prisoners) means that the great achievements in minimising disease transmission through providing NSPs in the community are being undermined by failing to do so in the highest-risk environments, our prisons.

Many authorities argue that failing to provide to prison inmates a quality of health care at least as good as that found in the community, including access to sterile injecting equipment, contravenes our obligations under international law. It would be tragic if we had to wait until the courts find that Australia's corrective services are acting unlawfully in refusing to provide the means by which inmates can maintain their health and well-being.

The Australian Correctional Ministers and Administrators are to be commended for moving some way towards adopting harm reduction strategies within Australian prisons, as demonstrated by the availability of bleach and condoms in some institutions. While necessary, they are not sufficient to achieve important public health goals.

The evaluation research evidence as to the processes of introducing NSPs into prisons, and the impacts of the NSPs, is now well documented in peer-reviewed scientific journals. It has been assessed by independent, prestigious organisations including WHO and the Australian National Council on Drugs, and they have concluded that the evidence base is strong enough for prison NSPs to be provided far more widely.

The research findings from the NSPs in six nations where over 50 prisons are providing these interventions are remarkably consistent— positive on all variables assessed including those related to the health of inmates, their drug use, impacts on prison drug treatment services and on the safety of prison staff and inmates. The diversity of situations in which these NSPs operate suggests that we will have no real difficulty in finding one or more models that will work in Australia.

As one authority put it, 'Prison systems and governments can no longer avoid their responsibilities to provide for the health of prisoners by dismissing prison needle-exchange programmes as something new or untested. They are neither' (Lines 2005, p. 61). A trial of a prison NSP is needed in Australia, and the establishment of a world's best corrections health service at the Alexander Maconochie Centre, Canberra's new prison, provides an ideal opportunity to implement this important intervention, at least on a trial basis.

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