Balancing access and safety

Meeting the Challenge of Blood Borne Viruses in Prison

Report for the ACT Government into implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

Report for ACT Health

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Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

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Thank you.
Executive Summary and List of Recommendations:

‘Balancing access and safety’

While timely and appropriate access was deemed to be of paramount importance in ensuring prisoner engagement with any Needle and Syringe Program (NSP), likewise unrestricted availability of injecting equipment throughout the Alexander Maconochie Centre (AMC) was also deemed to be potentially problematic.

The title of this report ‘Balancing Access and Safety’ reflects the vital importance of balancing these key considerations, and the significant challenges for achieving this objective.

(Chapter 4, Section 4.3)

The Public Health Association of Australia (PHAA) was engaged by the ACT Government in May 2011 to investigate and report on models for the implementation of an NSP in the AMC. The project also entailed an assessment of barriers to implementation and broad consultations with key stakeholders. The emphasis of the project has been on seeking to develop a model that ensures optimal health and safety outcomes for everyone impacted upon by a custodial sentence. This includes not only the person being detained in custody but all prison staff and the broader community. This report outlines outcomes and recommendations from the project and proposes a way to meet this challenge.

Rather than address the terms of reference (TORs) in a step by process it was decided to consider the aims of the project within the context of the AMC, examine the literature, consult widely and then begin to build models that would address the TORs. However, great care was taken to in this report to address all of the issues identified in the TORs.

Chapters 1 and 2 of the report provide an introduction to the aims of the project and context in relation to the outcomes sought and the methodology employed. Chapter 3 provides an analysis of the existing literature from both Australia and overseas. It outlines the evidence in relation to: the need for NSPs in correctional settings; consistency of the proposal with key national strategies; legislative considerations; and the demonstrated success of such programs overseas.

Chapter 4 identifies key themes emerging from the consultation process, developing a set of criteria for the analysis of models for implementation of an NSP in the AMC. Chapter 5 provides an outline of key lessons from programs operating overseas and consultations with stakeholders working in those countries. Chapter 6 contains an analysis of the preferred model options based on the main considerations of barriers and characteristics identified through the consultation process.

Chapter 7 examines in detail potential issues in relation to criminal and civil liability for staff.

Chapter 8 outlines conclusions and recommendations arising from the preceding chapters. Below is a summary of the recommendations outlined in detail in Chapter 8.
Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

Recommendation 1: Requirement Under Law

The ACT Corrections Management Act 2007 be amended to require the establishment of an NSP at the AMC.

Recommendation 2: Rules, Procedures and Protocols

A clear set of rules, procedures and protocols be established through an appropriate process guided by the ACT Corrections Management Act.

Recommendation 3: Implementation through a Flexible Contingency Process

Adopt a contingency process for the implementation of appropriate model/s for a needle and syringe program at the AMC. If the initially preferred model does not meet the needs of stakeholders the procedure should be to move to the next preference. The order should be as follows:

- **Preferred Initial Model: NSP Model 3 (Contained NSP)**
  - Model 3B: Contained NSP operated by external agency (within Health Centre)
    Should an external provider fail to deliver the necessary outcomes, Model 3 could alternatively be operated by ACT Health.
  - Model 3A: Contained NSP operated by ACT Health/Nursing Staff (within Health Centre)

- **Contingency Step 1: NSP Model 2 (Equipment provision from Health Centre)**
  - Model 2B: NSP operated by an external agency
    Should an external provider fail to deliver the necessary outcomes, Model 2 could alternatively be operated by ACT Health.
  - Model 2A: NSP operated by ACT Health/Nursing Staff

- **Contingency Step 2: NSP Model 1 (Vending Style Machines)**
  - Model 1: ‘One for one’ Exchange Vending Style Machines

(See diagram at 8.4.1)

Recommendation 4 Aboriginal Health Worker

Recruitment of a dedicated Aboriginal Health Worker position in an NSP and related service provision would be worthy of consideration.

Recommendation 5 Secure Syringe Disposal Bins

The installation of secure syringe disposal bins would further reduce the potential for accidental needle-stick injury and be worthy of consideration even without the implementation of an NSP.

Recommendation 6 Retractable Syringe Technology

Future developments in retractable syringe technology will need to be considered as part of the ongoing development of an NSP in custodial settings.

Recommendation 7 Civil and Criminal Liability

Legislative amendments be considered to protect all staff from potential civil and criminal liability.
Chapter 1: Introduction

The Australian Capital Territory Legislative Assembly was informed by the then Deputy Chief Minister and Minister for Health (now Chief Minister) on 7 April 2011 that further work would be undertaken regarding a Needle and Syringe Program (NSP) at the Alexander Maconochie Centre (AMC) – the ACT prison. The Minister was responding to a report into health issues at the AMC and made the following statement:

“The Burnet Institute report looks briefly at the issue of a trial needle and syringe program at the AMC. Recommendation 69 advocates that a process should be commenced to instigate a trial NSP at the AMC. I have previously placed on record my understanding of and support for the underpinning health rationale for such an approach. Indeed, I do support a needle and syringe program at the AMC as health minister. However, I also acknowledge that this is a complex issue that requires a considered response by government before any final decision is made.

Since the report has been received, I have been seeking the views of a range of stakeholders in relation to this matter. However, I believe that further work is required before the government will be in a position to reach a final decision on this important issue. The government will immediately commission a project that will look at further work around a future needle and syringe program. This work will cover potential models for an NSP, how they could work in the prison setting, barriers to implementation at the AMC, and how and if these barriers could be overcome. I have asked Mr Michael Moore, former ACT health minister and currently Chief Executive of the Public Health Association, to lead this work.”

(ACT Legislative Assembly 2011 pg 1576)

1.1 Terms of Reference

The terms of reference for the work are as follows:

1. Investigate models for the delivery of needle and syringe programs in custodial settings, including existing programs in other jurisdictions, their applicability to the AMC and evidence for the effectiveness of different models.

2. Consider the views of staff at the AMC, and relevant stakeholders to better understand their knowledge, beliefs and perceptions about needle and syringe programs in custodial settings and in the context of the AMC in particular.

3. Identify barriers and enablers for the implementation of a trial needle and syringe program at the AMC. Where barriers are identified, provide advice on specific strategies to overcome these.

4. Consider and advise on the potential impact of a trial needle and syringe program on services for prisoners post-release.

5. Provide analysis on the feasibility and likelihood of successfully implementing a trial needle and syringe program at the AMC.

6. If appropriate, provide recommendations on implementing a preferred model of a trial NSP at the AMC.
The Board of the Public Health Association of Australia (PHAA) considered it appropriate that the CEO of the Association be assisted in this task by the Deputy CEO of the Association, Ms Melanie Walker. In making this decision consideration was given to Ms Walker’s extensive background in alcohol and other drug and justice health sector service provision, policy and program development in both government and non-government roles prior to her appointment at the PHAA. Ms Walker has continued to play a key role in these areas of public health policy development since commencing work with the Association. In further consideration the Board determined that as there are no NSPs operating in prisons in Australia it would be appropriate for the CEO, Mr Michael Moore, to examine NSPs operating in Europe to inform this report. The PHAA provided funding to allow for an examination of a range of existing programs in Europe.

1.2 Background

The AMC was established by the ACT government within the Framework of the Human Rights Act with the express intention of ensuring that the punishment of being imprisoned was specifically about the deprivation of liberty, rather than also being characterised by the host of prison-related hardships that are often experienced by prisoners in Australia. It is the first prison in Australia to be established in this manner. As such there are community expectations that the ACT prison will operate in some ways that are quite different to other prisons in Australia and be able to achieve better rehabilitative outcomes for detainees. This expectation may be considered to place an additional burden of expectation on custodial and non-custodial officers working in the prison environment who have been charged by our community with carrying out one of the most difficult tasks of any government workforce. The men and women who undertake this work in the ACT have understood this challenge from the time that the AMC was established.

In line with this broader philosophical framework, there are also a range of complementary statutory obligations requiring the AMC to operate differently than custodial facilities in other jurisdictions. The ACT’s Corrections Management Act requires “promoting the rehabilitation of offenders and their reintegration into society” (ACT Govt 2011 pg 6) and “to ensure the detainee is not subject to further punishment (in addition to deprivation of liberty) only because of the conditions of detention” (ACT Govt 2011 pg 7). Additional health service commitments are at Section 53 of the Act which require “a standard of health care equivalent to that available to other people in the ACT” and “as far as practicable, detainees are not exposed to risks of infection” (ACT Govt 2011 pg 7).

The health of prisoners has been the subject of recent reviews including reports that have been provided to the Assembly by Knowledge Consulting and the Burnet Institute. Both reports were extensive in their examination of health issues within the AMC. In their response to the Burnet Report, the ACT Ministerial Advisory Council on Sexual Health, AIDS/HIV, Hepatitis C and Related Diseases suggested a principle consistent with the broader Human Rights approach that services available in the community should also be available to prisoners unless there was a compelling reason not to do so.
Chapter 2: Context

The context of an NSP in detention proposal assists in developing an understanding of the background and reasons behind such a proposal and the barriers to implementation. This chapter explores: acknowledged achievements of the AMC; how the concept of implementing an NSP aligns with broader strategic policy objectives; the role of custodial officers; and the requirement for pragmatism in the development of approaches to achieving broader health objectives in the custodial context.

2.1 Achievements of the AMC

2.1.1 Independent Review of Operations at the AMC (Hamburger Review)

The AMC is a relatively new prison. While some will dwell on negative aspects of reports conducted into its operations it is worth noting that in the first independent report into the operations of the AMC in its first year, led by Mr Keith Hamburger AM for Knowledge Consulting, the following positive aspects were highlighted:

- No riots, fires or infrastructure failures;
- A strong basis to provide for a human rights compliant facility;
- Accommodation standards are high;
- The services to detainees are generally of a high quality;
- A good suite of programs and activities is available to detainees;
- Good induction processes;
- Strong case management approach; and,
- Therapeutic Cottage and Transitional Release Centre are excellent models.

(Knowledge Consulting 2011 pg 25-28)

Even though its operations are of a very high standard compared to other Australian correctional facilities, this prison is by no means perfect and Mr Hamburger provided a series of suggestions as to how to make improvements that are being carefully assessed by a taskforce that has been appointed by government to carry out this task.

On the matter of an NSP in the prison Mr Hamburger had the following comment at 12.1 of his report:

“Sharing of needles and the concomitant spread of blood-borne diseases is a perennial problem in correctional institutions. There are two mutually incompatible positions: First drug use is illegal, but inevitable, and second that the inevitable consequence of drug use is the spread of blood-borne disease. Stopping the spread of blood-borne disease would not, essentially, be difficult were it not for the fact that it cannot happen without a quasi-legalisation of drug use within the correctional centre environment and that this can only occur with the support of correctional centre staff.

Drugs are illegal in a correctional centre. Considerable effort is made in the discovery of drug contraband and the prosecution of those in possession. There are no
The notion of “quasi-legalisation” implies the necessity for staff to accept that drug use is occurring. However, as in the broader community, every effort should be made to reduce supply – it is not the drugs themselves that are in question it is the equipment used to inject. The illicit nature of the drugs and the provision of sterile equipment are two separate issues. It is simply not necessary to consider a concept of “quasi-legalisation”. The imperative in the custodial setting is similar to the non-custodial setting where law enforcement officers do not use the intelligence associated with the legal provision of injecting equipment to target specific individuals or groups as likely users of drugs.

2.1.2 Burnet Report

The matter of an NSP was also considered by the Burnet Report which reported multiple prisoners, ex-prisoners and some custodial staff (who did not wish to be named publicly) who believed the introduction of an NSP in the prison to be appropriate.

“Despite these conflicts, among prisoners, ex-prisoners and community-based service providers there was overwhelming support for an NSP to be implemented at the AMC. Health staff from the prison also strongly supported the introduction of NSP services”.

and later:

“There were several reports that indicated that an informal exchange program was already operating. Prisoners and ex-prisoners noted that prison staff had safely disposed of used injecting equipment on behalf of prisoners and that injecting equipment including needles and syringes and other items like alcohol swabs had been provided to prisoners by prison staff. The evaluation team also observed the presence of multiple sharps disposal bins in different areas of the prison”.

Approximately one third of prisoners reported having injected in prison and a quarter to having done so in the previous four weeks (Burnett 2011 pg 126). These statistics are a matter of significant concern regarding the spread of infection in the prison context. The reality is that an unregulated needle and syringe program does operate in the prison at the moment. The problem is that it is controlled by prisoners rather than health workers. The priority for those running the illicit NSP is therefore associated with financial and power advantage of the illegal commodity. Needles and syringes are traded and used in the least safe manner with regard to the spread of disease, the nature of the equipment and the power of those controlling the commodity.
2.1.3 The ACT Alcohol, Tobacco and Other Drug Sector

The ACT Alcohol, Tobacco and Other Drug Association (ATODA) indicated as part of the consultation process a commitment in the ACT, and within the ATOD sector, to ensuring that ATOD services within the AMC are equal to those in the broader Canberra community. ATODA identified this approach as aligning with the legal and moral responsibilities of our jurisdiction and our sector under the ACT Human Rights Act 2004.

The ATOD sector has always worked with detainees and has been part of the AMC workforce. The sector is well aware that its client groups are people who frequently come into contact with the criminal justice system. Prior to 2009 many were detained in NSW prisons and since April 2009 people have been detained in the ACT with the opening of the AMC.

ATODA noted that a person is detained in the AMC for an average of 5.9 months. This requires a commitment to throughcare. ATOD sector approaches reflect that detainees continue to be their clients whilst they are in the AMC, and that detainees return to the broader Canberra community. The ACT ATOD sector knows this and reflects this in its approaches to the provision, evaluation, development and enhancement of all ATOD policies, services and programs in the AMC.

In 2009 the sector conducted the ATOD Sector and Prison Project, which included a sector survey, a report, and a conference. This process identified that the ATOD sector has been part of the AMC workforce from the beginning, and some of the first services to work in the AMC.

2.2 National Drug Strategy 2010 - 2015

The Australian government web page on the National Drug Strategy (NDS) identifies that

“the National Drug Strategy, a cooperative venture between Australian, state and territory governments and the non-government sector, is aimed at improving health, social and economic outcomes for Australians by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in our society”.

(Australian Government Department of Health and Ageing-DoHA, 2011)

The NDS is based on three inter-related strategic approaches to dealing with drugs in our community – the NDS refers to them as the “three pillars” of the overall approach of harm minimisation.

Harm minimisation, therefore, is our agreed national approach to drug policy which encompasses the three pillars of:

2.2.1 Demand Reduction

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community. To achieve this requires effort to:
  - prevent uptake and delay onset of drug use
  - reduce use of drugs in the community
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- support people to recover from dependence and reconnect with the community
- support efforts to promote social inclusion and resilient individuals, families and communities

2.2.2 Supply Reduction

- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs. To achieve this requires effort to:
  - reduce the supply of illegal drugs (both current and emerging)
  - control and manage the supply of alcohol, tobacco and other legal drugs

2.2.3 Harm Reduction

- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs. To achieve this requires effort to:
  - reduce harms to community safety and amenity
  - reduce harms to families
  - reduce harms to individuals

Our NDS does not simply limit its scope to the broad community but states categorically:

“The approaches in the three pillars will be applied with sensitivity to age and stage of life, disadvantaged populations, and settings of use and intervention”.

(DoHA 2011)

The PHAA considers that prison is a key setting of a disadvantaged population whose vulnerability to the spread of infectious diseases and blood borne viruses (BBVs) such as Hepatitis C and HIV/AIDS means that it is critical in the prison setting to “apply the strategy with sensitivity” in such a way as to minimise the potential spread of such diseases. The approach taken in this report is to make recommendations that remain consistent with Australia’s NDS.

2.2.4 National and ACT Strategic Frameworks

Additionally, Australia’s NDS has also adopted The National Needle and Syringe Program Strategic Framework 2010-2014. The aims of the NSPs in Australia, according to this framework, are to protect the health, social, and economic wellbeing of the community through the priority focus on the following:

- Human immuno-deficiency virus (HIV);
- Hepatitis C virus (HCV);
- Hepatitis B virus (HBV);
- Injecting related injury and disease (IRID); and
- Facilitating Injecting Drug Users access to other health and related services

(DoHA 2011 pg 15)
None of the goals of the National Drug Strategy should be lost simply because a person is incarcerated:

- Supply reduction
- Demand reduction
- Harm reduction

It is the view of the PHAA that none of the goals of the NDS should be lost simply because a person is incarcerated. The sentence that they are serving is about ‘deprivation of liberty’ and should not mean exposure to disease in a manner that is now unacceptable in the broader community. This framework specifically mentions the importance of NSP to people “who are currently in prison”.

The PHAA understands the international impact of the principles of the Ottawa Charter for Health Promotion (WHO 1986). It is this Charter that frames Australia’s approach to HIV/AIDS and viral hepatitis and establishes an overarching international policy basis for the framework. The Ottawa Charter defines health promotion as the process of enabling people to increase control over and thereby improve their health. It provides a holistic approach to thinking about health and wellbeing as well as to planning health promotion activities that improve health outcomes for individuals and populations.

The National Needle and Syringe Program Strategic Framework 2010 – 2014 makes specific reference to the WHO Constitution, which states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (WHO 2005 pg 12). Both the Ottawa Charter and the WHO Constitution play a key role in informing the context and principles of NSPs in Australia.

These same issues are canvassed extensively in the ACT’s own HIV/AIDS Hepatitis C Sexually Transmitted Infections: A Strategic Framework for the ACT 2007–2012. The same publication specifically addresses prisons as an appropriate setting to apply the principles of the NDS and identifies the following important human rights issues as they impact on injecting drug users which are “underpinned by the human rights principles outlined in the ACT Human Rights Act 2004”. The Framework recognises basic rights such as:

- Treating people with dignity and respect;
- Empowering people to participate directly in decisions about their health and well being;
- Self-determination in relation to their life choices;
- Informed consent and adequate and accurate information to support decision making;
- Adopting strategies to improve self-esteem and self-worth;
- Access to non-judgmental and non-discriminatory services;
- Access to advocacy processes to protect rights in service delivery, basic consumer rights; and
- Respect for the right to privacy.

(ACT Health 2011 pg 16)

Both these strategies identify the complex nature of taking action to prevent the spread of infectious diseases and emphasise the importance of empowerment as a tool rather than punishment. There is also reference to providing best practice standards of medical care for people living with HIV/AIDS and with Hepatitis C in the AMC including encouraging appropriate referral pathways and the concept of ‘throughcare’. The strategy states that

- “the overall objective of education and prevention initiatives is to minimise the risk of transmission of HIV/AIDS, hepatitis C and STIs through:
There is widespread concern on the part of officers that the introduction of an NSP in the prison will create an environment that is less safe than the one that currently exists. However, this concern is not reflected in the evidence. Secondly, it is also clear that some officers are open-minded to an NSP depending on how the model is developed.

In order to illustrate their concerns about the safety of custodial officers there is often reference made to an attack that occurred over twenty years ago. According to a research report by Ms. Sarah Larney and Associate Professor Kate Dolan - Needle-stick injuries and the contents of syringes confiscated in prisons:

“A prison officer in NSW acquired HIV after being assaulted by a prisoner with a blood-filled syringe (Egger & Heilpern, 1990). In response to the assault, the Department of Corrective Services placed correctional institutions in lockdown and dramatically decreased the amount of personal property each inmate was permitted to possess.

The NSW Government introduced the Prisons (Syringe Prohibition) Amendment Bill, specifically outlawing the introduction of syringes into prisons. The prisoner died before the charges against him could be heard (Norberry, 1991) and the prison officer subsequently sued the Department of Corrective Services for negligence. This case was heard in 1994 and the officer received an undisclosed sum in compensation (Jurgens, 1995). The officer died of an AIDS related illness in 1998”.

(Larney and Dolan 2006 pg 4-5)

This is a serious matter and does provide some insight into the concerns of prison officers. However, it is also important to identify that the attack occurred at a time when there were no legal NSPs operating in prisons. It is also pertinent that there have been no cases reported of an attack with a needle or syringe in any of the regulated programs that were studied in Europe as part of this report (further information in Chapter 4).

The situation for custodial officers is difficult in a number of ways beyond the issue of safety if the prison is ‘flooded with needles’ as some in the public have suggested. Custodial officers are law
enforcement officers and take very seriously the responsibility of managing prisoners in a manner that respects the law. Considered in a black and white sense the possession and use of some substances is prohibited by law and law enforcement officers have a role to uphold the law. This is a similar issue that police officers wrestle with in all Australian jurisdictions. However, all jurisdictions are also committed to implementing the three pillar approach of the NDS, and related National Blood-Borne Virus (BBV) Strategies, which have been responsible in the general community for limiting the spread of HIV/AIDS and Hepatitis C compared to the high rates of such BBVs experienced in the general populations of other countries. The demonstrable achievements of key national strategies in limiting BBV rates in the community are explored further in Chapter 3.

Law enforcement officers remain committed to supply reduction. We should expect nothing less of their role in the prison. The approach is consistent with the NDS and in a contained environment efforts to interrupt supply should be much more effective than in the broader community. According to those that we interviewed, including prisoners and ex-prisoners who have served time in both the ACT and NSW, the AMC disruption to drug supply is more effective than in most prisons.

2.5 The Choices

However, despite excellent efforts from custodial staff it is clear that injectable substances are still getting into the prison. Therefore, there is a clear choice:

- Stop the drugs getting into the prison altogether OR
- Apply the same approach as the NDS:
  - Demand Reduction
  - Supply Reduction
  - Harm Reduction

2.5.1 ‘Just Stop the Drugs’ Getting into the AMC

A number of media and other commentators have asked why it is not possible to stop the drugs getting into the prison. Therefore, it is appropriate to consider what steps would really need to be taken and what the impact might be on prisoners, staff and visitors.

Whether or not there is an NSP in the prison it is appropriate for officers in applying our national policy to seek to reduce supply into the prison. If they are entirely successful there will be no drugs or syringes in the prison and an NSP will become redundant. However, it has previously been acknowledged by government that the challenge inherent in attempting to prevent all drugs entering the prison would require the most draconian of methods. Even if such methods could be applied they would invariably have the impact of undermining rehabilitation and demand reduction programs that are a key element of our expectations of a modern prison.

The improvisation and initiative of prisoners cannot be underestimated. There is a great deal of time that they have to contemplate methods of bringing contraband into their environment. A former ACT Supreme Court judge told the Annual General Meeting of the Australian Parliamentary...
Group for Drug Law Reform (APGDLR) in March 2011 that he became aware of the challenges of keeping drugs out of prison at a time when prisoners were much less sophisticated over thirty years ago. At that time a technique was used to provide a code for a library book numerically identifying a page, a paragraph and a sentence. At the full stop was the area injected with LSD. If systems could be as refined at that time, how much more so in the current era?

(APGDLR AGM 2011)

A draconian regime would need to include a close examination of all food entering the prison. Even a tea bag within a box, within a carton could contain illicit substances. There are in the order of two hundred and fifty prisoners in the prison at any given time. This would mean a very close examination of huge amounts of flour, rice, vegetables, fruit, dairy and so the list goes on.

One of the main methods of drugs getting into any prison is understood to be through hiding contraband internally in body orifices such as the mouth, ear, rectum or vagina. In order to deal with this a draconian regime could mean body cavity searches of everyone entering the prison. Although some custodial officers have referred to new electronic surveillance equipment available at the AMC to replace body cavity searching, others indicated that although they provided a significant improvement, the system was by no means foolproof. Therefore, to be 100% effective all visitors would need to be subjected to this type of search. Custodial and non-custodial officers may need to look forward to starting their day in the same manner – hardly a conducive start to a day where people have a positive attitude to working with prisoners to achieve a rehabilitative outcome. The currently earned privilege of private visits would need to come to an end and prisoners would not be able to touch their loved ones. Rather than remaining close to families (a key element in positive rehabilitation) there would be a considerable disincentive for prisoners to have visitors. Not many would approve of their children or any of their loved ones visiting them if they could be subjected (even randomly) to internal examination. As unpalatable as it may seem to be, people desperate to use drugs do use extreme methods that include concealment in such things as babies’ nappies, tampons and devices carried in the rectum.

Contraband, either the drugs or the paraphernalia, become very valuable items in the prison setting and desperate measures are used to achieve access.

2.5.2 Being Pragmatic

The alternative is to take a pragmatic approach and recognise that such searches would be draconian. Such a regime is simply unacceptable as it would undermine the morale of custodial and non-custodial staff as well as the majority of prisoners who either have never used drugs or are not using them in the corrections setting. Very little understanding is needed to comprehend how such draconian measures would also undermine the opportunities for rehabilitation not only amongst drug users but amongst the large numbers of prisoners who have never been involved with drugs or who have determined to use the opportunity while incarcerated to stop using. Such decisions would be undermined by a regime that effectively cut off visits from family and friends, severely restricted access to sporting and social activities and limited opportunities for improving their lot as a prisoner.
Custodial officers at the AMC largely maintain positive and respectful relationships with those who are incarcerated. There is a clear understanding that the custodial officers have a job to do that includes searching for contraband, maintaining discipline and ensuring prisoners’ behaviour is appropriate to the circumstances. Demanding a more draconian regime would also have the impact of undermining this positive and respectful approach and relationship. As such it also has the potential to devastate the opportunities provided for people who are incarcerated to become better socialised and prepared to play an effective role in the broader community after they have served their sentence.

Like so many other policy areas within the alcohol and other drugs arena, the solutions are often counter-intuitive. Recognition of the economic and social costs associated with finding what at first may seem like the ideal, black-and-white solution often leads policy makers to adopt a more pragmatic approach designed to minimise the range of potential harms. Rather than necessarily being able to achieve perfect or ideal outcomes, policy makers are often required to find the resolution that offers the most realistic and workable option to achieve the best outcomes possible given a range of constraints – adopting what is often referred to as the ‘least-worse’ approach.
Chapter 3: Key Themes from the Literature

This paper does not seek to repeat the comprehensive literature reviews undertaken by previous studies in relation to needle and syringe programs (NSPs) in prisons. This chapter merely seeks to summarise some of the key points arising from the literature, to provide a background and context to analysis contained in following chapters.

3.1 Evidence of Need for NSPs in Correctional Settings

There is abundant evidence in the literature from both Australia and abroad that demonstrates a need for NSPs in correctional settings to reduce the spread of Blood Borne Viruses (BBVs).

For instance, Hepatitis Australia’s recent paper on addressing hepatitis C in custodial settings points out:

“Prisoner health studies in Australia have estimated the overall prevalence of hepatitis C infections to be between 23% and 47% for male prisoners, rising to between 50% and 70% for female prisoners. Demographic trends associated with the prevalence of hepatitis C in Australian custodial settings include: increasing prevalence with age; higher prevalence among female prisoners; higher prevalence for Indigenous prisoners; and increasing prevalence with multiple admissions to prison.

Incarceration itself is a risk factor for hepatitis C transmission due to high-risk activities such as the sharing of non-sterile equipment used for injecting drugs, tattooing, body piercing and barbering within prisons. Injecting drug use in custodial settings places inmates at high risk of hepatitis C. About half of Australian prisoners have a history of injecting drug use. About half of all imprisoned people who inject drugs continue to inject drugs in prison”.

(Hepatitis Australia 2011 pg 5)

The Hepatitis Australia paper goes on to recommend trialling and evaluating across all jurisdictions a range of proven harm reduction measures, including prison-based needle and syringe programs accompanied by appropriate infection-control procedures for tattooing, body art and barbering. Further, Hepatitis Australia goes on to note that:

“Given the inability of custodial authorities to achieve and maintain the unrealistic expectation of a drug-free prison environment, imprisonment exposes people who inject drugs to greater risks of infection with hepatitis C than those in the community. These findings confirm the risk posed to public health by the current failure to effectively educate, prevent, treat and reduce the harm associated with hepatitis C in Australian custodial settings”.

(Hepatitis Australia 2011 pg 6)

Anex’s 2010 paper summarising the case for controlled NSPs in Australian prisons reinforces the need to develop strategies to address BBV transmission in prisons:

“Rates of hepatitis C infection are up to 60 times higher in correction facilities than in the general population. Hepatitis C antibody sero-prevalence among injecting drug users was found to be 71 per cent in NSW prisons in 2007.”
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A recent study led by Dolan examined risk behaviours and hepatitis C transmission among 120 male injecting drug users in NSW prisons. 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”.

(Anex 2010 pg 7)

In looking specifically at the ACT, the Anex report goes on to state:

“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’”.

(Anex 2010 pg 11)

The recent evaluation of drug policies and services within the Alexander Maconochie Centre (AMC) undertaken by the Burnet Institute (the Burnet Report) provides further ACT-specific evidence indicating a strong need for the provision of clean injecting equipment in the ACT prison:

“Qualitative data suggest that injectable drugs are entering the AMC and that injecting drug use is occurring. High blood-borne virus prevalence in this population and the inevitability of risky injecting practices in an environment without access to clean injecting equipment means that disease transmissions at the AMC is highly likely. Quantitative data validate these findings, with seizure data indicating that 28 syringes had been seized at the AMC in the 12 months to May 2010, seven of which had been interdicted prior to entering the AMC. Responses from the Inmate Health Survey also indicate that injecting drug use is occurring at the AMC. In addition, one in-prison case of HCV transmission has been recently reported at the AMC. Although it is highly likely that other blood-borne virus transmissions have occurred at the AMC given the drug using contexts described above, current testing practices are inadequate to reliably estimate the rate of in-prison blood-borne virus transmission at the AMC”.

(Burnet Institute 2011 pg 145)

The Burnet Report went on to describe how injecting drug users in the AMC were regular users of community-based NSP services and therefore likely to engage with a prison-based NSP:

“Three quarters of these participants reported having ever used an NSP service in the community and NSP was the most common source of obtaining injecting equipment in the 12 months prior to entering prison. In addition to the use of vending machine and pharmacy sources, this data indicates the high acceptability of NSP services to the target population”.

(Burnet Institute 2011 pg 145)

In relation to the establishment of NSP in the AMC, the Burnet Institute report recommended:
It is appropriate for State and Territory Governments to identify opportunities for trialling the (NSP) intervention in Australian custodial settings.

(Australian Government Department of Health and Ageing-DoHA 2010 pgs 18, 26 and 38 respectively)

While the ACT Government may be the first jurisdiction to act on the recommendation, it is a proposal that has been endorsed by all jurisdictions as part of the comprehensive range of initiatives designed to reduce the spread of BBVs in the Australian community outlined in these three key national strategies.

The implementation of NSPs in correctional settings is also consistent with the ‘three pillars’ of the National Drug Strategy (NDS). The latest version of the NDS, released in February 2011, reinforces the three pillars as the foundation of efforts to reduce drug-related harm in the Australian community.

The overarching approach of harm minimisation, which has guided the NDS since its inception in 1985, will continue through 2010–2015. This encompasses the three pillars of:

- **demand reduction** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community

- **supply reduction** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs
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- **harm reduction** to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs”.

(DoHA 2011 pg ii)

The current NDS acknowledges the success of NSPs in the community setting as part of the range of initiatives implemented as part of the three pillar approach, stating:

“Harms associated with injecting drug use have also been reduced. It is estimated that from 2000–2009 needle and syringe programs, which ensure the safe supply and disposal of syringes to injecting drug users, have directly averted over 32 000 new HIV infections and nearly 97,000 hepatitis C infections”.

(DoHA 2011 pg 4)

The new NDS outlines an increased focus on targeting initiatives to address the particular needs of disadvantaged groups in the community, noting that:

“Injecting drug use and the associated risk of blood-borne virus infection is a particular issue for prison populations”.

(DoHA 2011 pg 6)

The specific actions to be undertaken as part of NDS harm reduction measures include:

“Continue existing harm-reduction efforts including needle and syringe programs and safe disposal of used injecting equipment and improve access for disadvantaged populations”.

(DoHA 2011 pg 17)

Key national strategies that apply specifically to correctional settings are similarly built on the foundation of the three pillars approach. The Corrective Services Ministers Conference (CSMC) and the Conference of Correctional Administrators *Standard Guidelines for Corrections in Australia*, state that prisoners are entitled to the same standard of evidence-based health care provided in the general community.

The *Standard Guidelines for Corrections in Australia* states:

“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”.

(CSMC 2004 pg 20)

The analysis recently undertaken by Hepatitis Australia notes that the relevant National Strategies and Corrections Guidelines developed by the Corrective Services Ministers Conference envisage all correctional services providing:

“... a full range of health and drug services and support for prisoners with hepatitis C or who are at risk of infection including 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 and which increases the risk of the transmission of hepatitis C”.

(Hepatitis Australia 2011 pg 14)
The Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) has produced the **National Guidelines for the Prevention, Treatment and Care of Hepatitis C in Custodial Settings**. Key prevention activities outlined in the Guidelines include the following:

- Education, including peer education about hepatitis C and the routes of transmission for inmates
- Recreation, sport and exercise to improve and promote general health
- Provision of bleach and disinfectant and education about their use
- Access to razors, toothbrushes and safe barbering
- Education and counselling related to injecting drug use
- Drug treatment
- Tattooing and body art under appropriate infection-control procedures
- Prison-based Needle and Syringe Programs.

(MACASHH 2008 pg 3-4)

### 3.3 Legislative Considerations

Prior to considering specific legislative and regulatory barriers to the implementation of an NSP in the AMC, it is worth noting the broader legislative and philosophical foundations that provide the context for AMC operations.

AMC operation is intended to comply with human rights legislation and principles. Anex notes that in outlining the responsibilities of ACT Corrective Services, the ACT **Corrections Management Act** (s53), 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”.

(Anex 2010 pg 11)

While the introduction of NSP in the AMC would require some legislative and regulatory change, this does not pose a significant barrier to implementation. In his 2005 information paper on the proposed NSP at the AMC, David McDonald notes that:

> “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’ 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. In 2004 the Legislative Assembly passed the Drugs of Dependence (Syringe Vending Machines) Amendment Act to authorise a trial of syringe vending machines in..."
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Canberra. These are all examples of legislative changes made to facilitate access to sterile injecting equipment as a public health measure”.

(MacDonald 2005 pg 9)

McDonald goes on to outline how legislative and regulatory instruments specific to operational and procedural measures in place at the AMC may equally be quite easily addressed:

“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”.

(MacDonald 2005 pg 9)

The implementation of an NSP in the AMC is entirely consistent with the legislative and philosophical foundations that provide the context for AMC operations within the ACT. While there will undoubtedly be legislative and regulatory considerations that will need to be considered and addressed to enable the implementation of an NSP at the AMC, these barriers are largely unproblematic. The nature and extent of legislative and regulatory change required to enact an NSP in the prison will also be dependent on the type or types of model to be implemented. Further considerations regarding civil and criminal proceedings for staff at an NSP in the prison are considered in Chapter 6 of this report that examines models and Chapter 7.

3.4 Success of Overseas Programs

Overall, it must be noted that the literature overwhelmingly indicates that the range of NSPs implemented and currently operating in overseas prisons have been a great success and demonstrated comprehensive benefits across a broad range of indicators.

Operational factors contributing to the successes of various models operating abroad will be considered further in other chapters. The following information provides a brief overview of the demonstrable benefits achieved in line with key outcome goals relevant to considerations in the ACT context.

According to a 2009 Canadian analysis of evidence from NSPs operating in 50 prisons across 12 countries:

“Many studies reported high levels of injecting drug use in prisons, and HIV transmission has been documented. There is increasing evidence of what prison systems can do to prevent HIV transmission related to injecting drug use. In particular, needle and syringe programs and opioid substitution therapies have proven effective at reducing HIV risk behaviours in a wide range of prison environments, without resulting in negative consequences for the health of prison staff or prisoners”.

(Jurgens, Ball and Verster 2009 pg 57)
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According to this analysis, specific benefits of the range of overseas programs have included:

“...all available reports have shown that sharing of injecting equipment either ceased after implementation of the NSP, or substantially declined...Additionally, the following ancillary benefits are associated with the implementation of NSPs: (1) a reduction in overdose incidents and deaths; (2) facilitation of greater prisoner contact with drug treatment programmes; (3) reduction in abscesses, improved relationships between prisoners and staff, and increased awareness of infection transmission and risk behaviours; and (4) increased staff safety, because accidental injuries from hidden injecting equipment during cell searches decreased. There have been no reports of syringes having been used as weapons in any prison within an operating NSP. The availability of sterile injecting equipment has not resulted in an increased number of prisoners injecting drugs, an increase in overall drug use, or an increase in the amount of drugs in prisons. Once in place, acceptance of NSPs is generally high among staff and prisoners”.

(Jurgens, Ball and Verster 2009 pg 59)

The analysis noted that Germany was the only country in which NSPs in prisons had been closed, following changes in jurisdictional governments. The decision to close a number of NSPs operating in German prisons had been taken without consultation with prison staff and apparently resulted in the resumption of sharing and hiding of injecting equipment by prisoners, increasing the risk of BBV transmission and potential needlestick injuries for staff. Interestingly, the analysis reported that:

“Staff have been among the most vocal critics of the governments’ decision to close down the programmes, and have lobbied the governments to reinstate the programmes”.

(Jurgens, Ball and Verster 2009 pg 59)

An American analysis of the current international evidence also conducted in 2009 similarly concluded that:

“Prison-based hepatitis A and hepatitis B vaccination programs, needle exchange programs, methadone maintenance programs, risk education programs, and hepatitis C virus antiviral programs, for example, have been shown to be safe and effective risk reduction and management strategies... Needle exchange programs have been shown to reduce risk of transmission of viral hepatitis in incarcerated populations. No needle exchange programs exist in US prisons, but successful programs exist in at least 50 prisons...throughout the world. Numerous studies have shown that such programs do not compromise security or inmate /correctional staff safety and they effectively reduce spread of infection and needle sharing”.

(Hunt and Saab 2009 pg 1024-1029)

A preceding 2005 analysis of prison NSPs in six countries, undertaken by Irish, Canadian and German authors, reinforces similar observable outcomes:
“Based upon the evidence emerging from the investigation, the paper concludes that while prison syringe-exchange programmes have been implemented in diverse environments and under differing circumstances, the results of the programmes have been remarkably consistent. Improved prisoner health and reduction of needle sharing have been achieved. Fears of violence, increased drug consumption, and other negative consequences have not materialised. Based on the evidence and experience, it can be concluded unequivocally that prison needle-exchange programmes effectively address the health-related harms associated with needle sharing in prisons and do not undermine institutional safety or security.”

(Lines, Jurgens, Betteridge and Stover 2005 pg 49)

The 2010 Australian analysis of the international evidence undertaken by Anex echoes the conclusions of the international analyses:

“...many countries have established a variety of carefully controlled programs that allow prisoners who inject drugs to access sterile needles. 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. 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...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”.

(Anex 2010 pg 9)

The literature and analysis undertaken both in Australia and abroad consistently demonstrates that the range of NSPs implemented in overseas prisons have produced comprehensive benefits across a broad range of indicators, well beyond the primary intended outcomes of reducing the use of shared injecting equipment and BBV transmission among prisoners.
Chapter 4: Stakeholder Consultations

4.1 Outcomes of Stakeholder Consultations

Outcomes from Key Informant Meetings/Interviews, Stakeholder Focus Groups and Workshops

An extensive stakeholder consultation process was undertaken in relation to this project throughout May, June and July 2011. A series of Key Informant Meetings/Interviews, Stakeholder Focus Groups and Workshops have been conducted. The participants list and schedule outlined for the consultations was designed to be inclusive of a wide range of perspectives under the following broad categories: prisoners and families; custodial staff/representatives; ACT Health staff; community health and related service providers; community interests and other key informants. The stakeholder consultation program and participant list is provided at Attachment A.

The list of consultation questions for Key Informant Meetings/Interviews, Stakeholder Focus Groups and Workshops that has formed the basis of discussions is provided at Attachment B.

This chapter seeks to identify the key themes emerging from the consultations, with a view to informing consideration of models for implementation of an NSP in the AMC in Chapter 6. Despite the differing views of the very broad range of stakeholders consulted in relation to this project, there was a surprising level of consensus with regard to the main considerations and characteristics necessary to guide implementation.

4.2 Access, Anonymity and the Absence of Negative Consequences for Participants

The related issues of access, anonymity and the absence of negative consequences for participants were raised over and over again throughout the consultation process. While differing rationale for raising these issues were provided by the very broad range of stakeholders, it was clear from the consultations that these are fundamental considerations in the development of any implementation model.

It was universally emphasised that the successful engagement of prisoners with any NSP would be dependent upon ensuring timely and appropriate access to injecting equipment. While views differed on means by which this outcome may be most successfully achieved, the vast majority of stakeholders agreed that prisoners would not engage with the program if it was unable to provide them timely access to injecting equipment subsequent to obtaining substances for injecting.

Participants in the consultations emphasised that fear of being caught with a prohibited substance was a key consideration motivating prisoners to use substances as quickly as possible after obtaining them. Being detected by prison authorities and incurring a series of negative consequences as a result was a key factor. Likewise, there were concerns about being found to be in possession of substances by other inmates who may wish to share or take the drugs, or inform others of their whereabouts.

The fear of being caught with a prohibited substance was closely related to the need for anonymity in accessing any NSP. It was almost universally accepted by participants in the consultations that a guarantee of anonymity in accessing any NSP would be vital to ensuring prisoner engagement. Any
Numerous stakeholders pointed out that the current unregulated availability of shared injecting equipment within the AMC meant that existing levels of safety were compromised, and that the introduction of any model of NSP should aim to at least significantly reduce the use of illicit injecting equipment. Shared injecting equipment poses an obvious contamination risk for those using it, but also a secondary risk related to accidental needle-stick injury for staff or other prisoners due to being hidden.

However, there were also concerns raised by numerous stakeholders that unrestricted availability of injecting equipment could pose a host of different risks. The majority of consultation participants accepted that the introduction of an NSP should be based on the principle of exchange, rather than unlimited availability, and accompanied by appropriate provisions for the disposal of used injecting equipment to avoid any increased risk of needle-stick injury for all the relevant groups.
In relation to the concept of unrestricted availability, concerns were also raised about the availability of injecting equipment to prisoners who do not inject drugs. It was felt that such access could result in unnecessary nuisance in relation to potential needle-stick injury resulting from improper disposal, as well as creating unnecessary potential for bullying/menacing of staff and/or other prisoners.

Given the broad prison community within the AMC, concerns were also raised by numerous stakeholders about the possibility of unrestricted access for people with mental health problems who could potentially make use of injecting equipment to either self-harm or inflict harm on others as a result of their diminished capacity.

So, while timely and appropriate access was deemed to be of paramount importance in ensuring prisoner engagement with any NSP, likewise unrestricted availability of injecting equipment throughout the AMC was also deemed to be potentially problematic. The title of this report ‘Balancing Access and Safety’ therefore reflects the vital importance of balancing these key considerations, and the significant challenges for achieving this objective.

### 4.4 Consistency and Linkages with Existing Health and Corrections Programs

The importance of ensuring consistency and linkages with existing health and corrections programs was another universally agreed theme to come out of the consultations. While some stakeholders struggled with the idea of balancing the promotion of abstinence with the provision of injecting equipment, others pointed out that such harm reduction initiatives were merely one part of a continuum of strategies including a range of: supply control; education and health promotion; drug treatment; risk management; and aftercare and transition to community initiatives. Given the coexistence of supply reduction, demand reduction and harm reduction initiatives as part of the comprehensive three pillar approach of the National Drug Strategy (NDS), many stakeholders felt that balancing abstinence-based approaches with pragmatic risk mitigation measures was integral to ensuring both a comprehensive response to drug use behaviours and equity in service delivery within the corrections context. However, it was also widely acknowledged that the Solaris Therapeutic Community would not be involved in the provision of injecting equipment under any NSP model, given the abstinence-based nature of the program and the importance of respecting participants’ decisions to work towards an illicit-drug-free lifestyle.

Numerous stakeholders with backgrounds in delivery of drug treatment services made reference to the ‘stages of change’ model and the importance of engaging people no matter ‘where they are at’ as a means of minimising harm in the short term, with a view to facilitating their engagement with the full range of health and drug services in the longer term. Facilitation of greater prisoner contact with drug treatment programs is one of the reported outcomes of NSPs in overseas prisons, and numerous stakeholders felt that ensuring an element of human interaction as part of the model for an NSP would be beneficial in working towards achieving better health outcomes for prisoners who had currently not engaged with a range of health and rehabilitation programs.

A number of stakeholders expressed concern about the apparent inconsistency of allowing prisoners engaged in pharmacotherapy treatment to access clean injecting equipment. Others emphasised that again, this would be no different to the realities of community-based programs, where
pharmacotherapy programs have been demonstrated to significantly reduce, if not entirely stop, illicit drug use. Again, many expressed that human interaction as part of the implementation of any NSP would also be valuable to ensuring positive health outcomes for this cohort, given the enhanced opportunity to provide complementary counselling and health-related interventions, but it was emphasised that participation in a pharmacotherapy treatment program should not be used to exclude people from accessing an NSP.

The previous section outlined why the direct involvement of prison officers in distribution of injecting equipment would be inappropriate, given their duty to stop the supply of illicit substances within the prison and implement a range of supply control measures consistent with this objective. If anonymity is to be guaranteed and the engagement of prisoners encouraged, prison officers need to be at arm’s length from any distribution mechanism.

However, given the conceptual framework of the three pillars of the NDS, there is no doubt that facilitating access to clean injecting equipment is consistent with broader supply reduction measures. Numerous respondents pointed out that in this respect, the role of prison officers in the prison context is not dissimilar to the role played by police in community settings. While still actively pursuing a range of strategies to interrupt the supply of illicit drugs and apprehend those involved in distribution, police across the nation do not target those entering community-based NSPs, accessing vending machines or using the Sydney Medically Supervised Injecting Centre. In line with this approach, it is envisaged that prison officers would continue to implement the full range of existing measures designed to stop the supply of illicit drugs in the AMC. Equally, penalties for possession of illicit substances applied to prisoners would remain. However, prison officers would need to take care not to undermine the provision of clean injecting equipment by agreeing not to specifically target prisoners accessing any NSP. A number of the models to be considered in Chapter 6 present options that are designed to ensure that prison officers do not automatically become aware of prisoners accessing an NSP. The majority of stakeholders consulted agreed that the capacity of a preferred model/s to ensure anonymity for prisoners accessing an NSP would be vital to both ensuring prisoner engagement and avoiding potential conflict of interest concerns for prison officers in carrying out their duties.

In acknowledging the broader operational context for the implementation of any NSP in the AMC, it is worth noting that from the consultations it was abundantly clear that some highly publicised operational and procedural teething problems at the AMC - and reported negative commentary in relation to operations at the AMC stemming from recent review reports - have left many prison officers feeling somewhat under-valued and under-supported. In many ways, the current opposition to the NSP proposal from prison officers and their representatives may be at least partially symptomatic of broader issues stemming from a basic lack of faith and trust in government and management’s capacity to support the delivery of basic programs, culminating in fear of further perceived criticism of operational staff and of implementation of any new program suggestions at this stage. It is fair to state that in the context of these perceived operational and procedural
constraints prison officers believe implementation of various NSP models in the AMC will be problematic at this stage. It will be vital to ensure that any implementation model/s adopted will be flexible and adaptable and take into account the concerns of prison officers in relation to the constraints applicable in the current working environment.

4.5 Flexibility and Adaptability in Implementation

Another theme emerging from the consultations was the importance of flexibility and adaptability in the implementation of any NSP model/s in the AMC. While numerous models have been trialled and implemented in overseas prisons, and lessons can be learned from the evaluations of these programs and experiences of key stakeholders involved in their implementation, many stakeholders noted that the direct applicability of these models in the Australian context is untested. While the literature outlines key characteristics of successfully implemented NSP models in a range of countries, whether the responses to and experiences of key stakeholders to such initiatives will be mirrored in the ACT is unknown.

This issue was raised by a broad range of stakeholders who emphasised the importance of ensuring that any model/s implemented in the ACT are flexible and capable of being adapted in response to on-the-ground experience and learnings derived from implementation. Implementation will need to be subject to ongoing review in relation to a range of factors and criteria, not the least of which will be the framework of considerations and characteristics outlined in this chapter. Participants involved in establishing the various operational protocols supporting the establishment of any model/s adopted will need to be involved in a process of ongoing review and revision, informed in part by key external stakeholders, such as community sector health service providers and prisoner representatives.

Given the ‘unknowns’ associated with implementation, this report seeks to provide analysis in Chapter 6 in relation to the relative suitability of preferred models for implementation and contingency options to be incorporated should unforeseen considerations arise during the implementation phase. This matter is discussed in more detail in Chapter 8 and forms part of the recommendations.

4.6 Data Collection and an Evidence Base for Evaluation

Related to the previous section, which highlighted stakeholder consensus on the need for flexibility and adaptability in implementation is the issue of data collection and ensuring an evidence base for evaluation. While ongoing monitoring, review and refinement mechanisms will be required to ensure effective implementation, many participants emphasised the importance of the establishment of effective data collection criteria and mechanisms to enable meaningful evaluation of any NSP model in the longer term.

While again, monitoring and evaluation systems established for overseas programs will be instructive, it will be vital that data collection and evaluation criteria developed reflect the key strategic priority goals of the ACT’s NSP. Careful consideration will need to be given to the range of outcomes being sought. While some criteria are obvious, such as observable reductions in the use
Careful consideration will need to be given to the range of outcomes being sought ... the timeframes for any initial evaluation will need to be sufficiently long to reflect outcomes beyond an initial establishment and implementation phase.

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of shared injecting equipment, others such as reductions in rates of BBV are more problematic, given factors such as the transient nature of prison populations and capacity for infection with multiple strains of hepatitis C. Further, the necessary non-compulsory nature of BBV testing also makes definitive quantitative analysis somewhat problematic.

Numerous stakeholders advocated for the inclusion of a range of qualitative and complementary indicators as part of data collection measures. Indicators such as engagement with health and related services and referrals to treatment and rehabilitation have been among the popular suggestions. Ongoing data collection and evaluation will need to monitor and measure progress in relation to a broad a range of factors and criteria, building on the framework of considerations and characteristics outlined in this chapter.

Many participants also noted that while ongoing review and refinement mechanisms should enable continuous improvement throughout the implementation phase, the timeframes for any initial evaluation will need to be sufficiently long to reflect outcomes beyond an initial establishment and implementation phase. It was noted that a full evaluation should not be undertaken until a reasonable amount of time after the implementation phase has been concluded, so that it is not merely reporting on a series of highly variable outcomes reflecting changes to an adaptable model that has undergone a period of ongoing refinement in response to the on-the-ground experience and learnings derived from implementation.

The longer term evaluation should be inclusive of an extended period of time following the implementation phase and completion of program refinements to ensure that it is capable of adequately capturing outcomes of the ongoing program structure and format.
Chapter 5: Key Lessons from Overseas

The board of the Public Health Association of Australia agreed that a report on any NSP would benefit from on the ground observation of successful programs operating in other places. There are no other programs of this kind operating in Australian prisons but there are programs operating in a number of other places in the world. Institutions in other countries as diverse as Moldova and Iran, Luxembourg and Spain have a different community culture and correctional cultural context from Australia. The aim, therefore, was to determine what could be extrapolated rather than what could be copied for implementation at the AMC.

Financial and time constraints meant that a decision was taken to examine the programs in communities that are culturally similar from a corrections and community perspective to Australia, so as to maximise the potential for identifying key characteristics and considerations with applicability in the ACT context. The following programs were the subject of examination:

- JVA Lichtenberg Women’s Penitentiary – Berlin, Germany
- Schrassig Penitentiary – Luxembourg
- Solithurn Penitentiary – Solithurn, Switzerland
- Champ-Dollon Penitentiary – Geneva, Switzerland
- Valencia Penitentiary - Spain

The generosity of the representatives of these institutions cannot be underestimated as they made their time available and were prepared to provide insights into the implementation of the programs that existed within their institutions along with the evidence that illustrated the challenges and successes that they had. They certainly deserve thanks for their generosity, openness and helpfulness.

5.1 Characteristics of Successful NSPs in Overseas Prisons

5.1.1 Needle/Syringes as Weapons

Since the implementation of NSPs there were no attacks recorded with a needle/syringe in any of the prisons that were visited. The academic literature also suggests that there have been no recorded incidents in any prison in the world that operates an NSP. A number of the overseas prison officers suggested that this was due to a number of important factors including the different ways that relationships were developed with people who use drugs and the rules that governed the programs. The rules included the exclusion of prisoners from the program whose behaviour had the potential to in any way undermine the program. This was made clear in all the programs that were observed and effectively used the pressure of other prisoners as well as health and custodial staff on all those participating in the program.

The use of peer pressure in this way was pointed out as the main reason that it was much less likely that needles would be used as weapons. The second reason commonly suggested was that prisoners have enough initiative to make and use much more effective weapons if they are in that
frame of mind. Examples given included sharpened toothbrush handles and similar implements and the power of fists over a small needle.

The medical director of the Champ-Dollon prison in Geneva suggested that the fear that is expressed by officers in Australia has no basis in evidence. He suggested it masked a concern about being ‘complicit’ in an illegal activity and reflected a lack of understanding of the principles of harm minimisation. This concept was supported by a number of other officials who all emphasised the importance of ongoing education to ensure the pragmatic nature of the principles of harm minimisation are both understood and reinforced.

5.1.2 Broad Approach to Dealing with Illicit Drug Use

In Australian terms we would characterise the approach as similar to that taken in the National Drug Strategy (NDS) with all the prisons operating on a normal supply reduction approach including the use of random searches, dog squads and prison security to minimise the drugs that get into the prison as the first step. The second step we would characterise as demand reduction – ensuring there were as wide as possible range of programs to encourage abstinence as the first priority and to provide pharmacotherapy treatment to stabilise users as the second. The third step was to apply harm reduction including the distribution of clean needles on a one for one swap basis, as well as swabs, filters and disinfectant.

At Solothurn prison two of the prisoners who were long term chronic heroin users also elected to use heroin that was provided by prescription and injected in the presence of a nurse. Although there were many more places available on the program, the other heroin users had, through discussion with the nursing staff, determined that it was time to move to methadone maintenance or choose a detoxification plan. These decisions were based on broader consideration of longer term goals in relation to rehabilitation, health outcomes and lifestyle change. Detoxification is the first step to engaging with drug-free rehabilitation programs. As a maintenance pharmacotherapy, methadone is a longer acting substance, requiring a less time-consuming dosing regime, and is therefore ultimately seen to be more conducive to enabling participation in employment and education/training programs on return to the community. One of the two current participants in heroin maintenance was also contemplating a change to methadone. Other former participants in the heroin maintenance program had completed their sentence and been moved to community-based treatment programs.

Although a heroin maintenance program could not apply in Australia - as it is not consistent with current ACT and Federal legislation – it was interesting to note how the heroin maintenance program was seamlessly integrated with other pharmacotherapy maintenance treatment options, conducted with minimum fuss, used effectively to reach chronic drug users and that so few prisoners availed themselves of the opportunity to participate in the longer term.

Treatment for drug use, it was suggested by a number of prison representatives, should be seen in the context of “normalisation”. In this context, at least as important as the NSPs was the emphasis on opportunities to work and study. The prison hierarchy took their rehabilitation role very seriously and where possible opportunities for prisoners to study, to work and to earn a (minor) income were taken. In Luxembourg, for example, a major employer was a contracted industrial laundry business that supplied clean linen to hospitals. In Switzerland and Germany there were agricultural pursuits,
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repetitive assembly tasks (particularly for some with psychiatric illness) and two teachers were employed who were taking some prisoners from grade levels at about three or four to improve mathematical, computing and literacy skills that would allow normal functioning in the community and particularly access to jobs. A small number of prisoners were doing apprenticeships such as cooking/chef.

5.1.3 Relationship with Prisoners

In all of the prisons visited the staff, including custodial officers, agreed that the process of introduction of the NSP had side benefits of improving the relationship between prisoners and the staff at the institutions – including health and custodial officers. Reasons for this were suggested as an increased level of respect for each other and the program providing a catalyst for rethinking the role of custodial officers.

A key element for the improved relationship was identified as a clear understanding in the program as to what was sanctioned and what was still contraband. There were increases in sanctions for people who undermined the program – for example by retaining an illicit syringe or not having the syringe contained (used or not) within a safety container in the designated position.

In all institutions custodial officers were still expected to carry out normal supply reduction tasks to ensure that the level of illicit drugs in the prison was minimised. However, use of a regulated (provided) syringe in a prisoner’s possession was not used as a method of collecting intelligence. In some cases custodial officers passed this information to senior officers who argue that the information was not used, for example, to target specific cells for searching nor was the intelligence used for targeting specific visitors.

5.1.4 Custodial Officers

There was general agreement amongst the health staff that the programs were well understood by the senior staff with overall responsibility for the correctional institution. The health staff were also very supportive as they had a clear understanding of the role of harm minimisation and, as an important part of their role spent a significant amount of time reinforcing harm minimisation education with the officers. In a number of institutions there was a difference of opinion between long-term custodial officers who felt uncomfortable with the program and the implication of ‘complicity’ in illegal drugs and the younger custodial officers. The acceptance of the programs had grown after implementation but there was a different response at the different levels of responsibility.

Senior staff: The perspective put by a number of these officers was that the responsibility of the corrections institution included priority in this order:

- Security in delivering the court ruled punishment of deprivation of liberty
- Rehabilitation
  - Arguing that overly severe measures undermined this goal
  - “Normalisation” to the greatest extent possible
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- Safety of the staff and other prisoners
  - Which they saw as enhanced by the NSP (as it was operating in these prisons)

**New recruits:** Resistance to harm minimisation was minimal amongst the more recently employed professional staff who had been through appropriate certificate and diploma level training which included a component of harm minimisation.

**Long-term staff:** A number of the prisons pointed out that the main resistance came from officers who had been in the prison workforce for an extended period but were not in a promotion position.

### 5.1.5 Transition from Illicit Needle and Syringe Programs

There are either regulated or unregulated needle and syringe distribution systems operating in all prisons. Many of the people interviewed overseas saw the challenge for communities as a whole, for prison authorities and for health staff to determine the least harmful and the least risky method for such distribution to occur.

It is interesting that many of the regulated programs that are operating overseas followed a period of civil disobedience by a medical officer. The fact that these medical officers were prepared to distribute injecting equipment at great risk to their professional careers illustrates the importance they placed on stopping the spread of HIV, Hepatitis C and other BBVs.

At the time of introduction of the programs there was a transitionary period which allowed formulation of the specific method of introduction, discussion, education of custodial officers, prisoners and health staff.

### 5.2 Flexible Approach

There was widespread agreement between the health staff and senior custodial officers that the implementation of any program would need to be flexible to some degree. Suggestions were made that the broader the methods of distribution the more effective in the prevention of BBVs. They indicated that they would like to have as many possible alternatives to their own style of program.

### 5.3 Anonymity

There was widespread agreement in the prisons that most of those using drugs in prison would only participate in the system (and therefore be part of stopping the spread of BBVs) if the distribution of needles and syringes was done without the custodial officers knowing who was participating in the program.

Elaboration on this from the custodial officers made it clear that they felt that they could more effectively continue their work of supply reduction without undermining the NSP if they were not aware of who was participating in the program.

### 5.4 Implications for successful implementation and model options for the ACT

The NSPs were not seen in isolation in any of the settings in which such programs took place.
They worked closely with demand reduction programs so that those distributing the needles and syringes were in a position to counsel prisoners who might consider embarking on a substitution program or an abstinence program similar to the substitution and Therapeutic Community programs available at the AMC. Education on harm reduction, the spread of BBVs, sexually transmitted infections and withdrawal from drugs was part of the information and counselling conducted by the programs.

5.4.1 Setting Clear Rules and Procedures

A common theme from each of the prisons was the importance of setting clear rules and procedures for the implementation of the program.

The rules for prisoners included such elements as:

- A clear set of parameters for prisoners participating in the program
- Admission to the program followed advice about alternative options
- Needles and syringes to be kept in containers prior to using and afterwards
- Sharing of program-provided needles and syringes was unacceptable
- Use when in therapeutic community was unacceptable and could mean removal from the abstinence program
- Times for return and collection needed to be respected

The procedures for health staff who were directly involved in the distribution of the needle and syringe packs covered:

- What was included in the packs
- Method of distribution
- Style of access to prisoners
- Protection of anonymity
- Action if there is a needle stick injury of any type
- Monitoring and evaluation of the program

Procedures for custodial officers included:

- Continuing to take actions on supply prevention and reduction including searching for contraband substances and equipment
- Reporting needles and syringes where appropriate
- Most prisons had no reporting of program-provided needles and syringes where stored correctly
- Some prisons had custodial officers report but senior officers made decisions about intelligence to ensure the program was not undermined
- Monitoring of the distribution program was inappropriate

Programs that were operating in the custodial settings in those countries visited had been established in discussion with as wide a number of stakeholders as possible. No program was 100% effective at eliminating the spread of BBVs but all could provide evidence of a reduction in sharing of
equipment and a consequential reduction in the spread of BBVs. The most effective of the programs were those where trust was built with prisoners so they were willing to use the equipment provided rather than sharing out of fear of being identified as a known drug user and therefore targeted inappropriately by custodial officers and other prisoners.

5.4.2 Restrictions and sanctions

In all of the penitentiaries visited there was an emphasis that participation in the NSP, like participation in almost all programs in a prison, was a privilege. The rules for prisoner participation were made very clear from the beginning and where the rules were not followed there were sanctions, including exclusion from the program. These rules included such things as:

- The NSP was acknowledged as a harm reduction mechanism designed to reduce the spread of BBVs associated with the use of illicit injecting equipment. Prisoners were made aware that the existence of the program was designed to complement – rather than replace - existing supply and demand reduction measures designed to minimise harm
- Violence was a reason for excluding a prisoner from starting in the program or continuing
- Non-program needles and syringes or those not in a safety container were considered contraband
- In some jurisdictions where a cell was about to be searched a prisoner could identify a program-supplied needle/syringe prior to the search and although the search would be completed no further action would be taken regarding the health-supplied equipment
- Needles and syringes could not be collected for other people
- Exchange was on a one for one basis (sometimes the exchange was two for two)

The fear that custodial officers express in Australia with regard to prisoners potentially using needles and syringes as weapons was partially addressed by ensuring the program was not available to prisoners who were known to be violent. The process was much less difficult in larger prisons where violent prisoners were often accommodated in a different area or wing than those who had no history of violence. The nurses and other medical or non-government organisation (NGO) staff involved with the program were very firm about the importance of the rules. In some prisons these rules were reinforced by having participants ‘sign a contract’ agreeing to the conditions of the program.
Chapter 6: Models for Implementation of an NSP in the AMC

There are a variety of model options for NSPs within custodial environments as outlined in the literature and in programs operating overseas. This chapter contains an analysis of preferred model options based on the main considerations and characteristics necessary to guide implementation that have been identified via the domestic consultation process outlined in Chapter 4.

Given the level of consensus with regard to the main considerations and characteristics necessary to guide implementation of an NSP within the ACT prison among the key stakeholder groups, a number of model options from the literature and overseas can be discounted on the basis that they are not able to satisfactorily meet these criteria. Given the key criteria of ensuring safety for prison officers; ACT Health and external health and community workers; prisoners and other visitors to the prison, and majority concerns in relation to unrestricted availability of injecting equipment, two model options have been discounted at the outset and will not receive further consideration in this chapter. The majority of consultation participants accepted that the introduction of an NSP should be based on the principle of exchange, rather than unlimited availability, and accompanied by appropriate provisions for the disposal of used injecting equipment to avoid any increased risk of needle-stick injury for all the relevant groups.

Due to inconsistency with such criteria, the following model options have been discounted:

- Provision of sterile injecting equipment by ‘peer workers’ (identified prisoners); and
- Provision of injecting equipment to all inmates as standard issue (on entry).

Likewise, potential storage of injecting equipment by prisoners in clear plastic containers on display within cells (as is the practice in some models operating overseas) has been discounted because of a number of operational factors particular to the AMC context, including: capacity for injecting equipment to be accessed by other prisoners; requirement for retro-fitting of storage equipment within existing infrastructure; and the burden associated with adequate monitoring of compliance with such storage provisions for custodial staff.

The following models explored in this chapter are those that have either the capacity (or at least the potential) to address the agreed criteria (the main considerations and characteristics necessary to guide implementation) established in Chapter 4. Specifically, the criteria identified in Chapter 4 included:

- Access, anonymity and the absence of negative consequences for participants;
- Ensuring safety;
- Consistency and linkages with existing health and corrections programs;
- Flexibility and adaptability in implementation; and
- Data collection and ensuring an evidence base for evaluation.

6.1 Model 1: ‘One for One’ Exchange (Vending Style) Machines

This model involves the installation of vending style machines that enable prisoners to obtain clean injecting equipment on an exchange basis i.e. used injecting equipment is inserted into the machine, enabling the prisoner to obtain clean injecting equipment. Given the differing requirements for
injecting equipment based on the use of different substances for injection (different gauge syringes, filters, swabs etc), the vending machines would be required to offer a range of package options for suitable injecting equipment, although a single syringe only would be dispensed in each package.

This model would require initial provision of injecting equipment to prisoners by staff working within the Health Centre (either ACT Health staff or workers from an external provider located within the Health Centre), to enable prisoners to then subsequently exchange the initial syringe via disposal in the vending machine. Given that disposal of a used syringe would enable prisoners to obtain a clean one, it is envisaged that some prisoners may be able to access the vending machine without being issued with an initial syringe by staff in the Health Centre by disposing of illicit injecting equipment already in their possession.

This model would require the ACT Government to purchase purpose-built vending style machines to meet the specifications outlined above, but given technology already in use overseas and existing domestic capacity to develop a range of vending machines to meet differing requirements within the community setting, this should not be an insurmountable barrier to implementation.

In terms of addressing the established criteria, Model 1 has the capacity to ensure timely access, anonymity and absence of negative consequences for participants. If vending style machines are installed in discrete locations within the facility that are not monitored via security cameras, this objective is achievable. However, given the different classification and population areas within the AMC, meeting this criterion may present some challenges in enabling access for all prisoners, and this issue would require further consideration in implementation.

However, Model 1 has some drawbacks in terms of criterion 2 – ensuring safety. The one-for-one exchange nature of the model means that it does not deliver unrestricted availability of injecting equipment and the quantity of injecting equipment in circulation would be limited and could be monitored. However, any access to injecting equipment could not be very easily be limited to exclude particular individuals, such as those who could potentially harm themselves or others. Model 1 would also mean that injecting equipment would be circulating within the general population areas of the prison.

In terms of consistency and linkages with existing health and corrections programs, Model 1 also has a number of limitations. Human interaction is somewhat limited in this model, meaning that opportunities to deliver information and education on safe injecting practices and vein-care etc would be minimal, and opportunities to provide other health promotion information or discuss other health-related referral needs would also be restricted compared to other models.

It is envisaged that the current roles and duties of corrections officers would remain largely unchanged with Model 1, although a protocol would need to be developed to ensure that supply control and interception measures do not include surveillance of the vending style machine sites. Drugs and injecting equipment seizures during searches within the prison could carry on as normal, as prisoners would be able to access the Health Centre to obtain another syringe if the need arose at
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a later date. However, this model may require removing offences relating to the possession of program provided injecting equipment, while the treatment of offences relating to the possession of illicit substances would remain unchanged.

Model 1 is broadly consistent with the remaining criteria in relation to flexibility and adaptability in implementation; and data collection and ensuring an evidence-base for evaluation, but probably does not enable the level of monitoring and data collection that would be achievable with other models.

6.2 Model 2: One for one NSP

6.2.1 Model 2A: NSP Operated by ACT Health/Nursing Staff (located within the Health Centre)

6.2.2 Model 2B: NSP Operated by Outside Agency (located within the Health Centre)

Models 2A and 2B are in effect variations on the same model option, but would be delivered by different agencies and staff. Both models involve the operation and delivery of a face-to-face NSP by staff within the Hume Health Centre, on an exchange basis. Injecting equipment (a syringe and necessary related items such as filters, swabs etc) would be provided to individuals at an initial consultation, and thereafter used syringes (and related items) could be exchanged for clean ones via contact with staff located in the Health Centre.

Models 2A and 2B would not require any infrastructure changes, as consultations and appointments could take place within the existing Health Centre.

In terms of addressing the established criteria, these models do pose some challenges for ensuring timely access and anonymity for prisoners. The current Blue Form (or ‘bluey’) system, whereby a prisoner fills out a blue request form outlining his or her reason for needing to attend the Health Centre, which is then given to prison officers and delivered to the Health Centre for processing, would require changes. In order to ensure both anonymity for those seeking to access clean injecting equipment and timely access to staff within the Health Centre to obtain the equipment, a number of changes to the current system would be required.

The need to list a reason for seeking to go to the Health Centre on the request form would need to be removed. Prisoners would need to be conveyed to the Health Centre by prison officers on presentation of the request form. On arrival at the Health Centre, the prisoner could then indicate the reason for their visit and be triaged appropriately.

In Model 2A, this would involve the prisoner entering the Health Centre with ACT Health staff and advising them of the reason for their visit. Prisoners seeking to access injecting equipment could be dealt with directly, along with other prisoners whose health concerns required immediate attention. Appointments to return at a later date could then be made for those whose needs were less immediate. Following these assessments and/or interventions, prisoners would be escorted away from the Health Centre as usual.

A prisoner would therefore approach the staff at the Hume Health Centre and seek triage for the needle and syringe program. In the initial instance a detainee seeking a syringe would be provided with the equipment including such items as swabs. All other engagements would require a one for
one exchange. The one for one exchange would take place in a closed room within the centre without direct or electronic observation by custodial staff. This exchange would also provide the opportunity to provide health promotion advice.

In Model 2B, this would involve the prisoner indicating to the reception personnel at the Health Centre whether they were seeking access to ACT Health staff, or staff from the external agency located within the Health Centre who would be operating the NSP. Given the multi-faceted roles envisaged for such an external provider of an NSP (detailed further in section 6.4 of this chapter) seeking to access staff from the external agency would not necessarily indicate that a prisoner was seeking to access clean injecting equipment.

Both Models 2A and 2B therefore have the capacity to safeguard anonymity for prisoners. Access however, would be limited to the operating hours of the Hume Health Centre. It is anticipated that a small increase in staffing would also be necessary specifically to facilitate the foreshadowed changes to the current request form/‘bluey’ system. For both Models 2A and 2B, an additional ‘roving’ prison officer would need to be rostered onto each shift to enable prisoners to be escorted to and from the Health Centre on request. Option 2A would require an additional ACT Health/nursing staff member to be rostered onto each shift to carry out assessments of those prisoners presenting to the Health Centre (and undertake provision of injecting equipment or immediate consultations for other matters as required). While Option 2B would require at least 1 (possibly 2) staff from an external provider agency to be rostered onto each shift to undertake the provision of injecting equipment, along with delivering complementary health promotion and education services.

Both Models 2A and 2B could therefore ensure timely access to the Health Centre for prisoners seeking to access injecting equipment, but hours of access would be limited to the operating hours of the Health Centre. Both Models 2A and 2B could ensure anonymity, given the operational changes outlined above.

Models 2A and 2B are similar to Model 1 in terms of their capacity to meet criterion 2 – ensuring safety. The one-for-one exchange nature of these models means that they do not deliver unrestricted availability of injecting equipment, and the quantity of injecting equipment in circulation would be limited and could be monitored. Therefore, any access to injecting equipment could not be guaranteed to exclude particular individuals, such as those who could potentially harm themselves or others. Although appropriate protocols may assist to limit the likelihood, prisoners accessing equipment via these models could quite easily pass it on to others. With Models 2A and 2B, injecting equipment could still also be circulating within the general population areas of the prison.

However, in terms of consistency and linkages with existing health and corrections programs, Models 2A and 2B have significant advantages over Model 1 in relation to linking with existing health programs in particular. Both of these model options involve human interaction, meaning that opportunities to deliver information and education on safe injecting practices and opportunities to provide other health promotion information or discuss other health-related referral needs would be significantly enhanced.

It is envisaged that the current roles and duties of corrections officers would remain largely unchanged with Models 2A and 2B. As with Model 1, seizures of drugs and injecting equipment
during searches within the prison could carry on as normal, as prisoners would be able to access the Health Centre to obtain another syringe if the need arose at a later date. However, both these models may require removing offences relating to the possession of program issued injecting equipment, while the treatment of offences relating to the possession of illicit substances would remain unchanged.

Both Models 2A and 2B are consistent with the remaining criteria in relation to flexibility and adaptability in implementation and data collection; and ensuring an evidence-base for evaluation, enabling enhanced levels of monitoring and data collection to that achievable with Model 1.

6.3 Model 3: Contained NSP

6.3.1 Model 3A: Contained NSP Operated by ACT Health/Nursing Staff (within Health Centre)

6.3.2 Model 3B: Contained NSP Operated by Outside Agency (within Health Centre)

As with Models 2A and 2B, Models 3A and 3B are in effect variations on the same model option, but would be delivered by different agencies and staff. Models 3A and 3B entail a contained needle and syringe program model – where the objective would be to contain the provision and use of injecting equipment within the Hume Health Centre area within the AMC.

Given the need to ensure anonymity for prisoners, both Models 3A and 3B propose operating the contained NSP within the existing Health Centre facility. Therefore, as with the previous Models 2A and 2B, prison officers would be required to convey prisoners to the Health Centre on request, without being able to identify the person’s reason for seeking to access the facility.

As with Models 2A and 2B, both models 3A and 3B involve the operation and delivery of a face-to-face NSP by staff within the Hume Health Centre. Injecting equipment (a syringe and necessary related items such as filters, swabs etc) would be provided to individuals in the context of a consultation, the key difference between Models 2A, 2B and Models 3A, 3B being the requirement for the prisoner to use the injecting equipment within the Health Centre and provide it to staff for disposal prior to leaving.

Models 3A and 3B would not require any significant infrastructure changes, as the provision and use of injecting equipment could take place within the existing Health Centre, utilising existing consultation areas that are currently not in constant use with the area also being used for health education and health promotion purposes.

In terms of addressing the established criteria, these models pose similar challenges for ensuring timely access and anonymity for prisoners as with the previous Models 2A and 2B. The current Blue Form (or ‘bluey’) system, whereby a prisoner fills out a blue request form outlining his or her reason for needing to attend the Health Centre, which is then given to prison officers and delivered to the Health Centre for processing, would require similar changes. In order to ensure anonymity for those seeking to access and use clean injecting equipment facilitated by staff within the Health Centre, similar changes to the current system would be required.

Specifically, the need to list a reason for seeking to go to the Health Centre on the request form would need to be removed. Prisoners would need to be conveyed to the Health Centre by prison
officers on presentation of the request form. On arrival at the Health Centre, the prisoner could then indicate the reason for their visit such as accessing health promotion staff.

In Model 3A, this would involve the prisoner entering the Health Centre with ACT Health staff and advising them of the reason for their visit. Prisoners seeking to access and use clean injecting equipment could be dealt with directly, along with other prisoners whose health concerns required immediate attention. Appointments to return at a later date could then be made for those whose needs were less immediate. Following these assessments and/or interventions, prisoners would be escorted away from the Health Centre as usual.

In Model 3B, this would involve the prisoner indicating to the reception personnel at the Health Centre whether they were seeking access to ACT Health staff, or staff from the external agency located within the Health Centre who would be operating the contained NSP. Given the multifaceted roles envisaged for such an external provider of a contained NSP (detailed further in section 6.4 of this chapter) seeking to access staff from the external agency would not necessarily indicate that a prisoner was seeking to access the contained NSP. It would be quite appropriate for detainees to seek advice, for example, on the spread of infections including BBVs.

Both Models 3A and 3B therefore have the capacity to safeguard anonymity for prisoners. As with the previous Models 2A and 2B, access would be limited to the operating hours of the Hume Health Centre. The main difference being that with Model 3A and Model 3B, use of injecting equipment provided would also be limited to the operating hours of the Health Centre. Given this additional restriction on access, it would be worth considering extending the number of hours that the Health Centre is accessible to prisoners to facilitate greater access. Considering some of the criticisms in relation to the accessibility of the Health Centre for prisoners seeking assistance with a range of health-related matters outlined in previous reports and echoed during the consultations, expanding the number of hours that the Health Centre is accessible to prisoners may well give rise to beneficial improvements in service delivery unrelated to the implementation of an NSP.

It is anticipated that a small increase in staffing would also be necessary specifically to facilitate the foreshadowed changes to the current request form/‘bluey’ system. For both Models 3A and 3B (as with 2a and 2b), an additional ‘roving’ prison officer would need to be rostered onto each shift to enable prisoners to be escorted to and from the Health Centre on request. Option 3A would require an additional ACT Health/nursing staff member to be rostered onto each shift to carry out assessments of those prisoners presenting to the Health Centre and undertake either provision of injecting equipment and related supervision of use and disposal, or immediate consultations for other matters as required. While Option 3B would require at least 1 (possibly 2) staff from an external provider agency to be rostered onto each shift to undertake the provision of injecting equipment and related supervision of use and disposal, along with delivering complementary health promotion and education services for prisoner and custodial staff.

Both Models 3A and 3B could therefore ensure timely access to the Health Centre for prisoners seeking to access and use injecting equipment within the contained NSP area, but hours of access would be limited to the operating hours of the Health Centre. Both Models 3A and 3B could ensure anonymity, given the operational changes outlined above.
In terms of their capacity to meet criterion 2 – ensuring safety – Models 3A and 3B are clearly superior to the previous Models (Model 1, Model 2A and Model 2B). Availability to and use of injecting equipment would be completely contained within the Health Centre facility under both Model 3A and 3B. Under each of these models there would be no injecting equipment circulating within the general prison population, and access for individuals with the potential to harm themselves or others could be monitored and controlled. With Models 3A and 3B, no injecting equipment would be circulating within the general population areas of the prison. Both of these models also provide additional safety benefits for prisoners in terms of overdose prevention, given the element of both limited supervision and ready availability of other health staff within the Hume Health Centre. Nursing staff already have established procedures for overdose management, and the limited supervision provided by either external agency or ACT Health staff in Model 3 would facilitate a rapid response to an identified potential overdose. While close and constant supervision of actual injecting is not envisaged, obviously staff in either Model 3A or 3B would need to be able to keep an eye on the person to ensure they were not able to roam freely around the Health Centre unescorted. Further, the instigation of a relatively short timeframe for injecting would ensure that staff would be able to interrupt proceedings when the timeframe for injecting was up, also enabling the timely identification and management of acute intoxication and potential overdose situations. In addition, existing procedures for the management of aggressive or unmanageable patients would also be adequate to manage any problematic behaviour on the part of participants.

In terms of consistency and linkages with existing health and corrections programs, Models 3A and 3B have significant advantages in relation to linking with existing health programs in particular. Both of these model options involve human interaction, meaning that opportunities to deliver information and education on alternatives to using drugs, injecting or safe injecting practices and opportunities to provide other health promotion information or discuss other health-related referral needs would be significantly enhanced. Models 3A and 3B have the additional capacity to enable education and health promotion activities in relation to promoting safe-injecting practices, vein-care and BBV prevention to be accompanied by supervision to ensure that subsequent injecting practices reflect the uptake of key messages. As previously stated, while close and constant supervision of actual injecting is not envisaged, the instigation of a relatively short timeframe for injecting would ensure that staff would be able to interrupt proceedings when the timeframe for injecting was up, facilitating appropriate interventions for any participants with vein-care issues or problematic injecting practices.

It is envisaged that the current roles and duties of corrections officers would remain largely unchanged with Models 3A and 3B. As with the previous models outlined (Model 1, Model 2A and Model 2B), seizures of drugs and injecting equipment during searches within the prison could carry on as normal. However, both these models would have the additional advantage of not requiring the removal of offences relating to the possession of injecting equipment (with the treatment of offences relating to the possession of illicit substances also remaining unchanged).

Both Models 3A and 3B are also consistent with the remaining criterion in relation to flexibility and adaptability in implementation and data collection; and ensuring an evidence-base for evaluation,
enabling enhanced levels of monitoring and data collection to that achievable with the other model options, given the completely contained environment for the distribution and use of injecting equipment, complete control over disposal of equipment and the supervisory/monitoring element in relation to injecting practices and overdose prevention activities.

It should be acknowledged that implementation of Models 3A or 3B may require some further consideration of potential additional legislative and/or regulatory requirements in relation to a number of issues specific to the contained NSP concept, for instance limited liability for operating staff and compatibility with professional registration requirements for nursing staff in particular. However, given the operation of similar programs in community settings within Australia, it is anticipated that such considerations, while requiring due attention, do not pose insurmountable barriers to the implementation of contained NSP models in the AMC. Chapter 7 of this report further addresses the issues of criminal and civil liabilities.

### 6.4 Additional Roles for an External NSP Provider

#### 6.4.1 Health Promotion, Education, Training and Transition to the Community

Implementation of Models 2B and 3B, and possibly also initial provision of injecting equipment to prisoners under Model 1, would require the engagement of an external agency as provider of NSP services, located within the existing Health Centre. It is envisaged that the selection of the external provider would be via a tender (or selective tender) process, seeking applications from existing community-based agencies/service providers (or a consortium of agencies/service-providers) with relevant experience in alcohol and other drug service provision within the community context.

There are significant potential advantages to engaging an external provider to operate NSP services co-located with ACT Health staff in the existing Health Centre. Co-location of the NSP with existing health services would facilitate consistency and linkages with existing health service provision, and appropriate referral arrangements between ACT Health and external agency services, as well as facilitating the establishment of linkages with external community-based agencies in planning for transition to community for those exiting the AMC.

During the consultation process, a number of stakeholders also expressed concern with regard to possible perceived conflict of interest between some of the current roles of ACT Health staff (Medical Officers, Registered Nurses and Pharmacists) and the operational requirements of NSP services. For instance, concerns by nursing staff involved in pharmacotherapy program management in relation to illicit drug use by prisoners on the program, and conversely, concerns by pharmacotherapy program participants in relation to possible impacts for their continued participation in pharmacotherapy programs. Whilst such barriers are not insurmountable in practice, perceptions and concerns of various stakeholders would be most effectively addressed by ensuring that ACT Health staff are at arm’s-length from the operation of NSP services.
Additionally, a number of stakeholders raised concerns in relation to the current workload and range of duties undertaken by ACT Health staff, as well as perceived gaps in the delivery of education, information and health promotion activities relating to BBVs for both staff (corrections and health) and prisoners in the AMC. An external agency (or a consortium of agencies/service-providers) engaged to operate NSP services, should also be required to design and deliver a range of complementary information, education, training and health promotional activities designed to reduce the spread of BBVs and STIs within the prison population. These measures should have the capacity to focus on harm minimisation and related issues, including sharing of injecting equipment, but also covering areas such as unsafe sexual practices, sharing of toothbrushes and razors, and unsafe tattooing practices within the custodial environment. In addition to the obvious benefits arising from enhancing service provision in these areas, given the portfolio of responsibilities envisaged for an external NSP provider, prisoners seeking to access these staff would not be able to be singled out as users of NSP services by custodial staff.

6.5 **Aboriginal and Torres Strait Islander Health Worker**

Given the over-representation of Aboriginal and Torres Strait Islander peoples within prison populations across the country (ABS 2010 pg 47-64), and disproportionate rates of BBV and injecting drug use demonstrated in the literature among Indigenous prisoners nationwide (Kratzmann et al. 2011 pg 16-112), the appointment of an external agency as the provider of NSP and related services may also facilitate the recruitment of an Aboriginal Health Worker, catering to the particular needs of this population group within the AMC.

6.6 **Additional Disposal Mechanisms**

While methods for disposal of injecting equipment are outlined under each of the model options in this chapter, additional disposal mechanisms are worthy of consideration given the need to dispose safely of existing injecting equipment in the prison and the capacity of some of the models to allow restricted availability of injecting equipment within cells and general population areas of the prison.

In addition to the disposal mechanisms outlined in each of the models, secure syringe disposal bins (that prevent the extraction of used injecting equipment) should also be placed in discreet locations of the prison in areas accessible to prisoners who may be using injecting equipment either provided by the NSP, or old injecting equipment that has previously been smuggled into the prison.

These additional measures would further reduce the potential for accidental needle-stick injury to both prisoners and staff, and given the current availability of illicit (smuggled) injecting equipment in the AMC, would be worthy of consideration even without the implementation of an NSP.

6.7 **Retractable Syringes**

The Australian Government’s Retractable Needle and Syringe Initiative was ceased in 2005 as a result of trials which showed that the available technology was not appropriate for the use required and could represent a health risk.

The evidence-based trials examined the acceptability of retractable needle and syringe equipment by injecting drug users. The trials showed, however, that retracting the needle outside the body resulted in a visible blood splatter, raising possible health risks of blood-borne infections. The
Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

Retractible needles used were designed for injection into muscles, usually in clinical settings. The pilots showed that the available technology was not appropriate for injection into veins by injecting drug users.

(DoHA 2005 pg 3)

However, the potential for such technology to reduce the safety risks associated with NSPs in custodial settings should be acknowledged (particularly in relation to the potential to eliminate risks associated with accidental needle-stick injury from used syringes) and further developments in appropriate technology applicable in programs in the community setting will need to be considered as part of the ongoing development of comparable programs in custodial settings.

6.8 Conceptual Assessment Table

<table>
<thead>
<tr>
<th>Scale 1-5</th>
<th>Access</th>
<th>Anonymity</th>
<th>Negative impact for prisoners</th>
<th>Ensuring safety</th>
<th>Consistent and linkages</th>
<th>Flexible and adaptable</th>
<th>Data, evidence, evaluation</th>
<th>Legal issues</th>
<th>Total score</th>
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<tr>
<td>Vending style machines Model 1</td>
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<tr>
<td>NSP ACT Health Model 2a</td>
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<td>NSP NGO Model 2b</td>
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<tr>
<td>Contained NSP ACT Health Model 3a</td>
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<tr>
<td>Contained NSP NGO Model 3b</td>
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<td>33</td>
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</table>

This table is not meant to be definitive. It sets out a conceptual overview to provide an indication of the issues that have been under consideration and the relative capacity of each model to meet the established criteria. It provides an illustrative summary of the detailed analysis undertaken in this chapter which examines alternative models.
Chapter 7  Other Potential Legal Issues – Criminal and Civil Liability

Following an approach from Hume Health Centre staff additional consideration has been given to the need to protect staff from criminal or civil liability. Subject to the normal processes of government in preparation of legislation, such as review by parliamentary counsel, the following amendments could be considered in relation to the establishment of an NSP in the AMC:

7.1 Exemption of Staff and other Persons from Certain Criminal Proceedings

(1) This section applies to a person who is or has been—
(a) a Minister or public employee; or
(b) a member of the staff of the facility; or
(c) a person contracted to work in the facility; or
(d) the owner or occupier of the premises where the facility is situated.

(2) A proceeding for a criminal offence (including an offence against the Criminal Code, section 717 (Accessory after the fact)) does not lie against a person to whom this section applies in relation to an act—
(a) done in good faith by the person in the person’s capacity as a person to whom this section applies; and
(b) that consists of participating, or being in any other way concerned, in the establishment of the facility or in its operation as a supervised injecting place; and
(c) done in accordance with the requirements (if any) prescribed under the regulations.

7.2 Exemption of Persons from Certain Civil Proceedings

A civil proceeding does not lie against the Territory or anyone else in relation to the death of, or any loss or injury sustained by, someone (the affected person) caused by, or arising out of—
(a) the self-administration by the affected person of a substance at the facility; or
(b) anything else done by the affected person, whether or not at the facility, in relation to the self-administration.

7.3 Compliance with the ACT Work Safety Act 2008 and Work Safety Regulation 2009

It is also worth noting that detailed policies and procedures developed in relation to any NSP model will need to take into account and comply with the provisions of both the Act and the related Regulation.
Chapter 8: Conclusions and Recommendations

8.1 Legislation to Establish an NSP in the AMC

The rule of law is one measure of a civilised society—especially when those laws have been established through a democratic process. Most citizens at some time believe that one law or another should not exist or should not apply to them. However, we do not have a choice in this area and are required to comply with laws that are passed in our parliaments. Custodial officers, like all citizens and particularly as law officers themselves, are required to comply with the law even when they believe that the law is not appropriate. Many of the people who use drugs, including those in prison, disagree with the current prohibitionist laws but are required to comply with them anyway. Prison officers may disagree with the law and have the right through democratic processes to resist a change to the law or to seek to have a law withdrawn. However, once the law is enacted compliance is appropriate.

The ACT Corrections Management Act 2007 has at Section 7 of its objectives:

“(a) ensuring the secure detention of detainees at correctional centres; and
(b) ensuring justice, security and good order at correctional centres; and
(c) ensuring that detainees are treated in a decent, humane and just way; and
(d) promoting the rehabilitation of offenders and their reintegration into society.”

(ACT Government 2011 pg 6)

Each of these objectives is consistent with the establishment of an NSP in the AMC as has been explained throughout this report. Additionally, Sections 8 and 9 of the Act also provide strength to the argument that an NSP is not only consistent with the Act but an approach that reduces harm to the prisoners, is considered appropriate in decision making and that decent, humane and just treatment is a normal part of the operation of the centre. It is entirely appropriate, therefore, that the Act be amended to establish an NSP at the AMC. This report considers that the most appropriate amendment, subject to normal legislative process such as consideration by the ACT Parliamentary Counsel’s Office, is as follows:

Section 12
Correctional Centres – minimal living conditions
Subsection (1) (j)

- following the words “detainees must have access to suitable health services and health facilities”
- insert the words: “including a needle and syringe program”.

It should be noted that Section 14 of the Act then allows the Chief Executive to make corrections polices and operating procedures that are consistent with the Act.

8.1.1 Recommendation 1: Requirement Under Law

- The ACT Corrections Management Act 2007 be amended to require the establishment of a needle and syringe program at the AMC.
8.2 Establishing Rules, Procedures and Protocols

8.2.1 Trust

A constant theme through the literature review, the stakeholder consultations and the overseas experience was the importance of building trust for custodial officers, health staff, prisoners in general and potential users in whatever the system of NSP to be adopted. However, the overseas experience indicates that this cannot be expected within the short term. That experience indicates that the process is likely to start after a few months but is unlikely to be consolidated within the first year.

8.2.2 Education and Training Programs

The establishment of an NSP will require significant training programs for all of the staff involved. Those who are experienced in running NSPs in the broader community should be asked for their advice on key elements of such training programs and may be recruited, at least for the short term, to run the programs. Harm minimisation education programs should be part of every custodial officer’s initial training.

8.2.3 Clear Rules, Procedures and Protocols

From the start of the program there needs to be a set of clear rules, procedures and protocols. These rules and procedures will need to be established by the prison authorities in consultation with health staff working in the AMC, custodial officers and prisoners. The rules and procedures need to remain consistent with the legislation covering corrections. As a starting point, however, the discussions should include the type of issues covered in Chapters 5 and 6.

8.2.4 Recommendation 2: Rules, Procedures and Protocols

A clear set of rules, procedures and protocols be established through an appropriate process guided by the ACT Corrections Management Act.

8.3 Approach to the Establishment of an NSP – Flexibility and Adaptability

Different models for an NSP will be favoured by the stakeholders from different sectors. However, it is important to be cognisant of the goal of introducing an NSP into the prison. The recommendation for the method of proceeding is to provide an implementation process for an NSP that is as successful as possible. Advice provided indicates that a single rigid and inflexible model is not appropriate and a number of groups consulted are strongly of the view that flexibility and adaptability in the implementation of potential models will be vital to arresting the spread of BBVs.

Taking into consideration the concerns raised by many of the stakeholders in regard to this proposed program, it is considered appropriate to ensure that there is a step by step process which addresses the effectiveness of any model that is implemented at the facility.
8.4 Preferred Model Options and Rationale – a Contingency Process

The stakeholders are not unanimously in agreement on the most appropriate model for implementation. However, there was a remarkable level of consensus with regard to the main considerations and characteristics necessary to guide implementation. These factors were used to develop a set of agreed criteria against which possible models for implementation were then assessed as set out in the table at the conclusion of Chapter 6 of this report.

The models explored in detail in Chapter 6 all demonstrated the potential to address the agreed criteria (that is, the main considerations and characteristics necessary to guide implementation) which were established in Chapter 4. Hence, a flexible and dynamic contingency process is proposed for implementation of an NSP in the AMC, which would begin with the introduction of the initially preferred model (based on performance against the assessment criteria) acknowledging that the other models would offer viable contingency options in the case of inadequate performance of the initial preference.

Given differing views of key stakeholders on the most appropriate model for implementation, a flexible and dynamic implementation process is likely to be best in meeting the needs and concerns of all the stakeholders.

Based on the analysis in Chapters 4 and 6, an external provider, operating within the existing Health Centre, would be preferable for operating NSP services in relation to all the model options, and could also perform a range of additional complementary roles in relation to the delivery of health promotion, education, training and transition to community activities.

8.4.1 Recommendation 3: Implementation through a Flexible Contingency Approach

- Adopt a contingency process for the implementation of appropriate model/s for a needle and syringe program at the AMC. If the initially preferred model does not meet the needs of stakeholders the procedure should be to move to the next preference. The order should be as follows:

Preferred Initial Model Step 1: NSP Model 3 (Contained NSP)

- Model 3B: Contained NSP operated by an external agency (within Health Centre)
  This model best meets the criteria established in Chapter 4 in relation to the range of key considerations and characteristics identified by stakeholders as necessary to guide implementation. An external provider, operating within the existing Health Centre, would be preferable for operating NSP services, and could also perform a range of additional complementary roles in relation to the delivery of health promotion, education, training and transition to community activities.

- Model 3A: Contained NSP operated by ACT Health/Nursing Staff (within Health Centre)
  Evidence of inadequacy of an external provider in Model 3B would require a contingency plan that should have as its next stage control of the program by ACT Health staff in the Hume Health Centre.
Should Model 3 fail to deliver adequate outcomes in relation to the range of indicators (e.g. reduction in the use of shared illicit injecting equipment) following the implementation phase it will be appropriate to fall back to the first contingency model option, as per below.

**Contingency Step 2: NSP Model 2 (Equipment provision from Health Centre)**
- **Model 2B: An NSP operated by an external agency.**
  Evidence of inadequacy of the contained NSP concept would mean that the next contingency plan would be the distribution of needles and syringes on a ‘one for one’ exchange basis. This process would be conducted from the Hume Health Centre by an external agency.
- **Model 2A: An NSP operated by ACT Health staff.**
  Evidence of inadequacy of an external provider in Model 2B would mean that the next contingency plan would be the distribution of needles and syringes on a ‘one for one’ exchange basis by the ACT Health staff in the Hume Health Centre.

Should Model 2 fail to deliver adequate outcomes in relation to the range of indicators (e.g. reduction in the use of shared illicit injecting equipment) following the implementation phase it will be appropriate to fall back to the next contingency model option, as the next step.

**Contingency Step 3: Model 1 (One for One Machines)**
- **Model 1: ‘One for one’ Exchange Vending Style Machines**
  Evidence of inadequacy of Model 2 would mean that the next contingency plan would be the distribution of needles and syringes on a ‘one for one’ exchange basis by the use of a series of machines located in convenient and unmonitored locations. The support of the machines could be conducted by ACT Health staff or by an external agency.
8.5 A Flexible Implementation Approach for Most Effective Balance

The contingency plans suggest an implementation method to ensure that the most effective balance is met through a system that addresses the series of criteria outlined in Chapter 4. However, as this is likely to be the first NSP in a prison setting in Australia it is also important to maintain an open mind for minor changes and adjustments to the program. One such possible course of flexibility would be to consider implementation of a number of the models concurrently, either in part or in full, in different classification areas within the AMC. One possibility would be to start a carefully controlled one for one exchange based on Model 2 in the Transition Cottages at the same time as starting the Contained NSP for the broader prison population.

8.6 Possible Additional Actions

In line with the analysis contained in Chapter 6, the following additional recommendations are worth noting as possible further actions for government:

8.6.1 Recommendation 4: Aboriginal Health Worker

• Recruitment of a dedicated Aboriginal Health Worker position in NSP and related service provision would be worthy of consideration.

8.6.1 Recommendation 5: Secure Syringe Disposal Bins

• The installation of secure syringe disposal bins would further reduce the potential for accidental needle-stick injury and be worthy of consideration even without the implementation of an NSP.

8.6.3 Recommendation 6: Retractable Syringes Technology

• Future developments in retractable syringe technology will need to be considered as part of the ongoing development of NSPs in custodial settings.

8.7 Protection from Criminal and Civil proceedings

The specific need to protect employed and contracted staff from criminal and civil liabilities may be considered in the context of the existence of comparative legislative protection for staff currently working in similar illicit drug harm reduction programs, such as community-based NSPs and the Sydney Medically Supervised Injecting Centre. Additional legislative amendments may be worthy of consideration in this context, as outlined in the analysis in Chapter 7. The examples of possible legislative amendments provided would also need to be subject to the usual parliamentary counsel drafting, Assembly debate and approval processes.

8.7.1 Recommendation 7: Protection from Criminal and Civil Liability

• Legislative amendments be considered to protect all staff from potential civil and criminal liability.
8.8 Conclusion

The Public Health Association of Australia (PHAA) was engaged by the ACT Govt in May 2011 to investigate and report on models for the implementation of an NSP in the AMC. The project also entailed an assessment of barriers to implementation and broad consultations with key stakeholders. The emphasis of the project has been on seeking to develop a model that ensures optimal health and safety outcomes for all prison staff and the broader community, as well as prisoners. This report outlines outcomes and recommendations from the project.

The first few chapters of the report provided an introduction to the project and context in relation to the outcomes sought. This was followed by an analysis of the existing literature from both Australia and overseas, outlining the evidence in relation to: the need for NSPs in correctional settings; consistency of the proposal with key national strategies; legislative considerations; and the demonstrated success of such programs overseas.

The report then identified key themes emerging from the consultation process, developing a set of criteria for the analysis of models for implementation of an NSP in the AMC. Despite the differing views of the very broad range of stakeholders consulted in relation to this project, there was a surprising level of consensus with regard to the main considerations and characteristics necessary to guide implementation. An outline was then provided of key lessons from programs operating overseas and consultations with stakeholders working in those countries.

The next steps were an analysis of the preferred model options based on the evaluation criteria outlined earlier in the report. The analysis identified the key considerations for AMC staff, prisoners and community stakeholders regarding barriers to introducing an NSP and outlining how these could be addressed by various model options. Analysis in relation to each model’s capacity to address the established criteria was able to incorporate further consideration of operational logistics, as well as addressing the concerns and expectations identified by the full range of stakeholders across health, corrections and community sectors. The basis for each of the first four of the terms of reference was addressed in this part of the report.

The models explored in detail all demonstrated the potential and the capacity to address the agreed criteria. Hence a contingency process has subsequently been proposed for implementation of an NSP in the AMC, which would begin with the introduction of the initially preferred model, acknowledging that the other models would offer viable contingency options in the case of inadequate performance of the initial preference.

The final chapters have examined in further detail potential issues in relation to criminal and civil liability for staff and outlined a series of conclusions and specific recommendations arising from the investigations and consultations identified in the preceding chapters.

The options for the implementation of an NSP in the AMC put forward in this report, along with the complementary recommendations in relation to key supporting measures, demonstrate that implementation of an NSP in the AMC is capable of delivering significant health benefits for prisoners, staff working within the prison and the broader community. Additionally, these positive outcomes which finalise addressing the terms of reference could be achieved with minimal change to existing AMC operations and staffing levels, representing a highly cost-effective investment for the ACT Government.
References


Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre


Burnett Institute (2011) External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. Macfarlane Burnet Institute for Medical Research and Public Health Ltd. Melbourne.


Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre


Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre


McDonald D (2005) 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. Directions ACT, Canberra.


Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre


Sydney Medically Supervised Injecting Centre (2003) SYDNEY MEDICALLY SUPERVISED INJECTING CENTRE INTERNAL MANAGEMENT PROTOCOLS. Sydney MSIC. NSW.


Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre


Written Submissions

In addition to input received via the Key Informant Meetings/Interviews, Stakeholder Focus Groups and Workshops listed in the Stakeholder Consultation Program and Participant List at Attachment A, written submissions were received from the following individuals and groups:

- Australian Nursing Federation, ACT Branch
- Bill ALDCROFT OAM JP
- Katrina BRACHER, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health and Michael LEVY, Director, Justice Health Service, ACT Health
- Bill ARNOLD, ACT Pharmacy Guild delegate on ACT Health Alcohol and Other Drugs Task Force and Opioid Treatment Advice Committee. NSW Corrective Services Chaplain
Attachment A: Stakeholder Consultation Program & Participant List

A series of Key Informant Meetings/Interviews and Stakeholder Focus Groups and Workshops have been conducted. The participants listed and schedule outlined for these consultations was designed to be inclusive of a wide range of perspectives under the following broad categories: prisoners and families; custodial staff/representatives; ACT Health staff; community health and related service providers; community interests and other key informants.

**ACT Key Informant Meetings/Interviews**

**Prisoners and families**

- Wayne Hutchison, Prisoners Aid (Mon 9 May)
- Annie Madden, Executive Officer, Australian Injecting & Illicit Drug Users League (AIVL); and Nicole Wiggins, Manager of Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) (Wed 11 May)
  - AIVL and CAHMA conducted two further Focus Group Workshops with ex-prisoners and injecting drug users to provide further input to PHAA re barriers/challenges and possible models:
    - a) a generic focus group workshop for male and female ex-prisoners & illicit drug users (Mon 30 May); and
    - b) an additional focus group workshop specifically for Indigenous ex-prisoners and illicit drug users (Tues 31 May).

**Custodial staff/representatives**

- Custodial and non-custodial staff at AMC (including CPSU union delegates) (Mon 6 June – all staff meeting at the AMC)
- Simone Fowlie, A/g Superintendent, Custodial Operations, ACT Corrective Services (Mon 30 May)
- Jeremy Boland, Official Visitor to the AMC (Thurs 7 July)
- Bernadette Mitcherson, Executive Director of ACT Corrective Services and Barry Folpp, Deputy Executive Director (Tues 17 May)
- Gayle Berthold, Clinical Nurse Consultant, Justice Health (Mon 30 May)
- Focus Groups with a cross section of custodial and non-custodial staff at AMC (4 Focus Groups with a maximum of 20 participants) (First Focus Group – Tues 31 May; 3 Subsequent Focus Groups – Mon 4 July)
- ACT Corrective Services Court and Transport staff meeting (Mon 18 July)

**ACT Health staff**

- Dr Peggy Brown, Chief Executive, ACT Health (Fri 6 May)
- Katrina Bracher, Executive Director, Division of Mental Health, Justice Health, Alcohol & Drug Services (Wed 4 May)
Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

- Tony Blattman, Population Health Division (Secretariat Officer for ACT Ministerial Advisory Council on Sexual Health, AIDS/HIV, Hepatitis C and Related Diseases) (Wed 25 May – attended group meeting with SHAHRD)
- Professor Michael Levy, Director, Justice Health Service (Tues 17 May)

Community health and related service providers
- Simon Rosenberg, CEO, Northside Community Services (Wed 25 May)
- Julie Tongs, CEO; Jane Sharman, Clinical Nurse Consultant with The Opiate Program; Dr Ana Herceg; and Dr Peter Sharp - Winnunga Nimmityjah Aboriginal Health Service (Mon 16 May)
- Carol Mead, Executive Director, and Leanne Drury, NSP Manager, Directions ACT (Tues 17 May)
- Peter Townsend, Manager, Solaris Therapeutic Community, Alexander Maconochie Centre and Sharon Tuffin, Services Director, Karralika Programs Inc. (Tues 24 May)
- Dr Graeme Thomson (interview conducted via email while participant was overseas)

Community interests and other key informants

CANBERRA MEETINGS
- Fred Monaghan from Gugan Gulwan Youth Aboriginal Corporation, AMC Taskforce member and former member of the ACT’s Aboriginal and Torres Strait Islander Elected Body (Justice, Correctional Services) (Wed 8 June)
- David Templeman, CEO and Brian Flanagan Manager, Strategic Communications and Policy, Alcohol and other Drugs Council of Australia (Wed 11 May)
- Helen Tyrrell, Chief Executive Officer, Hepatitis Australia (Mon 23 May)
- Dr Helen Watchirs, ACT Human Rights and Discrimination Commissioner and staff (Wed 25 May)
- Christine Brill, Chief Executive Officer, ACT AMA (Tues 5 July)
- David McDonald, Drug Policy Modelling Program, National Drug and Alcohol Research Centre and Visiting Fellow, National Centre for Epidemiology and Population Health (Tues 14 June)
- Jane Timbrell, Australian Manufacturing Workers’ Union (AMWU) and Jenny Miragaya Australian Nursing Federation (ANF) (Fri 8 July)
- Steve Sant, CEO, ACT Divisions of General Practice (Thurs 7 July)

MELBOURNE MEETINGS
- John Ryan, CEO, Anex (Thurs 12 May)
Implementation of a Needle and Syringe Program at the Alexander Maconochie Centre

- Dr Mark Stoové, Head, HIV/BBV Research, Centre for Population Health, Burnet Institute (Fri 13 May)

SYDNEY MEETINGS

- Dr Alex Wodak AM, Director, Alcohol and Drug Service, St. Vincent’s Hospital (Thurs 19 May)
- Professor Tony Butler, Program Head, Justice Health Program, Kirby Institute (formerly National Centre in HIV Epidemiology and Clinical Research) (Thurs 19 May)
- Michael Frommer, Policy Analyst, Australian Federation of AIDS Organisations (Thurs 19 May)
- Brett Collins, Justice Action (Thurs 19 May)
- Gino Vumbaca, Executive Officer, Australian National Council on Drugs (Fri 20 May)
- Dr Ingrid van Beek, Director and Tony Jackson, Clinical Services Manager, Kirkt on Road Centre (Fri 20 May)

TELEPHONE INTERVIEWS

- Dr Alun Richards, Executive Director, Offender Health Services Directorate, QLD Health (Tues 10 May)
- Professor Kate Dolan, National Drug and Alcohol Research Centre (Thurs 19 May)

**NOTE:** A number of additional informal key informant meetings/interviews were held with stakeholders from the above categories who wished to remain anonymous.

**Additional PHAA ACT Stakeholder Focus Group Workshop** (Thurs 26 May)

The additional PHAA ACT Stakeholder Focus Group Workshop was designed to enable participation from a variety of stakeholders who fit under the broad categories identified, with perspectives that may not necessarily have been fully canvassed by the Key Informant Meeting/Interview process or other Focus Group and Workshop processes.

- Carrie Fowlie, Executive Officer, and Amanda Bode, Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Brian McConnell, Marion McConnell and Bill Bush, Families and Friends for Drug Law Reform
- Paul Cubitt, Law Enforcement Against Prohibition (LEAP) Australia
- Robyn Davis, Executive Officer, ACT Hepatitis Resource Centre
- Jacky Cook, Executive Director, Toora Women Inc
- Rachelle Cole, Women’s Centre for Health Matters (ACT) auspicing body for the ACT Women and Prisons Group
- Kiki Korpinen, Acting Director, ACTCOSS
Presentation and Workshop Session at Alcohol Tobacco and Other Drug Association ACT (ATODA) Conference (Thurs 23 June)

An additional stakeholder workshop was held in conjunction with the ATODA Annual Conference, to seek input from a broad range of stakeholders from the ACT alcohol and other drug sector and related fields. This workshop was attended by approx. 50 conference delegates representing research, policy and program management and service delivery perspectives.
Attachment B: Consultation Questions

Used for key informant meetings/interviews, stakeholder focus groups and workshops

Question 1
What do you see as the main barriers/challenges to introducing a Needle and Syringe Program (NSP) in the Alexander Maconochie Centre (AMC)?

Question 2
If an NSP was to be introduced, what would be the main features or characteristics that you think would be most important to ensuring its success?

Question 3
What measures need to be taken to ensure that the safety of the following groups is protected?
   a) corrections officers
   b) health workers
   c) prisoners

Question 4
What practical or operational factors would need to be considered in the development of a model NSP in AMC? For instance, how might prisoners access injecting equipment?

Question 5
What factors would be most important to ensuring that prisoners made use of clean injecting equipment provided, rather than continuing to share equipment brought in through other means?

Question 6
What factors would be most important to securing the support of corrections and health staff for the provision of clean injecting equipment? What practical measures might be taken to make staff comfortable with the introduction of an NSP in AMC?

Question 7
Do you have any other comments/suggestions in relation to the introduction of an NSP in AMC?