

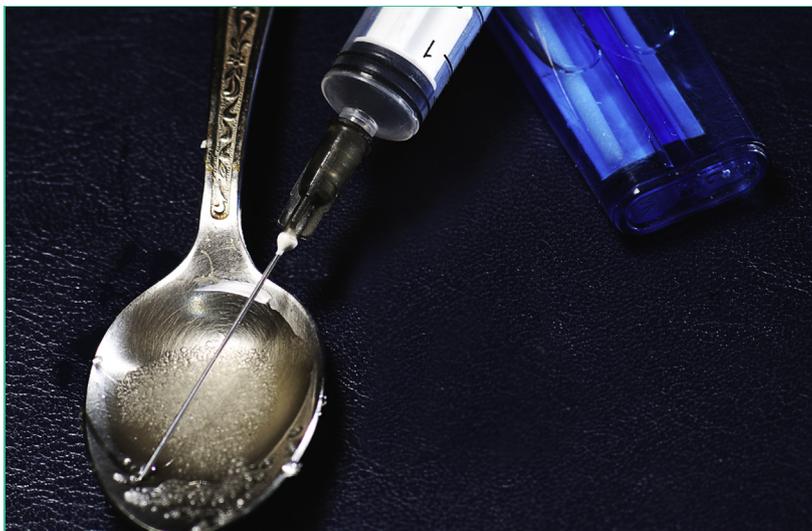
Salvaging a prison needle and syringe program trial in Australia requires leadership and respect for evidence

Many countries, including Australia, support needle and syringe programs ... but not for prisons

People who inject drugs (PWID) are grossly overrepresented in Australian prisons. Up to 58% of prisoners nationally report lifetime injecting histories.¹ The prevalence of blood-borne viruses (BBVs) — commonly transmitted through sharing injecting equipment — is also substantial in prison,¹ with high rates of intraprisn hepatitis C (HCV) transmission reported.² However, unlike in the community, PWID in Australian prisons cannot access sterile needles and syringes. Incarcerating PWID in prison environments where drugs are widely available, BBV prevalence is disproportionately high and access to sterile injecting equipment is prohibited breaches basic human rights and international law that ascribes prisoners' rights to health care standards equivalent to those in the community.³

Prison needle and syringe programs (PNSPs) are endorsed by Australian health and medical peak bodies, including the Australian Medical Association, Australasian Society for HIV Medicine and the Royal Australasian College of Physicians, as well as global bodies like the World Health Organization, UNAIDS and the United Nations Office on Drugs and Crime. Advocacy success resulting in PNSP implementation has been well characterised;⁴ however, only eight countries currently maintain PNSPs. This leaves 74 countries — including Australia — that support community needle and syringe programs but not PNSPs, in the belief that they implicitly condone illicit behaviour and present particular challenges if applied to correctional settings.

Australian policy and practice targeting BBV prevention in prisons has been inconsistent and largely piecemeal. Despite all four National Hepatitis C Strategies acknowledging people in custodial settings as a priority population, endorsement of effective prevention approaches has varied. The Third National Strategy (2010–2013),⁵ approved by the Commonwealth and all jurisdictional health ministers, made a strong commitment “for state and territory governments to identify opportunities for trialling [needle and syringe programs] in Australian custodial settings”. In the current, Fourth Strategy (2014–2017),⁶ however, there is no reference to PNSPs, with only endorsement of substantially less efficacious prevention (eg, bleach provision) or drug demand reduction (eg, drug treatment) approaches.



This lack of an evidence-based BBV prevention policy has supported a reliance on haphazard and largely ineffective interventions in Australian prisons. Despite Australian drug policies being underpinned by harm minimisation approaches that include supply, demand and harm reduction, only costly and ineffective interdiction-based supply reduction approaches and, to a lesser extent, treatment-based demand reduction, have been implemented substantively in prisons.⁷ Pragmatic regulation to reduce drug-related harm is also found in South Australian, Queensland and Victorian prisons, with lesser penalties for possession of drugs perceived as less harmful (eg, cannabis).⁸ This approach demonstrates that public health benefits can occur through security regulations and within corrections legislative regimens that prioritise security over prisoner health and human rights. However, there remains an overriding belief in Australian correctional systems that PNSPs are incompatible with security; a contention not borne out by international experience.

While limited progress towards a PNSP trial in Australia is disappointing in a country that once led the world in drug harm reduction policy and practice, one jurisdictional government has consistently demonstrated political leadership on the issue. Successive Australian Capital Territory chief ministers, Jon Stanhope and Katy Gallagher, steadfastly supported trialling a PNSP at the Alexander Maconochie Centre (AMC) — a prison commissioned in 2009 on human rights principles in accordance with the *Human Rights Act 2004* (ACT). The 2011 evaluation of drug policies and services at the AMC⁹ recommended a trial PNSP, while the subsequent government-commissioned report recommended

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suitable PNSP models and consultation processes based on international experience.¹⁰ Key stakeholders, including prison officers and the Community and Public Sector Union (CPSU), were closely involved with each step of this process.

In April, an end to the long-running enterprise bargaining agreement (EBA) stalemate between the ACT Government and the CPSU that centred on a PNSP trial was announced. In his press release,¹¹ the ACT Minister for Justice Shane Rattenbury maintained the “Government’s commitment to implementing an NSP”, but emphasised “the need for this to be developed with input from ACT Corrective Services staff ... [to] recognise the genuine concerns”. A Deed of Agreement enabling the EBA states that majority staff support is needed for any PNSP trial to proceed. Given the CPSU’s historical resistance to PNSPs, this requirement may doom any prospect of an AMC PNSP trial.

CPSU resistance nationally has mostly centred on workplace health and safety concerns and encouraging drug use in custody. These concerns are not supported by over 20 years of PNSP operations in 13 countries. Research and evaluation evidence shows no increase in drug use or availability following PNSP implementation and no reports of needles and syringes provided by PNSPs being used as weapons, or safety problems associated with syringe disposal. Evaluations have also noted PNSPs reduce BBV transmission risk, facilitate entry into drug treatment programs, coexist with drug interdiction strategies and contribute to workplace safety.⁴

The Deed of Agreement states that PNSP negotiations with the CPSU must be conducted in good faith. The discordance between PNSP experiences and the current

“the ACT can show genuine leadership by becoming the first Australian jurisdiction to introduce a PNSP”

Podcast with Professor Mark Stoové available at www.mja.com.au/multimedia/podcasts and from iTunes. Also available as a video at www.mja.com.au/multimedia.

CPSU position makes it crucial that AMC staff have opportunities to review and openly discuss evidence supporting the benefits of PNSPs for prisoners, staff and the community as part of good faith negotiations. Guidelines and recommendations for engaging effectively with prison staff have been documented internationally, alongside prominent examples of shifts in attitude towards PNSPs by staff before and after PNSP implementations.⁴ The potential for honest negotiations to deliver such attitudinal shifts in the ACT also exists, given the significant number of AMC prison officers interviewed in the 2011 evaluation who privately supported a trial PNSP, but feared peer and CPSU recriminations if they were to openly express this support.⁹

With ongoing policy inertia on prison BBV prevention in other Australian jurisdictions, the ACT can show genuine leadership by becoming the first Australian jurisdiction to introduce a PNSP. The recently tabled House of Representatives report on HCV in Australia¹² specifically notes that outcomes of a PNSP in the ACT will inform broader Australian debate. While it is hoped that AMC staff might depart from the CPSU’s historical resistance to PNSPs, the ACT Government must show the leadership lacking in other jurisdictions by allowing evidence and expert advice, rather than unions, guide public health policy.

Competing interests: Mark Stoové led the ACT Government-commissioned evaluation of drug policy and services at the Alexander Maconochie Centre in 2010–2011, but has since had no financial relationship with the ACT Government. The manuscript is, in part, informed by this experience but we do not feel it represents any current conflict of interest.

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