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ATODA's response to the Draft Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre 2012-2014

To Whom It May Concern:

Please find the attached the Alcohol Tobacco and Other Drug Association ACT's (ATODA) response to the *Draft Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre 2012-2014*.

ATODA is the peak body representing the alcohol, tobacco and other drug sector in the Australian Capital Territory. ATODA works collaboratively to provide expertise and leadership in the areas of social policy, sector and workforce development, research, coordination, partnerships, communication, information and resources. ATODA is an evidence-informed organisation that is committed to the principles of public health, human rights and social justice.

ATODA congratulates the ACT Government for taking the necessary steps to develop and implement a comprehensive and evidence-informed approach to preventing and managing blood borne viruses in the ACT's adult prison, the Alexander Maconochie Centre.

ATODA stands ready to support the ACT Government in accessing and making use of the sector's expertise in further developing evidence-informed responses to managing blood borne viruses in all parts of the Canberra community; and to preventing and reducing alcohol, tobacco and other drug related harms.

We look forward to working in partnership with the ACT Government, affected communities and all stakeholders on this important public health initiative.

Sincerely,

Carrie Fowlie
Executive Officer
Alcohol Tobacco and Other Drug Association ACT (ATODA)

31 October 2012

ATODA's response to the Draft Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre 2012-2014

1. Introduction and Background

ATODA would like to thank the ACT Government for the opportunity to respond to the *Draft Strategic Framework for the Management of Blood Borne Viruses in the Alexander Maconochie Centre 2012-2014* (the Framework). ATODA believes the Framework is an important mechanism to promote transparency and accountability to the management of blood borne viruses (BBV) in the Alexander Maconochie Centre (AMC); and will provide guidance to the range of stakeholders involved in supporting the health and wellbeing of people in the AMC and their communities.

ATODA strongly supports evidence-informed responses to preventing and responding to BBV across all parts of the ACT community including within closed settings, such as the AMC.

Since ATODA became operational on 1 July 2010, we have been actively engaged in policy and program developments related to alcohol, tobacco and other drugs (ATOD) and BBV in the AMC, including assisting the ACT Government to develop the draft Framework through the provision of a number of policy documents, submissions and activities, such as:

- Membership of the *ACT Alcohol, Tobacco and Other Drug Strategy 2010 – 2014* Evaluation Group;
- Participation in the *External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre* (the Burnet Report) consultations;
- Providing a response to the Burnet Report;
- Developing a discussion paper on a *Needle and Syringe Program Trial in the Alexander Maconochie Centre*;
- Incorporating BBV management in the AMC as a priority area in ATODA's first submission to the ACT Budget 2011-2012 consultation;
- Conducting a workshop with all ACT Government Health Directorate funded ATOD services and ACT Corrective Services to map service provision and gaps in the AMC;
- Engaging in the consultations regarding the *Balancing Access and Safety: Meeting the challenge of blood borne viruses in prison report* (the Moore Report);
- Providing the *Implementing a needle and syringe program in the Alexander Maconochie Centre: ATODA submission to the ACT Government on the Moore Report consultation;*
- Engaging stakeholders with the evidence base and local developments related to BBV management through the 2011 ACT Alcohol, Tobacco and Other Drug Sector 4th Annual Conference titled *Not If But Now: Collaboratively Implementing Innovative and Evidence-Based ATOD Policy and Programs;*
- Membership of the AMC Health Policies and Services Advisory Group;

- Developing a proposal with the Canberra Collaboration (Centre for ATOD Policy, Research and Practice) to conduct a further ATOD specific analysis of the first ACT Inmate Health Survey data including elements related to BBV management;
- Contributing to the development of the *Drug Policies and Services Framework for the Alexander Maconochie Centre 2012-2014 (Draft).*

ATODA will continue to provide support to the ACT Government and other stakeholders to access and make use of the sector's expertise in further developing evidence-informed responses to managing BBV in all parts of the Canberra community.

This submission provides:

- General comments about the Framework;
- Comments on specific sections and issues in the Framework;
- Appendix A that relate to the management of BBV through the provision of sterile injecting equipment in prisons.

2. General Comments

2.1 BBV Management and Harm Minimisation

The relationship between illicit drug use and BBV is substantial. Over 80% of all newly acquired hepatitis C infections in Australia, the ACT[1] and vast majority in most western countries are associated with injecting drug use. Sharing injecting equipment is the primary manner in which BBV (including HIV/AIDS, hepatitis C and B) are spread amongst this population.

The Framework is guided by the principle of harm minimisation, consisting of the three pillars of supply reduction, demand reduction, and harm reduction enshrined in Australia's *National Drug Strategy 2010 - 2015*[2] and the *ACT Alcohol, Tobacco and Other Drug Strategy 2010 - 2014*.[3] ATODA strongly supports this approach, which has continuously demonstrated effectiveness in addressing the harms caused by ATOD.

For nearly three decades in Australia, harm minimisation has provided an effective and evidence based approach with which to address the complex issues of ATOD use and its associated harms. The result has been a world leading response to drug use and associated BBV epidemics, such as HIV. For example, by employing strategies such as opioid maintenance therapy, peer education, and needle exchange programs, HIV prevalence among injecting drug users remains at less than 1% in Australia[4] while it is much higher in other comparable countries.[5]

ATODA emphasises the need to ensure that the Framework functions within a harm minimisation framework by actioning a range of supply, demand, and harm reduction strategies that have the potential to support a range of improved outcomes, rather than simply a suite of measures to specifically manage the spread of BBVs.

This will require comprehensive:[6]

- Supply reduction activities 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 - such as continued cell and area searches, and visitor and staff screening;

- Demand reduction activities to prevent the uptake and/or delay the onset of use of ATOD and support people to deal with dependence and reintegrate with the community - such as widespread provision of opioid maintenance therapy, validated screening, brief intervention, withdrawal management and support, effective counselling and other therapeutic interventions, case management and continuity of care planning and support; and,

- Harm reduction measures to reduce the adverse health, social and economic consequences of the use of ATOD - such as peer education, access to sterile injecting equipment and to full strength household bleach, BBV testing, hepatitis B vaccinations, access to condoms, pre-release and transitional planning and support, access to opioid overdose management and prevention programs which include naloxone, and referral to appropriate services.

Such services should be considered a priority at all stages of detention, and appropriate provision should be provided upon entry to the AMC, throughout detainees' time at the AMC, and at pre-release, transitional and post-release periods.

ATODA notes that the need to extend many of the above interventions into correctional settings has already featured in a range of reviews, reports and policies, including:

- The Burnet Review;[7]
- The Moore Report;[8]
- The ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014;
- Australia's National Drug Strategy 2010 – 2015;
- The National Corrections Drug Strategy 2006 – 2009.[9]

ATODA acknowledges the efforts made across ACT Corrective Services and the Health Directorate towards implementing the three pillars and supports efforts to further strengthen these responses.

2.2 Expertise of the ACT Alcohol, Tobacco and Other Drug Sector

The ACT ATOD sector leads Australia in many areas of service provision including opioid maintenance therapy, needle and syringe programs, drug diversion and opioid overdose prevention and management. The ACT community can be proud of its ATOD treatment and support sector and know that when help is needed, they will receive high quality, effective, efficient and evidence-informed services. However, it is essential that we ensure that all Canberrans have access to this support - both in detention and in the community.

Prevention and management of BBV is core business of the ACT ATOD sector. Since 1989, the sector has been involved in the development and delivery of needle and syringe programs in the

community, and has developed sound expertise in the provision of sterile injecting equipment, harm reduction education and information, treatment, support and referrals.[10] As such, significant expertise exists to inform the development and delivery of appropriate harm minimisation measures that prevent and manage BBV.

ATODA has strong working relationships with representative bodies from affected communities and policy, research and practice experts in the ATOD and related fields and stands ready to assist the ACT Government with the implementation, management and evaluation of the Framework. An example of how this has worked in practice is provided below.

Case Study of Effective and Collaborative Policy Development: Implementing Expanded Naloxone Availability in the ACT

An example of how the ACT's ATOD sector can draw together national and international experts to assist the ACT Government is well demonstrated by the activities of the Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Committee and program. The primary aim of the program is to reduce opioid overdose morbidity and mortality, through:

- Increased effectiveness of interventions in opioid overdose management;
- Provision of comprehensive overdose management training;
- Provision of take-home naloxone to potential overdose witnesses in the ACT;
- Reduction in opioid overdose through overdose prevention education.

The purpose of the Committee is to oversee, provide expert guidance and support to develop and implement an overdose prevention and management program which includes the provision of naloxone in the ACT to potential overdose witnesses, including peers, friends, family and ATOD workers.

Owing to the high risk of overdose death following release from prison, AMC detainees are a priority group for this program. The ACT Government's status report details progress in relation to a number of issues, in particular ATODA emphasises the agreement in principle to develop a model for the provision of naloxone to detainees. ATODA understands that referrals to the community program have begun from health professionals in the AMC and looks forward to further working with AMC based staff to strengthen this program for AMC detainees.

Similar expert collaborations for the Framework can be developed in the ACT to ensure evidence-informed responses are implemented and evaluated in relation to managing BBVs in the AMC.

3. Responses to Specific Areas within the Framework

3.1 Background (p.3)

ATODA supports that the Framework:

- Seeks "to promote transparency and accountability in the management of blood borne virus infections in the Alexander Maconochie Centre (AMC)." ATODA suggests that 'evidence-informed' be included before the word management in this statement.

- Acknowledges the important and essential partnership between the Justice and Community Safety and the Health Directorates, which aligns with the approach in both the national and ACT drug strategies; and functioning within the *ACT Human Rights Act 2004.*

- Recognises and works within the *ACT Alcohol Tobacco and Other Drug Strategy 2010 – 2014;* the *HIV/AIDS, Hepatitis C, Sexually Transmissible Infection: A Strategic Framework for the ACT 2007-2012,* and the *Drug Policies and Services Framework for the Alexander Maconochie Centre 2012-2014 (Draft)*.

- Seeks to actively action areas of the *Corrections Management Act 2007* which BBV policies and programs in the AMC has previously been unable to achieve, particularly in regards to Section 21 (2) (a) and (2) (b) as "(a) to provide health services to detainees; and (b) to protect the health of detainees (including preventing the spread of disease at correctional centres)."[11]

- Is grounded in a harm minimisation approach, which mirrors the Framework's broader policy context (see section 2.1 of this submission for further information).

3.2 Purpose and Strategic Goals (p.4)

ATODA supports both the purpose and goals of the Framework. We specifically note the acknowledgement of the roles of non-government organisations, researchers, community groups and affected communities in achieving the strategic goals (see section 2.2 for information on how ATODA can support engagement with these stakeholders).

3.3 Guiding Principles (p.5)

ATODA supports the guiding principles for the Framework. We note that the inclusion of important contextual information related to harm reduction may be valuable under principle one. That is, that ATOD harm reduction does not condone drug use itself rather it accepts that drug use will occur in society and therefore seeks to prevent and reduce the harms associated with these behaviours.[12]

Principle 3, an evidence-based approach, is laudatory. The Framework could note, however, that the absence of a strong body of scientific evidence should not be an impediment to innovation. It is important to try out new ideas, provided this happens with a sound monitoring and evaluation approach included.

3.4 Roles and Responsibilities (p.6)

ATODA supports the joint approach to the Framework from both the Justice and Community Safety and the Health Directorates and acknowledges the inherent tensions that can sometimes exist across the health / corrections partnership. It is important to note that such tension should not be a barrier to implementing effective programs (such is the case with some of Australia's most successful public health and BBV initiatives such as needle and syringe programs).

This partnership approach is likely to achieve better outcomes across the board rather than vesting governing responsibility in one or the other. This will help ensure that the Framework is implemented in the context of a broader health agenda which emphasises a holistic approach to maintaining and promoting the health and wellbeing of detainees; so that they can most effectively undertake rehabilitation and return to the community as healthy and productive members of our community.

3.4.1 Reporting

The bodies already listed in section 8 of the draft Framework (p. 10) have well developed reporting structures that can be used efficiently to comply with the reporting requirements of the Framework. However, ATODA believes that there will be a need to develop specific means of reporting against the Framework. This is permitted under the Corrections Management (AMC Health Policies and Services Advisory Group) Procedure 2012.[13]

It will be important to have the evaluation designed, and baseline data collected, before sterile injecting equipment starts being provided within the AMC.

We note that section 8 of the draft has a hanging 'and' after the fifth dot point on page 11. This implies that a dot point may be missing.

3.4.2 Clinical Governance

ATODA recognises the important role that the AMC Health Policies and Services Advisory Group can play in governing the clinical aspects of the Framework, and acknowledges the inclusion of a new member – the ACT Hepatitis Resource Centre as a representative of the ACT BBV and Sexually Transmitted Infection sectors, which should be reflected in the group's membership within the Framework.

However, primary oversight by this Group should allow for, and be informed by, the clinical judgements of the Doctors at the Hume Health Centre, including scope for appropriate courses of action when dealing with individual patients. There is a need to ensure that relevant clinical decisions and policies are developed by appropriate medical professionals to ensure the integrity of the services being provided, such as the provision of sterile injecting equipment to patients. Medical professionals should make medical decisions, and while input from policy-makers and other stakeholders (such as ATODA) is often required, ultimate decision-making responsibility for medical services should lie with medical professionals.

A number of components of the Framework relate specifically to the provision of health services at the AMC, and will need to be informed by clinical decisions. These include, but are not limited to:

- Access to sterile injecting equipment (s5.1.c.);
- Opportunities for BBV screening and vaccinations (s5.3.a.);
- Post-exposure prophylaxis against HIV (s5.4.a.); and,
- Drug treatment (s5.4.b.).

ATODA understand that an existing clinical group is involved in coordinating health services at the Hume Health Centre could provide the mechanism for this clinical governance, as the group already provides reports to the AMC Health Polices and Services Advisory Group.

3.5 Profile of the Prison Population and Current Service Array (p. 7 – 8)

3.5.1 Profile of the Prison Population

Understanding the health status of detainees of the AMC is one of the ways to develop appropriate policy and service responses to for this unique population. Conducting inmate health surveys is a key mechanism towards developing this understanding.

In 2010, the Health Directorate conducted the first inmate health survey at the AMC with a summary results paper being completed in July 2011 and released publicly that November.[14] The summary report provides broad information about ATOD and BBV related issues for detainees and commits to a series of additional reports, including one focused on ATOD.

ATODA believes that conducting a thorough analysis of the ATOD and BBV data collected in the Inmate Health Survey could be timely to inform the ongoing development of the Framework. A proposal has been developed by a collective of ACT ATOD researchers (the Canberra Collaboration) to conduct a further analysis of ATOD data from the Inmate Health Survey so as to be able to better understand inmates' ATOD related issues and to inform policy, practice and future research in this area. ATODA understands that the Health Directorate has expressed an interest in having further analyses conducted and we urge that this to be undertaken as a matter of priority.

ATODA also believes that obtaining information related to other infection control strategies, such as tattooing and piercing practices of detainees, could help inform the Framework (see section 3.6.1 g. for more information).

3.5.2 Current Service Array

ATODA acknowledges the role of the *Adult Corrections Health Services Plan 2008-12* in guiding the provision of services in the AMC. As such, specific comment on this plan is beyond the scope of this submission. However, ATODA acknowledges the importance of ensuring consistency and linkages across these policy frameworks (given the high likelihood of intersection between the actionable areas within the Framework and the provision of health services more broadly). Given the expiration of the plan in 2012, it will be timely to develop the appropriate synergies across these documents. This could include, for example, the inclusion of

people with, or at risk of, BBV infection or transmission as a specific population group in part C of the Corrective Health Services Plan.

ATODA urges the Health Directorate to develop a new Adult Corrections Health Services Plan and to engage in public stakeholder consultations on its development. This overarching plan can provide a means of addressing additional health concerns of detainees, such as their physical needs, and a context for both the Framework and the *Drug Policies and Services Framework for the Alexander Maconochie Centre 2012-2014 (Draft).*

ATODA acknowledges the significant policy and reporting requirements of both Corrective Services and the Health Directorate in regards to the AMC. However the additional health needs of detainees (such as being over/under weight, having asthma, back problems, etc) are of equal importance and interrelate to program and policy areas discussed within the Framework.

3.6 Actionable Priority Areas (p.8)

3.6.1 Prevention and Education (p.8)

a. ATODA notes the importance of, and evidence for, emphasising BBV treatment and prevention, particularly amongst injecting drug users.

b. ATODA supports the provision of education and counselling, including the provision of peer based harm reduction information and education to detainees.

ATODA acknowledges the current BBV harm reduction education sessions conducted by the ACT Hepatitis Resource Centre at the AMC. These sessions incorporate harm reduction information related to injecting drug use, tattooing, bleach and safer sexual practices. Some sessions have been co-facilitated by the AIDS Action Council and the Canberra Alliance for Harm Minimisation and Advocacy, which supports the provision of peer based information related explicitly to injecting drug use risks and prevention. However we also understand that the number of education sessions being delivered could easily be doubled and still not meet demand.

c. ATODA supports the provision of regulated sterile injecting equipment and suggests the inclusion of the wording ‘appropriate and discreet access’.

ATODA applauds the ACT Government for inclusion of such an initiative as an important component of a comprehensive BBV management strategy (see appendices for further evidence related to the provision of sterile injecting equipment in prisons). As noted through previous ATODA submissions, prison needle exchange programs are cost-effective, safe, and endorsed by international and Australian expert bodies. They have been introduced in 12 countries, where they have been the subject of extensive evaluation. The results demonstrate that prison needle and syringe programs can:

- Reduce rates of needle stick injuries among corrections staff and reduce the likelihood of contracting a BBV among those who do sustain a needle-stick injury;
- Reduce the rate of BBV transmission among prisoners who inject drugs in prisons; and,

- Improve the uptake of appropriate treatment among people who inject drugs in prisons.[1516171819]

As noted in section 2.2., sterile injecting equipment has been provided to injecting drug users in the community by the ACT ATOD sector for decades. This serves as a fundamental component of the ACT's response to BBV and serves as a point of contact and referral to health and other services. ATODA can provide linkages with this expertise to inform relevant developments in the AMC.

ATODA acknowledges that implementing the Framework's priority action (1)(c)– *Detainees have regulated access to sterile injecting equipment* – will require consultation with the Justice and Community Safety Directorate and the relevant unions under the terms of Section U3.1 of the *ACT Public Service Justice and Community Safety Directorate Enterprise Agreement 2011-2013.* However, ATODA reiterates statements made in section 3.4.2 of this document related to clinical governance, and the following excerpt from the ATODA submission to the Moore Report:

Excerpt from ATODA Submission to the Moore Report:

The operationalisation of the NSP is an expert health matter best dealt with by the health professionals who will implement the program

One of the strengths of the Moore Report, in the view of ATODA, is the way the authors have identified a set of criteria against which to assess the large number of implementation modalities that are available. These criteria are: 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.

ATODA fully supports these criteria and urges that they be considered when determining which of the recommended models is most apposite.

It is tempting to discuss the details of how a NSP might be operationalised within the AMC. ATODA believes, however, that this detail is beyond the scope of a broad community consultation and for those who do not have detailed knowledge of the day-to-day operations of the Hume Health Centre and other parts of the AMC.

The roll out of the NSP is an expert health matter best dealt with by the health officials and others whose responsibility it will be to implement the program. This is a matter of clinical and health provision integrity - the community would not usually drive or comment on clinical details as it related to any other health matter – such as mental health or HIV treatment. Therefore, the same respect should be allowed to this health intervention.

d. ATODA supports the provision of full strength bleach and associated education.

ATODA believes that full strength bleach should be provided by Hume Health Centre staff, as per recommendations from a range of stakeholders and previous review processes to address

issues of inconsistent access to bleach. ATODA understands that the ACT Hepatitis Resource Centre provides education related to the use of full strength bleach within existing education sessions in the AMC; however, opportunities to provide this education more comprehensively to all areas of the prison should be explored.

e. ATODA supports detainee access to their own razors, toothbrushes and barbering equipment.

ATODA again notes the potential roles of AMC health staff and community services in education related to infection control, for example, the ACT Hepatitis Resource Centre provides education sessions related to infection control. However, opportunities to expand the frequency and reach of education and information should be pursued.

f. ATODA supports detainees' discreet access to prophylactics, including condoms and dental dams, as a key harm reduction intervention.

g. Although not currently identified, ATODA believes the Framework could be strengthened through the inclusion of additional infection control strategies such as tattooing and body piercing, which are high risk behaviours for the transmission of BBV. Whilst these activities are less risky with consistent ready access to full strength bleach (as per section d above), and are currently included within education sessions provided by non-government services, specific actions related to these are not explicit within the Framework. ATODA acknowledges that there are significant, new initiatives included within the current Framework, however suggests that exploring the feasibility of expanding infection control initiatives (such as tattooing and body piercing) should be referenced in the Framework.

3.6.2 Workforce Development

a & b. ATODA supports comprehensive education and training on BBV transmission and infection control procedures in relation to BBV for the AMC workforce.

ATODA notes that non-government service providers are also part of the AMC workforce and that it will be essential that this training and education be shared across all members of the workforce regardless of where they are employed. The ACT ATOD sector, in particular, is part of the AMC workforce and has been working alongside Correctional Officers, health staff and other service providers since the opening of the prison (and are contracted to do so).

3.6.3 Detection, including Testing and Diagnosis

a. ATODA supports opportunities for BBV screening and vaccinations for those coming into the AMC at regular intervals during their stay. ATODA reiterates statements made in a submission to the *Draft ACT Immunisation Strategy 2012 - 16:*

Excerpt from the ATODA draft ACT Immunisation Strategy Submission:[20]

The current *Australian Immunisation Handbook* states that injecting drug users are at risk of acquiring hepatitis A and hepatitis B, and should be vaccinated against these infections.[21] Further the *ACT Immunisation Strategy 2007 – 2010* identified injecting drug users as a high-risk group…[22]

In addition to improved immunisation at the AMC, ATODA reiterates the need for improving uptake of blood-borne virus (BBV) screening/testing upon admission and at regular intervals and pre-release. This would inform a better understanding of BBVs prevalence and rates of transmission in this complex setting and potentially leading to increased immunisation.

It would be useful if this work aligned with other preventative measures, including blood borne virus management strategies such as the provision of a one-for-one needle exchange between an inmate and the Medical Officer. Further, it would be useful if immunisation information was included as part of through and aftercare initiatives in place and under development.

3.6.4 Clinical Treatment and Management

b. In addition to providing comprehensive treatment programs for BBV's, ATODA supports the provision of comprehensive, evidence based drug treatment programs to detainees.

The draft Framework makes reference to drug and alcohol risk assessment and drug treatment services when describing the current service array in the AMC. The Draft Framework also includes drug treatment programs under Actionable Priority Area 4 (S5.4.b.) Drug treatment, especially the provision of opioid maintenance therapy for heroin and other opioid dependence, is highly effective at reducing injecting behaviour and, as a result, the spread of BBV.[23]

ATODA recognises that there has been substantial work to provide comprehensive drug treatment to prisoners at the AMC, including the efforts of the Burnet Review and the Alcohol and Drug Services in the AMC Workshop (co-hosted by ATODA, Corrective Services and the Health Directorate in 2011). We understand that detoxification is currently available at the AMC, along with the following drug treatments:

- Counselling;
- Opioid Maintenance Treatment;
- Therapeutic Community (Solaris).

It is important to recognise, however, that the ATOD services provided to detainees should be at least equivalent to those provided to drug users in the community, and must extend beyond currently available treatments to include a range of additional adjunct supports and harm reduction measures, such as peer education (see section 3.6.1.b) and expanded access to naloxone (see section 2.2).

Another important consideration is the appropriate identification of ATOD issues, as a threshold to identifying and providing appropriate ATOD treatment. ATODA can provide access to a range of tools that could support this work, including the *electronic Alcohol, Smoking and Substance*

Involvement Screening Test which could act as a screening and brief intervention tool, detainees' feedback mechanism, referral tool, and an outcome measure regarding the reduced use of injecting and other ATOD use. ACT ATOD services are currently considering implementing this tool within their services with five services looking to implement it in stage one. ATODA also understands that the Solaris Therapeutic Community staff is exploring opportunities to embed this instrument within their practice and can provide support in area.

3.6.5 Surveillance and Research

b. ATODA supports the continuous, systematic collection, analysis and interpretation of data on detainee BBV transmissions and infection status to improve planning, implementation and evaluation of public health and clinical practice in the AMC. We also note the value of associated work such as inmate health surveys to identify potential risk factors (see section 3.5.1). It will be important to consider how information can inform program developments and service provision including continuing care (e.g. real time data reporting).

ATODA also supports ongoing research and evaluation of activities as a requirement of evidence informed practice, including developing and monitoring potential outcome measures (e.g. reductions in high-risk injecting behaviours). As previously noted, ATODA has strong linkages with local and national researchers that could help inform this work. See section 3.8 for more information on evaluation.

3.6.6 Enabling Environment

a. ATODA strongly supports strengthening linkages between Government and non-government stakeholders and consumers to improve coordination and delivery of services and in continuity of care (throughcare), and highlights the significant collaborations across the ATOD sector as examples of good practice in this area (see section 2.2 for an example of good practice).

ATODA notes the new AMC throughcare program funded through the 2013-14 ACT Budget. ATODA understands that this program is under development and includes an evaluation component. It is important to ensure that this Framework and the *Drug Policies and Services Framework for the Alexander Maconochie Centre 2012-2014 (Draft)* are reflected in both the program and evaluation.

Further ATODA notes that there are significant developments underway in ACT ATOD services which need to be clearly linked with throughcare initiatives within the AMC, including:

- The cessation of funding for Direction's Inside Out Program, which focused on detainees with ATOD issues in and post-release from the AMC. Therefore all throughcare initiatives within the AMC would need to ensure that they engage with detainees who were involved in this program;

- The commitment of ACT ATOD residential services to expand access to people on opioid maintenance therapy, with Karralika Programs Inc currently developing a demonstration project of this initiative;

- Development of the Model of Care (Phase 3) of the Ngunnawal Bush Healing Farm;

- Improved opioid overdose management and education, including the prescription of naloxone, program;

- Expansion of the Canberra Recovery Service to include women within the target group;

- Development of a structured therapeutic non-residential program (e.g. day and evening programs) at Directions.

ATODA can provide further information about these developments in the sector and links with ATOD services. In light of these and other planned developments in the sector, ATODA recommends the Framework include reference to the *ACT Alcohol, Tobacco and Other Drug Treatment Services Plan* (currently in development), which, amongst other things, will incorporate recommendations from the ACT Government's 'Review of Rehabilitation Services'.

b. ATODA supports the active participation of individuals and communities affected by BBV in the development of policies and programs impacting on their health and relationships.

ATODA commends the AMC Health Policies and Services Advisory Group for including two consumers as part of its membership and suggests that consumer participation be an additional priority area for action for this group to oversee.

Further, ATODA also notes the pending development of an ACT ATOD Sector Consumer Participation Framework (action item 33 in the ACT ATOD Strategy). This should provide improved mechanisms for consumer engagement in Government and non-government ATOD services that provide supports in the AMC, and may warrant referencing in the Framework.

c. ATODA supports the reduction of violence and barriers such as discrimination and stigma and isolation for detainees. ATODA refers you to the work of the *NSW Anti-Discrimination Board Inquiry into Hepatitis C Related Discrimination* and the *Senate Community Affairs Reference Committee on hepatitis C and the Blood Supply in Australia* which found that hepatitis C is a highly stigmatised condition, with negative associated social, economic and health effects.

We also refer you to the stigma and discrimination report undertaken by the Australian Illicit and Injecting Drug Users League (AIVL) which found that "stigma and discrimination associated with people who inject drugs is both institutionalised and pervasive and that AIVL and its member organisation are aware of many individual drug users who live with painful, debilitating and even life-threatening conditions rather than seek treatment from health services, including blood borne virus prevention and treatment services".[24]

The *Barriers and Incentives to Drug Treatment for Illicit Drug User National Research Project* reported that participants experienced discrimination in a range of setting including; pharmacy staff (63%) doctors and nurse (54%) and health workers other than doctors, nurses and pharmacy personnel (36%). This level of discrimination translates into vulnerable populations missing out on essential health services.[25]

Therefore, ATODA would like to see specific actions developed by the AMC Health Policies and Services Advisory Group to address stigma and discrimination in accessing health services in the AMC.

3. 7 Current Treatment Options for BBV

ATODA calls for greater clarity in the Framework regarding the extent of BBV treatments available in the AMC, and the manner in which they are provided (including continuing care post release). By clarifying the nature and extent of available treatments, the scope of unmet treatment demand could be better monitored and addressed. ATODA understands that currently there is significantly more demand for BBV treatment then there are available places.

3.8 Monitoring and Reporting

The Framework makes specific provisions for monitoring, reporting and evaluation.

ATODA supports the proposed monitoring and reporting requirements against the Framework which include:

- Key roles for the Executive Director of Corrective Services and the Executive Director of Mental Health, Justice Health, and Alcohol and Other Drug Service;

- Annual progress reports provided by the AMC Health Policies and Services Advisory Group to the Evaluation Group which oversees the *ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014*[26] and the ACT Ministerial Advisory Council on Sexual Health, HIV/AIDS, Hepatitis C and Related Diseases; and

- Specific criteria against which performance will be monitored.

ATODA notes that changes in self-reported rates of drug use and tattooing by detainees is included as a specific monitoring criteria within the Strategy; however, the framework does not provide any specific strategies to improve tattooing related infection control (see section 3.6.1 g.)

ATODA believes that the evaluation design should have a formative element, providing information to programs on any desirable changes, as well as an outcome element that would assess, among other things, the degree to which the Framework's actions achieved their goals, and any unintended consequences produced.

Evaluative activities should be external and independent, led by an evaluation expert, preferably based within the ACT so as to provide opportunities for regular contact with the program and to reduce overall program costs. ATODA understands that this expertise exists within the ACT and can assist with accessing this and national bodies that would be required. In the ACT alone, there are over 40 multidisciplinary national and international experts linked through the Canberra Collaboration.

3.8.1 The Need for Evaluation of Individual Components

ATODA wishes to emphasise the need to ensure that specific components of the Framework should be evaluated to identify which components have been effective at achieving its aims and objectives. It is very likely that certain actionable priority areas will be implemented with varying degrees of success and effectiveness. Additionally, some components are likely to have a greater impact upon preventing and managing the spread of BBVs than others, and it is important to know which components are most effective so that resources can be allocated in the most efficient manner. Consequently, it will be necessary to not only gain an understanding of the effectiveness of the Framework as a whole, but also each component so that efforts can be directed towards areas in need of improvement.

ATODA believes that consideration should be given to such an evaluation taking place in relation to the Framework, especially initiatives that are being introduced for the first time. This will require different indicators, evaluation methods, and expertise depending upon the component being evaluated. Of particular importance to evaluate are:

- Access to sterile injecting equipment;
- Ready access to full strength bleach;
- Drug treatments, including counselling and opioid maintenance therapy;
- Workforce development;
- BBV screening; and
- BBV treatment.

ATODA recognises that there are already substantial reporting requirements placed upon the AMC, however ATODA also acknowledges the value placed on evaluation within the AMC as demonstrated through conducting an evaluation of Solaris and the new throughcare program.

Of particular relevance to any evaluation is the existence of data collected as part of the previously discussed Inmate Health Survey. Data collected as part of the survey can be used to evaluate the effectiveness of, in particular, drug treatments. ATODA understands that a number of items related to drug use in the AMC were collected as part of the survey, but that the findings have not been published. ATODA emphasises the need to publish the findings of this part of the Survey to ensure that policies are developed in response to evidence of drug use in the AMC. Extended delays in publishing such data mean that their usefulness is diminished because they no longer represent a temporally appropriate form of monitoring.

3.8.2 The Need for Cost-Effectiveness Analysis

Regardless of whether evaluation of specific components of the Framework is undertaken, there is an imperative to consider the cost-effectiveness of the Framework. This is important because the ACT spends more than any other Australian jurisdiction, per prisoner, on incarceration.[27] Consequently, it is important to ensure that funds are spent in a cost-effective manner to minimise waste and maximise benefit. There is a substantial literature documenting the cost-effectiveness of certain ATOD interventions, services and programs, with a substantial number highlighting the cost effectiveness of needle exchange programs in the community and within prisons and provision of opioid maintenance treatment. As a result, ATODA urges the ACT

Government to consider including a cost-effectiveness or cost-benefit analysis of the Framework and its components in any evaluation of the Framework.

4. Conclusion

ATODA reiterates its acknowledgement of the ACT Government for this important public health and evidence informed policy document; and its ongoing support in developing policy, programs and evaluations.

Almost all AMC detainees will return to the communities from which they came - half of them within six months. This further strengthens the rationale for the Framework, whereby:

- Prisoner health is public health, including the prevention and reduction of disease transmission
- The AMC as an organisation, and both the Government and non-government staff who work within it, have a responsibility and opportunity to improve the health outcomes of detainees
- Prisons can be effective in improving health outcomes of some of the most vulnerable members of our community.

5. Further Information

For further information regarding this submission or the ACT alcohol, tobacco and other drug sector please contact:

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References

[1] Awofeso N. (2009) Updating the hepatitis C infection risk reduction hierarchy in prison settings. *Australasian Journal of Correctional Staff Development*. Volume 4, No 1-4
[2] Ministerial Council on Drug Strategy (2011). National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs. Canberra Commonwealth of Australia. Available online at: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds2015
[3] ACT Government (2010). ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014. Canberra: ACT Government. Available online at:
[4] United National Office on Drugs and Crime (2009). World Drug Report 2009. UNODC: Vienna.
[5] Tempalski, B., Lieb, S., & Cleland, C.M. Et al., (2009). HIV Prevalence Rates among Injection Drug Users in 96 Large US Metropolitan Areas, 1992-2002. J Urban Health. 86(1): 132-154.
[6] Ministerial Council on Drug Strategy (2011). National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs. Canberra Commonwealth of Australia. Available online at: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds2015
[7] Stoove, M, Kirwan., A. (2010). *External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Cente.* Burnet Institute: Melbourne, Australia.

[8] Moore, M. (2011). *Balancing access and safety: Meeting the Challenge of Blood Borne Viruses in Prison.* Public Health Association of Australia: Canberra.
[9] Australian Government. (2008). *National Corrections Drug Strategy 2006 – 2009.* National Drug Strategy: Canberra.
[10] Alcohol Tobacco and Other Drug Association (2012). *ACT ATOD Services Directory.* Available online at: www.atoda.org.au.
[11] ACT Parliamentary Counsel. (2012). *Corrections Management Act 2007: Republication No 17.* ACT Government: Canberra
[12] Ministerial Council on Drug Strategy (2011). National Drug Strategy 2010-2015: A framework for action on alcohol, tobacco and other drugs. Canberra Commonwealth of Australia. Available online at: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/nds2015
[13] ACT Parliamentary Counsel. (2012). *Corrections Management (AMC Health Policies and Services Advisory Group) Procedure 2012*. ACT Government: Canberra.
[14] Levy, M., Halliday, L., Guthrie, J. & Li, J (Ed.). (2011). 2010 ACT Inmate Health Survey Summary Results: Health Series Number 55. ACT Health: Canberra.
[15] Dolan K, Rutter S, Wodak, A.D. (2003) Prison-based syringe exchange programmes: a review of international research and development, *Addiction*, vol. 98, no. 2, pp. 153-8.
[16] Lines R, Jürgens R, Betteridge G, Stöver H, Laticevschi D, Nelles, J (2004) *Prison needle exchange: lessons from a comprehensive review of international evidence and experience*, Canadian HIV/AIDS Legal Network, Montréal, Québec.
[17] Niveau, G (2005) Prevention of infectious disease transmission in correctional settings: A review, *Public Health*.
[18] Stöver H, Nelles J (2003) Ten years of experience with needle and syringe exchange programmes in European prisons, *International Journal of Drug Policy*, vol. 14, no. 5-6, pp. 437-44.
[19] Rutter S, Dolan K, Wodak A, Heilpern H (2001) *Prison-based syringe exchange programs: a review of international research and program development*, NDARC technical report no. 112, National Drug & Alcohol Research Centre, Sydney, NSW.
[20] Alcohol Tobacco and Other Drug Association ACT. (2012). *ATODA Submission to the Draft ACT Immunisation Strategy.* ATODA: Canberra. Available upon request.
[21] Department of Health and Ageing (2009). *The Australian Immunisation Handbook 9th Edition* - 2.3 Groups with special vaccination requirements. p18. Available online at: http://www.health.gov.au/internet/immunise/publishing.nsf/Content/65BF44D8607619C5CA2574E2000F9A03/$File/2.3%20Vaccination%20of%20persons%20with%20Special%20needs.pdf
[22] ACT Government. (2007). *ACT Immunisation Strategy 2007 – 2010*. Available online at: http://health.act.gov.au/c/health?a=dlpubpoldoc&document=948
[23] Ritter & Chalmers (2009). Polygon: the many sides to the Australian opioid pharmacotherapy maintenance system. ANCD Research Paper 18. Canberra: Australian National Council on Drugs.
[24] Australian Illicit and Injecting Drug Users League (2011). *Why Would I Discriminate Against All of Them? – A report on stigma and discrimination towards the injecting drug user community.* Available online at: http://www.aivl.org.au/?p=50#p=50
[25] C Treloar & J Abelson et al. 2004, *Barriers and Incentives to Drug Treatment for Illicit Drug Users*, Monograph Series no. 53, Commonwealth of Australia, Canberra, p. 62.
[26] ACT Government (2010). ACT Alcohol, Tobacco and Other Drug Strategy 2010-2014. Canberra: ACT Government. Available online at:
[27] Steering Committee for the Review of Government Service Provision (2012), Chapter 8 Corrective Services in Report on Government Services 2012, Productivity Commission, Canberra. Available online at: http://www.pc.gov.au/gsp/rogs/2012

APPENDIX A

Better Managing Blood-borne Viruses in the Alexander Maconochie Centre (AMC)

Question and Answer (Q&A)

Version 2 - August 2012

1. What is a needle and syringe program? Do we have them in the ACT?

Needle and syringe programs (NSP) provide sterile injecting equipment to people who inject drugs. Their purpose is to prevent the transmission of blood-borne viruses, such as HIV and hepatitis C. Blood-borne viruses are spread when the blood of an infected person enters the blood stream of another person (for example, when infected injecting equipment is re-used by another person). People re-use syringes when they do not have access to new syringes. NSPs can remove the need for people to re-use injecting equipment and make the public safer by reducing the spread of disease.

2. Does the ACT know how to run NSPs?

YES. The ACT has had NSPs since 1989. There are two primary NSPs in the ACT and more than 40 programs distributing injecting equipment from health services, pharmacies and other sites. NSPs are core business of the alcohol, tobacco and other drug sector in the ACT and Australia.

3. Are used needles disposed of safely?

YES. NSPs distribute more than half a million syringes each year in the ACT and almost all are disposed of safely and appropriately.[1] In 2006-07, only 0.2% of syringes were inappropriately disposed of and that figure remains well below 1% in 2010-11.[2]

4. Are NSPs effective?

YES. NSPs in the community are very effective at preventing the spread of blood-borne viruses. It is estimated that NSPs have prevented 1,482 hepatitis C infections in the ACT between 2000 and 2009. Across Australia, that figure is 96,667 cases of hepatitis C and 32,050 cases of HIV. In fact, the introduction of NSPs in Australia has been heralded as a major reason that rates of HIV infection have remained so low.

5. Have NSPs impacted on the spread of HIV in Australia?

YES. Reusing syringes is one of the major ways that HIV is spread in the developed world. In the United States, where Governments have been slow to implement NSPs, the prevalence of HIV infection among injecting drug users is about 8%.[3] This compares with Australia where the prevalence of HIV among injecting drug users is about 1%.[4]

6. Are NSPs a good investment?

YES. The evidence indicates that NSPs are cost-effective, meaning that the economic benefit of needle exchange programs far outweighs the cost of investing in them. Each case of hepatitis C costs community and health services an average of between $798 and $18,835 per year.[5] Loss in productivity can be much greater. From 2000 to 2009, the ACT Government spent $8.8 million on NSPs. This resulted in a saving of $11.5 million in healthcare costs alone.

7. Is injecting drug use a problem in the AMC?

YES. Injecting drug use is a problem at the AMC. Reported findings from the 2010 ACT Inmate Health Survey indicate that 67% of inmates have a history of injecting drug use. Of these, 32% admitted to having injected while in the AMC and some prisoners admitted to injecting on at least a weekly basis while in the AMC.[6] The Burnet Institute[7] and the Public Health Association have confirmed that injecting drug use occurs in the AMC.[8]

The very worst model of a needle and syringe program is operating at the AMC right now. It is unregulated, re-circulates a limited supply of unsterile equipment, and fails to connect its "clients" with health professionals.

8. What is Hepatitis C?

Hepatitis C is a virus that causes liver inflammation and liver disease. It is spread through blood-to-blood contact. That is, when the blood of an infected person enters the blood stream of another person. There is no vaccine for hepatitis C.

9. Are blood-borne viruses a problem in the AMC?

YES. According to the 2010 Inmate Health Survey, 48% of prisoners who took part in the survey had been exposed to the hepatitis C virus. There have also been 9 documented cases of in-custody transmission of hepatitis C at the AMC.[9]

10. Is needle sharing a problem in the AMC?

YES. Sharing needles is the primary manner in which hepatitis C is spread in prisons and in the community. Syringes have been found by staff in the AMC[10] and it is believed that almost all cases of in-custody transmission of hepatitis C at the AMC are attributable to the sharing of injecting equipment.[11]

11. Can't we just keep drugs out of the AMC?

NO – no prison has been able to. When the AMC first commenced operations, the ACT Government intended to keep drugs out. The intention was to create the world's first drug-free prison. That is why a NSP was not introduced initially. If there was an effective and cost-effective manner of stopping drugs getting into the AMC, the ACT Government would have attempted this by now.

12. What approaches currently exist to keep drugs out?

Despite current efforts, we know that drugs are available in the AMC.
Reported findings from the 2010 Inmate Health Survey indicate that half of prisoners find illicit drugs either "easy" or "very easy" to obtain.[12] Introducing measures that would guarantee drugs do not enter the AMC are likely to be far too expensive and far too restrictive of prisoners and staff to be justifiable.

13. What would need to be done to keep drugs out of the AMC?

Drugs and other contraband are smuggled into prisons by visitors, staff and other people entering. Contraband enters by being concealed within body orifices and in food and other materials brought into the prison. The Moore Report suggests that to effectively ensure that no drugs enter the AMC, there would be close examination of all food entering the prison, body cavity searches of everyone entering the prison (including staff), and cessation of private visits for prisoners. Such efforts would be extremely costly, severely undermine efforts to rehabilitate prisoners, and represent a substantial breach of human rights.

14. Won't prisoners use more drugs if they can get needles?

NO. Evidence from NSPs in the community indicates that making injecting equipment available to people who inject drugs does not lead to increased drug use. The same can be said for prison NSPs where international evidence shows that no increase in drug use has been found among prisoners where NSPs have been implemented. Additionally, it is important to remember that providing sterile syringes to prisoners does not limit the current efforts to keep drugs out of the AMC.

15. Are there other countries that have NSPs in prisons?

YES. In 2012 prison NSPs are operating in ten countries in Western Europe, Eurasia and the Middle East. In 2009 there were NSPs in 50 prisons in 12 countries.

16. Won't the needles be used as weapons?

There has not been one single reported case of syringes being used as weapons in a prison anywhere in the world where a NSP has been introduced. To that extent, prison NSPs can be considered to contribute substantially to institutional safety. [13] Syringes exist in the AMC now, and there has not been a report of a syringe being used as a weapon.

17. Isn't having a needle and syringe program just giving up on the drug problem?

NO. Just as NSPs in the community are seen as one part of multiple approaches to dealing with the harms caused by drugs, prison NSPs should be viewed in a similar light. This is why NSPs are an important component of the National and ACT Drug Strategies. These strategies commit to the principles of harm minimisation that encompass supply, demand, and harm reduction measures in concert with law enforcement. Regulated access to sterile injecting equipment in the AMC will help to mitigate the harm caused by drugs. It will work in conjunction with the breadth of other approaches to dealing with drugs in the AMC such as the suite of

programs providing treatment, monitoring of visitors and staff, and penalties for prisoners found in possession of contraband.

18. Why should I care if a prisoner gets hepatitis C or HIV?

You don't have to – but almost all prisoners eventually return to the community. In the ACT, as with all other Australian jurisdictions, most prisoners return to the community within 6 – 12 months of entering prison. This means that the problem of blood-borne viruses becomes a public health issue for the community. Additionally, "[t]he failure to reduce the risk of hepatitis C and other blood borne viral infection transmission in prisons severely undermines the work being conducted in the community with injecting drug users."[14]

Once in the community, blood-borne viruses can have devastating effects upon a range of community members. Take for example the comments from Professor Penny and Dr Wodak, leading Australian HIV experts:

> *"The risk of HIV in injecting drug users is not limited to themselves but to their sexual partners and, tragically to their children. In New York City, which has a population about the same size as New South Wales but rampant HIV among IDUs [injecting drug users], more than 17,000 pediatric cases of AIDS have been reported, compared to 42 in New South Wales.*
>
> *These pediatric cases in New York City were in almost all cases the direct result of one or other parent being an IDU. There is a serious risk to Australian children of HIV infection acquired from their parents should an uncontrolled epidemic erupt among IDUs, if present programs are curtailed"*[15]

19. I have heard there is not enough evidence to support an NSP in the AMC, is this true?

NO. Prison NSPs have been introduced in 12 countries and have been extensively evaluated. The overwhelming weight of this evidence shows that they are safe and, when used, effective at reducing the spread of blood-borne viruses. In fact, prison NSPs are the single most effective means of preventing the spread of hepatitis C in prison populations.

Take, for example, an evaluation of a NSP in Pereiro de Aguiar prison in Spain. An evaluation of their NSP after ten year of operation showed that the prevalence of hepatitis C in the prison population had dropped from 40% to 26.1% and the prevalence of HIV infection had dropped from 21% to 8.5%.[16] This coincided with the perception among staff that there had been no increase in drug use or injecting in the prison. These types of findings have led a number of organisations to recommend the introduction of a prison NSP into the AMC.

20. What international organisations advocate for prison NSPs?

A range of international bodies with responsibility for developing an international response to drugs and blood-borne virus transmission have indicated strong support for prison NSPs as one of many methods to reduce the spread of hepatitis and HIV/AIDS in prisons. These include the United National Office on Drugs and Crime,[17] the World Health Organization, and the Joint United Nations Programme on HIV/AIDS.[18]

21. What Australian organisations advocate for prison NSPs?

A range of Australian organisations have called for NSPs to be introduced in Australian prisons.

The Australian National Council on Drugs (ANCD), the primary advisory council to the Australian Government, appointed by the Prime Minister, has recommended:

> "That each jurisdictional department responsible for the management of prisons and juvenile detention centres, in consultation with staff, health authorities and relevant community-based organisations, develop occupationally safe and culturally appropriate policies, protocols and procedures regarding the introduction of trial needle and syringe programs within at least one of its prisons and juvenile detention centres."[19]

Other Australian organisations that advocate for the introduction of NSPs into Australian prisons include:

- Alcohol and Other Drug Council of Australia
- Anex
- Australian Drug Foundation
- Australian Federation of AIDS Organisations
- Australian Injecting and Illicit Drug Users League
- Australian Medical Association
- Australian Health Ministers Conference
- Australasian Society for HIV Medicine
- Australasian Therapeutic Communities Association
- Drug and Alcohol Nurses Association
- Hepatitis Australia
- Law Enforcement Against Prohibition
- National Centre in HIV Social Research
- Family Drug Support Australia
- The Pharmacy Guild of Australia
- Public Health Association Australia
- Royal Australasian College of Physicians

In addition, calls for introducing NSPs in Australian prisons can be found in a range of national policy documents and frameworks, all of which have been endorsed by every Australian state and territory Government. These include:

- The National Hepatitis C Strategy[20]
- The National HIV Strategy[21]
- The National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy[22]
- The National Corrections Drug Strategy[23]

22. What ACT organisations advocate for a NSP at the AMC?

In the ACT, a number of reports by respected researchers and the activities of other organisations have called for the implementation of a NSP in the AMC. These include:

- ACT Council of Social Service (ACTCOSS)
- ACT Hepatitis Resource Centre
- ACT Ministerial Advisory Council on Sexual Health, AIDS/HIV, Hepatitis C and Related Diseases
- The ACT Human Rights Commission
- AIDS Action Council
- Alcohol Tobacco and Other Drug Association ACT (ATODA)
- Australian Medical Association (ACT Branch)
- Canberra Alliance for Harm Minimisation and Advocacy
- DIRECTIONS ACT
- *External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre* by the Burnet Institute[24]
- Family and Friends for Drug Law Reform
- Karralika Programs Inc.
- Public Health Association of Australia (ACT Branch)
- Sexual Health and Family Planning ACT
- Ted Noffs Foundation ACT
- Toora Women Inc
- Winnunga Nimmityjah Aboriginal Health Service

23. Won't people be less likely to get treatment and stop using drugs, if they can get needles in prison?

No. Evidence from international prisons where NSPs have been introduced indicates that prison NSPs actually improve the uptake of appropriate treatment among prisoners who inject drugs in prison. [25,26,27,28,29]

About this Q&A

The Alcohol Tobacco and Other Drug Association ACT (ATODA), the peak body for the non-government and government alcohol, tobacco and other drug sector in the Australian Capital Territory, developed this Q&A in consultation with key stakeholders. It is hoped that this document will raise awareness and support stakeholder engagement and discussion of the evidence regarding this important area of public health.

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References

[1] National Centre in HIV Epidemiology and Clinical Research (2010) Return on Investment 2: Evaluating cost-effectiveness of needle and syringe programs in Australia 2009. Commonwealth Department of Health and Ageing: Canberra. Available online at: http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-return-2
[2] Personal Communication with the AOD Policy Unit, ACT Government Health Directorate on 5 June, 2012.
[3] Tempalski, B., Lieb, S., & Cleland, C.M. Et al., (2009). HIV Prevalence Rates among Injection Drug Users in 96 Large US Metropolitan Areas, 1992-2002. J Urban Health. 86(1): 132-154.
[4] United National Office on Drugs and Crime (2009). World Drug Report 2009. UNODC: Vienna.
[5] National Centre in HIV Epidemiology and Clinical Research (2010) Return on Investment 2: Evaluating cost-effectiveness of needle and syringe programs in Australia 2009. Commonwealth Department of Health and Ageing: Canberra. Available online at: http://www.health.gov.au/internet/main/publishing.nsf/Content/needle-return-2
[6] Epidemiology Branch, ACT Government Health Directorate (2011), ACT Inmate Health Survey 2010: Summary results, ACT Government, Canberra, ACT.
[7] Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. Burnet Institute: Melbourne, Australia.
[8] Moore, M. (2011). Balancing access and safety: Meeting the challenge of Blood Borne Viruses in Prison. ACT Health: Canberra.
[9] Canberra times article. 31 May 2012. Available at: http://www.canberratimes.com.au/act-news/fresh-jail-infections-to-reignite-needle-talk-20120530-1zjjn.html
[10] Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. Burnet Institute: Melbourne, Australia.
[11] Canberra times article. 31 May 2012. Available at: http://www.canberratimes.com.au/act-news/fresh-jail-infections-to-reignite-needle-talk-20120530-1zjjn.html
[12] Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. Burnet Institute: Melbourne, Australia.
[13] Ryan J, Voon D, Kirwan A, Levy M, Sutton. (2010) Prisons, needles and OHS. *Journal of Health Safety and Environment*. 2010; 26(1): pp. 63-72.
[14] Australian National Council on Drugs 2002, *Needle and syringe programs: position paper*, ANCD, Canberra, p. 3.
[15] Sydney Morning Herald. 1997. August 19, 15.
[16] Ferrer-Castro, V., Crespo-leiro, M.R., & Garcia-Marcos, L.S. et al., (2012). Evaluation of needle exchange program at Pereiro de Aguiar prison (Ourense, Spain): ten years of experience. *Rev Esp Sanid Penit*. 14(1): 3-11. Available online at: http://www.ncbi.nlm.nih.gov/pubmed/22437903
[17] United Nations Office on Drugs and Crime (2008) *HIV and AIDS in places of detention: a toolkit for policymakers, programme managers, prison officers and health care providers in prison settings*, United Nations Office on Drugs and Crime, Vienna.
[18] World Health Organization, United Nations Office on Drugs and Crime & Joint United Nations Programme on HIV/AIDS (2007) *Interventions to address HIV in prisons: needle and syringe programmes and decontamination strategies*, World Health Organization, Geneva.
[19] Australian National Council on Drugs (2002) *Needle and syringe programs*. ANCD Position Paper. ANCD, Canberra. Available online at: http://www.ancd.org.au/images/PDF/Positionpapers/pp_needle_syringe.pdf
[20] Australian Government Department of Health and Ageing. (2010) Third National Hepatitis C Strategy 2010-2013. (2010) Canberra: DoHA .
[21] Australian Government Department of Health and Ageing. (2010) Sixth National HIV Strategy 2010-2013. (2010) Canberra: DoHA.
[22] Australian Government Department of Health and Ageing. (2010) Third National Aboriginal and Torres Strait Islander Blood Borne Viruses and Sexually Transmissible Infections Strategy 2010–2013. Canberra: DoHA.
[23] National Drug Strategy (2008). National Corrections Drug Strategy. Canberra: National Drug Strategy.
[24] Stoové, M., Kirwan, A. (2010). External component of the evaluation of drug policies and services and their subsequent effects on prisoners and staff within the Alexander Maconochie Centre. Burnet Institute: Melbourne, Australia.
[25] Dolan K, Rutter S, Wodak, A.D. (2003) Prison-based syringe exchange programmes: a review of international research and development, *Addiction*, vol. 98, no. 2, pp. 153-8.

[26] Lines R, Jürgens R, Betteridge G, Stöver H, Laticevschi D, Nelles, J (2004) *Prison needle exchange: lessons from a comprehensive review of international evidence and experience*, Canadian HIV/AIDS Legal Network, Montréal, Québec.
[27] Niveau, G (2005) Prevention of infectious disease transmission in correctional settings: A review, *Public Health*.
[28] Stöver H, Nelles J (2003) Ten years of experience with needle and syringe exchange programmes in European prisons, *International Journal of Drug Policy*, vol. 14, no. 5-6, pp. 437-44.
[29] Rutter S, Dolan K, Wodak A, Heilpern H (2001) *Prison-based syringe exchange programs: a review of international research and program development*, NDARC technical report no. 112, National Drug & Alcohol Research Centre, Sydney, NSW.