"Finding A Better Way"

A review on the policies, programs and practices currently being implemented in overseas jurisdictions to deal with HIV/AIDS, hepatitis and drug use issues both within the prison system and the wider community.

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Executive Summary

This report is the result of a Churchill Fellowship visiting a number of agencies across Europe and Canada and consulting with a number of practitioners, researchers, policy makers and service providers in the fields of public health, drug use and corrections.

The report examines the path taken by a number of jurisdictions and makes a number of recommendations that have been developed with a view to reduce the impact of HIV, hepatitis and drug use on the community as a whole. Whilst some of these recommendations may be considered contentious, it is the intention of this report to raise issues for discussion. Of particular concern is the continued focus in Australia on supply reduction measures as a means of addressing the negative impacts of drug use and the failure to continue to introduce measures that are truly based on the premise of reducing harm for the individual and the community from drug use and risk behaviours.

Accordingly, some of the recommendations include:

**Prison and the General Community**

⇒ the introduction of a trial heroin prescription programs;
⇒ introduction of a targeted campaign to encourage heroin users to smoke heroin rather than inject it, particularly in areas where needles are not available (e.g. prisons);
⇒ expansion of methadone and other drug substitution programs;
⇒ expansion of the methadone program and other drug substitution programs in both the community and prison;

**General Community**

⇒ establish injecting rooms in areas with high profile street based drug scenes;
⇒ establish clearer distinctions in the drug laws and policies in dealing with cannabis use and injectible drug use;

**Prison**

⇒ introduction of conjugal visits;
⇒ establishment of drug free units;
⇒ removal, or at least restrictions, on urine testing for cannabis use;

Introduction

This report provides a description of the prison and community policies and program responses to HIV, hepatitis and drug use implemented by Switzerland, Holland, England/Wales and Canada. Information collected from the World Health Organisation and UNAIDS on the future and world trends concerning these and related issues is also presented.

The main body of the report contains five sections. Each section commences with a brief description of the country visited, its prison system and basic information on its drug use patterns. References to particular cultural traits of the countries are also introduced, where relevant. This is then followed by a description of the country's current policies and practices in prisons and the community. A discussion on the relevance and potential lessons of these responses for Australia is then presented. Finally, a set of key findings and recommendations based on the large number of professional consultations held within each country and the previous experience of the author in a range of policy and program developments within the public health, drug treatment and prison systems is presented.

It should be understood and appreciated that this document has been prepared in a manner that is intended to provided clear, descriptive and generally practical measures to reduce the negative impacts of blood borne communicable diseases and drug use in our prisons and community. Although some of the findings and recommendations may be considered to be controversial, contentious or difficult to implement, they have been included. This is to allow those persons with responsibility in the areas of public health, drug use and prisons the opportunity to read a reasonably concise and experienced account on the lessons that can be learnt from overseas jurisdictions and the measures that need to be seriously considered and discussed in order to address and improve the situation, as it currently exists within Australia.

Furthermore, whilst this report is not presented in a scientific or formal research format it should also be noted that a large volume of valuable information and documentation was provided by all countries and agencies visited and this report represents a distillation of this information into a brief and accessible report.
Part One

Switzerland

Switzerland has a population of over 7 million people. In general terms, Switzerland is a small country divided into German, French and Italian regions. Although the Swiss themselves often consider their country to be reasonably conservative, its political structure and host of international organisations allow for a strong emphasis on progressive and humane approaches to many of the problems raised by social, health and drug related issues.

The country itself is administratively divided into 26 Cantons, with each having responsibility for implementation of drug and prison policies. The role of the Federal Offices of Health and Justice is to generally establish guidelines and recommendations for Cantons in order to establish some uniformity amongst the Cantons. However, the power of the Federal Offices over the Cantons is limited to the distribution of funds and the subsequent leverage this can provide.

The Prison System

Specifically, there are approximately 5,000 inmates in the 170 prisons across the country. The majority of prisons are small in population, particularly in comparison to Australia. In regard to the characteristics of this prison population, over half are non-Swiss nationals and have been in prison previously. The majority are male (94%) and a substantial number are imprisoned for drug related crimes. It is estimated that 3-5% are HIV positive and a much higher number are hepatitis positive (although no official figures were available).

Whilst the number of Cantons, with their range of political characteristics, results in a varying level of program implementation across the 170 prisons it can be surmised that condoms are fairly well available, methadone is generally available (especially for those received into prison on methadone), needle and syringe exchange programs exist in 4 of the major prisons (2 via the medical services and 2 via automated dispensing machines) with another 4 to establish programs in the Berne Canton by the end of 1998. Heroin prescription is available in 1 prison to a small number of inmates.

National consultative groups have been established with health, justice and law enforcement agencies to ensure that the 4 pillars of the Swiss Model on dealing with drug use (law enforcement, prevention education, treatment and harm reduction) are implemented appropriately and with a complementary rather than adversarial approach.

Community Drug Use

In regard to the level of drug use in Switzerland, it is estimated that there are 30,000 injecting drug users. Furthermore it is estimated that from this group currently 15,000 are on methadone, 1,500 in rehabilitation or detoxification programs and 800 on heroin prescription. The others are either classified as social/irregular users or continue to use regularly with little formal contact with drug agencies, although they are likely to at least be in contact with some form of needle exchange program. There is also an increasing trend amongst users to mix heroin and cocaine (known locally as cocktails) which results in users having to inject far more frequently than those just using heroin. These users are more likely to be seen at injecting rooms which fortunately has significantly reduced the rate of overdose and sharing of equipment and thus HIV or hepatitis transmission. It is also important to highlight that the availability of heroin prescription programs is actually more likely to retard the growth of this drug mixing as users are given heroin, which most actually prefer to use. It has also been noted by many drug professionals that the level of availability of heroin and its purity has increased significantly over the past few years (similar to the situation in Australia) and can now sometimes be easier for younger experimental users to obtain than other drugs like cannabis (again similar to Australia where the price trend of cannabis in relation to heroin has been significantly higher).

Heroin Prescription Programs

Currently there are 18 heroin prescription programs operating in Switzerland, although this is set to expand in the next few years. In total, these programs provide heroin to 800 individuals. One of the major programs operates in Berne (Koda-1) with 120 people attending the service up to three times a day. These centres are generally open for a couple of hours three times a day and sometimes also have methadone available for those clients having trouble injecting. All client details are entered onto a computer program including information on the dose to be given (in pre-filled syringes). Any person wishing to enter the program is thoroughly assessed and must have repeatedly tried - and failed - at other treatments (eg methadone, counselling, rehabilitation etc). The dose is established in discussions with each client and in most programs case management exists. Basically, these programs are for the intractable or long term “hard core” users only. This program is not an option for new or casual users of heroin.

Some of the results of Koda-1 and Project-H (a smaller program in nearby Thun) include the following:

- there has been a measured and statistically significant reduction in the level of criminal activity engaged in by clients
- the number of overdoses has been significantly reduced (clients are also alcohol breath tested before receiving their heroin to ensure that the risk of overdose is reduced)
• a significant number of clients are able to obtain and keep employment (generally part-time)

• there has been very little trouble at the programs - this is believed to be a result of giving clients what they want (ie heroin) and making it clear that any problems either at the centre or nearby may result in the person being removed from the program and thus result in their access to heroin also being removed

• whilst the majority of clients initially come to centre three times a day, over time many reduce their intake to twice a day (either because of the pure heroin they receive at the centre rather than the variable purity of street heroin or because the reality of their drug use becomes clearer and leads to a self imposed reduction)

• the average dose is 430mg a day.

• counselling is available at all programs.

• there is no limit to the length of time that people can stay on the program. There has however been a disincentive for people to leave the program, because of the limited spaces available. That is, if someone tries abstinence they will have to re-join a waiting list if they fail.

• the clients contribute a modest amount each week to the cost of the program (less than 30% of the cost)

• of the 70 clients that have been to the Thun centre over the past four years;
  ➢ 8 - 12 have become abstinent and 10 have moved back to oral methadone
  ➢ there has been only one case of confirmed HIV seropositive conversion (acquired sexually from a long term positive partner)
  ➢ none of the clients are homeless (previously 18% were homeless)
  ➢ the unemployment rate has dropped from 78% to 28% (with 15% being employed on a full-time basis)
  ➢ the Manager of the Thun centre for the past 4 years has seen significant improvements in clients health and social situations, with clients achieving many of the goals established in the case management process
  ➢ the local police also now acknowledge that there has been a significant decrease in the level of street based crime since the centre began operation, they also agree that the clients at Thun, whilst previously involved in the majority of this crime are now rarely involved in such crime.

• it is acknowledged by most professionals in this area that the reduction in crime committed by these clients has also resulted in a reduced level of imprisonment

Reports and evaluations of the community based heroin prescription program have shown a decrease in the number of clients involved in criminal activity from 70% to 10% since its inception a number of years ago. The level of police co-operation with the program has also increased significantly due to the strong results of the program in reducing criminal activity, the majority of which was street based.

It is now envisaged that heroin prescription will be normalised as a form of treatment by the end of 1999 when Swiss legislation will be amended to allow the program to expand from its current client capacity of 800 to over 1,500. It will nonetheless still be a tightly controlled program to ensure the current success of the program is maintained. Since the referendum on harm reduction policies in 1997 there has been an increasing level of public support for the program as the cities with programs have shown a noticeable decrease in both street based drug dealing activity and crime. With reductions in both these areas being warmly welcomed by the public.

Prison Based Programs

As stated earlier, the programs in prison also vary from Canton to Canton. Nonetheless some of the more innovative programs include needle exchange and heroin prescription in some prisons. A description of these two programs follows below.

In the Hindelbank Prison for women over 60% of the 93 inmates have been jailed for drug related crimes.

On the first occasion of testing positive to drug use inmates are cautioned and counselled. This is in order to initially try and motivate inmates to do something about their drug use rather than use sanctions or penalties immediately. Inmates are also subject to lesser penalties if they admit to drug use and thus save the prison authorities money on testing.

There is also no urine testing for cannabis. This is due to a belief that cannabis represents a far less problematic drug in terms of public health and good order of the prison. Nonetheless, cannabis is confiscated if found by staff and is not permitted to be used by inmates. Whilst this may be seem contradictory there is an understanding that the testing and punishment of cannabis use will only serve to move inmates to use drugs that are less detectable (eg. injectibles) and thus create potential serious health consequences and create a bigger and more dangerous market for syringes and heroin in the prison.

In relation to the syringe exchange program, inmates with a history of injecting drug use are provided with one dummy syringe on reception. The safe use and storage of this syringe, which can be exchanged via discreetly located vending machines, are explained to all recipients of the syringe. Since 1995 there have been no incidents involving misuse of the syringes and inmates have complied with all the storage requirements (in a glass in
cabinet above the basin in their cell). There has also been no record of any inmate commencing injecting drug in prison because of the availability of the needles and syringes in the prison.

Staff support for this program was initially non-existent. Many staff were concerned about the potential for misuse, particularly against prison staff by inmates, however, over time the level of support has grown significantly. This rising support has been a result of staff being at a lesser risk from needlestick injuries (as injectors no longer need to secrete syringes) and is demonstrated by a recent proposal where staff offered a 5% pay decrease to ensure the co-ordinator of the program was maintained on staff when budget difficulties were faced by prison management.

The male prison at Oberschongrund offers heroin prescription (since 1995), methadone and needle and syringe exchange (since 1992) via the medical and social services within the prison. Of the 76 inmates, at the prison 9 are on the heroin prescription program and 15 - 20 are on methadone.

There have also been no acts of violence or threats of violence with needles and syringes since the program was introduced in 1992. Inmates requiring syringes are able to confidentially see a doctor at the medical service to initially obtain or exchange their syringe. Indeed, staff of the prison have noted that the level of drug related violence (standovers, prostitution etc) has been significantly reduced with the introduction of these 3 programs (methadone, heroin prescription and needle exchange).

Again there is no urine testing for cannabis for public health and good order reasons although it is confiscated if discovered. This decision was in fact reached after discussions with inmates revealed that testing for cannabis will only serve to "push" inmates to using injectibles which would be of benefit to no-one. There is an understanding that many of the inmates are incarcerated for drug related crime and some, if not many, will continue to use drugs given the opportunity. Accordingly, it was agreed that it serves all interests best for the prison not to be as hard on non-injectible drugs as injectible drugs.

In regard to the needles and syringes provided by the prison, these must be kept in a designated place (the cabinet above the wash basin). There are severe penalties if syringes are found in any other location. These penalties are even more severe than those for possession of drugs and serve to encourage inmates to be responsible with the syringes that are provided.

In relation to the heroin prescription program, inmates received who are part of the community based program are eligible, as are inmates with a history of having failed on other drug treatments (although numbers are limited by funding arrangements to only 9 inmates with a fairly constant waiting list of 4-5 people). Inmates on this program are brought to the medical centre where they are given pre-filled heroin syringes for self-injection in the room (limited to 3 inmates at one time) three times a day. The program operates exactly as that in the community although an officer, as well as nurse, are always present whilst the inmates are injecting. Some of the results noted by staff are that inmates on the program have an improved prison based work performance and they are no longer involved in the violence or problems created (especially at visits) with trying to obtain illicit heroin to inject whilst in prison.

It also needs to be reported that there is a range of opinions amongst executive and senior prison staff on the validity or usefulness of the programs in Hindelbank (needle exchange) and Oberschongrund (needle exchange and heroin prescription). The contradiction of imprisoning people for drug use and then providing these same people with the same drug that led to their imprisonment remains a much discussed issue for many prison staff.

Although Hindelbank and Oberschongrund Prisons display a tolerant attitude to drug use within prisons (to both injecting drug use and cannabis), this cannot said to be the case throughout all of Switzerland's prisons. In most prisons there are no needle exchange or heroin prescription programs and there is urine testing for all drugs, including cannabis, with prescribed penalties in place. However, the political power of each Canton makes uniform policy difficult. Although, the Fribourg Centre for Training of Penitentiary Staff is now addressing this situation to an extent through the provision of centralised and specialised training.

The area of agreement across all the Cantons health and justice portfolios in relation to prisons appears to be that a range of programs is required, including some innovative and experimental programs, as the majority of prisoners either have direct or indirect drug related problems.

Injecting Rooms

Although injecting room programs can be just as controversial, if not more so, than heroin prescription, they are seen to play an important role in the myriad of programs provided in the community. The success of the injecting rooms (where injecting drug users are provided with injecting equipment and a safe place to inject) appears to be highly related to the location (that is, more successful and appropriate in areas of high and visible street based drug scenes - such as Kings Cross in Sydney - and not in suburban areas where methadone, needle exchanges and heroin prescription programs can operate with a measure of anonymity). These programs significantly reduce the risk of overdose, as well as, removing the unwanted public menace of injecting drug users having to use drugs in the streets. They also provide a safe area for youth, sex workers and other vulnerable street people involved with injecting drug use.

However, the problem with injecting rooms, as opposed to heroin prescription programs, is that drug dealing can occur near the premises. This can create a range of obvious public perception problems, which is why the locations need to be carefully assessed. Nonetheless, this is far preferable, in public health terms, than the development of "shooting galleries" in disused and derelict buildings with all the associated health and hygiene problems.
Part Two

Holland

Holland has a population of over 15 million people in a country that is administratively divided into 11 regions. The Dutch population can be generally characterised as having high levels of migration from previous Dutch colonies and other areas of Europe and Africa, resulting in a culturally diverse community, particularly in the major cities. The Dutch are also well known for their often innovative and pragmatic approach to a variety of difficult circumstances and controversial issues including drug use and the sex work industry.

The Prison System

In regard to the Dutch prison system, there are over 12,000 inmates (with about 35,000 receptions per year) housed in 40 prisons across the country (as well as 12 custodial psychiatric institutions). In the past few years there has also been a fairly substantial rise in the number of inmates in the Dutch prison system. Males make up the majority of the population (96%) and the size of the prisons range from around 50 to over 700 beds. Each prison is under the control of the Federal Justice Ministry including the medical services although prison doctors appear to have a high level of discretion in some issues such as whether to provide methadone prescription, than exists in the New South Wales prison system. A large number of inmates are also in prison for drug related charges with over 50% being estimated to be imprisoned for direct and indirect involvement with drugs.

Inmate testing for HIV is low compared to most countries although it is estimated that around 5% of the inmates are HIV positive. There is actually an ongoing debate as to whether HIV testing should be encouraged amongst inmates as many professionals believe that the prison environment is not conducive for inmates having to deal with positive results. In contrast, a smaller number of professionals believe it may provide the catalyst or opportunity for inmates to address lifestyle issues that can affect their health status. The same debate is now surrounding hepatitis C testing in prisons. Nonetheless, rates of hepatitis C are believed to be significantly higher. Condoms are generally available (via clinics, vending machines or buy-ups) although access appears variable with very low levels of distribution being the norm in most centres. Whilst there is a significant level of education available in the prison system there are no needle exchange programs available.

The Dutch also allow conjugal visits between some sentenced prisoners and their partners every 3 weeks, at which condoms are provided. This is a program that prison staff believe contributes significantly to reduced sexual activity and assault amongst inmates and can be used as a management or incentive system for better inmate behaviour.

Drug Free Units

In many Dutch prisons there are also Addiction Guidance Units (previously known as drug free units) that exist in the prison. The programs in these centres are often operated by community based agencies which also operate residential programs in the community. In these units inmates are encouraged and expected to make contact and attend these centres upon release. The programs operate on a principle that the inmates are attending voluntarily and have expressed a desire (as well as concrete goals) to amend their drug using behaviour. There is a urine testing program that is part of the program and on testing positive for cannabis or other “soft” drugs inmates are given a warning, on the second positive test inmates are removed from the program. On testing positive for heroin or other “hard” drugs the inmates are removed from the program on the first occurrence. Employment and vocationally based training also forms an integral part of the program and is conducted in close co-operation with employment agencies to enhance employment or further training opportunities on release. Community based agencies in a range of areas including drug treatment services are also given regular access to inmates in the program. The program generally is of 3-6 months duration with inmates nearing the completion of their sentence being encouraged to attend.

In general, there are increasing links between methadone and drug treatment clinics and prisons (including police cells) being established in order to offer a continuity of treatment. As many doctors are not well trained on the nature of the prison clientele and their public health and drug use characteristics, prisons are increasingly contracting public health units and drug treatment centres to provide medical and treatment services for prisoners rather than generalist practitioners. Education of all inmates, including those in drug free units, issues of public health, drug use, communication and relapse prevention is also provided by outside agencies in the health sector.

In general there is a targeted and random urine testing program for drugs in the prison system. However, whilst urine is also tested for cannabis, penalties are less severe than for injectable or harder drugs. Authorities also acknowledge the difficulty of testing for drugs which have wide variations in the period of detection. A number of staff also acknowledge that cannabis use by inmates presents fewer problems than harder drugs although it is understood that drug trade of any type in prison creates its own set of problems.

An interesting program in regard to the sentencing and imprisonment of inmates also occurs in Holland. That is, people convicted of minor crimes who are given custodial sentences are advised of the dates of the term of imprisonment (usually starting 6 months after the court date) in order to put their affairs in order (work, home, family etc) and thus significantly reduce the stress on both the person and the system when the inmate is received into the prison. People who fail to attend the lower classification of prison (half-open or open) on the appointed date are however immediately classified to a closed or maximum prison to serve their sentence.
There also appears to be far less violence in the Dutch system (compared to Australia) because of the decision to get prison staff (officers in particular) to work more closely with inmates rather than just secure them in the prison. Interestingly, the specialisation of staffing to allow officers to either work as security personnel or case management staff or escort staff etc (a process which began about 15 years ago when the military rank system that characterises NSW also existed) has fostered an even better environment for reduced violence. Officers working with inmates are paid at higher rates and are also able to wear civilian clothes which reduces the usual officer - inmate barriers even further. However, all officers are trained in techniques to de-escalate violence and are encouraged to work in a case management style with inmates. Training programs about HIV and hepatitis infection are also given to all staff.

Community Injecting Drug Use Programs

It was noted at many agencies that there is a distinct preference amongst heroin users to smoke (“chase the dragon”) rather than inject heroin. This preference appears to be cultural with the influence of people with a Surinamese background being an important factor. This preference has however also been reinforced by campaigns to encourage heroin users to smoke the drug because of the reduced public health risks this poses compared to injecting. One of the major campaigns, run by the organisation Mainline was known as “Switch” and appears to have been quite successful in maintaining smoking as the preferred method of use despite the overwhelming increase in injecting across most other countries in the world. Currently, there is evidence that the level of injecting drug use in Amsterdam has actually fallen from 8,000 persons to 6,000 persons over the past few years with an estimated 70% of heroin users being smokers.

This preference of drug administration also results in needle availability being less important in the prison system than is the case for most other countries. A view confirmed by prison authorities who report very few needles being found or confiscated across the system each year. A flow-on effect of this situation has however been restricted availability of bleach, despite its importance for a range of hygienic practices other than disinfecting syringes. It should also be noted that some level of injecting does occur in the prison system.

Medical clinics, including methadone programs, for street workers and drug users are also available and a heroin prescription program was scheduled to commence in June 1998. The heroin program is to be operated as a clinical trial with 2 control group programs. One group will receive heroin only, one group will receive oral methadone only and one group will start on methadone and then change to heroin. The trial is scheduled to last for 12 months and will involve approximately 800 people across a number of clinics. The heroin users will also be able to choose to either smoke or inject heroin although switching between the 2 methods of administration will be limited once a choice has been made by the client.

In regard to sex workers, it is acknowledged by professional staff that the increasing use of cocaine by this group is work related. That is, the preference amongst workers appears to be for heroin but cocaine is used to allow them to work for longer periods and thus acquire enough funds to support their heroin addiction. Whilst there is a sanctioned system of sex work (via authorised brothels etc) a separate system is also acknowledged to exist amongst drug users who work on the street. In order to both reduce the incidence and impact of this type of street based sex work the local authorities in Amsterdam (including police) have established an area especially for street sex work to occur. It is in an industrial area and is protected by police and provides access to outreacher health workers. Unfortunately this area is well outside the centre of Amsterdam and due to transport problems is not as well patronised by the sex workers as was hoped. Nonetheless some street workers are now able to work in an area with a much higher degree of safety and with good access to a range of health and social based services.

The attitude of “Care not Cure” (coined by Marteen Van Doorninck) is an increasing attitude of professionals in this area. That is, like mental illness, drug addiction needs to be treated as an ongoing condition for some people and so the goal of cure may be inappropriate. In effect, authorities may need to recognise that for some people a goal of ongoing care and health maintenance is more appropriate. This is particularly the case for the group that would benefit greatly from programs such as heroin prescription.

Dutch Drug Policy

The Dutch drug policy provides a clear distinction between “soft drugs” (cannabis) and “hard drugs” (heroin, cocaine etc) which has created a situation where people are able to purchase cannabis through licensed coffee shops and grow a limited number of plants for personal use. Possession of cannabis whilst technically illegal is thus generally tolerated by police and the community. The result of this policy has not led to a huge increase in the number of “hard drug” users but rather a reduction. This is explained by the majority of Dutch youth being able to distinguish between the impact of various drugs and their effects in both the short and long term. In fact it is now clear that the average age of heroin users is well over 35 years with a much lower number of youth becoming involved in this type of drug use than is the case in nearly all other countries.

The cannabis “coffee shops” are also seen as not providing a gateway to harder drugs. In fact many professionals believe the opposite has been the case. That is, any harder drug sales on or near these premises is not tolerated by police or the coffee shop owners. Indeed the closure of the coffee shop if it is involved in any way with other drugs provides a strong business incentive for owners to also police such activity. The fact that those people wishing to use cannabis (often youth) are not required to come into contact with the sellers of “hard drugs” to purchase the “soft drugs” is also seen as reason why there is less harder drug use amongst Dutch youth.

The average age of injectors has been increasing every year and is now estimated to be 38 years of age. The reduction in new injectors is attributed, in part, to the soft and hard
drug distinction in Dutch drug policy. Even the number of needles given out in Amsterdam has been steadily declining for the past few years and has gone from a peak of 1,000,000 needles to 500,000 needles per year. Injectors are also encouraged to exchange needles free or with a small payment if needles are required without exchange. However, the current laws in Holland allow this policy to be implemented by not permitting charges against users possessing needles. The needle exchanges sometimes also provide a drop-in centre and in some cases showers, laundry services etc., at a small charge, to assist users and street people.

In general the drug scene in Holland differs not only in the method of administration of drugs (ie smoking is preferred to injecting) but also in the trends being noted in the actual drugs being used. Basically, there has not been a significant increase in the level of heroin use although an increase in the free basing of cocaine is a concern for authorities. The resurgence of heroin as a popular drug has not materialised in Holland.

Recent information has also been published which shows the success of the Dutch drug policies. For example:

- the rate of cannabis use by high school students was higher in the USA (23.7%) than in Holland (18.1%)
- lifetime use of cannabis by 15 year olds was higher in the UK (41%) and USA (34%) than in Holland (29%)
- in regard to heroin use there are 430 heroin users per 100,000 people in the USA whilst there are only 160 heroin users per 100,000 people in Holland
- Holland spends only $27 per capita on drug related law enforcement whilst the USA spends $81 per capita.

Injecting & Smoking Rooms

The establishment of injecting (and smoking) rooms for harder drugs like heroin and cocaine has also occurred in some areas of Holland. The program in Arnhem operates in close co-operation with a methadone program and with the support of both health, police and business authorities in the area.

Specifically, clients must register to use the rooms and injectors and smokers are provided with access to different rooms and provided with clean injecting equipment. The centre also provides shelter, laundry and food services for clients are prohibited any drug dealing on the premises. In keeping with the characteristics of the Dutch drug scene the clients tend to be older with an average age of well over 30 years.
Part Three

England & Wales

The United Kingdom has a population of over 60 million with England contributing over 48 million people and Wales over 3 million people. As would be expected there are strong traditional links between the United Kingdom and Australia and there are many cultural similarities that exist.

The Prison System

Her Majesty's Prison Service covers around 135 prisons throughout Wales and England and has custody of over 65,000 inmates although there are over 140,000 receptions each year. The service is very similar to NSW in terms of structure and operation (even prison architecture) although the health services are under the control of the Prison Service.

The Prison Service has seen a substantial increase in the number of people entering the prison system - from a population of 40,000 in 1983 to over 65,000 in 1998. The number of inmates in custody for drug related crimes is also estimated to be much higher in this period of time.

In some prisons, regular public health clinics, operated by external health agencies within the prison clinic, offer inmates confidential services including testing and counselling. Community agencies are also contracted to provide HIV and drug and alcohol related services. Whilst this provides definite advantages in terms of confidentiality and ability to gain inmate trust quickly there are issues of wider concern that need to be taken into account. Specifically, this includes the ability of these agencies to become involved in any wider or uniform policy or program discussions and developments from the position of outside contractors. There are also concerns with the staff of these contracted agencies fully understanding the constraints and workings of the prison system.

Perhaps the best solution to this issue, and indeed the general issue of privatisation in prisons and the role of public sector administrations, is the establishment of separate business units within the overall Prison Service (eg Communicable Diseases Service or Drug & Alcohol Services). These services would then be able to operate as both part of the organisation by providing policy advice and other corporate services and yet also be able to be contracted by each prison to provide a certain level of service, in accord with contractual obligations, within a dedicated budgetary framework. The sale of services to other agencies or jurisdictions would also be possible under this model.

An admirable feature of the Prison Service, is that it now conducts a range of audits (both internal and external) on the operations of prisons including the health care. The health services in prison are sometimes internally audited by a health services team that on short notice is able to review a sample of medical records, interview staff and provide inmates with a questionnaire. Suggestions of improvements to the service are also sought by the review team. There is also the Inspectorate of Prisons that is able to conduct reviews at any time within a prison to ascertain the quality of service delivery and compliance with policy and procedure in all areas of prison operation, including health care. These audits are an important tool in maintaining minimum standards within the prison service.

Although to operate effectively, the review team needs to be involved with the appropriate level of authority to gain access and report on the activities performed within the prison. Drug free units have also been established at many English prisons and offer inmates opportunities to address drug use in a supportive and positive environment. Testing contracts are also part of the arrangement for entry into these programs.

Prison Urine Testing Program

At face value the recent results of the English random mandatory drug testing show a decrease in cannabis use and stable heroin use. However, both scientifically and statistically these figures from the program have been shown to underestimate the level of drug use. The impact of the testing program on actual drug use in prison is also questionable as the program must be truly random to be of use as a predictive tool. In addition, not to have a trial where punishments are given in some centres but not others also fails to establish whether the program itself has actually been responsible for a decrease or whether it is other factors (such as availability etc)

Independent scientific evaluation is an extremely important part of any new trials or programs introduced such as urine testing, heroin prescription, drug courts etc. The use of randomised trials to determine the actual impact of the new programs is vital if objective assessments are to be obtained.

British Based European Network

As part of the European approach to prison issues a formal network of services targeting communicable diseases and drug use has been established in London, some of the findings from this network are as follows;

♦ There are expected to be 10 needle exchange programs operating with prisons in Europe (Switzerland, Germany and Spain) by the end of 1998.

♦ Success with drug users in the prison system appears to be heavily reliant on the ability of the system to re-integrate inmates into general society and link them to appropriate community based agencies.
♦ Prisons in the Lower Saxony region of Germany do not test for cannabis.

♦ Most European countries have targeted rather than mandatory random drug testing programs. People who test positive are sometimes referred to treatment though this may not be possible or appropriate for the large number of prisoners which can test positive for cannabis.

♦ Hepatitis C will be the next big problem - there is a need to identify carriers (now available via a simple saliva test) and target these people for education, especially those with long sentences.

Community Programs

There has been an increasing trend of heroin use in England which has been exacerbated by the high cost of cannabis relative to heroin. A trend that is similar to that experienced in New South Wales and other parts of Australia, although in England smoking heroin seems to be increasing in popularity especially with younger age groups.

Recent reports suggest that public support for needle exchange programs is dropping in England. This current pressure on needle exchange programs is due to the misconception that HIV is no longer a problem and that hepatitis C is so well established in the injecting drug use community that it is impossible to do anything effective to reduce the rate. It is also based on the misconception that needle exchanges have failed in their goal to reduce the level of drug use within the community, despite the clear role of the program being the reduction of HIV infection, which it has done quite successfully and efficiently.

It must be remembered that, in part, HIV prevention, particularly among injecting drug users and thus the wider community, has been successful because of the important work done by needle exchange programs. Additionally, although hepatitis C is well established this is because the needle exchange programs were unable to educate injectors of its existence and transmission for the most part. The exchanges now have a crucial role in educating new and young injectors on how to maintain a negative hepatitis C status if the rate of infection is ever going to see a decline.

If needle exchanges are to effectively educate injectors on hepatitis C then it needs to be done in detail and in person with each client. The level of detail and understanding required by clients if they are to remain hepatitis C negative is highly high and necessitates this level of intensive interaction. The expansion of the pharmacy scheme and secondary outlets, whilst increasing access to sterile injecting equipment also undermines the level of contact required to address hepatitis C. Messages of simply "don't share" are not enough and time with the individual is required to explain the potential areas of transmission. For example, the preliminary results from a recent British survey on injection sharing by drug users shows that their interpretation of sharing equipment can be vary greatly. Sharing with partners and close friends is still very high although the chances of infection are limited due to the restrictive nature of these networks. Exchanges may need to work to contain sharing to these restricted networks or just partners to effectively address the situation. The implication of this interpretation does however raise serious questions for prisons in that people outside these restricted networks are more likely to mix in prison (where the definition of a close friend is different) and result in an increase in the number of infections outside these limited circles.

The links between crime and drugs also appears to be taking over the public debate and consciousness in England, rather than HIV and drugs. Accordingly, there is an increasing level of co-operation between the criminal justice system and the drug treatment (health) sector on dealing with the issue of drug use than ever before.

Innovative Programs:

The United Kingdom is currently implementing and discussing the implementation of a number of innovative programs to address drug use in the community. Some of these measures are listed and briefly described below;

♦ An arrest referral program

This is where police refer drug users onto treatment programs and services. Drug treatment agencies will also sometimes have staff based at police cells to advise and refer people onto community based treatment agencies (if they are released, bailed etc) or assist the person to access services within the prison they are being placed within (if remanded into custody). The staff member can also be in the position of assisting and advising police on dealing with drug affected persons.

♦ Drug treatment and testing orders

This is where a court can order the individual to attend a drug treatment centre during which time the individual will be regularly urine tested and which can result in a reappearance before the court for re-sentencing (usually a custodial sentence) if more than 2-3 positive tests are recorded. The order is voluntary in that the individual is given a choice if they wish to participate in treatment. It should however be noted that these treatment and testing orders if imposed on existing services are unlikely to succeed. Special new and well resourced centres need to be established to deal with these types of "bonded" clients. Care must also be taken to ensure that treatment and testing orders do not become an inappropriate sentencing option for minor drug offences but rather a true alternative to prison. That is, only cases where a prison sentence would be expected should result in a treatment and testing order being imposed, not all drug offences.
Drug courts

These are a North American phenomenon where specialised courts have been established to deal with drug related crimes. These courts are set up with specialised staff and are able to free the general courts from dealing with a range of drug cases for which expertise and understanding in the staff is widely varied. In many cases the drug courts are also able to uniquely apply the treatment and testing orders, as described above.

The establishment of a senior government position known as the “drug csar”

The “drug csar” with their specialised team to co-ordinate the national response to drug use has also been borrowed from the USA. Basically, the “drug csar” attempts to co-ordinate the response of all the portfolios involved in drug use (health, criminal justice etc) to effectively manage the country’s response. The authority of the position is clear in that it reports directly to the Prime Minister and Cabinet.

Part Four

Canada

Canada has a population of approximately 30 million people spread across a large land area. Due to its geographic location Canada is reasonably influenced by the United States of America, although it could also be argued that the nature of Canada is also, in part, characterised by its desire to be distinct from the United States of America.

The Prison System

The Canadian prison system is divided into two distinct streams. One system caters for prisoners with a sentence of less than two years, operated by provincial governments whilst the other system is for prisoners serving a sentence of two years or more, operated and managed by the Federal government.

Over 118,000 people pass through the correctional system each year, with the majority being in the provincial system (114,000). At any one time there are over 34,000 prisoners in the combined system with almost 20,000 of these people in a provincial prison. The distinction made between inmates serving a sentence of more or less than two years causes the majority of people in Canada being imprisoned to encounter the provincial system (a characteristic that would be repeated in most Western prison systems because of the majority of sentences being less than 2 years on average) rather than the federal system.

Whilst the provincial system is substantial, there are difficulties in summarising the type and levels of policies and programs available in this system. As the responsibility for this system lies with each provincial government there is a wide disparity in responses to HIV, blood borne communicable diseases and drug issues depending on the views of that administration. However, in regard to the federal system there is a far greater level of co-ordination and standardisation of policy and service delivery across all federal prisons. Accordingly, this report will focus on the issues and workings of the Federal system when discussing the prison system.

The Federal prison system is characterised:

- by housing over 14,000 inmates in 49 prisons across the country
- the inmate population being 97.5% male
- more likely to be under 34 years of age
- more likely to be single
have over 14% identify as Aboriginal

have over 36% admit to having used cocaine or heroin prior to arrest

almost half the population have previously served a sentence in prison.

A major factor in the development of a comprehensive and sometimes innovative approach to dealing with HIV and hepatitis C in the prison system has been a result of the establishment and work of the Expert Committee on AIDS in Prisons. This Committee has a wide membership from both the government sector (prisons, health etc) and the community sector (research organisations, non-government agencies etc) and has been responsible for providing advice to the government and Canadian Correctional Service on the type and quality of policies and programs that need to be delivered in the prison system to effectively deal with AIDS. This Committee has also written reports on the progress in this area and acts as an independent and important evaluator of the Canadian response.

Prison Based Programs

Like all prison systems, the Canadian system has many common and unique elements. Some of these include the prison health services being a part of the general prison system and the introduction of internal audits on HIV and related health services being conducted at each prison with the report going direct to the Commissioner.

Canada has also expanded the availability of methadone programs to provide maintenance programs for inmates. This expansion, which is set to continue, is based on an acceptance that methadone is instrumental in reducing the level of injecting drug use and therefore HIV and hepatitis infections within a prison and thereby increase safety for all staff and inmates.

Conjugal visits are also available in Federal prisons. Generally, a demountable apartment is made available, via a roster system, to inmates for a 72 hour period. The inmate is able to have their family (including children), partner or other approved visitor stay at the apartment. Furnishings, television, video, children's playground etc are provided by inmate committees and food and personal items by the inmate and their visitors. There is no specific targeted urine testing for inmates using the apartment although they could be tested at any time under the random program in place for the general prison population.

To date there have been very few problems with the program as any inmate who breaches the rules for either the prison system in general or whilst on a conjugal visit will lose their privilege to be eligible for such visits. It is also the responsibility of inmates using the apartment to keep it clean and maintained. In regard to eligibility there are restrictions, for example those with a history of family violence are not permitted to utilise the service. Condoms and dental dams are also provided in the apartment.

Condoms and bleach are available in the prisons through a variety of means as the implementation of these policies is the responsibility of each prison. The provision of vending machines for condoms and dispensers for bleach appears to be reasonably prevalent in the system with inmates (equivalent to our trusted inmate status or sweeper) being responsible for stocking and maintaining these machines.

In regard to accessing health services one system in operation is to allow inmates to place their requests for medical services in a locked box provided in each wing. The nursing staff then clear the box each evening to schedule the clinic visits for the next day. This way only clinic staff are aware of the reasons for inmate requests to see medical practitioners. A system of double enveloping and sealing medical files to travel with inmates being transferred also ensures confidentiality of medical issues.

Tuberculosis testing is also provided to all inmates on reception. An initial mantoux test is provided after which chest x-rays are provided if a positive result is recorded. A sputum test is then conducted if a positive x-ray test is recorded.

Each prison also has an identified staff member (usually nursing) to implement HIV/AIDS and hepatitis training at each prison. These identified staff are also provided with resources and regular training by Head Office.

The mandatory random urine testing program for drugs aims to test 5% of all inmates in each prison each month. The list of people to be tested is selected randomly by Head Office. There is also no real distinction between cannabis and other drugs in regard to the penalties or loss of privileges imposed for inmates recording positive tests.

In regard to the drug and alcohol programs, prison based staff in this area provide a range of programs with the national emphasis being on formal pre-release programs with a component of the program being delivered in the community, after release. In general, drug and alcohol staff are encouraged to establish and maintain strong links with community based services as well as deliver services to meet the localised needs of inmates. An interesting feature of the programs available is the distinguishing of levels of drug use (high, moderate and low) to guide the type of intervention required.

A number of professionals in Canada are also advocating anonymous HIV testing in prisons. This is where external agencies provide the testing for inmates and the inmate is then given the choice of deciding whether to inform the prison health services. The reasoning for this position is to ensure confidentiality as well as increase the level of testing (and thus information) of HIV in prisons.

The Government and prison system are also currently establishing a new committee to look into to dealing with tattooing and needle use in prisons. In regard to tattooing, it is the intention of the current administration to have the committee investigate the provision of sterile tattooing equipment at each prison. It is assumed that for such a system to operate effectively at least 2-3 inmates at each prison will need to be accredited or trained to provide tattoos to other inmates.
In regard to the introduction of needle and syringe exchange programs the committee is expected to report on the feasibility of introducing such a program into the prison system, including a review of the applicability of overseas programs that exist in prisons. If any proposal is to be taken on board then the expectation is that it will only be a pilot program with strict protocols and evaluation although the issue of staff and inmate safety remains a significant area of concern for many people associated with the prison administration.

Community Programs

Whilst Canada provides a number of programs in response to HIV, hepatitis and drug use similar to those in other countries around the world, the reported failure of the Canadian needle exchange programs to restrict the transmission of HIV amongst injecting drug users does appear to be overstated by recent reports. The increase in HIV appears to be attributable to a very limited number of needle exchanges and appears to have more to do with the enforcement of a strict one for one needle exchange policy. This policy seems to have been misguided as it proved to be inappropriate for a clientele of cocaine injectors whom require 20-30 injections per day and are more likely to be homeless and not able to store/keep needles for exchange. Nonetheless, a possible lack of educative interventions at the exchange program may have also contributed to poor needle hygiene practices by injectors.

In regard to drug use, many agencies reported an increasing trend in the popularity of heroin (particularly on the West Coast) although cocaine use remains very high in most parts of Canada particularly on the East Coast.

Part Five

Future and World Trends

The plateau of new infections for HIV in Australia has potentially created a sense of complacency amongst some policy makers. However, it must be stressed that the level of HIV infection around the world is still increasing at alarming rate. In particular, the rates in emerging economies and developing countries, especially those in Africa and the Sub-Continent are of extreme concern. Th impact on children in these areas has been devastating to say the least. THE UNAIDS facts and tables presented below highlight this tragedy.

- There were approximately 16,000 new HIV infections every day in 1997
  - Over 90% of these were in developing countries
  - 1,600 are in children under 15 years of age
  - Over 40% of new infections are in women
  - Over 50% of new infections occur in people aged between 15 - 24 years

- It is now estimated that over 30 million people in the world are living with HIV

- At current rates, it is estimated that over 40 million people will be living with HIV by the year 2000

<table>
<thead>
<tr>
<th>Region</th>
<th>Est. No. of people living with HIV</th>
<th>Adult Prevalence Rate</th>
<th>No. of Orphans Due to HIV Deaths of Both Parents</th>
<th>Percentage of Women with HIV</th>
<th>Main Modes of Transmission For Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>20.8 million</td>
<td>7.40%</td>
<td>7.8 million</td>
<td>50%</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>210,000</td>
<td>0.13%</td>
<td>14,200</td>
<td>20%</td>
<td>Injecting drugs &amp; heterosexual</td>
</tr>
<tr>
<td>South &amp; South East Asia</td>
<td>6 million</td>
<td>0.60%</td>
<td>220,000</td>
<td>25%</td>
<td>Heterosexual</td>
</tr>
<tr>
<td>Region</td>
<td>Population</td>
<td>Prevalence</td>
<td>Number</td>
<td>Percentage</td>
<td></td>
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<td>-------------------------</td>
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<td></td>
</tr>
<tr>
<td>East Asia &amp; Pacific</td>
<td>440,000</td>
<td>0.05%</td>
<td>1,900</td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Latin America</td>
<td>1.3 million</td>
<td>0.50%</td>
<td>91,000</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>Caribbean</td>
<td>310,000</td>
<td>1.90%</td>
<td>48,000</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td>Eastern Europe &amp; Central Asia</td>
<td>150,000</td>
<td>0.07%</td>
<td>30</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Western Europe</td>
<td>530,000</td>
<td>0.3%</td>
<td>6,700</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>North America</td>
<td>860,000</td>
<td>0.6%</td>
<td>70,000</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Australia &amp; New Zealand</td>
<td>12,000</td>
<td>0.1%</td>
<td>300</td>
<td>5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>30.6 million</strong></td>
<td><strong>1.00%</strong></td>
<td><strong>8.2 million</strong></td>
<td><strong>41%</strong></td>
<td></td>
</tr>
</tbody>
</table>

It should also be understood that the rates of HIV and hepatitis are closely related to the level of poverty and/or social disadvantage within a society. The fact that a number of socially disadvantaged people in Western economies are likely to encounter a prison system stresses the need to incorporate prisons within any HIV, hepatitis and drug use related strategies and programs, for the broader community.

In effect, emerging economies are equal to emerging drug markets for those involved in this illicit trade. Current policies in terms of supply reduction (eg customs and law enforcement) and demand reduction (eg public awareness campaigns and treatment programs) need to be expanded to include cycle breaker programs. These cycle breaker programs need to address both the supply and the demand for drugs by reducing the number of high level users dependent on the illegal drug market and then working with these people to reduce their individual demand level for drugs.

In Europe there is an increasing trend of illicit drug use (including injecting drug use) and this is particularly so for Eastern European countries. In regard to prisons, this has resulted in a changing prison population with drug use becoming a far more common characteristic of prisoners. In turn, an increase in HIV and hepatitis infections are expected as are problems with tuberculosis (something which is already proving to be a major problem in many Eastern European countries where the tuberculosis rates in prison being up to 40-60 times higher than in the general community).

Heroin production and trafficking also continues to increase and efforts to reduce supply appear to be ineffectual because of the money generated for both local producers (though low in our monetary terms it is high for very poor farmers) and suppliers. Basically, whilst supply reduction of drugs is important it can never be a solution within itself. It is accepted wisdom amongst free market economists that in general where there is demand a method of supply will be found. For a product with high demand and low price elasticity (such as illicit drugs) it is more likely that by successfully reducing supply the result will be an increase in price and thus an increase in attractiveness for potential suppliers rather than a corresponding reduction in demand. Given that those with a demand for drugs are more likely to resort to crime to fund their demand, the result of an increase in price is therefore likely to be an increase in criminal activity.

Given the current HIV/AIDS situation in Australia, one could be forgiven for questioning whether there is any need to review or amend current strategies and policies in dealing with drug use and prison issues. However, it must always be remembered that the figures for hepatitis C in Australia are at a level that equates to the current world trends for HIV. The crisis of infection amongst injecting drug users and prisoners necessitates reform and innovation if the cycle of drug use, crime, infection and imprisonment is to be broken. There is a world wide trend for younger age groups to be engaging in drug use and a resurgence of heroin use. This further necessitates a change to our current thinking and practice if a large group of our youth are to be spared this tragic cycle.
drugs. The historical lessons of prohibition (such as alcohol) cannot be ignored. At the very least the current situation where cannabis users are increasingly being pushed towards the injectable drugs market must be addressed. As a society we must be intelligent enough to recognise that drug use will always exist and that punishment of those addicted to drugs is not, in the main, likely to provide solutions.

The lessons from Holland with its distinction between hard and soft drugs are clear. An approach that acknowledges the differences between drugs and the impact on the individual and the community, particularly in health terms, is more likely to produce the desired outcomes on levels of drug use. Whilst the establishment of the Dutch "coffee shops" may be inappropriate for Australia, the current reliance on a penalty approach to cannabis use, in both prisons and the community, is also inappropriate.

Whatever the debate about the health effects of cannabis use it cannot be reasonably argued that cannabis use is a greater personal health and public health danger than heroin or other injectable drugs.

Prison Specific Findings

All inmates are entitled to be housed in a safe and healthy environment and it is the State's obligation to provide this environment. In fact, basic health is a right and includes proper shelter, food and safety as well as protection from infection.

If the transmission of HIV, hepatitis and other diseases is to be effectively addressed in Australian prisons then a range of measures need to be considered or at the very least trialed. It also needs to be acknowledged at this point that the current disparity of responses across Australian prisons presents problems. Whilst some jurisdictions such as New South Wales have progressed well down this path many other jurisdictions still need to initially introduce some basic and publicly available measures such as peer education, condom availability, bleach availability and methadone programs into the prison system. In fact, methadone needs to be more widely recognised as a crucial tool in reducing both drug use and injecting in the prison environment.

A current real concern for the prison system is the continued incarceration of injecting drug users. If injecting drug users continue to constitute a sizeable proportion of the prison population then the difficult issue of needle and syringe usage and availability needs to be addressed. Whilst it is acknowledged that the introduction of needles and syringes may represent a potential occupational threat to staff and inmates in the prison system, particularly given the more violent culture of Australian prisons, the fact that these implements are currently in circulation and use in prisons cannot be ignored. It seems clear that the safest methods of dealing with this issue are to significantly expand the methadone program and introduce heroin prescription programs in prisons. In this way inmates wishing to continue to inject and thus require needles will be provided with the necessary drugs and equipment, via a clinically controlled program (which reduces overdose potential and violence generally associated with drug use in prisons) and thus removes the need for those used needles currently in circulation. This method also increases the level of safety for staff as it reduces the current practice of inmates hiding or secreting needles in various locations that will eventually be searched by staff and therefore represent serious needlestick injury risks.

The other area of concern is the current widely accepted practice of prisons systems introducing random and mandatory urine testing programs without proper distinctions between the types of drug used. As stated earlier, there needs to be much clearer legal and policy distinctions between hard and soft drugs. Urine testing for cannabis in prison presents real problems by increasing incentives for cannabis users to switch to harder drugs. Cannabis is obviously much easier for prison authorities and staff to detect (due to its bulk and smell) and for laboratory technicians (given it can be detected for weeks longer in the urine than many other drugs) yet presents a much less public health risk than injectible drug use.

Accordingly, prison urine testing needs to either be restricted in its use for detecting cannabis (for example it would be appropriate in drug free units) or at the very least incentives as well as punishments for negative and positive tests are required. For instance, a positive test may result in referral to drug service rather than immediate punishment and a series of negative results, particularly by those prisoners with a history of drug use, may result in an increase in privileges rather than just a lack of penalties being imposed. The cost effectiveness of a program, that when widely applied (as is the case with current random mandatory programs), seems to only confirm that a group, with a high proportion of drug users, are involved in drug use, obliges further evaluation.

The other lessons from overseas prisons jurisdictions that require serious consideration for introduction in Australia have been previously raised in the body of this report and include:

- introducing conjugal visits to potentially reduce the level of sexual activity and violence and increase inmate management programs available to staff
- addressing the cultural environment of prisons by specialisation of staff, that is, acknowledging the differing requirements and training for those staff working with inmates and those maintaining security
- the establishment of drug free units with strong community alliances to allow inmates an environment to address their drug whilst in prison and when released
- the establishment of innovative diversion programs designed to reduce the level of incarceration of drug users
- the introduction of independent audits and inspection of prisons to ensure policy and program compliance and standards of care and treatment
- Prisons should be limited in size, preferably around 200-300 beds, to maximise both staff and inmate safety.

Recommendations

I. Implement a pilot heroin prescription program in both the community and in prison.

II. Establish injecting rooms in areas where there are high profile street based drug scenes.

III. Introduce a public education process to make the community aware of the differences between drugs and types of drug use, alternatives to the so-called "tough" policies for drug use, in particular highlighting the consequences of various drug use and law and order policies on the community as a whole.

IV. Promote a targeted campaign to encourage heroin users to smoke heroin rather than inject it, particularly in areas where needles are not available (eg prisons).

V. Increase methadone and other drug substitute alternatives in prison and the community.

VI. Expand the role of needle exchange programs to implement a greater educative intervention with users to ensure better knowledge of hepatitis C.

VII. Establish Drug Courts that are fully resourced and with specialist rehabilitation services, separate from those in the community, for users to attend.

VIII. The legal and justice systems need to be reformed to ensure a clear distinction between possession of personal use amounts of soft and hard drugs. The current impact of laws targeting cannabis needs urgent assessment.

IX. Develop a co-ordinated national approach on prison drug use, HIV and hepatitis issues.

X. Introduce conjugal visits programs for prisons.

XI. Introduce regular independent audits of the prison service (including health related services).

XII. Abandon mandatory random urine testing for cannabis in prisons, other than in drug free units.

XIII. Investigate the introduction of staff specialisation for prison staff, that is, distinguish between those working directly with inmates and those working in security only.
XIV. Introduce harm reduction measures to address the hepatitis C risk of tattooing in prisons.

XV. Establish drug free units in prisons.

XVI. The introduction of heroin prescription programs, drug courts and a number of the other aforementioned programs needs to include a component for evaluation, preferably using models based on randomised trials.

Appendix One

Fellowship Program

Switzerland 18 May - 3 June

Swiss Federal Office of Public Health (Berne)
Heroin Prescription Programs (Berne & Thun)
Prison Needle and Syringe Exchange Program (Hindelbank)
Prison Heroin Prescription Programs (Oberschongrun)
Methadone Programs (Berne)
Swiss Federal Office of Justice (Berne)
UNAIDS (Geneva)
World Health Organisation (Geneva)
Swiss Centre for Penitentiary Staff Training (Fribourg)
International Committee of the Red Cross (Geneva)
University Institute of Social Medicine and Prevention (Lausanne)

Netherlands 5 - 16 June

Justice Ministry (Utrecht)
Trimbos Institute for Mental Health & Addiction (Utrecht)
Foreigners and Sex Workers Clinic (Amsterdam)
Rainbow Needle Exchange Program (Amsterdam)
Municipal Drug Treatment Program (Amsterdam)
Health Office (Den Haag)
Scheveningen Prison (Den Haag)
Over-Amstel Prison (Amsterdam)
Maashegge Prison (Overloon)
Ter Peel Prison (Overloon)
Central Health Bureau (Arnhem)
Judicial Addiction Service (Arnhem)
The Living Room (Arnhem Injecting Room)
Methadone Program (Arnhem)
Arnhem Prison (Arnhem)
De Berg Prison (Arnhem)
United Kingdom  18 June - 6 July
Brixton Prison (London)
HM Prison Service (London)
HM Prison Service - Health Care (London)
The Centre for Research on Drugs and Health Behaviour (London)
Glen Parva Young Offender Centre (Leicester)
National AIDS & Prisons Forum (Brighton)
European Network of Drug & HIV/AIDS Services in Prison (London)
Institute of Public Health - Cambridge University

Canada  7 - 20 July
Correctional Service Canada (Ottawa)
Correctional Service Canada Health Services (Ottawa)
St Anne des Plaines Institution (Quebec)
Canadian HIV/AIDS Legal Network (Montreal)
Jamaican Prison Delegation Visiting Canada (Montreal)

Appendix Two

List of Consultations

Alex Stevens  European Network
Andre Vallotton  Vaud Canton Penitentiary Service
Andrew Ball  World Health Organisation
Ariane Schweizer  Project H - Thun
Auke van der Heide  Dutch Ministry of Justice
Christopher Eastus  Swiss Federal Office of Public Health
Cick Pouw  Scheveningen Prison
Daniela de Santis  Hindelbank Prison
David Patterson  UNAIDS
Dina Zeegers Paget  Swiss Federal Office of Public Health
Ernestine Nisingh  Public Health Clinic
Executive & General Staff  Over-Amstel Prison
Franca Steghs  Dutch Ministry of Justice
General & Medical Staff  Maashegge Prison
General & Medical Staff  Ter Peel Prison
Gerda van't Hoff  Over-Amstel Prison
Gillian Parsons  The Centre for Research on Drugs & Health Behaviour
Hanne Brasser  Scheveningen Prison
Hernan Reyes  International Committee of the Red Cross
Jamaican Prison Delegation  Study Tour of Canada
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Appendix Three

Report Distribution List

Winston Churchill Memorial Trust of Australia
Premier of NSW
NSW Minister for Corrective Services
NSW Minister for Health
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Senior Assistant Commissioner - NSW Department of Corrective Services
Assistant Commissioner - NSW Department of Corrective Services
Chairman - Australian National Council on AIDS and Related Diseases
NSW Police Commissioner
Federal Minister for Health & Family Services
Federal Opposition Spokesperson for Health
Federal Minister for Justice
Federal Leader - Democrats
Chair - NSW Corrections Health Services Board
Chief Executive Officer - NSW Corrections Health Service
Director - St Vincent's Hospital Drug & Alcohol Services
Director - AIDS & Infectious Diseases Branch NSW Health Department
President - AIDS Council of NSW
Director - NSW Users and AIDS Association
Manager - Alcohol & Other Drug Services, NSW Department of Corrective Services
Manager - Illicit Drug Services, NSW Health Department
Director - Australian Harm Reduction Centre
Chief Executive Officer - South Australian Correctional Services
Chair - NSW Parliamentary Committee on Social Issues
Executive Officer - Hepatitis C Council of NSW
Director - National Drug and Alcohol Research Centre
President - Australian Federation of AIDS Organisations
President - Australian Law Reform Commission
Executive Officer - Australian Drug Foundation
Chair - Commonwealth Drug Strategy Advisory Committee
Chair - Ministerial Committee on Drug Strategy
Parliament of Victoria - Drugs and Crime Prevention Committee

And all persons consulted for the preparation of this report, as listed in Appendix Two.
Appendix Four

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