

**THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA**

*Report by Friederike Veit – 2001 Churchill Fellow*

To study syringe exchanges in European prisons

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## ***INTRODUCTION***

The Churchill Fellowship enabled me to gain an in-depth understanding of the complex issues involved in the decision for and implementation of prison syringe exchanges (PSE) in Europe. In addition to visiting the PSEs in Germany and Switzerland, I was also able to visit a number of programs in the UK. These visits provided an added context and comparison of services for offenders with drug problems. I found that I was able to benefit from my knowledge of German in discussions with program administrators, service providers and prisoners in Germany and Switzerland. I was also able to gain additional information from the written materials not available in English.

I acknowledge the interest and support I received from a number of remarkable and dedicated people including Dr Karl-Heinz Keppler, Mr Volker Kuester, Dr David Shewan and Dr Heino Stoeber. Heart-felt thanks also to the people who supported me in this endeavour in Australia including Professor Robert Adler, Professor Glenn Bowes, Professor Nick Crofts, Dr Kate Dolan, Professor Margaret Hamilton, Professor George Patton and Gino Vumbaca.

## ***EXECUTIVE SUMMARY***

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**Project:** To study syringe exchange programs in European prisons to inform the development of these treatment options for heroin addicted Australians.

The nexus of drugs, crime and public health has been at the forefront of government and community concern for the last decade. The market for opiates has expanded in Australia with selling pressure from suppliers. The mortality and morbidity attributable to opiate use has been rising sharply despite the 'war on drugs' and all efforts of agencies and service providers involved in the health, legal and corrective systems. The cost to the community of the combined consequences of heroin use is immense.

One aspect of the toll of heroin use is the spread of blood borne viruses (BBVs) amongst users sharing injecting equipment and to their family and friends. In the community syringe exchange programs have been developed to combat this problem and these have been shown to be successful in significantly reducing the transmission of BBVs. It is well documented that drug users continue to inject drugs when imprisoned. Transmission of Hepatitis C and HIV have been proven to occur in Australian prisons, yet here are no syringe exchange programs provided in any Australian prison.

The question of prison syringe exchanges (PSEs) creates a minefield of political, legal and practical issues. In discussing the potential benefits of a trial of PSE in Australia, the outcomes of the European PSEs established in the last decade should be considered.

Switzerland, Germany and more recently Spain and Moldova have developed and implemented PSEs using a variety of models. The best evaluated PSEs in Germany and Switzerland show positive effects not only in the reduction of sharing injecting equipment but also increased referrals to drug rehabilitation programs and better communication between prisoners and prison staff. Most importantly, they also show a reduction in the transmission of BBVs amongst prisoners, and there have been no assaults or violent incidents involving syringes. Some difficulties remain and some programs show some negative results also, but the overwhelming experience in Europe has been positive.

The question for Australia is whether we want to discuss the issue and determine an appropriate way forward to protect the health of our community. The Europeans have commenced this process and may give us some clues but in the end we need to develop a response to the issues that is relevant to our systems and needs.

The opportunity provided by the Winston Churchill Memorial Trust of Australia has made it possible for me to gain detailed inside information and experience of the PSEs in Europe. I am looking forward to sharing these insights with a wide professional and community audience through this report, conferences and other speaking opportunities.

## **PROGRAMME**

Prison syringe exchanges visited:

- Germany: Vechta Women's Prison, Niedersachsen  
Dr Keppler, senior medical officer  
Chief Administrator  
A number of nursing staff, prison staff and prisoners
- Lingen Men's Prison, Gross-Hesepe, Niedersachsen  
Herr Schauer, Chief Administrator  
Frau Gross, counsellor, Aids-Hilfe  
Frau Lettau, Drug counsellor  
Herr Tieding, Nursing staff  
Frau Schulten, Drug counsellor  
A number of prisoners
- Berlin Lichtenberg Women's Prison  
Frau Kux, Deputy chief administrator,  
Frau Schwarzlow, Clinic Coordinator  
Frau Dr Friedeman, Senior medical officer  
A number of nursing staff and prison staff
- Berlin Ploetzensee Men's and Youth Prison  
Herr Fiedler, Chief administrator  
Frau Gawelysk, Unit manager, Youth Prison
- Hamburg Am Hasenberge Men's Prison, Fuhlsbuettel  
Herr Andreas Thiel, Dept of Justice, Hamburg, official  
responsible for the implementation and maintenance of  
the PSE.  
A number of nursing staff and two doctors
- Switzerland: Oberschoengruen Men's Prison  
Peter Faeh, Chief Administrator  
Deputy Chief Administrator  
Dr M Wassmer, Senior medical officer  
Two members of the nursing staff

Written information gained about PSEs:

Germany: Vierlande Prison, Hamburg

Switzerland: Hindelbank Prison  
Realta Prison

Moldova: Prison H18

Spain: six prisons with PSE

Heroin prescription program visited:

Switzerland: Oberschoengruen Men's Prison

Other establishments and organisations visited:

- Germany: University of Bremen  
Heino Stoeber, Senior research officer  
Dept of Justice, Berlin  
Volker Kuester, Senior officer, Prisons Administration  
Men's Prison, Berlin Ploetzensee  
Youth Detention Centre, Berlin Ploetzensee
- Switzerland: " Drugs and Prisons" WHO conference in collaboration with the  
Council of Europe, Berne

Organisations visited in relation to drugs and offenders

- England: Institute of Psychiatry, University of London, London  
Professor Anthony Mann
- National Addiction Centre, Institute of Psychiatry, Maudsley  
Hospital, London  
Senior Lecturer, Michael Farrell  
Professor John Marsden
- Acute Drug and Alcohol Assessment Unit, Maudsley Hospital,  
London  
Dr Una Watters, Senior medical officer
- The Adolescent Forensic Service, Gardner Unit, Mental Health  
Services of Salford, Prestwich, Manchester  
Dr Lynne Daly, Consultant Psychiatrist  
Tim McDougall, Senior nurse coordinator, Clinical  
services, Gardner Unit
- Kenyon House Drug Rehabilitation Unit, Drugs North West,  
Manchester  
A number of nursing staff
- Scotland: Department of Psychology, Glasgow Caledonian University,  
David Shewan, Reader, Department of Psychology  
Josie Galloway, PhD student

## **DESCRIPTION**

### **Germany**

Germany has implemented seven PSEs since 1995. I was able to visit four of the prisons with PSE and a youth detention centre where there was no PSE.

#### **Vechta**

Vechta is a closed women's prison in northern Germany housing 260 women including juveniles. The PSE was established by the collaboration of the senior medical officer of the prison, Dr Karl-Heinz Keppler, and the chief prison administrator. They applied to the Minister for Health in 1993 for a PSE to be officially sanctioned. The application was based on the data about seroconversion of women in the prison: in the years 1992 – 94, 13 of 23 Hepatitis B cases and 8 of 19 Hepatitis C cases were shown to have occurred in prison. The then Minister gave permission for the PSE to go ahead with a parallel research evaluation to be carried out by University of Bremen researcher Dr Heino Stoeber.

The PSE pilot project was conducted from April 1996 to July 1998 and the evaluation has been published. The PSE is in the form of five one-for-one syringe exchange machines that are installed throughout the units of the prison where inmates with drug use histories are housed. Each inmate who is assessed as drug dependent by the medical officer, is given a dummy syringe in a small plastic case and required to keep this in a specific place in her cell.

The prison health team also provides education about safer sex and safer drug use on a monthly basis to all interested inmates. The prison houses non drug-using women and women who want to abstain from drug use in drug-free units. The exclusions for the PSE are women on the methadone program, the assessment unit, the mother and baby unit and the drug-free units. Prison staff are required to attend education sessions on infection prevention, drugs and their effects, working with drug users and resuscitation.

The findings of the evaluation are that it is successful on a number of criteria. Both the inmates of the prison and the staff have positive views of the PSE. There have not been any violent episodes related to the PSE. There is no evidence of increased drug use and there have been no new infections with Hep B or C or HIV in clients who have been constant members of the PSE program.

The PSE is carried out in the context of a wider health programme that includes general medical, surgical, gynaecological and obstetric services. Counselling and mental health services are also provided. A methadone substitution programme is also available for women not on the PSE. This is monitored by regular urine drug screens to establish whether women on the methadone programme are using illicit drugs. Officially, methadone was withdrawn if urine drug screens were found to be positive, but unofficially, the medical officer informed me that he does not usually cease methadone in this situation (as this may defeat the intended purpose). The PSE is not officially available for participants in the methadone programme.

Prisoners are expected to work normal office hours from Monday to Friday. Work is paid at 20DM per day and includes garment manufacture, catering, and components

manufacture. Clients of the PSE are expected to work in the same way as other clients.

During my visit, I met with inmates using the PSE, nursing staff, medical staff, prison staff and the chief administrator of the prison. The six women I spoke with were very candid about the PSE. They thought that it was excellent and absolutely necessary.

“it’s much better in here than before the program”

“I don’t use it but it is very good for the health of the others”

There was criticism of the methadone program in that it was capped at 40 clients (only one medical officer to manage program).

“I wouldn’t need the PSE if I could get back on the methadone program”

The methadone program was officially capped at 20 but the medical officer provided the program for 40 inmates. There was obviously unmet demand for this service, highlighting medical staff resources as an important issue.

Nursing staff were accepting of the PSE as a normal part of the services provided. Dr Keppler is the sole full-time prison doctor and has been very involved in the setting up of the program. He believes that the program is essential to prevent further blood-borne virus (BBV) infections and a right of all prisoners.

I spoke with six of the prison staff who were also very accepting of PSE in the prison. The chief prison administrator has always been strongly supportive of the PSE and was a member of the founding group in 1993. Only two staff were unconvinced that PSE was necessary and were certain that there was very little drug use in their unit. They worked in the ‘assessment’ unit where all newcomers stay for 2 weeks (and where there is no PSE). This belief was contradicted by Dr Keppler who felt that many clients coming through the unit were able to access drugs and non-PSE syringes.

Dr Keppler stated that the weaknesses of the PSE at Vechta Prison were that it was not available in the ‘assessment’ unit and nor for the clients of the methadone program. The formal evaluation however did not comment on these issues. The political climate has significantly changed since the program was initiated, with the departure of the previous Minister. Despite the positive pilot program evaluation, a cautious and hands-off approach has been taken by the current government of Niedersachsen, sanctioning only a continuation of the program without any modifications or expansions to other prisons.

## Lingen

The semi-open men's prison in Lingen, Gross-Hesepe houses 331 adult men. This prison is somewhat unusual as it is 'open' during the day; that is, the prisoners are all able to mingle with each other, both inside the living quarters and outside in the extensive well-groomed grounds. At night the prisoners are locked in their single cells. An additional important issue for this prison is the relative overcrowding, the result of the fact that it must accept all prisoners sent to it by the courts. Despite these factors, the prison has an excellent history with few escapes and little violence or corruption. The prisoners here are expected to work, mostly on-site but some also working at sites external to the prison.

The PSE was established here by the prison administration in collaboration with the health services staff and the workers of the Deutsche AIDS-Hilfe (German AIDS Help - a non-government organisation which provides services to HIV positive clients and works on HIV/AIDS related issues). Here the process started apparently coincidentally, at almost the same time as the PSE in Vechta. Again, after permission was granted from the same Minister, there followed a lengthy period of information, education and discussion with staff, unions, politicians, government officials and the prisoners themselves. These formal discussion sessions were viewed as essential to generating support and acceptance of the planned PSE. The pilot project ran from July 1996 to July 1998 and is being continued.

The PSE is a hand to-hand program; counselling staff give out the syringes each afternoon as part of their 'open door' program. The syringe must be kept in a clear plastic box for safe transport and stored easily visible in the cell. The medical officers working with the counselling staff assess eligibility for the program. Prisoners can also initiate their inclusion if they declare themselves to be drug dependent. They are excluded from the PSE if they are participating in the methadone program or if they are residing in the drug-free unit.

Inmates are able to avail themselves of counselling and practical advice in relation to drugs and other matters as a part of the PSE program time. The actual exchange occurs between 14.30 and 16.00 hours each day except Fridays, when it is from 08.30 to 09.30 hours, and at the weekend when conducted by the medical staff. Once a week a 'tea room' program is held; an informal open group discussion for prisoners and health staff to discuss drug issues. These are attended by approximately 20-30 inmates per week; many attracted by the coffee and pastries! The methadone program offers 50 prisoners supported substitution with urine drug screens as monitoring and regular education and information provision. Education sessions for prison staff on first aid and drug related emergencies are provided on a regular basis.

The counselling staff are concerned that the prisoners do not regard the program as anonymous, and have worked on this issue intensively. The actual location of the PSE and counselling area is in a building away from the main living quarters and the administration and health areas. The prisoners walking to the PSE cannot be identified from other prisoners walking in the grounds. Despite this, staff believe that a sizeable proportion of the prisoners are still concerned that being in the PSE program will have a negative influence on parole arrangements, etc.

I had the opportunity to discuss these issues with two prisoners who were attending the 'tea room' group. I spoke with them on my own. They freely stated that there were about twice as many prisoners injecting drugs than were attending the PSE. They said that these prisoners were too worried about the possible consequences of

attending the PSE and that their participation would be known to the prison officials. They stated that the PSE supplied most of these non-attenders unofficially through those who were prepared to attend. They also stated that there was a generally accepted rule that prisoners procuring syringes for others would be rewarded with money or tobacco. In other words, the syringes had become a type of blackmarket currency within the prison.

The prison staff and the deputy prison administrator who was originally responsible for the implementation of the PSE, were positive about the PSE and clear that it was an important part of the prison's work.

*"We cannot in all conscience deny prisoners the possibility of avoiding Hep C infection just because they have been convicted of a criminal offence"*  
*(prison administrator)*

The PSE has exchanged 1085 syringes from commencement in 1996 until December 2000. During this time, only 26 syringes were not returned. In 2000, 66 prisoners took part in the PSE.

The formal evaluation of the Lingen PSE was also positive; no violent incidents, no staff assaults, no increase in drug use, an increase in prisoners seeking drug rehab programs, and a reduction in the BBV infection rate.

The group responsible for the maintenance of the PSE is clear in their goal to consolidate the PSE, continue to work with prisoners to overcome their concerns about lack of anonymity and to work with participants of the program to address their drug use issues.

## Berlin

In Berlin I was able to visit two prisons. The women's prison, Lichtenberg, is a closed prison and houses 105 women with drug problems and/or long sentences. It also houses young women in a separate unit. The prisoners are expected to work on site. The building is old (dating from the 1870s) and has been renovated and extended for its current use. Situated in the former East Berlin, it had a plaque beside the front entrance describing its use in the 20<sup>th</sup> century as a prison in both the Nazi and communist eras, with numerous deaths having occurred.

The pilot project commenced in October 1998 and finished in April 2001, with the PSE having continued since then. It is a machine based one-for-one PSE with machines situated in each relevant unit. After admission and assessment, women are offered the PSE program if they have a significant history of intravenous drug use and are transferred from the admission section to a drug user unit. A glasses case with a dummy syringe, ascorbic acid sachet and an alcohol wipe and an information sheet are provided in each cell. The dummy is used to draw a clean syringe from the syringe machine. The syringe is required to be stored in the glasses case in the desk drawer in the cell. Prisoners under 18 year olds and those residing in the assessment unit are excluded from the program.

The alternatives offered to drug users were the methadone program and drug-free units. This ensured that women who were not (or no longer wanted to be) drug users could reduce their exposure to drugs.

The PSE was part of a comprehensive health program provided by the health staff of the prison. The prison was fitted out with an impressive array of equipment including fully equipped dental surgeries, radiology equipment, ultrasound equipment, physiotherapy and massage rooms, and a spa for medically prescribed baths. A range of fulltime and sessional staff staffed these facilities. In addition, a mental health team worked with inmates on a needs basis.

The PSE was implemented differently to the PSEs in Vechta and Lingen. In Berlin the Minister for Justice decided to implement PSE after visiting the Swiss PSE program. The Minister then went on to convince her party and their coalition partners so that legislation could be passed by both houses of parliament. This 'top-down' approach was then gradually implemented by the officials responsible for the prisons.

Herr Kuester, a senior officer in the Department of Justice, is responsible for the Lichtenberg Prison and three other prisons. In my discussion with him, he stated clearly that the PSEs are an important part of the prison's focus on reducing the spread of BBVs. Harm minimisation is the current government's policy. In his view, the right of prisoner not to have his/her health jeopardised while in prison is clearly relevant. This right is enshrined in German law. The implementation of the PSE has been accompanied by an evaluation research project. The preliminary results at one year were positive and promising. The three year evaluation has not yet been released yet (due to a pending state election).

The deputy chief prison administrator, Frau Kux, was also clearly in favour of the PSE. She was convinced of the rights issue - that prisoners should be able to access the same health services in prison as are available in the community.

The medical and nursing staff of the prison that I spoke with were not so enthusiastic about the PSE. They felt that it was correct to offer the PSE in order to prevent transmission of BBVs, but that the PSE program contradicted many of the other

processes in the prison. The health team staff are aware of the clients of the PSE from the initial assessment phase. They also manage the methadone program, and clients are not able to participate in both programs. The methadone program is monitored by the doctor using urine drug screens and any positive urine results require the doctor to take the prisoner off the methadone program. This was thought to be a contradictory situation by the staff involved.

The introduction of a new law also requires the staff to report any injecting activity observed by them, and this leads to further criminal processes against the inmate. Some of the health staff were perturbed by the fact that they were involved in providing syringes on the one hand, and were also required by law to report the use of the syringes if they happened to witness it. This had remained a relatively theoretical issue for them as they had not witnessed any use since the introduction of the new law. This situation was most likely to arise in the instance of an overdose where the syringe was likely to be still in evidence.

Another issue had arisen for the nursing staff during the implementation of the PSE. The syringe machines were to be emptied by prison staff who were provided with protective gloves and clothing in order to do the emptying. After a staff member sustained a needle stick injury while cleaning out a machine without his gloves on, the senior nursing staff decided to offer to clean out the machines. This offer was accepted by prison administration and there have been no further incidents. Fortunately, the initial injury did not result in the transmission of any BBVs.

I was not able to speak with prisoners or prison floor staff, but the health staff, the deputy chief administrator and the unit head reported that the inmates and floor staff had no problems with the program.

The other Berlin prison I visited, Ploetzensee Prison, is a male youth detention centre without a PSE. The prison houses 487 young men between 14 and 23 years of age. I was able to view the special drug unit 'Haus 8". The 58 inmates here are aged 18 to 23 and have a history of problematic hard drug use. They have a minimum of 6 months sentence and there are no remandees. The unit was run on a rigorous behaviour modification program that was monitored by urine drug screens. The young men with clean urines were rewarded by being able to progress through four levels of improved living arrangements and other freedoms. Positive urine results or an inability to provide urine was punished by a return to a lower level.

The inmates are expected to work in the unit, with provision of a range of workshops and tasks including woodwork, metalwork, painting, sign building, bricklayer, motor vehicle repair, gardening, etc. They can also complete trade school qualifications. School programs are available up to completion of Year 9.

The unit is supported by a team of psychologists and social workers as well as drug counselling provided by the external agency, AIDS-Hilfe. There was an emphasis on supporting the clients to choose a rehabilitation program. Of note, there was no medically assisted drug withdrawal or detoxification, and no methadone program available to these young men. All medical treatment was completed in the medical unit of the adult male prison next door prior to entry into the unit.

The benefit of the program was that the inmates with drug free urines on the top level of the program were able to begin reintegration prior to release by making use of the lighter restrictions on outings to go shopping, seek employment, visit family and friends.

The other Berlin prison with a PSE is Ploetzensee Men's Prison where a 4 year PSE pilot project commenced in February 1999. The prison houses approximately 108 men of whom approximately 50 are known to be opiate dependent. New prisoners are provided with a dummy syringe and an information sheet about the PSE in their cell. The syringe must be stored in the clear plastic cylinder provided in the cell cupboard. The dummy syringe can be exchanged for a clean syringe via the external counselling staff of the Berlin AIDS-Hilfe who attend the prison three times per week. The counselling staff are situated in a 'health room' that can be easily reached by inmates and cannot be directly viewed by prison staff, although there is a corner mirror installed near the 'health room' to allow monitoring of the corridor. The counselling staff also provide safer use and safer sex information as well as drugs counselling and advice for inmates not on the PSE program.

## Hamburg

I visited the Am Hasenberge Men's Prison in the suburb of Fuhlsbuettel in Hamburg with Dr Keppler from the Vechta Women's Prison and Dr Andreas Thiel, the Department of Justice official responsible for the implementation and maintenance of the PSE. This prison houses 450 men with shorter sentences in an old-style open design prison built in the 1890s. The original design consists of 3 cell wings and an administration block radiating out from a central control area. The three floors of each wing were designed to be visible from the central control area by the use of glass and wire mesh. Some efforts have been made to reduce the lack of privacy and segregation by installing some opaque flooring and some glass walls.

The PSE here was implemented as the result of a decision of the Minister for Justice. The prison staff, including the medical and nursing teams, were not in favour of the program. The PSE is administered by the nurses on a 'hand-to-hand, new-for-old' basis during clinic hours. The health team also run a methadone program for approx 40 clients which excludes them from the PSE. The other exclusion criteria for the PSE are the prisoners on the secure unit and those in the voluntary drug-free unit. Of the remaining approx 350 clients, currently 20 clients are participating in the PSE. Staff estimate that approx 70-80 clients are injecting in prison, so the PSE is officially only reaching one quarter of the clients who are thought to be IVDU.

During our visit, there was much discussion by the nurses about the fact that many prisoners were attending the PSE for new syringes and using a variety of excuses for not returning their used syringes. Frequently given excuses were that they had lost it or that it had been stolen. Officially, it is not permitted to give out new syringes without the return of the old syringes. This was causing nursing staff to become concerned, suspicious and angry. During further discussion, it became clear that the syringes had taken on considerable value amongst the prisoners, especially those who were not prepared to attend the PSE themselves. Lack of anonymity was cited by staff as the main reason for the relative low percentage of IV users presenting to the PSE.

The discussion then focussed on solutions to this problem including reducing the availability strictly to inmates who returned a syringe. Other methods of increasing the supply of clean syringes in the prison were seen as possibly too disruptive to the pilot program, but clearly required from a health perspective.

The number of syringes exchanged over the last known 12 months (Aug 2000 to July 2001) was 382 for an average of 13 clients per month. The July 2001 figures show a marked increase in exchanged syringes from previous months: 71 exchanged by 19 clients.

The results of the evaluation of this PSE are not available yet. One major issue remains the issue of syringes as currency in an environment where there are too few syringes. Another is the nurses' concern about their responsibilities and legal protection in regard to the PSE.

The Vierlande Prison in Hamburg also has an established PSE. The pilot project which commenced in February 1996, finished in December 1997 and has been continued. The prison houses approximately 100 male and 10 female drug dependent inmates. The PSE was initially commenced by external counselling staff who were available on a daily basis for provision of dummy syringes. Thereafter, syringe exchange occurred through machines installed in a number of quieter

locations in the prison. The syringes must be kept in a small clear plastic cylinder for safe transport and visibly stored in the cell cupboard.

Initial evaluation results were not positive: the PSE was not used by many prisoners. There had also been no reduction in BBV transmission during the pilot, which may be explained by the fact that the prisoners have a very high rate of Hepatitis B and C infection on admission.

The prisoners also expressed reservations about the PSE, citing that they were tempted to continue to use in prison with the PSE whereas they would abstain if there was no PSE.

## **Switzerland**

### **Oberschoengruen**

I visited the Oberschoengruen Prison for men in the Canton of Berne where the original PSE was commenced in 1992 as an act of 'disobedience' by the then prison doctor. The Swiss government was already exploring the need for PSEs and officially sanctioned the PSE after it was discovered.

The prison is an open prison, locked only at night, with 75 male prisoners deemed to be low escape risk. The prison operates an organic farm producing vegetables and pigs for sale at local markets. The prisoners are expected to work normal hours on the farm or in the supporting workshops eg metal work, carpentry. The sale of the farm products covers 25% of the cost of maintaining the prisoners in the prison.

Approximately fifty percent of the prison's inmates are IV drug users with longstanding histories of drug abuse, consequent physical and mental health problems as well as social difficulties. The prison health team operates a PSE, a methadone program and a heroin prescription program. The PSE is hand to hand by the prison nurse or doctor. There is relatively little demand for the PSE by inmates, in the order of 10 per month. The prison administrator stated that this was explained by the success of the methadone and heroin prescription programs that he felt had reduced that use of illicit IV opiates to almost zero. The evidence for this was the reduction in overdoses and overdose deaths in the prison since the introduction of the two substitution programs. Overdoses occurred regularly at a rate of approximately 2 per week and there were 4 to 6 overdose deaths per year prior to these programs. Now there are very infrequent overdoses and there have been no deaths.

The heroin prescription program (HPP) has 15 places and is usually full. Inclusion criteria are longstanding severely problematic opiate abuse, at least two failed treatment attempts including methadone maintenance and significant risk of death from overdose. Inmates deemed by the prison doctor to be appropriate for the HPP are maintained on the methadone program until there is a space on the HPP. Experience has shown that all HPP participants are Hepatitis C positive, one third are Hepatitis B positive and half are HIV positive.

The HPP is coordinated by the full-time nurse. After prescription by the doctor, the prisoner attends three times per day (8am, 1pm, 6pm) and injects the prescribed quality of heroin provided by the nurse under her supervision. Only three inmates are permitted in the HPP room at any one time. The maximum dose is 250mg; 750mg per day, which may be reached after commencing on a low dose and gradually increased doses titrated to minimise craving and avoid mini-withdrawals.

### **Hindelbank Women's Prison**

Hindelbank is a low security prison for approximately 100 prisoners with drug use histories. The PSE in Hindelbank has been in operation since 1994 following the results of the Swiss Government 'Drugs Inquiry' and the establishment of the PSE in Oberschoengruen. The original PSE method of hand to hand exchange by the prison medical officer was abandoned after six months due to low acceptance. The installation of exchange machines has resulted in a marked increase in syringe exchange.

The machines are installed in the communal bathrooms and cleaning store cupboards and can be accessed between 7am and 10pm. The syringes must be stored on the washbasin shelf in the cell.

### **Realta Men's Prison**

Realta is a low security prison housing approximately 100 opiate dependent men. The PSE has been in operation since 1997. The prisoners receive a dummy syringe and information about the PSE on arrival. Initially the exchange was done hand-to-hand by the counselling service with good acceptance of this method. A machine was installed later to reduce the workload. The machine is accessible between 7am and 10pm. The syringe must be stored on the washbasin shelf in the cell.

## Moldova

I was informed about the PSE in Moldova by Dr Keppler, medical director at Vechta Women's Prison. He has recently visited this small country formed after the breakup of the former Soviet Union. I also received a copy of the description of the PSE written by the Moldovan doctors responsible (Dr Dumitru Laticeschi, project coordinator and Director, Health Reforms in Prisons, and Dr Alexei Leorda, Consultant, Chief of Prison Health Service, Ministry of Justice) soon to be published in Germany. I have put together a detailed summary from these sources, as this is the only known 'peer support' model PSE.

The conditions in Moldovan prisons, as in most ex-Soviet Union countries, are poor due to chronic underfunding and a continuing preference for jail sentences in the Justice system. This has led to overcrowding, deteriorating facilities and additional health risks. Nutrition is poor with less than US\$0.50 spent per day per prisoner on food. Tuberculosis incidence is almost 50 times higher than in the general population and the prevalence of HIV was thought to be 3.5% in early 2001.

The average daily prison population is approximately 100,000, mainly young sexually active men. Estimates of drug use vary: prison administrators estimate 5-10%, but inmates state 30% is a more realistic figure. The PSE commenced in 1999, funded by the Soros Foundation. The exchange was approved by the Ministry of Justice as a pilot project in one prison. The initial exchange was done by the health staff and only a few inmates came forward. These were HIV positive men with low unofficial status and usually asked for more syringes "for their friends".

The project team realised that the PSE was bound to fail if only a handful of prisoners was using it. The option of exchange machines was out of the question due to the expense of the machines. After a study trip to Germany to explore other options for the PSE, the project team devised and implemented a 'peer support' model of PSE. The team identified six inmates who could act as 'voluntari', able to exchange syringes inside the prison. They were inmates with high unofficial status amongst other prisoners. They were also shown to have a sound understanding of the benefits of infection prevention as evidenced by knowledge tests after a harm minimisation seminar series for prisoners. The administration of the prison also sanctioned the choice of the six inmates for this task. A special cupboard was set up in the living area of four prison units, containing the syringes, bleach tablets, condoms and information pamphlets.

This model commenced operation in September 2000. It has been successful in the sense that clean syringes are very freely available within the prison. One disadvantage is that monitoring numbers of clients and syringes has been difficult. It is estimated that an average number of 30-50 clients use the exchange at any one time. The evaluation of this novel PSE model will be important to assess its success in preventing spread of Hepatitis B and C and HIV in the prison.

## **Spain**

I gained information about Spanish PSEs from abstracts for a conference presentation by Jose Carron, member of the Interdisciplinary Group against Drugs in Madrid.

The prevalence of HIV amongst Spanish prisoners is estimated to be over 20%. Spanish authorities have recognised the Council of Europe guidelines encouraging countries where community syringe exchange is available to also provide PSE. In 1997, a trial of PSE was held in one prison and after consideration of the evaluation results, PSE is being implemented in ten prisons.

## **World Health Organisation Conference “Drugs and Prisons”**

The three day WHO conference “Drugs and Prisons” was held in partnership with the Council of Europe and the Swiss Government. The conference was ‘by invitation’ and a small number of participants had observer status including Dr Michael Levy, Director, Population Health and Research, Corrections Health Service, NSW, and myself. There was strong participation from colleagues in the drugs and prisons field from Eastern European and Middle Asian countries including Poland, Russia, Uzbekistan, Bulgaria, Romania, etc. The Western European countries were also well represented.

The purpose of the conference was twofold. Firstly, to present the annual scientific meeting of the group, and secondly to finalise the draft document entitled ‘Prisons, Drugs and Society: A Consensus Statement on Principles, Policy and Practice’ produced by the WHO Health in Prisons Project and the Council of Europe Pompidou Group. This document will provide guidance to many governmental agencies, prison administrators and service providers on effective ways to tackle prison drugs issues.

One contribution highly relevant to PSEs was made by an English ex-prisoner “Andy”. He made a passionate plea for improved health services for prisoners including the provision of PSEs in UK prisons. He underscored this statement with a brief story of a friend in prison who has contracted HIV from shared injecting equipment and has left prison with a death sentence.

## **DISCUSSION**

### **Types of PSEs**

The types of PSEs currently in operation in Europe can be categorised by method of exchange; ie machine based, hand-to-hand by counselling or medical staff, and the peer model in Moldova. The information I gained during my visits shows that there are more syringes exchanged per prison inmate in the machine based PSEs, suggesting that the greater anonymity provided by the machines is an advantage for distribution of syringes. The hand-to-hand exchanges provide an additional opportunity for staff to engage the prisoner for information, education and counselling purposes. The Moldova peer support model provides an example of alternative methods that can be developed for both successful distribution of syringes and an increased opportunity to provide educational information. The method of PSE depends on the principle objectives of the project:

1. first and foremost to provide as many clean syringes into the prison environment to reduce sharing and therefore risk of BBV transmission (machine based PSE).
2. To provide clean syringes and increase contact with prisoners for health purposes (hand-to-hand).

The choice of PSE method must be made in the context of the prison and prison staffing situation, the prisoners' needs, the political context, and the external community environment.

### **Summary of PSE evaluation results**

The results so far of the evaluated PSEs in Germany, Spain and Switzerland show that:

1. PSEs are feasible and can be integrated into the normal functioning of a prison,
2. PSEs do not increase drug use according to a number of indicators: prisoner self-report, prison staff report, and drug finds in prisons,
3. PSEs are not associated with increased violence or prison staff assaults,
4. PSEs reduce or stop needle and syringe sharing by prisoners,
5. PSEs reduce the transmission of BBVs

In addition, a number of positive findings have been made at some prisons.

- In Vechta and Lingen, Germany, and Basuari Prison, Bilbao, Spain, the PSE was associated with an increase in referrals to drug treatment services.
- In Oberschoengruen and Hindelbank, Switzerland there was a reduction in the frequency of abscesses amongst prisoners.
- In Oberschoengruen there was a decrease in overdoses and overdose deaths.
- In Lingen, a reduction in stress and an overall improvement in relations between prison staff and prisoners were reported by both groups.

Difficulties were also reported, both in the evaluation reports and the informal discussions that I was able to have with staff and prisoners. These varied across sites also.

- In Vechta, Berlin Lichtenberg and Hindelbank, the technical failures of the exchange machines was reported as a major negative factor.
- In Lingen and Hamburg, the lack of anonymity was a major negative factor.
- In these two prisons, the syringes have become a trade commodity within the prison, in other words demand outstrips supply and other commodities eg cigarettes, money, drugs and possibly sex are traded for syringes.

- In the Vechta evaluation, the exclusion of methadone clients was reported as a negative as these clients may still be injecting illicit drugs and therefore still sharing syringes. This could be relevant at Lingen, Berlin Lichtenberg and Lehrter Strasse, and Hamburg.
- In Hamburg, nursing staff of the prison were concerned about the legal situation in regard to handing out syringes and whether they would be sufficiently protected in the circumstance of a legal claim of either providing syringes or *not* providing them in certain situations.

The evaluation studies strength is in their positive findings of feasibility, the lack of increased drug use and prison staff assaults, and reduction in sharing and transmission of BBVs. These results are based on data obtained by questionnaires and interviews, well-validated research methods. Nevertheless, there are no controlled trials of PSEs and no blinded trials. Thus, further rigorous evaluations may be required. This must be weighed against the evaluation results showing the effectiveness of community syringe exchanges and the perceived benefits obtained by these programs. It is difficult to argue that a more rigorous standard of evaluation should be implemented for PSEs if it has not been required for community exchanges.

The evaluations are not all directly comparable across the three countries. This makes clear-cut comparisons difficult. Nevertheless, it appears that more syringes can be distributed through exchange machines than by the hand-to-hand method. This is clearly desirable if the main objective of a PSE is to prevent BBV transmission.

### **Arguments against PSEs**

The arguments against PSEs are:

1. That it is illegal to provide syringes for illicit drug use
2. That there is insufficient legal protection for professionals engaged in the work of the PSE
3. That it will encourage and increase drug use in prisons
4. That it will increase the incidence of assaults on prison staff and violence in general
5. That an increase in the numbers of needles and syringes in a prison will increase the risk of accidental injury by staff and other prisoners
6. That prisoners using drugs without injecting will be encouraged to inject
7. That prisoners previously not using injectable drugs will be influenced to use IV drugs because of the availability of clean syringes
8. That the use of injectable opiates, specifically heroin, is reducing in popularity amongst drug users and will not be a major issue in a few years.

### **Arguments for PSEs**

The arguments for the European PSEs are overwhelmingly to prevent transmission of BBVs:

1. PSE provides for improved health for prisoners, both IV drug users and non-users through the reduction of the risk of BBV transmission.
2. The PSE regulates the use and storage of needles and syringes, and therefore reduces the risk of injury from a used syringe for staff and other prisoners.

In addition, German Law provides support for PSEs by stating that:

1. It is the duty of care of the prison administration to provide comprehensive health care to prisoners; ie PSEs are necessary to provide comprehensive medical care.
2. It is a requirement of prisons to counteract any negative effects of a prison sentence; ie PSEs are required to prevent the IV drug using prisoner from being detrimentally affected in the long-term by the prison sentence.
3. It is a requirement that prisons provide for as smooth a transition back into the community as possible for the prisoner completing a sentence; ie for the IV drug using prisoner who will return to the community, PSEs model healthy behaviour in the community.

A number of international organisations have also published statements in support of PSEs on the principle that syringe exchanges are available to drug users in the community and therefore should be available in prison (UN declarations and WHO and Council of Europe recommendations).

*“Prisoners are the community. They come from the community, they return to it.  
Protection of prisoners is protection of our communities.”  
(Joint United Nations Programme on HIV/AIDS, 1996)*

## **CONCLUSIONS**

There are no simple answers to the questions raised by prison syringe exchanges. The numerous perspectives must be clearly understood. The public health perspective suggests that PSE is essential as one aspect of the effort to reduce the risk of Hepatitis B and C and HIV spreading to the non-prison population.

The human rights perspective argues that health services available in the community should also be made available to members of the community who happen to be in prison.

The legal perspective varies from country to country and must be fully elucidated prior to any attempt to implement PSEs. In Germany and Switzerland legislation supports the availability of PSEs. This is necessary to safeguard the legal position of service providers and administrators.

The safety and security concerns of prison staff, service providers and administrators must be adequately addressed. In some PSEs, these concerns have been satisfactorily addressed in the lead up to implementation of the PSE or in the pilot phase. The most effective and successful PSE programs ensured a thorough introduction phase with plenty of opportunity for all involved to voice concerns and raise questions in an open forum.

In raising the question of PSEs in Australia, my role will be to circulate this report to policy makers and other interested parties as well as make myself available to speak about the issues to professional and community groups.

## **RECOMMENDATIONS**

In considering the implications and lessons of the European PSEs for Australia, there are a number of basic considerations. We need to ask ourselves: do we have a major problem with injectable opiates in our communities and our prisons? And if so, is this problem likely to evaporate in the short term? These questions can be simply answered by observing the trends in the supply of opiates into Australia and the trends in opiate related mortality and morbidity. There is also evidence of BBV transmission occurring in Australian prisons.

If there appears to be an ongoing problem related to the use of injectable opiates into the foreseeable future, then it is worthwhile to consider the pros and cons of PSEs in Australian prisons. The single most important potential benefit would be to protect individuals and the community as a whole from the spread of BBVs. Other benefits may also accrue as in the European PSEs. The legal situation needs to be fully explored to pave the way for a pilot PSE. For instance, in NSW the Prisons (Syringe Prohibition) Amendment Act of 1991 prohibits the introduction of syringes into a prison (with a maximum penalty of 2 years) unless “ the governor of the prison has consented to the persons introducing the syringe into the prison”. Legislative changes may be required to support the introduction of a PSE depending on the State or Territory involved.

The other major obstacle to PSE is the apparent reluctance of the some prison administrators and staff to consider a trial of PSE. The development of a PSE trial requires the collaboration of all stakeholders supported by strong government policy. Work in the area of eliciting stakeholder issues and evaluation of overseas PSEs for Australian purposes has already been undertaken.

The vital feature of a pilot PSE is the inclusion from the outset of an evaluation component that will elicit the key results of the trial. An evaluation must include qualitative measures such as participant and staff perceptions as well as quantitative measures of drug use, assault incidents, and BBV seroconversions.

The insights and lessons gained from the European PSEs must be usefully incorporated in the development of Australian models. While there are differences in systems that must be recognised, the fundamental principles of public health are the same. Responsible Australian governments will respond appropriately to the challenges of developing a PSE trial and ensuring an adequate evaluation.