

**IS SYRINGE EXCHANGE FEASIBLE
IN A PRISON SETTING?
AN EXPLORATORY STUDY OF THE ISSUES**

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Summary

Within a few years of recognition of the HIV pandemic, international authorities (including the World Health Organisation) recommended that HIV prevention measures implemented in communities should generally be available in prisons. Prominent Australian public health officials in recent years, such as Dr. Carmen Lawrence (Minister for Human Services and Health) and Dr. Brendan Nelson (former President of the Australian Medical Association), have urged serious consideration of Prison Syringe Exchange (PSE) programs. Some stakeholders in the correctional system, such as prison officers, have vehemently opposed consideration of PSE and proposed industrial action if a PSE is implemented.

Transmission of HIV and other blood borne infections in prisons associated with injecting and tattooing has been relatively rare for many years. Recent publications have begun to challenge that view. Sexual transmission may also be an important factor in the spread of some viruses such as HIV. These infections may subsequently be widely disseminated in the general community after inmates are released.

A number of HIV prevention measures have been established in the community in recent years. Several, such as needle exchange and methadone treatment, have been demonstrated to be effective. Few effective HIV prevention measures have been implemented in prisons anywhere in the world. There are only two (pilot) syringe exchange programs existing in the world, both in Switzerland. As yet, no assessment of the issues involved in implementation or feasibility of a PSE has been made in Australia. This study was conducted to consider the issues raised by PSE and assess possible benefits, possible adverse consequences and the feasibility of implementing PSE.

The feasibility of PSE was examined by documenting issues raised by key stakeholders in the New South Wales (NSW) prison system generated in facilitated discussion groups. Groups made up of individuals doing similar work pertinent to the NSW prison system were asked to discuss problems in a correctional context associated with syringe use, effectiveness of and problems associated with existing HIV and hepatitis prevention measures, and possible benefits and costs of establishing and evaluating a pilot syringe exchange program in prisons.

The views of stakeholders will directly influence the operation of a PSE. Groups comprising prison officers, prison medical staff and ex-inmates provided information on likely safety issues associated with a PSE, emphasising the necessity for effective, broad-range treatment and harm minimisation programs in prisons for injecting drug users. Groups, including prison staff, questioned the implementation and effectiveness of existing HIV prevention programs. Groups comprising community agencies and politicians addressed the likely wider community impact.

Based on these discussions, we conclude that a pilot PSE program in a prison setting would only be feasible provided there were certain strict limitations. The primary concern of all groups was the current policy of the Department of Corrective Services which opposes the introduction or exchange of syringes in any capacity. Prison officers were also unanimously opposed to PSE. This issue would need to be negotiated and cooperation of prison staff secured before implementation of any pilot PSE could be considered.

A frequently offered suggestion for reducing security risks of a PSE was the allocation of specialised sections of prisons to deal specifically with selected drug injectors. These specialised wings might provide a broad range of treatments and harm minimisation strategies, possibly including PSE. Custodial, counselling, and medical staff for these areas would be specially selected and trained and clearly appraised of their own roles and the goals of the unit.

Several options for implementing and evaluating a PSE were suggested. The relative merit of each option is discussed. We conclude that the introduction of a PSE in NSW is feasible only if strict guidelines are followed. The strenuous opposition to PSE under any circumstances by members of the prison officers group is noted. The strength of this opposition, if sustained, is likely to be a critical factor.

Recommendations

It is recommended that:

1. prison education programs include regularly updated information on hepatitis C regarding physical complications, management and prevention.
2. Health Department officials provide public education on prison public health issues involving rural and metropolitan media.
3. methods to improve access to liquid bleach (such as distribution units in cells) and ensure anonymity of inmates obtaining bleach be considered by the Department of Corrective Services.
4. the Prison Methadone Program receives substantially increased funding and rigorous scientific evaluation.
5. the Department of Corrective Services offer without charge routine hepatitis B vaccinations (including free testing of antibody response) for correctional officers and inmates.
6. condoms be provided and condom distribution be carefully evaluated.
7. serious consideration be given to the development of specialised drug rehabilitation and treatment prisons by the Department of Corrective Services and the Corrections Health Service.
8. Commonwealth and State Departments of Health, in consultation with Departments of Corrective Services in each State, clarify the role of harm minimisation within correctional centres.
9. in-service education for custodial and health services staff include values clarification which reinforces existing harm minimisation policies and procedures.
10. a working committee comprising representatives from the Corrections Health Services and the Department of Corrective Services discuss PSE to identify an option which does not represent any risk to staff and is acceptable to prison officers.
11. a feasibility study should assess the possibility of piloting a PSE in another state(s) if the cooperation of NSW prison officers unions is not secured.
12. NSW Parliament convene a multi-party Working Group to review prison and community drug policies affecting drug use among inmates, methods of reducing rates of reimprisonment - especially for drug offences, and inconsistencies between prison and community harm minimisation policies.

13. Conditions before considering a pilot PSE:

- !. a specialised drug treatment wing should be established
- !. custodial and health staff should be voluntary
- !. custodial and health staff should be specially trained
- !. distribution of needles and syringes in a PSE would have to be strictly one-for-one
- !. one of the following options for distribution should be selected by a joint committee of custodial staff, health staff, and inmates:
 - vending machines
 - nursing staff
 - outside agency
 - "injecting room"
- !. if the key stakeholders agree on a pilot, this should be subject to certain conditions including: no increase in risk of infections to staff, inmates, or visitors from assault, occupational injury, or accidental injury to visitors.

14. Conditions required for a pilot PSE:

- !. monitoring of a treatment wing and control wing for two years including 6-12 months before implementation of PSE
- !. testing participants in both wings for hepatitis B & C and HIV every 6 months
- !. involvement of participants in HIV/AIDS educational courses at recruitment
- !. training of peer educators
- !. availability of bleach in both wings
- !. hepatitis B vaccination of all participants not previously exposed to HBV at recruitment
- !. all inmates be assessed and offered methadone maintenance treatment if suitable

15. Procedures required for evaluation of a pilot PSE:

- !. monthly open ended key informant interviews with staff and inmates
- !. structured inmate interviews with inmates on drug and alcohol programs regarding drug use at 6 month intervals
- !. hair analysis of all participants at 3 month intervals
- !. monitoring of marked syringes to estimate circulation times
- !. focus groups with custodial staff, health staff, and inmates after first year
- !. review of DCS records for assaults and drug seizures in both wings at conclusion of study
- !. clinical evaluation of all participants at the end of evaluation

Introduction

Prisons offer the potential for the rapid spread of HIV and other infections through sharing syringes (Taylor et al, 1995), tattoo needles (Holsen et al, 1993) and sexual activity (Moran and Peterman, 1989; Cohen et al, 1992). Sporadic transmission of HIV in prison has occurred (Brewer et al, 1988; Horsburgh et al, 1990; Centers for Disease Control, 1986; Castro et al, 1991; Dolan et al, 1994).

About half of all inmates in Australian prisons are injecting drug users (IDUs) and at least a quarter of IDUs have been to prison (Gaughwin et al, 1991a; Wodak, 1991). This high proportion of IDUs contributes to the potential risk of infection. A review of studies on prison risk behaviours among IDUs entering prison indicates that one third continue to inject and three quarters of these share syringes (Gaughwin et al, 1991a). These studies indicate that syringe sharing is probably the most common route of HIV transmission in prison. An examination of syringes confiscated from a South Australia prison concluded that only one sixth were in good condition, one quarter had visible blood, and most had been cut down to aid concealment (Seamark and Gaughwin, 1994). Studies indicate that HIV infected IDUs are more likely to share syringes (Wolk et al, 1990; Gaughwin et al, 1991b; Dolan et al, 1990) and be sexually active (Dolan et al, 1995a) in prison than noninfected IDUs.

Mathematical modelling has been used to identify factors which determine the speed of transmission of HIV among a group of IDUs sharing needles (Kaplan, 1989). Random syringe sharing - which probably represents conditions occurring in prisons - tends to produce results close to the 'worst case' when HIV transmission is modelled (Kaplan and Heimer, 1992). In England, a mathematical model was used to estimate that two percent of prisoners who shared syringes would have become infected with HIV in 1990 (Medley, Dolan and Stimson, 1992). Preliminary results from a model using NSW data suggest that the number of IDUs infected in NSW prisons is at least 38 per annum (Dolan et al, 1994a). These mathematical models and recent reports of outbreaks of HIV infection in prisons, suggest that HIV can spread rapidly in correctional facilities.

In response to the nature and extent of the consequences of an uncontrolled HIV epidemic in prisons, the World Health Organisation has recommended that countries make every effort to provide the same prevention measures in correctional facilities as in the community including syringe exchange (WHO, 1993). Currently, 18 countries distribute condoms in prison, 13 provide bleach, five offer Methadone Maintenance Treatment, but only one has a (pilot) syringe exchange program. Among these countries, Australia provides all of the measures above except the syringe exchange scheme (Dolan et al, 1995b) although these interventions are not available in every state. However, senior public officials, including the Health Minister (Dr. Carmen Lawrence) and the former President of the Australian Medical Association (Dr. Brendan Nelson) have publicly called for syringe exchange programs in prison (Seven Thirty Report, 1995). Professor Robert Douglas, Director of the National Centre for Epidemiology and Public Health, Australian National University Canberra, also called for a careful, time limited evaluation of a pilot strict needle exchange program (Douglas, 1991).

There is now compelling evidence that syringe exchange can prevent the transmission of HIV

(Kaplan, 1992) and probably also hepatitis B (Lurie, 1993) in community settings without increasing the prevalence of injecting drug use (Hartgers 1993). It has been shown that by just reducing the time syringes are in circulation, new HIV infections decline even if there is no change in the number of syringes in use or in the level of risk behaviour (Kaplan et al 1994). Variations on community syringe exchange schemes have also developed. For example in Switzerland, "shooting rooms" have been established where injecting equipment is provided in an area set aside for injecting and disposal services are provided. Monitoring the use of these rooms allows for prompt medical attention in the case of overdose. This innovative syringe exchange program has also received support from the general public as a harm minimisation strategy (Leuthold et al, 1993). The notion of shooting rooms has recently become the subject of debate by Australian health officials (Jones and Garifalakis, 1995).

The Swiss experience

At present, there are only two syringe exchange schemes in prison settings anywhere in the world. Both are located in Switzerland. The first syringe exchange scheme was established in Switzerland in 1992 in a men's prison (Oberschongrun in Solothurn). The second program began operation in 1994 in a women's prison in Hindelbank (Burrows, 1995).

The program at the men's prison was developed by the prison doctor and the prison administration. Inmates must first identify themselves as current injecting drug users and this must be verified by the doctor before they can begin in the program. If the doctor confirms that the inmate is a drug user, syringes are exchanged with the inmates during visits to the prison health centre. Regulations require that syringes must be kept in the toilet cabinet of the prisoners' cells. Any syringes found outside of this area and drugs found anywhere in the prison are confiscated. A key component of this program is the emphasis on the concept of drug addiction as an illness. The prison director has stated that urine test results show that drug consumption in the prison had not increased since implementation of the PSE. In addition the prison doctor reported a decline of blood born viral infections among the drug users (Mr. Peter Fah, Personal communication April 1995).

The second prison syringe exchange program at Hindelbank was developed through collaboration between the Canton of Berne and the Swiss Federal Office of Public Health. This pilot program evaluation will be completed in 1997. This program employs syringe distribution machines in each of the six divisions of the womens prison. The machines were located in storerooms to ensure anonymity after discussion with the inmates. The regulations of the prison were also amended to allow possession of syringes in the toilet area of the prisoners' cells (Bernasconi, 1994; Rihs-Middel, Personal Communication March 1995).

Dr. Margaret Rihs-Middel, of the Swiss Federal Office of Public Health, indicated during a recent visit to Australia that such programs must be specifically developed to fit the individual prisons where they are located and that extensive consultation is required with officers, inmates, and medical staff of the prisons. She also noted that exposure to hidden needles and needle stick injury has notably decreased since both prisons permitted storage of syringes in toilet areas of the prison cells (Rihs-Middel, Personal Communication March 1995).

Prisons in NSW

The New South Wales prison system has implemented many HIV prevention measures with the exception of provision of condoms and syringe exchange. An extensive peer education program was established in 1991 and found to be effective on evaluation (Taylor, 1994). The NSW prison system is also one of five countries in the world that provides methadone maintenance treatment. The prison methadone maintenance treatment has been monitored (Hall et al, 1993) with research indicating that inmates on the program are less likely to inject or share compared to inmates not on the program (Dolan et al, 1995c). Bleach distribution is also available (Dolan et al, 1994b) but recent studies indicate that the efficacy of bleach in destroying HIV under field conditions is doubtful (NIDA, 1993). Compulsory HIV testing at prison entry was implemented between 1990 and 1995. During a three year period, testing detected 117 (0.6%) cases of HIV infection out of 19,908 entrants (Sara, Personal Communication 1994). No data has been released from exit testing which occurred to a lesser extent. The Department of Corrective Services has operated a Lifestyle Unit for some years where HIV positive prisoners can live for four months to learn how to cope with their status (New South Wales AIDS Project, 1994).

Current NSW prison policy forbids distribution of condoms but the "governor is empowered to make regulations for and with respect to the distribution and use of condoms in prisons and prison complexes" (Prisons (Administration) Regulation 1989, s 50(1)(j3) - Godwin, 1993 p279). The Department of Corrective Services policy forbidding the provision of condoms is currently being challenged in the Supreme Court on the grounds that the failure to provide condoms was a breach of the duty to care (Sider, 1994). The Minister for Corrective Services in NSW has been reported to have prepared a Cabinet submission for a pilot condom distribution program (Anonymous, Sydney Morning Herald, 1995 p. 9). However, the prison officers' unions have responded to this possibility of provision of condoms with threats of industrial action (Anonymous, The Daily Telegraph Mirror, 1995 p. 7).

In 1991, a prison warden in NSW was stabbed with a blood filled syringe by a prisoner known to be HIV positive. The officer subsequently became infected with HIV. The Department of Corrective services responded to the attack with strict control measures which resulted in prison riots (Egger and Heilpern, 1991). The Prisons (Syringe Prohibition) Amendment Act of 1991 was passed. This Act forbids the introduction of syringes into NSW prisons with a maximum penalty of 2 years imprisonment. However, the Act also allows for the distribution of syringes "if the governor of the prison has consented to the persons introducing the syringe into the prison" (s37A(2) - Godwin, 1993 p279). The Department of Corrective Services (DCS) and the Prison Officers Union responded to the calls for syringe exchange by Dr. Lawrence and Dr. Nelson with strong opposition based on union policy and the above mentioned Act against distribution of syringes. They claim the distribution of syringes represented a threat to officer safety (Houweling and Wilkins, 1994).

Prison syringe exchange programs are controversial in Australia as they are in other countries. Yet increasing evidence indicates that the spread of HIV in prisons has been under estimated. Furthermore, HIV prevention strategies acceptable in community settings are only implemented incompletely in prisons. This study aimed to assess the feasibility of operating a syringe exchange in NSW prisons based on the views of key stakeholders. We have documented some concerns and issues which were presented to us. We have also developed some

recommendations regarding implementation as well as a proposed protocol for its evaluation.

Methods

We identified the primary stakeholders as the groups affected by HIV transmission risks among IV drug using inmates. These included: custodial and non-custodial staff from the Department of Corrective Services; Corrections Health Service staff; and inmates. We also identified secondary stakeholders based on their possible interests in PSE. These included: politicians; community health officials; and community user groups. Prominent figures among the stakeholders and agencies were contacted for recruitment of focus group participants. The Department of Corrective Services declined to approve this study as it was contrary to current policy. The Prison Officers Union and a few prisoner's advocacy groups were contacted to gain access to officer and ex-prisoner participants. Published literature and media coverage of the topic were reviewed to list any additional key figures who had commented on PSE.

Individuals were contacted from initial referrals for recruitment. These individuals were asked to suggest other contacts who would be willing to engage in a group discussion. Through this snowball procedure, eight groups of two to six individuals were formed to discuss the topic. All identified stakeholders were represented in at least one group. The selection process for the study was not random, rather attempts were made to survey a range of views. Primary consideration for participant selection was a willingness to discuss the issues in a group setting. In addition to the groups, two individual interviews were conducted.

Discussion groups ran from April to May 1995. Ethics approval was sought and received from the University of New South Wales Committee on Experimental Procedures Involving Human Subjects. At the beginning of each group, a moderator explained the aims of the study and asked permission to tape record the session. Participants were requested to keep the group's discussion confidential and especially not to attribute any comments to persons in the group. Participants were also asked to allow others to speak without interruption to allow dissenting views to be expressed. Members were asked to base their comments on their own experience. The participants all signed consent forms after agreeing to participate (see appendix 1).

The groups lasted up to one and a half hours. The moderator presented summaries on HIV in prison and the PSE pilots in Switzerland. A structured format was used to elicit respondents' knowledge of syringe use in prison, current HIV prevention measures, and suggestions on the operation of a PSE (see appendix 2). Questions specific to the respondents' group were added to the structured format during each session. Standard focus group techniques were used such as the encouragement of quieter participants to talk, redirection of topics to the discussion outline, and written notes in addition to the audio tape (Hawe 1990, Krueger 1988, Murphy et al 1992). Notes were recorded on a white board so participants could follow the recording process. Audio tape transcripts of the groups and notes were analysed with NUD*IST v3.0 for common and differing opinions that were presented across the groups. Upon completion of all groups, written surveys (see appendix 3) were mailed to participants to assess any reluctance they may have had voicing opinions in the group format and to allow an opportunity to address any issues not already covered in the sessions.

A final group of research experts in the fields of injecting drug use, syringe exchange, HIV prevention, epidemiology and criminology were asked to develop a protocol for operating and evaluating a pilot PSE scheme. The group addressed the concerns of all stakeholder groups and known data on syringe use and HIV/hepatitis concerns in prison. The recommendations arising from this study appear in the final section of this report.

Problems encountered

This project received less than half the funding requested. This limited the recruitment for focus groups to the Sydney area.

As the Department of Corrective Services (DCS) had not approved the study, access to prisoners and DCS staff within the prisons was prevented. Former prisoners and representatives of a NSW Prison Officers' Union were contacted to represent prisoner and officers on stakeholder issues. The nature of the project resulted in some senior officials in the Department of Corrective Services and Corrections Health Service declining to be directly involved in the study.

While we did not actively recruit HIV infected participants in the study, they were present in some groups. However, personal experiences of being HIV positive were not discussed in the groups. One individual disclosed a seropositive status outside of the group and asked us not to reveal this information to the group. A participant commented in the follow-up survey that HIV infected participants would be unlikely to divulge their status or risk behaviours in a group setting.

A deviation from the standard group format occurred for sessions comprising prison officers and the researchers. The officers' union allowed us discussion time at a union delegates' meeting. Forty union representatives from each of the NSW prisons were addressed in an open forum concerning this study and their perceptions regarding syringe problems in prisons. Issues presented by the officers in the forum were recorded in written notes as the officers declined to have a tape recording made. The record of this meeting was presented to a union representative who attended this meeting to verify the accuracy of the report. This opportunity was only provided to the union as a substitute for the written surveys provided to participants from other groups.

Results

A total of eight groups and two individual interviews were conducted over a two month period (see appendix 4). Seventy-one individuals took part in eight stakeholder groups. These groups followed a structured discussion outline (see appendix 2). Nine researchers took part in a modified discussion group concentrating on the methods and indicators for evaluating a pilot PSE program. A former prisoner who is employed by a prisoner advocacy group was interviewed individually. Another interview was conducted with Dr. Margaret Rihs-Middel, Swiss Federal Office of Public Health, on the operation of the pilot PSE programs in Switzerland.

The following quotations are taken from comments made by individuals regarding PSE. Participants are designated by letter when quoted. A doctor from Corrections Health Service (CHS) participated in one of the CHS Staff groups and has been designated as a nurse to protect the doctor's anonymity. Specific prison names have also been replaced with numbers to protect the anonymity of participants.

Some participants provided perspectives from experience in more than one area (such as a former female inmate who works for a community agency). While comments are taken from each person's experience, they do not necessarily reflect the total stakeholder group they came from. These comments are meant to provide background on the range of concerns that was articulated during the groups. We have attempted to indicate the diversity of views which was evident and also indicate consensus across the groups when that was present.

Current injecting practices

The knowledge on current injecting practices ranged from none or very general assumptions to extensive description of the equipment, practices and risks. Participants from the Members of Parliament (MPs) group and Staff Members from community agencies expressed information which they felt reflected the opinions of the general public. There was agreement across the officer, CHS staff, and inmate groups that drugs were a problem in NSW prisons with varied availability based on the prisons security classification. Participants in these groups also agreed that syringes were much more scarce than the drugs.

MPs and Outreach Worker A from the Community Agency group based their knowledge on conversation with constituents and clients. The other groups provided actual examples from their involvement within the prisons.

Views like Outreach Worker A's statement that "drug use happens" were common among those participants with indirect knowledge of drug use in prison. MPs B and C also expressed general awareness on drug availability:

I was just like everybody. Aware that it's there but I don't have specific knowledge. The nurses and doctors tell you a lot about it.

I have no doubt that there are lots of drugs in prison.

Possible reasons for drug use in prison were considered. Outreach Worker A commented that it was probably to "to make [the] time bearable" while MP C stated that "it's a question of whether or not you will continue to inject when you're in prison."

Group members from the Ex-prisoner Group (II) noted an increase in injecting practices over the past two decades. Ex-prisoner E, who had prison experience in the 1970's, indicated that "In the early seventies, it was a bad rep [reputation] to be called a junkie." Ex-prisoner C, from the same group, agreed and indicated that he had "never seen a needle in gaol until [19]83." The Male Ex-Prisoners also noted variation across the prisons today in prevalence of injecting. Ex-prisoner D felt that in Prison 1 "(e)very third person" was injecting while in minimum security

about "50%" injected in Ex-prisoner E's guess. Participants from the CHS Staff Group (II) also indicated similar variation among prisons. Nurse D stated:

There is a lot of drugs in the remand gaol. It would be a lot different figure there than say Prison 2 or Prison 3 or wherever.

Nurse E agreed and felt the security classification affected this:

...even Prison 4 on works release, they've probably got more drugs than remand, they've got access to outside work.

Although the above groups indicated variation in drug use and injecting prevalence, most discussion of injecting equipment focussed on the scarcity of needles and syringes. Ex-prisoner C stated "They're few and far between." Officers provided estimates on the equipment available:

...we have one syringe per 50 inmates per gaol.

It needs to be noted that there's an average of 400 syringes confiscated in a year and that's probably only a small percent.

The value of a syringe in the prison system was discussed by the former inmates. The female ex-prisoner stated:

If you're the only person with a syringe and they've all got drugs it's a commodity.

Ex-prisoners C and E agreed that the cost of a syringe was a "Packet of [White] Ox [tobacco]" and a "\$20 deal of smoke [marijuana]."

Needles and Syringes

There was agreement across all groups that needles and syringes were primarily obtained from visitors, stolen from clinics or passed on from other inmates. Inmates and CHS Staff agreed that the syringes were very poor quality due to multiple use. Comments regarding extensive sharing were also common in these groups.

Outreach Worker A and an MP indicated their assumptions on what might take place in the prisons. Outreach Worker A stated:

I think that they get into prison through being stolen from medical facilities. Being brought in by visitors. Being brought in by staff, Corrective Services staff.

MP B's idea was:

I would imagine they were brought in by the relatives that visit or a percentage would be brought in by the prison officers and either sold or exchanged for something.

These responses came from second hand knowledge or assumptions on the part of the participants.

The members of the CHS Staff Group (I) identified the methods that visitors use to smuggle in syringes. Nurse C from the group indicated that "they come in with visitors, secreted on the person." He indicated that this could be done in "bras" and Nurse B from the group also indicated "body orifices, and body cavities." Ex-prisoner E described the following for minimum security prisons:

I was in minimum security with contact visits you know and people were just pulling in needles. Someone would bring in and pass it to me on a visit.

Ex-prisoner D indicated that "every maximum security gaol has outside workers who can pick up drops [drugs or syringes smuggled in by visitors]."

The prison medical clinics were also mentioned as sources for syringes. These syringes were smuggled out by clinic "sweepers" [inmates with work assignments over a certain section or wing] and patients. As Ex-prisoner E indicated:

Some blokes are pretty tricky because they can pull the nurses head and they can sneak a fit [needle and syringe].

Nurse A from the CHS Specialist group supported this:

Diabetics get it from the clinic....Or when somebody is taking their blood they distract that person. Nick it.

Nurse C from this same group emphasised that individuals who stole syringes were not necessarily users:

But even if you don't get the heavies or even the users into the clinics, other people are stood over....you end up being forced into stealing things

The groups described the impact that the scarcity of syringes had on injecting practices. The female ex-prisoner stated that:

People who are leaving will pass their syringe on. They don't need it any more. It goes back to the commodity idea.

Ex-prisoner B also stated:

you just keep sharpening them up and keep using them. They actually pass on the old ones.

Ex-prisoner A of the same group added:

To obtain a syringe is illegal anyway so, it goes from one wing to another wing. Under this and behind this person.

Nurse A also discussed the circulation of the syringes stating:

The needle disappears and then it comes back in. Then they get another shot.

Nurse C noted that this circulation can lead to "not only sharing [and] not cleaning" but also "multiple use" which he described as "different groups using the same needle over a period of days and weeks."

The condition of these syringes was said to be very poor. Nurse C stated that "they get so cut down from sharpening that they can't get cut down any more." Nurse G described the syringes she had seen as "little cut down things with a matchstick as a plunger." Finally, Ex-prisoner E described syringes he had seen as:

They're cut down. Bit of old foam used on your plunger. Use an aerial out of a radio for a plunger.

The poor conditions of the needles and syringes were suggested to be contributing to the risks for injecting. Nurse G indicated that syringes in such poor condition are very difficult to clean. Nurse C supports this with:

They are reluctant to use bleach because the bleach damages the plastic so there's a disincentive to use bleach because it destroys your one and only syringe.

Safety Issues

All groups included comments on the health risks associated with exposure to needles in prisons. Inmates and Community Agency staff expressed concern over the risks of HIV and hepatitis C due to injecting. Officers and CHS staff comments were similar regarding possibilities of infection risks to staff and visitors due to needle stick injuries. Stakeholder comments were divided on the risks of syringe attacks in prison. Officers, CHS staff, and one inmate suggested risks of assaults on staff and inmates. The remaining inmates suggested syringes were too valuable to use as a weapon when other possible weapons are available.

A more generalised summary came from MP B:

There are three groups at risk. There are prison officers who are subject to accident. There are inmates themselves who may be involved in activities that leads to cross infection. Then there are the people who they associate with upon release.

MP A added the people "whose occupation take them into the prison system as well" such as health staff or solicitors are also at risk.

Other groups were more specific about the risks. Outreach Worker A stated that health risks for

the inmate included "abscesses, hepatitis C, and vein damage." Ex-prisoner A mentioned hepatitis C and HIV stating that "out of a hundred guys that use, 50% have contracted hepatitis C or HIV." There was agreement across the CHS Staff Group (II) when Nurse I stated that the transmission of hepatitis C in prison was a lot higher than HIV.

The risk of hepatitis C infection also applies to accidental injury to staff. A prison officer stated:

One of my guys just got stuck with a needle....There's no vaccine for hep C so now this guy has a possibility of getting hep C just for doing his job.

Nurse C also mentioned the officers' risks as "they are constantly searching for them and they are hidden in corners." Nurse E also responded, "I feel for the officers, I wouldn't want to do any cell searches. There's no way!" Other members of the group agreed with this comment.

The Nurses also raised the problem of threats to other individuals who enter prison. Nurse I reported:

I had a maintenance man one day at the Training Centre, he was pricked by a syringe that was hidden in the cistern of the toilet block.

Further discussion about the planting of syringes in various public areas lead Nurse F to add:

If they are being hidden around the gardens, the trees and shrubs and that...its a safety matter, a security matter, for visitors and children who come in.

In addition to these risks of needle sticks, the risks of assaults were discussed. Nurse F stated in support of the officers that "they've been threatened with a bloody needle [and] a nurse could be held hostage." The officers provided more extensive responses. One officer stated, "You've got to realise when the inmate becomes hostile then the syringe can become a hostile booby trap." Another added an account of a prisoner who had threatened officers recently and the question of "what's to stop him from walking up behind anyone even another prisoner and jabbing em." Ex-Prisoners had varied responses to the possibility of using syringes as a weapon. The female ex-prisoner stated in women's prisons "you wouldn't use it as a weapon it's too valuable." The members of the Male Ex-Prisoner Group were more divided on the safety risks from current syringes. Ex-prisoner D felt there was "more trouble now" without access to syringes. Ex-prisoner E stated that "it's not a new threat."

Summaries

Each group was encouraged to summarise their knowledge of current injecting practices in prison with a single statement. The Community Agency Group agreed that:

Drug use occurs in prison with poor equipment leading to increased health risks. I think there have been cases where people have used syringes as weapons.

The Ex-Prisoner Group (I) supported that:

yes, there are syringes in prison, yes they are tampered with, and yes they are shared.

The Prison Officer's Union Group summary was:

There is a serious situation in terms of infections, drug users, and needles and syringes in prison and a needle and syringe exchange would only make it worse.

Members of the CHS Staff Group (I) provided several summaries:

There aren't many people in prison with HIV because there aren't many in the community. As the numbers rise the frequency of transmission will rise.

Hep C is transmitted in gaol through needles.

Whenever there's heroin outside, there will always be heroin inside. They'll always use, always.

The participants of CHS Staff Group (II) were more divided in their summary of current conditions:

If it's [introducing syringes] illegal to start with to make it legal would probably only intensify things [problems].

I've tested inmates and there are many who show up positive so that is a health issue for me.

We know that bleach is not doing its job too. That's significant.

We're not doing anything constructive for that population [drug users] that keeps coming in and out of gaol. It's [drug use] allowed outside until they get caught. It's allowed inside until they get caught.

And finally the Male Ex-Prisoners agreed:

The thing is the fits [needles and syringes] are in the gaols and you'll never stop the fits from coming in the gaols.

Current HIV and hepatitis prevention measures

All groups were encouraged to discuss the problems and benefits of current HIV and hepatitis prevention measures in prison. The programs discussed were AIDS peer education, segregation, bleach distribution and methadone maintenance treatment programs. No participants argued against any of the HIV prevention measures with the exception of segregation. A wide variety of problems were mentioned concerning all programs. The common problems noted in all

groups were a lack of resources and barriers to access by inmates. Other problems were more specific to the individual programs. A variety of suggestions for improving the programs were expressed in some groups.

HIV Education

Comments about the benefits of the peer education program in prison were noted in both the CHS groups and the Ex-prisoner Group (II). Nurse G had noted "tremendous improvement in recent years." Nurse B added:

I must say coming into the system from the outside the level of knowledge that the inmates actually have about HIV is quite outstanding...most can actually tell you back the main modes of transmission, how not to come in contact with it and what the risks are inside gaol.

All members of the CHS Staff Group (I) agreed with this. A former inmate who had been a peer educator stated "if the kids [new prisoners] do get access to the peer educators it does work and they get a great deal of benefit out of it."

Yet several problem areas were noted for the education program. The problem of timely education was discussed by the Community Agency Group when Outreach Worker A observed:

Incomplete knowledge can lead to increased anxiety and decreased hope. So, if you're sharing in prison for a couple of months and then you get all of this hepatitis C and HIV information, you may very well start thinking, I'm dead.

Access to the programs was also a problem noted by former inmates. Ex-prisoner B noted that:

[F]ine holders, which I've been all along, are not allowed to do any courses. They might be there for only 3 months out of the year.

Ex-prisoner E, who had been a peer educator, commented on the importance of knowing where to access the peer educators:

It all depends on what gaol you're in. You can be in a gaol where screws [prison officers] have a little bit of humanity about them. These officers let the young blokes know that there is a peer educator in the wing and that he can come and talk to the peer educator if he's got a problem. But that's where the communication breaks down.

Another problem raised in the CHS Staff Group (I) was that education couldn't be translated into behaviour in prison. Nurse A commented, "It's as though we're teaching them for the outside. It makes no difference on the inside." She elaborated that this was due to a lack of access to the same prevention measures as they have in the community.

There were few suggestions for improvement from the groups. An officer discussed the need to increase the funding for prevention programs that are in place:

They're operating on cuts. They need to work on what's there. Education is the only way to work with these problems.

Other suggestions were from Outreach Worker A who commented on the need for comprehensive hepatitis C education. He indicated a need for accurate "cleaning instructions, [information on the] impact [of hepatitis C after infection], the development of the virus and a lot of things that aren't well understood generally." His emphasis was on the "need for self-care stuff."

The MPs Group discussed political aspects of existing prevention measures and community attitudes to these prison programs. They emphasised the need to educate the community because the influence that community support has on the political expansion of existing and new projects. MP B noted:

I think the problem, really, is extending knowledge to people who are decision making as far as drug use is concerned....you have this overwhelming ignorance and prejudice in politicians and prison officers and the general public. And those three groups have to be in harmony before you can make any adjustments to the internal programs.

The education process discussed in the group also focused on the impact of the media. MP D noted that media in all communities, both rural and city, influence the public opinion. MP D stated, "I think it's time we get some general education through the media on public health issues."

Segregation

Although the Department of Corrective Services policy allows the integration of HIV positive inmates, the groups discussed the use of segregation as a prevention measure. The benefits centred around issues of safety for the HIV positive inmate and others in prison. Ex-prisoner A supported this:

Yes, for their own safety. If they assume that you are [HIV positive] you get treated like a dog.

Ex-prisoner B added:

Justification? Yeah....you might get on with everybody but there would be that couple that would kill you or want to kill you.

Another argument for segregation was made by Ex-prisoner F:

I think they should segregate everybody that's got HIV and keep them segregated....if they segregate them right away they can't pass them on.

Finally, Nurse C also argued that "from an epidemiological point of view it makes a lot of

sense."

In contrast to this support for segregation several problems were associated with it. Outreach Worker A didn't "think you can run a prison with complete segregation." Nurse C added that "60+% have hepatitis C, it would be hard to segregate them." Ex-prisoner C also added the problem of incubation periods for both HIV and hepatitis:

They're going to have to segregate every person that comes into gaol for the first 15 weeks.

Nurse A presented this final argument on the effectiveness of segregation:

It doesn't stop things going in and out of segro [segregation]. Putting them in segro doesn't stop needles going into segro....even if somebody was segregated and they had HIV and they wished to use they would share that same needle.

Suggestions for improving segregation as a prevention measure were limited. The female ex-inmate suggested a voluntary unit. Nurse C, although not suggesting actual implementation, stated:

The only way it would work is if you tested everybody for HIV and you put those who were HIV positive in a separate HIV gaol.

Bleach Provision

The following positive comments were made about the benefits and operation of bleach distribution in the prisons:

A benefit is that it's a method of reduction of transmission. A prevention technique. Outreach Worker A

We give out a lot quite liberally I would say. Drop them and leave them. Nurse I

I think most of ours is given out. Nurse D

It's very accessible. Ex-prisoner D

However, comments on problems were more numerous than benefits.

The problems mentioned across the groups were: fear of reprisal from officers; effectiveness; and inappropriate use. Most comments centred on officers or nursing staff using requests for bleach to identify drug users:

Because the screws will say, 'Well, why do you want bleach?' Next week, there's heat on this person and there's a ramp [cell search]. Ex-prisoner A

In the country gaols...I've had inmates tell me the nurses go over their head and point the finger and they get ramped the next day. Nurse B

...the prison officers, the smarter ones, keep an eye on who's got bleach in their cell and they smell a rat straight away. Nurse H

One of the clinic staff of one of the wings in particular says, 'Oh if you want bleach you better go to the officer in your wing.' You don't want the officer to know. Ex-prisoner E

The effectiveness problems mentioned were:

I think that one of the problems with that is that many people are still carrying around the old cleaning message. Outreach Worker A

...in a situation, as they often are, where you can't rinse out the things properly after you've used the bleach the residual bleach in the thing does terrible things to your veins. Nurse C

...the bleach they're getting is double strength....They're not diluting it and it's rotting the plungers causing problems with their veins Nurse B

The hepatitis C virus is stronger than the AIDS virus. It won't kill it. So the bleach they're giving us is a non-event. Ex-prisoner E

Possible inappropriate use of bleach was suggested. After discussing the possibility of dispensers in individual cells, Nurse F responded, "So, that means a guy can cup his hand and get a handful and throw it in an officers eyes and burn them." Nurse G added, "they've got it now that it interferes with their methadone urines so there's lots of things they can do if they want to do it." [Adding a small quantity of bleach to a urine sample can prevent accurate drug analysis]

The suggestions made for improvement were as follows:

Put it within the wings so people don't have to approach the authorities. Female Ex-prisoner.

The only discrete thing is having dispensers around so they could go and get it themselves. Nurse E

I think the thing we've got to look at with bleach in prisons is 1) availability and 2) is the effectiveness. Nurse G suggesting dispensers in cells and proper guidelines.

Methadone Maintenance Treatment

The effectiveness of the methadone program was also discussed. The following beneficial aspects to the program were noted during the group:

...it reduces the amount of injecting. It reduces the amount of sharing....It's also an in to treatment services for people who haven't previously been into treatment services
Outreach Worker A

It does make prison a lot more pleasant for everybody. Female Ex-prisoner

I think it has its place. It keeps a lot of people straight [heroin free]. It minimises the self harm risk. Nurse D

The problems mentioned within the groups included: limited access to the program; limited staff and clinical resources; abuse of the program through continued drug use and diversion; complaints about dosing; and disagreements with the philosophy of the program.

The comments about the difficulty with accessing the program were:

It might be available to some people and not to others. Difficult to get can create a bit of agro [aggression] Female Ex-prisoner

The programs aren't adequate and they can't get on them. Officer

What's been lost to a large extent is that its not available to the people in gaol, currently using and not on it. They can't get a place because of the numbers flooding in. Nurse C
[Prison methadone maintenance treatment programs must accept new inmates who were on methadone treatment in the community when they enter prison]

They get fobbed off every day. Fill in another application form. How soon do you want to be on it. Nurse E

I've seen blokes have a hard time getting on that. Ex-prisoner E

In addition to the access problems within the system, Nurse A noted problems with referral of released prisoners. She stated that "public methadone units don't afford enough places to put people from prison back to a public unit."

Another dominant problem area was the inadequate support and resources to operate the program. Participants observations included:

They've put in programs such as the methadone program which operates on half of the amount of money that community programs do. A \$4 dose of methadone has to be given for \$2 inside. Officer

We need more prescribers. We need doctors and nurses and better educators Nurse A

There's a clinical nurse consultant, who does a very good job. But that's it. She's got no team but she's expected to cover 500 clients, that's crazy. Nurse E

We're thin on staff. There's a huge problem as far as people for counselling services and just nursing staff in general to sit down and talk with these guys. Nurse H

We've got this huge number of inmates who are injecting drug users but there's no one there to support the clinic staff. They're the ones bearing the brunt of it all. Nurse G

Nurse D added that the limited staffing resources were monopolised by caring for the drug using inmates when he stated:

All the drug addicts have taken up all the time at the clinic. I get to hear lots of comments about that. The crims saying, 'All the junkies are in there all the time' 'Oh, I'm sick and I can't get anyone to see me because they are always there.' It's true.

Abuses of the program were also mentioned:

Methadone is used a lot just to con the parole board. Officer

I've watched crims swapping spit into cup. Watched them glugging the spit with the methadone. That's a blatant abuse of the system. Officer

I get a bit squatted when I see the guys who are on methadone and shoot up. And they come in from the outside and take up a spot cause they've got a history on methadone. Nurse G

I found everybody knows that methadone does cause drama because people are getting stood over for their methadone. Ex-prisoner E

A final area of problems was conflicts with acceptance of the program by staff and inmates. Nurse F commented that "methadone was just feeding the bloody habit." Nurse A indicated that other staff support similar views indicating that "they find it hard to take the side of the addict." However, this view was not limited to nursing staff, Ex-prisoner E described:

Now I don't want to be near a person on methadone. They talk shit, absolute shit. Prison I was excellent because you didn't have anyone on methadone.

The suggestions to improve the program ranged from instituting complete detoxification to expanding the present program. Nurse F supported the idea of detoxification with the following statement:

Why don't we do what Victoria does when they go to gaol, off the methadone program just as quickly.

In contrast to this Nurse G stated:

I'd like to see the methadone program extended [number of places] but I'd also like to

see a more comprehensive counselling service in place.

Finally, another nurse suggested that "methadone dispensing and the counselling should be divorced from the functions of the regular clinic." Other nurses in the group supported this idea to allow more time for other clinic patients.

Other Prevention Measures

Additional prevention areas discussed in other groups included the hepatitis B vaccinations, compulsory HIV screenings and condoms. The discussion in the Prison Officers Union Group included some officers indicating problems with receiving hepatitis B vaccines. An officer indicated that DCS doesn't support the follow-up testing which is necessary to make sure that the vaccine was successful. One CHS Group discussed the effectiveness of compulsory HIV screening. Nurse C felt that it was a "non-event" due to prisoners willingness to be tested when offered voluntary testing. However, Nurse B added that there were complications with "nurses actually offering a comprehensive voluntary communicable disease screen." Nurse A supported this by indicating that some nurses refused to perform tests due to "lack of skills" or because they "don't particularly like taking bloods." She also added that compulsory testing prevented nurses from making excuses. A final prevention measure was identified by a former inmate who believed "condoms" would help stop the spread of HIV.

Stakeholder's comments on a prison syringe exchange program

Groups discussed issues which would affect the operation of a PSE. While benefits and support were expressed by some participants, discussion in each group primarily focused on barriers such as current policy and opposition from the Department of Corrective Services and custodial staff. Participants also discussed more subtle problems such as possible staff resistance and inconsistencies in drug policy which would effect a PSE.

Most of the benefits associated with a PSE were noted by the former inmates and the agency staff members familiar with injecting drug user issues. Staff member A noted "access to clean equipment" and "a means of disease prevention" as benefits of a PSE. The former female inmate added, "Improved health in terms of vein care." Ex-prisoner C illustrated the benefits from "clean, sharp needles" by pointing out marks on his arm caused by "using a blunt syringe." Other benefits included reducing the risks associated with syringe use in the prison environment. Two ex-inmates noted that it would decrease the current problems with prisoners being "stood over" [forced to steal syringes for other inmates] or risking detection by the authorities. As Ex-prisoner A noted, "You wouldn't get people [relatives or visitors] risking their visits to drop clean syringes at the side of the gate."

The majority of discussion within all the groups centred on the problems which are present or might result from a PSE. These arguments covered concerns with staff and community reactions, contradictions with values and current policies, safety, inadequate resources, and increasing drug use inside. Some participants presented these arguments as possible barriers while still supporting a PSE.

The reactions of staff to the implementation of a PSE was discussed in all groups as a possible problem with the program. Members in every group expressed concern over the officers' reaction. Outreach Worker A noted the barrier of "prison officer anxiety" over syringes. MP B stated:

I would have thought your biggest single objection, apart from any personal views people might have about helping prisoners from a moral point of view, would be the prison officers themselves who would see it as it would give prisoners easy access to syringes....and threatening to stab [them].

The prison officers were definitive in their response to a PSE. They were unanimous in their opposition to a PSE or even a pilot program. One officer stated:

In my gaol I have 200 members who are totally and unequivocally opposed. If it's ever implemented, I will take my people out [on strike].

Such an action was supported by the union as an officer noted "we have union policy and motions against this sort of thing." This opposition was not limited to officers. Some Corrections Health Service staff expressed similar views or awareness of these views among their colleagues. Nurse C stated there would be a "large number [of clinic staff] who'd be dead against it for all sorts of reasons." Nurse D illustrated this when he stated, "A lot of them [nurses] won't give them [needles or syringes] out. I won't give them out."

While the possibility of refusal to cooperate among staff was a barrier, more subtle consequences of a PSE were voiced across the groups. A common argument expressed by ex-inmates, health staff, MPs, and agency staff was the possibility that a PSE would be used to monitor prisoners for drug use. The female ex-inmate stated that accessing a PSE "could create a lot of problems for the person with the authorities....they might say you are now on supervised visits to prevent heroin smuggling." MP C felt an "adverse consequence" of PSE might be the "way in which prison officers might manipulate the system in monitoring the behaviour of prisoners." Nurse C supported such a statement with, "Whatever method you use to give people syringes, you'd be targeting them in exactly the same way that they are targeted now when they ask for bleach."

CHS staff also noted problems which a PSE might cause between the officers and nurses. In addition to monitoring the prisoners, Nurse B added:

There would be a lot of pressure on nurses to disclose people's disease status. Report to them if we know if someone is injecting or using. It could put us in a difficult position.

Nurse D emphasised the importance of officer/nurse interaction:

We operate in a system here where there's a few nurses and lots of officers....They work very closely with us. We can't provide our service unless we've got them on side. Now if we're going to be dishing out needles to junkies in the place and one of the officers gets hurt, it's going to rebound.

Other nurses agreed with the strong interaction between their staff and the officers and the need for their cooperation in managing "difficult inmates."

The MPs Group indicated that key political officials needed to support such a program for it to be successful. Although public support was noted in the MPs Group from the Commonwealth Minister for Health, MP B believed that such statements were "easy when you're a Federal MP and you don't run the prisons." All MPs in the group were in agreement that this was a political fact. MP B later added:

I just feel that unless a politician has the power to do it [call for PSE], all sorts of well meaning people can make statements about what should be done. But until somebody says, 'I'm the Minister for Corrective Services in NSW and I'm going to introduce a needle and syringe exchange into our prisons.' That's the only way you'll gauge community response. Because there will be an uproar following such a decision.

Parliamentary support was not the only area of concern. MP C noted if individuals "set the Premier up against some of his MPs opposing new programs would lead to failure."

Many arguments against PSE were based on risks from syringes noted in earlier sections. Some participants felt a syringe exchange would only escalate the syringe problem and drug use in prison. One officer stated, "If 400 syringes confiscated is only one third to one fifth of the total it would skyrocket if you started exchange." Some members of the nursing staff also agreed with this. Nurse F felt even if numbers remained the same with a strict one for one exchange it was "only going to increase tensions over safety for nurses and the officers." Nurse D supported this with his views on the inmates response to a program:

There are some people in here who would make up a fist, not a set of iron knuckles, a set of needle jobs if you give them a whole bunch of needles.

Nurse F also added that there were potential problems if security became more relaxed:

If we're going to make it legal to hand out syringes...,some officers working in the maximum security area are going to be checking the area. They're supposedly checking on suspicion of bringing contraband. They're going to half cock their gun or half heartedly do it compared to what they do now for searches. I think its only going to encourage more stuff to come in, illegal stuff to come in.

Another officer also feared a PSE may remove the obstacles for new inmates experimenting with drug use:

How do you justify giving out the syringes when now a young bloke may come in and refuse to shoot up because he's afraid of getting the dreaded [HIV]. You start giving out syringes and he may have a mate who says, 'yeah, I got the dreaded but you can go first cause I got a clean syringe' and the young guy ends up hooked on it when he gets out. You're just going to introduce more people to drugs that way.

Nurse E agreed that injecting drug use might increase "because now there are more pills than heroin."

Another problem with the program was the resource problem mentioned with other prevention programs. One officer stated:

Problem is they start up all of these programs, push them in and forget about them. So if they started it they'd have the needle machines and if they ran out the junkies would just say, 'I'll just use the same one for the next six weeks till the next ones get through.

Nurse H also observed resource problems:

I don't think any government is going to have money to actually spend where we need it.

Nurse F also noted that "we don't have the resources and we'll never have them to carry it."

Many arguments against the program developed from conflicts between harm minimisation policy and drug use policy in prison. As one officer stated, "It's really radical to supply syringes and say how you get your drugs is up to you." Another officer added that "Fifty percent of people in gaol are being punished for using so why give them the utensils to continue use?" The conflict between community policy and prison policy was also noted by Nurse I who stated:

There is a culture that exists with a lot of the first offenders...They are aware of needle and syringe exchange outside. Then there are your hard core in house long serving inmates who are used to making do.

The two different policies lead MP B to question, "if we offer it to the community why are we excluding a high percentage of people?"

Among all of the problems discussed in the groups several suggestions were made to confront the issues. Most of them centred around dealing comprehensively with the inmates convicted for drug offences. Nurse C suggested:

There is only one way it would work. You need to accept that there's a group of people who'd continue to use heroin in gaol. You set up a separate gaol or part of a gaol and the ideal place would be the new gaol, Prison 4. You have specially trained prison officers to work in that gaol. You say this is a treatment option, there are other options, there is methadone, there is detoxification, there is a therapeutic community and some people would be classified to this treatment option.

Nurse E also supported this when she stated, "I'd like to see a huge hospital, rehab station, detoxification built." In support, Nurse I added "you could skim off the existing staff that are interested and that have a lot of experience." MP C also felt that this type of approach would deal effectively with many problems:

It is so complex that you have to have a number of interlocking strategies in place to end up having some impression on the problem....I think that's actually an excellent idea to actually call it a Drug Rehabilitation or Drug Treatment Unit. You would be saying to the prison officers and the public generally that this is not just a simple solution in support of an unhealthy habit. This is drug education. This is personal health. This is counselling. This is a range of responses to people who have this need for injecting drug using.

While still adamantly opposed a PSE, one officer did state that "they should be looking at harm minimisation as a total strategy and making sure what we've got is effective."

Other less comprehensive suggestions addressed problems with staff reluctance, high populations of drug users in gaol, and safety issues for PSE. In the area of staff disagreement with prevention programs, Nurse B suggested that "Corrections Health Service work with the staff doing in-service and actually doing values clarification for the staff." MP C suggested problems with convicted drug users should be addressed in conjunction with developing a PSE:

If you take up the issue of public education in the sense that no drug user should be in gaol [emphasis added by participant], I think the community is ready to accept that. If you could take up the proposition that the police should alter by policy their attitude to charging people who are simply personal users then you might get a dramatic shift in prison intake of IV users.

Another suggestion that arose from the arguments of safety issues was the concept of a "shooting room." Nurse G stated:

I think we should have a shooting gallery in every wing. That's what they are doing outside so it would be a safe way, one for one....The needle doesn't leave the shooting gallery.

Ex-prisoner B suggested an arrangement "like the methadone clinic where you go into a room and shoot the stuff up." Ex-prisoner A added, "Yeah, have a two way mirror so they can observe you and you must dispose of the implement when you leave." Further suggestions on the practical operation of a PSE are included in "Protocol for operation of a prison syringe exchange pilot" page 28.

Follow-up surveys

Surveys (see appendix 3) were sent to 22 participants in six groups. Sixteen useable surveys were returned. The Researchers' and the Prison Officer's groups received copies of the drafted report for review in substitution for the follow up survey.

When asked if they were able to express their opinion, 15 or 94% (n=16) said yes. One participant answered No because of other members interrupting during the discussion. Fifteen or 94% (n=16) of the participants stated they had not changed their views since being in the group. Some participants restated their views on the form. One did not answer the question but

wrote personal views held on PSE. Respondents were asked if they thought the people who did the study listened to their views. All (16) answered Yes.

The sections for open answers reflected the range of views expressed in the groups. The views expressed in the write-ins were as follows:

The same. NO SYRINGE EXCHANGE. [Emphasis included in survey]

That needle and syringe exchange is an important harm minimisation strategy that would benefit the prison client group enormously. A planned and reasoned approach involving all the major stakeholders is imperative for the introduction, implementation, and success of the program.

I am still in favour of some sort of "shooting gallery" type supervised arrangement.

The final section of the survey provided opportunity for additional comments to be made. These included:

Legal issues on condom use as weapons.

...the fact that trafficking needs to also be addressed

Privacy for inmates as far as syringe use.

One respondent noted that the focus groups may have hindered discussion of risks due to fears of being seen as irresponsible, ideas behind relationships in prison, or fear of revealing HIV status.

Protocol for operation of a pilot syringe exchange in prison

All groups, with the exception of the prison officers, discussed the practical operation of a PSE if it were implemented. A variety of suggestions were recorded among CHS staff, inmates, and community agency staff for the location of a PSE. Most arguments were divided between the stable environment of higher security level prisons and the minimum security or remand prisons where drugs were more prevalent. The common operational concern across these groups was avoiding inappropriate use of a PSE to identify drug using inmates. Officers had unanimously opposed even a pilot program so no input was provided from their group.

Prison Type

A wide range of issues were mentioned as criteria for selecting the prison to pilot the PSE. The majority of discussion within the groups was the debate between placing the program into a stable environment or placing it into an area with a greater amount of drugs.

Suggestions for the stable environment of a maximum security, sentenced prison were provided

by nurses, ex-inmates and an MP. Nurse A suggested placing it in a "maximum because it's a stable environment....you could use one of the Swiss systems in a gaol with a stable environment." Nurse G also suggested "SPC [Special Purpose Centre]" because it was a "smaller more controlled environment." The Ex-prisoners from Group 7 agreed on a maximum security and sentenced gaol and elaborated on why. Ex-prisoner C stated:

You're aiming out at long term prisoners first. You really want to get people doing six or more years with four or more of those six years to go. So you can educate those people and while you're educating those people they're out educating the others.

The inmates then suggested some of the maximum security gaols with which they were familiar. MP B felt that a stable environment was necessary as opposed to the "volatility and particular difficulties" of remand centres.

In contrast to this, some participants felt that prisons or sections of prisons with more drug use were favourable areas for a PSE. The former female inmate suggested "minimum" security prisons because "they're more laid back in minimum [low security]" and "it's easier to obtain drugs." Ex-prisoner A also agreed with an area with more drugs such as "Remand...because that's where they're [inmates and drugs] coming in off the street." Nurses from the CHS Staff Group (II) also felt that remand was an important area because of its lack of other prevention programs. Nurse E felt remand would be a good area because "the majority of requests [to go on the methadone program] came from remand." Nurse G supported this and stated "that's where the majority of the problems are."

Another area of division on the prisons was between male or female prisons. Some participants felt male prisons were more likely because of their larger numbers. The former female inmate stated:

I suppose you'd have to start with a male [prison] wouldn't you. I don't like saying this because I think female prisons get ignored a lot but there's more people there [male prisons].

Ex-prisoner D agreed with this noting that there were only "two female prisons in NSW." However some participants felt that female prisons had a greater drug problem. Nurse D pointed out:

It's significant that Prison 5 wasn't mentioned. It's a very big problem there [drug use]. They're a different lot too. Their remand has far more drugs going in and it's a lot easier [to smuggle drugs in].

MP C also supported Prison 5 as a "good place to do a pilot."

One final option was presented by MP A who felt that a private prison would be a better choice for the pilot. The motivation behind this was that it "would bring in more guards who don't have any background [with prison syringe problems or objections]."

Operational management

The range of suggestions on who should distribute the syringes included: Drug and Alcohol workers of DCS; Corrections Health Services staff; prisoners; outside agencies; or vending machines.

Suggestions arose from Outreach Worker A and Nurse F to give the responsibility to the Drug and Alcohol workers in the prison. When it was pointed out to Outreach Worker A that this was under the DCS, he felt they might not be appropriate. However, Nurse F stated:

The professional health employee that should run it should be the Drug and Alcohol people. If we're going to foster their habit, why don't they look after them? They're Corrective Services.

Other nurses in the group opposed the idea of Drug and Alcohol workers running it due to the lack of cooperation coming from them. Nurse I stated:

We aren't going to have any feedback from the services in Drug and Alcohol. I refer all of them [inmates with injecting drug use problems] and that's [no feedback] all I've got. I'm not quite sure what they do.

Ex-prisoner B felt operation of the PSE should "not be controlled by Corrective Services" for fear of monitoring.

Support for CHS staff distributing syringes was divided. The ex-inmates supported nurses distributing the syringes. Ex-prisoner A felt they [nurses] are closer to the inmates. Ex-prisoner D said he would rather be picking up from a nurse than someone else. Nurses indicated the problems this would cause with their working relationships with officers. Suggestions to bypass these problems included specialised nursing staff. Nurse H stated:

I don't think you could have the clinic nurses doing anything. You'd have a special group of clinical staff who are not nursing staff related to general clinic cause they'd get pressure from the officers. A special group of clinical nurses to look after that area so they could keep accounts.

Some participants suggested this could be a component of the methadone program staff. Nurse I suggested:

I think a dedicated staff who work with the methadone clinic hand in hand. They're there in a dual role which would overlap some of the time. There's an understanding with the group of people whereas if you disseminate that role [syringe exchange] you have [some nurses who are] for and against.

Nurse I also added this would be valuable for "case management" of the participants. Nurse C repeated his suggestion of the specialised prisons or sections and suggested that the staffing of the PSE would "need custodial people and health people."

Mixed views were presented regarding prisoners running the PSE. Ex-prisoner E felt the sweepers should handle the exchange:

You give the sweepers a box of them [syringes]. Once a week he goes around with the box of fits and throws them on every bed.

While Outreach Worker A felt that "prisoners would be fantastic," the former female inmate felt there could be problems with confidentiality. She stated that the prisoners operating the program might use it to learn who has "a whole load of gear [heroin]" and that might cause standovers [threats to obtain the drugs]. Nurse B however felt that they would have to be involved at some level to help "facilitate things."

Vending machines, like the Swiss program, were also suggested for the PSE. The Community Agency Staff participants agreed when Outreach Worker A stated:

You may find that the best mechanism is to run it through the kitchen or the wings with whichever mechanism the people use as a distribution technique. I really like the idea of vending machines.

Nurse H felt this solved problems with tensions from officers or nurses also:

...vending machines, that sounds like a good idea because no prison officers would be involved. There'd be no nursing staff involved. It could be placed in a discrete area. They'd have to put one syringe in.

Ex-prisoner C also agreed with the vending machines suggesting that "you have one on each landing or one in each cell block."

A final suggestion arose in the Community Agency Staff group where they discussed the possibility of an outside agency operating the PSE. This idea presented problems with security for the worker who came into the prison. However, group members did provide suggestions for its operation. Outreach Worker A suggested:

I think if the security issue was dealt with...the first time you go in you'd want to break ice and become known.

This networking would familiarise the worker with the prison network and who had syringes for exchange. The former female inmate also suggested:

Even if you logged in the health area. Like have a private room in the health area and people come over wing by wing and see you rather than you turning up at the wing. You being at a central area and they come to you as long as everything was 'OK' with the wardens.

However, additional problems were foreseen if prisoners requested more syringes than a one for one exchange would allow.

Prison Regulations

Few comments were made on the regulations that would need to be changed to implement a PSE. Nurse D state that "presently, if a prison officer is searching a cell and finds a syringe they [the inmates] get charged and they go to court." Outreach Worker A suggested a similar change to the regulations as instituted in the Swiss PSE pilot:

If we get this approved then it could be a matter of the syringe is legal as long as it's within the hit kit as long as the hit kit is within such and such a space.

Nurse C stated that more extensive changes would be necessary for the success of such a program:

Now unless you have some acceptance, either implicit or explicit, in the fact that they [prisoners] are using, they will simply be punished and it will defeat the whole exercise because they won't go to get a clean fit because it will mean they'll get tipped to another gaol, lose their class, lose their buy up, lose their visit. You will defeat the purpose of the program because you will build in the disincentives to use the clean needles.

Access Limitations

Few suggestions were provided for the limitations on access to the PSE. Outreach Worker A felt that "defining the population by location such as wing would be difficult" and could "antagonise people by selective availability." Nurse A stated:

We would have to watch the ones that are developmentally delayed, the ones that have tried it once or twice, people with psychiatric illness, and violent people [who use] heroin in gaol because they get bored.

In contrast to this, Ex-prisoner A felt the violent offenders were well informed and "they would want to be involved." A final suggestion from Nurse E was to limit it to people on the methadone program waiting list:

Maybe we should work this needle and syringe exchange in with the methadone program. We say, 'OK, your name is down on the list. We know now that you'll be waiting anything from between one month to two years before you get on. We'll do a needle exchange in the meantime until we can get you on the program.

Injecting Equipment

There was more consensus on the equipment which should be provided by the exchange. Most participants felt that complete injecting kits should be provided by a PSE. These kits would include syringes, swabs, distilled water, spoon, and filters. The suggestions included:

Distilled water, bleach Outreach Worker A

Cotton wool for filters, swabs, spoons would be a good idea as well...an injecting kit.
Former female inmate

Condoms Nurse B

A fit pack...a syringe, normal saline, swab Nurse E

If you're going to give out the fits, why not give out all of that. Nurse C

Swabs Ex-prisoner F

Distilled water Ex-prisoner D

Nurse G also felt that "retractable needles" and "one-use syringes" would be a good suggestion to prevent safety problems.

The issue of larger barrels was a problematic area in two groups. Outreach Worker A stated:

I've actually been rung from Prison 6 with people asking me how to stack [inject] the three types of steroids that they've got. So they're getting ampoules of steroids. It's not just a matter of injecting cocaine, heroin or amphetamines.

However, Nurse A felt that larger barrels may be used to inject methadone:

This is where I get a bit twitchy because I don't know how many people do shoot up methadone in gaol....I don't know if I could handle those sorts of barrels going out.

Protocol for evaluation of a pilot syringe exchange in prison

The last focus group conducted for the study concentrated on the requirements for evaluation of a pilot PSE program. The participants were research experts in the area of HIV/AIDS, prisons, or injecting drug use. The participants for the researcher group are listed in Table 1. The researchers discussed what indicators would be most appropriate to evaluate a PSE and the research methods to document them. The indicators and methods for measuring them are summarised in Table 2.

Table 1
Researchers from Group 8

RESEARCHERS	
AMA Consultant	Criminologists A-B
Ethnographer	Epidemiologist
Prison Consultant	Psychologist
Public Health Officer	Sociologist

Indicators

The researchers identified several indicators of the effectiveness of a PSE. Those identified for positive outcomes included: reduction in transmission of HIV or hepatitis B or C; reduction in sharing; reduction in the circulation time for syringes. Indicators for negative consequences were: assaults; conflicts between officers and inmates; increase in number of injectors; increased syringe confiscations; and increased drug use.

Certain indicators were noted as better measures than others. Participants indicated that the low prevalence of HIV would make it difficult to be certain whether observed differences in infection rates were meaningful. The prevalence of hepatitis C is greater and less politically sensitive. The problem with using hepatitis C or B as an indicator is the six month incubation period before a positive result registers. Prisoners using the program would need to be there for longer time periods, such as those in maximum security, to detect seroconversion. Participants also proposed that reduction in the circulation time for syringes would require some type of syringe marking so that they could be tracked from time of exchange to return. The machine distribution was noted as preferable for this type of tracking. Participants agreed that initial levels must be measured before intervention for all indicators.

Many of the researchers indicated that the complex prison environment could cause many interfering variables. Conflicts between staff and inmates could negatively affect the operation of the program. The culture of the prison would influence the effectiveness of distribution by a machine, by clinic or Drug and Alcohol staff. There were also additional problems with possible infection through sexual activities or tattooing.

Method

Various research methods for evaluating these indicators were proposed. Clinical evaluation of all participants would identify any seroconversions. Interviews and focus groups were discussed for identifying conflicts and other social influences within the prisons. The idea of marked syringes was indicated to record circulation times. Prison records could be monitored for increased assaults and drug seizures. Urinalysis was also proposed for increases in drug use.

The participants agreed that a proper evaluation would require a two year time frame. They also agreed that the effectiveness of all other prevention measures would need to be maximised. The epidemiologist proposed to follow one prison for the intervention and one for the control. Measurements in the intervention prison would require pre-intervention and post-intervention monitoring.

Table 2
Indicators and Methods for Evaluation

INDICATOR	METHOD
HIV transmission	Antibody test Antigen test PCR
Hepatitis B or C	Antibody test
Reduction of sharing	Self report Blood type in syringes
Reduction of circulation time	Marked syringes
Assaults	DCS records
Conflicts between staff and inmates	Interviews Focus groups DCS records
Increase in numbers injecting	Self report Hair testing
Increase in syringes confiscated	DCS records
Increased drug use	Self report

INDICATOR	METHOD
	Hair testing

Discussion

Group discussion highlighted the complexity of developing and implementing policies on HIV prevention in prison. Participants drew attention to many problems with current prevention measures which would also affect the development of a PSE. Resources supporting these programs are limited. Policies and attitudes to harm minimisation for drug users in the community conflict with those within prisons. The ambivalent commitment to harm minimisations in prison impairs the effectiveness of measures such as bleach distribution and methadone provision. Custodial and nursing staff were divided about the appropriateness of prevention and harm minimisation in correctional settings. These divisions need to be resolved to improve the effectiveness of existing and possible future HIV prevention measures.

Discussion of PSE revealed many barriers to implementation. Perhaps the most crucial factor likely to determine effectiveness of PSE would be staff support. The Prison Officers' Unions are unequivocally opposed to the program because they believe it poses a threat to their safety. These concerns would need to be addressed before a PSE could be considered. Any pilot PSE would need to be developed in consultation with prison officers and acknowledge their concerns. Some CHS staff supported PSE while others expressed strong opposition. This suggests that there may be problems if CHS staff who objected to the program were forced to take part.

The cooperation of the prison officers is the most critical element of implementing this program. Even if officers were required to take part on a voluntary basis, the Prison Officers Unions may consider the risks too great to support such a program.

Appendices

Appendix 1 Consent form

UNSW CONSENT FORM FEASIBILITY RESEARCH INTO PRISON SYRINGE EXCHANGE

Principal Investigator:
Dr. David Dixon
Faculty of Law
UNSW

Contact: Scott Rutter
Research Asst.
NDARC - UNSW
ph 398-9333

You have been asked to take part in a group discussion of the problems and/or advantages of setting up a prison syringe exchange. This discussion group is part of a larger project exploring the possibility of a syringe exchange scheme in Australian Correctional Centres. The purpose of these discussions is to allow groups who will be affected by syringe exchange to explore the possible results of prison syringe exchange and any alternatives. During the discussion, the group will be asked general questions about syringe use in prison, how a syringe exchange might work, and possible problems associated with syringe exchange.

The groups will include 4 to 10 participants. The discussions will last approximately one hour. You will be encouraged to respond to the questions and provide your opinions. Responses will be tape recorded during the discussion. You will not be personally identified with your response in any way. All responses will be kept strictly confidential.

Your participation is strictly voluntary. If you are uncomfortable discussing a topic, you do not have to answer. If, at any time, you wish to leave the group, you are free to do so. If you wish to provide information in a private interview, that can also be arranged. There is no penalty for refusing to participate in these groups.

If you have any questions about the project or the discussion groups you may ask the researcher at any time. If you agree to participate in the project please sign the following statement:

I, _____, understand the purpose of the study entitled Feasibility Research into Prison Syringe Exchange, as explained above. I consent to participate in the study and to permit the recording of my discussion responses for the purpose of the study. My consent is voluntary and I understand that all information will be handled in the strictest confidence and that my participation will not be individually identifiable in any reports. I further understand that there is no penalty or prejudice of any kind for not participating in the study and that I can withdraw at any time.

(Signature) - Participant _____ Date _____

(Signature) - Witness _____ Date _____

Appendix 2 Instrument

DISCUSSION AREAS

Introduction

5 min KD

Introduce facilitator, recorder, and participants. Provide a background on the feasibility study, its funding, and other groups that have been completed. Ask if everyone is comfortable with tape recording the discussion. [Have participants sign consent forms.] Emphasise that we are attempting to access potential benefits or problems of a working syringe exchange strategy for HIV and hepatitis prevention among prison syringe users. Note that everything is strictly confidential and the study will not identify individuals with statements made in the group. Request that all participants also keep everything discussed confidential as well. Emphasise that there is no right or wrong answers and that all opinions - negative, positive or indifferent- are important to the study. Responses should be based on the respondents own knowledge and experience with the issues. Inform participants that an opportunity for feedback would be available at a later date and ask if they would be willing to participate. Ensure everyone is clear on the procedures and the study.

I. General Views

10 min KD/SR

Provide a brief background on the state of syringe use in NSW prisons (KD)
Overview of the two PSE programs in Switzerland (SR)

Ask each person to provide key words or statements about syringe use in prison.

Focus on the following:

Current injecting practices in prison.

Safety problems surrounding injecting for inmates and/or staff.

Health problems surrounding injecting for inmates on release.

How are syringes introduced and disposed of?

Accepted truths about syringe use, HIV, and Hep in prison.

Discuss with the group what this means

II. Reactions to PSE and HIV Prevention

10 min KD

Current Measure?

Benefits

Problems

Ways to improve

Education

Segregation

Bleach

Methadone

Other

Focus: What are the current HIV prevention measures?

How effective are the current HIV prevention measures?

What alternatives are there?

How would the alternatives work?

III. Questions for [Specific Groups - See "Questions"]

10 min KD

IV. How to Do It (Pilot)

10 min KD

List and Priorities:

Which Prison	What equipment is provided
Which Section	Regulations changed or added
Who runs it	Who gets it
Confidentiality protection	Insurance of safety of inmates and staff
What advantages would PSE have?	
What disadvantages would PSE have?	

V. Summarisation

5 min KD

Consensus of recommendations and obstacles to PSE
Other options for the future
Role of Corrections Health Service in HIV/hepatitis prevention

Questions:

1. Questions for Custodial Staff

- What are the issues surrounding HIV/hepatitis for officers?
- What types of HIV/hepatitis prevention measures do officers believe would work best?
- How are syringes used as weapons?
- How would custodial staff suggest dealing with syringe use in prison?
- What are the major safety issues surrounding a PSE?
- What alternatives are there for prevention of HIV or hepatitis?

2. Questions for Inmates

- Would injectors in prison use a PSE?
- What barriers would stop them from using the PSE?
- What are the current options for disposal of equipment?
- How often do inmates dispose of needles?
- What options should be available for disposal?

3. Questions for Health Services Staff

- What types of health problems resulting from syringe use are dealt with by CHS?
- How are diabetic syringes dealt with in correctional centres?
- Would a PSE pose a safety problem?
- How supportive would the health services staff be of a PSE?
- What are the major difficulties with being supportive?
- What impact would a PSE have on CHS staff's interaction with the custodial staff?

4. Questions for Community Agencies

- What are the issues for the community?
- What role would community agencies play in a PSE?
- How do prison syringe and HIV/hepatitis problems impact the agencies?

5. Questions for MPs

- What are the current policies affecting HIV/hepatitis prevention in prisons?
- How effective have these policies been?
- What other options does the government have for HIV and Hep prevention in prisons?
- What have the political reactions been to calls for PSE by public health officials?
- How would the public react to PSE if it were introduced?

6. Questions for Researchers

- What prototypes of pilot PSEs suggested from previous groups seem most feasible?
- What indicators should be studied for evaluation of a pilot PSE?
- What methods should be used in the evaluation of the pilot PSE?
- What guidelines should be followed for the implementation and evaluation?

Appendix 3 Follow up survey form

**FEASIBILITY RESEARCH
INTO THE EXCHANGE OF INJECTING EQUIPMENT IN PRISON**

FOLLOW-UP SURVEY OF PARTICIPANTS

You may remember being asked to attend a focus group on prison syringe exchange. We want to know if the controversial topic influenced your inability to attend. Please complete this brief questionnaire. You may add comments if you wish.

PLEASE DO NOT WRITE YOUR NAME ON THIS SHEET.

1. Do you think you would have been able to express your views in the focus group?

Yes _____ No _____

If No: Why?

2. Do you think the people who are doing the study would have listened to your views?

Yes _____ No _____

3. What are your views on the possibility of syringe exchange in prison?

4. Are there any additional issues that we should consider?

RETURN SURVEY ASAP (ENVELOPE ENCLOSED). THANK YOU.

Appendix 4 Interview and Group schedule

Interview 1	Researcher - Dr. Rhis-Middel/Swiss Federal Office of Public Health 20 March 1995 at NDARC Interviewers: Kate Dolan and Scott Rutter	
Group 1	Community Agency Staff 18 April 1995 at NDARC Facilitator: Kate Dolan	2 user group representatives* Recorder: Scott Rutter
Group 2	Ex-prisoner Group (I) 26 April 1995 at the Gender Centre Facilitator: Kate Dolan	2 ex-prisoners; 1 staff member* Recorder: Scott Rutter
Group 3	Members of New South Wales Parliament 3 May 1995 at the NSW Parliament House Facilitators: Alex Wodak, Kate Dolan	4 MPs* Recorder: Scott Rutter
Group 4	New South Wales Prison Officers' Union 10 May 1995 at the PSA Headquarters Facilitator: Alex Wodak	40 delegates* Recorder: Scott Rutter
Group 5	Corrections Health Service Staff (I) 16 May 1995 at NDARC Facilitator: Kate Dolan	3 nurses* Recorder: Scott Rutter
Group 6	Corrections Health Service Staff (II) 29 May 1995 at the Nursing Administration Building-Long Bay Complex Facilitator: Scott Rutter	6 nurses* Recorder: Kate Dolan
Group 7	Ex-prisoner Group (II) 30 May 1995 at NDARC Facilitator: Kate Dolan	4 local hostel residents* Recorder: Scott Rutter
Interview 2	Male Ex-prisoner - Member of local prisoner advocacy group* 30 May 1995 at NDARC Interviewer: Scott Rutter	
Group 8	Researchers 2 June 1995 at NDARC Facilitator: Alex Wodak	9 researchers from Sydney* Recorder: Scott Rutter

71 Group Participants

2 Individual Interviews

*Names have been omitted to protect anonymity of the participants. Individuals are identified

by letter in the report.

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