Needle Exchange in Prison
Carol Polych, MSc, Nursing; PhD, Adult Education
Canadian Harm Reduction Network: http://www.canadianharmreduction.com/

Illegal drug use in Canada continues in spite of the incarceration of legions of illicit drug users, dealers, growers, and manufacturers, held captive in a senseless draconian war against drugs. About 93% of the money spent each year on Canada’s Anti-Drug Strategy goes to enforcement that is supposed to reduce the supply of illegal drugs, despite documentation that drug seizures have no effect on street availability, price to the user, or overdose (Wood, et al., 2003). As the war has ground along, the price of cocaine, for example, has fallen dramatically even as purity has increased; In 1981, one gram of cocaine cost US$600, but 25 years later in 2006, the same gram only cost the end user Cdn$70 for 99%-pure cocaine (UN Office of Drugs and Crime, 2009, p. 261). Prohibition just isn’t working -- again. Not in the community and not in prison either.

In Canada, 17% of male prisoners and 14% of female inmates admit to injecting drugs while inside, 60% of the time with a used syringe ([Correctional Service of Canada] CSC, 2010, p. 12). Anecdotal evidence, however, places the benchmark closer to ⅓ of those who are incarcerated injecting illegal drugs while behind bars. Voluntary urinalysis for drugs showed that 11.3% of inmates tested positive for drugs, with the same percentage refusing to be tested (CSC, 2008). In British Columbia, incarceration has been shown to increase the risk of catching Human Immunodeficiency Virus (HIV) infection by 2.5 times (Werb et al., 2008). And death from overdose has been documented at a rate 20 times more often among those behind bars in provincial custody and 50 times more often among inmates of federal penal institutions than among people living in the community (Fruehwald & Frottier, 2002).

Line Beauschesne (2002) professor of Criminology at the University of Ottawa, advised the Senate Special Committee on the Non-Medical Use of Drugs that Canada has the second highest rate of drug-user imprisonment in the world, after only the land of stars and bars (Hedges, 2006, p. 18). Roughly 150,000 Canadians yearly are under the supervision of the criminal justice system (Prison Justice, 2007) with almost 40,000 people locked up in 2009 (Statistics Canada, 2009). As of 2002, Canadian drug laws had criminalized an astonishing 1.5 million Canadians for simply using marijuana (John Howard Society, 2002), with 56,870 more charged last year alone with possession (Statistics Canada, 2011). In Ontario, police laid drug charges in 22,500 incidents in 2003, which resulted in a conviction rate of about 30% for possession and about 40% for trafficking (Canadian Centre on Substance Abuse, 2006). The Correctional Service of Canada (2007) found that roughly 80% of inmates arrived for incarceration with a serious substance abuse problem, half of those imprisoned had committed their crime while under the influence, and 90% of offenders had been previously convicted. (It almost makes you think that something isn’t working.) But the
Federal Conservative government under Stephen Harper is expanding prison capacity by a further 5,775 beds (Piché, 2010), even while the crime rate has dropped like a stone to its lowest level in 38 years (Statistics Canada, 2011). Who is the government planning to incarcerate next?

Despite tacit recognition of illegal drug use in prison, the crying need for appropriate intervention is met only by deliberate ignorance and calculated neglect in Canada. In 2007, Stockwell Day, Canada's Public Safety Minister in the early years of the Conservative Federal regime, exercised the power of his office to shut down programs for safer tattooing, established in 6 prisons, claiming that he didn't want to “waste taxpayers' money.” In that same year, 68% of inmates admitted to getting a tattoo behind bars and 60% had received a piercing (CSC, 2010, p. 22). The Chief Public Health Officer of Canada, Dr. David Butler-Jones, was concerned then about the staggering potential consequences of the programs' closure. He said that the safer tattooing program would have recovered the full annual implementation cost of $100,000 cost per prison by preventing only 4 new Hepatitis infections yearly, but it was not given enough time to demonstrate its worth (cited in Kondro, 2007a).

This backward step was followed by another. Also in 2007, Day, an active fundamentalist-Christian (Hedges, 2006) and extreme right-winger (Hoover, 2000), cancelled consideration of implementing needle exchange behind bars (Kondro, 2007b). This foolhardy action flew in the face of evidence from the Public Health Agency of Canada that needle exchange behind bars clearly decreases infection rates while causing no new security problems (Elliot, 2007). His alleged concern for taxpayers' money just doesn’t add up, considering that the lifetime cost of treatment for one Canadian who contracts HIV in Corrections (or elsewhere) is estimated to be over $250,000 (Werb et al., 2008). Werb et al. further point out that genetic typing of HIV now enables identification of the exact source of infection, evidence that may open the door to financial compensation for preventable infection, similar to that provided for some Canadians who tragically acquired Hepatitis C Virus (HCV) through government laxity about the safety of blood harvested in blood banks.

Government closure of the safer tattooing program and stonewalling of needle exchange took place in 2007, even while the prevalence of HCV among the 13,250 prisoners held by the federal system was documented at 31% (CSC, 2010, p. 32), a stark contrast to the less than 1% Hepatitis C infection rate found among Canadians living in the community in 2004. About half of all inmates were tested for HCV upon admission to prison (CSC, 2010, p. 29); of the men who tested negative upon arrival, 4.4% later reported that they contracted HCV over the next 2.9 years that they were imprisoned (CSC, 2010, p. 35). Between 2007, the time that prison needle exchange was blocked and safer tattooing programs were closed, and 2010, the rate of known HIV infection among male prisoners tripled from 1.5% (CSC, 2007) to 4.5% (CSC, 2010, p. 31) and the rate among women was 7.9%.
The CSC study, carried out in 2007, was based on voluntary self-report, that is, on information already 4 years old, which likely seriously underestimated the amount of HIV present in prisons. Even so, this rate compares at about 15 times higher than the 0.3% rate of HIV infection among people living in the community at that time. This figure is supported by data from Vancouver, which shows that, in 2007, among people who identify injection drug use as the means by which they contracted HIV, 20% reported that they caught the virus while they were in prison (Kerr, 2007). About 30% of people who test HIV positive are also known to have HCV infection (Cowan-Dewar, Kendall, & Palepu, 2011): double trouble. And who knows what the figures are now, 4 more years into the epidemics?

Incarceration has been found to not reduce injection drug use whatsoever (Public Health Agency of Canada, 2010, p. 12). The Cedar Project found that 41% of young Aboriginal people struggling with drug dependency had already spent time in Corrections. Upon being asked in 2007, 17% of men and 14% of women admitted to injection drug use while in federal prison (CSC, 2010, p. 39) and, of those who injected their drug, 55% of men and 41% of women reported that they had shared needles. In 2003, male injection drug users in provincial prison in Quebec were shown to have an HIV prevalence of 7.2% while, among those who did not inject, it was 0.5%. Hepatitis C prevalence among men who injected was 53.3% and 2.6% among those who did not. Among women in prison who injected, HIV was shown to run at 20.6% and HCV at 63.6%, while among women who did not inject, the prevalence of HIV was 0% and HCV was 3.5% (Public Health Agency of Canada, 2010).

Bleach to clean used needles is supposed to be provided by Correctional staff upon request, and 57% of men said that they did ask for it, however 37% also reported access problems. Sixty nine percent of inmates did clean their needle with bleach; so did most (60 to 68%) of the 70% of inmates who received a tattoo or piercing while incarcerated (CSC, 2010, p. 22). Prisoners clearly are making use of what harm reduction measures are open to them, despite the breaches of confidentiality experienced, for example, when they have to ask Correctional staff for bleach.

Prison needle exchange was begun by physicians in Switzerland 20 years ago in 1992, and now takes place in 60 prisons around the world from Germany and Spain to Kyrgyzstan and Iran (Chu, 2009). Uninformed Correctional staff have expressed many fears about needle exchange that are not supported by research or in practice. They fear that needles may somehow be turned against them as weapons. This has not ever happened in any prison program anywhere around the world. Staff may also fear an increase in needle stick injuries. Evidence shows however that used needles are consistently placed in safe disposal containers, not hidden everywhere; so workplace safety for Correctional staff is actually improved since needle stick injuries become even more rare. Another common objection is the sense that staff, expected to eliminate drug use
in prisons, are condoning or even encouraging drug use by implementing needle exchange. Evidence from around the world, though, shows that drug use does not rise with prison needle exchange, rather referrals into treatment rise (Jurgens, Ball, & Verster, 2009, p. 59), possibly due to more positive, respectful contact with staff. Further, Corrections already has acknowledged that injection drug use is common in prison, as evidenced by the provision of bleach. Staff may also raise the issue of the cost of needles, but the cost of treating illness contracted through injection drug use while in prison eclipses the relatively low cost of providing sterile needles. Seems like needle exchange just makes practical good sense for everybody, inmates and workers alike.

Set aside for now the incomprehensible response to addiction of imprisonment, particularly in a system where illegal drugs are rife but treatment is almost unattainable. Incarceration takes an already vulnerable population and places their every movement under the authority of the state for the duration of the sentence, during which time Corrections assumes the responsibility to provide for the ordinary care and safety of the inmate, all within the purview of security. Together with the acknowledged mandate to protect the public from individuals who might pose a risk, Corrections has also been charged by the courts with the responsibility to ensure that those under its supervision receive the same level of health care as that provided to citizens living in the community. However the current practices of Corrections Canada place its charges squarely in harm’s way. Other deadly infections wait their chance to pounce. For example, HIV infection makes a person more susceptible to Tuberculosis (TB). Sterling et al. (2006), estimated that 12% of all new TB infections yearly are acquired in prison. It is only a matter of time until the more deadly strains of multi-drug resistant TB are loosed behind bars, where, in such a closed and crowded environment, transmission is efficiently facilitated. From prison, TB is sure to travel home with correctional officers, visitors, contract workers, and released prisoners. For that matter, so are Hepatitis and HIV.

Needle exchange and safer tattooing provisions make Corrections a safer, saner place for inmates, workers, and the community. Even if Corrections Canada’s stated goal is perfect abstinence, Harm Reduction can be understood and implemented as simply the first practical step to keep people alive until the goal is reached.

What more can we say?

What will it take?

References


