

**ANEX Conference ‘Development of Harm Reduction Approaches in Australia:
Current & Future Challenges in Human Rights’
by Dr Helen Watchirs OAM, ACT Human Rights & Discrimination Commissioner
26 October 2010, Melbourne Cricket Ground**

Thank you Professor Pennington for your kind introduction, and to ANEX for inviting me here to speak. I’d like to begin by acknowledging the traditional owners of the land on which we meet, the Wurundjeri of the Kulin Nation, and pay my respects to their elders past and present.

Today I’ll speak about the context of my work, what a human rights approach is for harm reduction, the impact of discrimination law and the need for a Needle & Syringe program at the new ACT prison, the Alexander Maconochie Centre.

Legislative mandate

The ACT Human Rights Commission (‘the Commission’) is an independent agency established under the *Human Rights Commission Act 2005* (‘HRC Act’). The Human Rights & Discrimination Commissioner’s functions are to:

- provide education, foster public debate, identify issues, and publish information about human rights and discrimination under the *Human Rights Act 2004* (the first in Australia and based on the UK model) & *Discrimination Act 1991*;
- advise the Attorney-General on anything relevant to the operation of the HR Act;
- review the effect of laws on human rights under s.41- Human Rights Audit of adult correctional facilities (2007); and
- intervene (with leave) in court proceedings under s. 36 that involve the application of the HR Act, eg ACT Supreme Court – potential litigation by detainee infected with Hepatitis C while in prison, due to lack of access to a Needle & Syringe Program equivalent to the community.

Unlike the Discrimination Act, there is no complaint handling function under the Human Rights Act, but I have an inspection power under s.56 of the *Corrections Management Act 2008*.

We handle about 100 discrimination complaints annually under the *Discrimination Act 1991*, using a conciliation resolution model. Remedies available include apologies, new policies, anti-discrimination training, public/newspaper advertisements and reinstatement in a job, home or improved services etc. The main message to get across to people is that discrimination on the basis of disability is against the law. In the case of Hepatitis, HIV/AIDS & injecting drug use, we have had several cases of health care workers calling clients insulting names such as ‘junkies’, which not only undermines self-esteem, but also is a large barrier to accessing services. Our educational work is aimed at advising people of their rights, as well as potential respondents about their obligations not to discriminate.

A Human Rights Approach

In 1989 I worked on the First National HIV/AIDS Strategy, then the Intergovernmental Committee on AIDS Legal Working Party which made its *Final Report* in 1992, and for UNAIDS in Geneva in 1997 and 1999. The IGCA Report was the platform for the 1996 *International Guidelines on HIV/AIDS and Human Rights* – both documents have stood the test of time well, except in relation to treatment advances.

Human rights reflected in UN treaties are international obligations that Australia has agreed to implement by formal ratification. Human rights are worthy of protection in their own right, but it has been increasingly recognised that public health is an additional and compelling reason to comply with these obligations. There is a challenge in identifying specific requirements for compliance to bridge the gap between aspirations in broad human rights treaties to concrete actions, which can be measured as improved or retrograde.

A human rights approach recognises social vulnerability, not just in terms of individual choice and risk behaviour – it acknowledges that disempowered populations are constrained by their social conditions and may not be fully free to choose rational actions, eg the sexual partner who is afraid of domestic violence. Discriminatory treatment increases the negative impact on people who have the virus – social and other burdens are magnified when you lose your job, need to find alternate health care, move house or find other services that are changed or removed. Lack of human rights protection also creates or further deepens vulnerability, as the impact of infection becomes disproportionate in stigmatising and isolating people in the community, and making them less able to protect themselves and seek support, testing and treatment. Detainees in prisons are a group that automatically become more prone to infection because the means of protection are removed by being made ‘contraband’, ie sterile needles/syringes & tattoo guns. There are also priority groups that are already discriminated against on the ground of race, such as indigenous people & people who are Culturally & Linguistically Diverse (CALD), not only because of the higher rate of infection than the rest of the community.

Discrimination law

Discrimination laws focus on the human right of equality covering public acts of government and private bodies (eg medical practitioners) in areas of public life. It attempts to provide a supportive environment with increasingly positive public opinion through exposing stereotyping. This legislation at Federal, State & Territory level covers disease status (actual, past, present, future and assumed status, as well as associates eg family and friends), such as HIV/AIDS and Hepatitis C as a disability.

In February 2010 the Australian Injecting & Illicit Drug Users’ League (AVIL) released a *National Anti-Discrimination Project: Qualitative Research Report*. It highlighted the negative stereotypes that many people had of injecting drug users: dishonest, out of control, lazy, violent, losers, unpredictable and unreliable. The public lacked empathy and distanced themselves from injecting drug users for several reasons including a fear of

needles and disease, disapproval of illegal drugs, and not wanting to be seen as guilty by association. Research noted a difference between younger and older health care workers with the latter being more understanding of users trying to change by seeking treatment, with others hiding behind 'duty of care' notions in order to excuse the potential negative reactions of other patients. This means that we should be focussing our training efforts on students and interns early in their health care career.

In some jurisdictions - NSW in 2002 - legislation has been amended to exclude addiction to prohibited drugs in the area of employment following the Federal Court case of *Marsden v Coffs Harbour & District Ex-Servicemen's Club* in 2001 where Justice Branson (now President of HRC) found that addiction to methadone was a disability. Ironically, the NSW Administrative Tribunal also found in *Carr v Botany Bay Council* in 2003 that the addiction to methadone was still a disability (after the amendment), as it is excluded in the definition of 'prohibited drug' under the *NSW Drug Use & Trafficking Act 1985*. In that case a worker was forced to resign from his job when he was victimised because of his need for treatment.

Criminalisation of behaviour is most pronounced in the case of injecting drug users, which is a barrier to access prevention measures and treatment, as well as information. Historically society has dealt with diseases by demonising 'vectors of infection', such as the plague, leprosy, cholera and polio – this response exposes deep-rooted shame and fears associated with contagion, illness, pleasure and death. There is an even more potent ingredient of blame in the case of injecting drug use, therefore the most resistant form of discrimination. This is explicitly noted in the Third National Hepatitis C Strategy which states that the barriers identified as needing reform in the 1992 IGCA Legal Working Party *Final Report* that have been the most intransigent are in the area of injecting drug use, specifically self-administration of drug offences, and unauthorised peer distribution of sterile injecting equipment. In the ACT our legislation does not authorise non-injecting equipment, information, secondary distribution of needles/syringes (unlike Tasmania), and self-administration is still criminalised (unlike Queensland).

The Recent Policy Discussion Paper by AVIL on *Legislative and Policy Barriers to Needle & Syringe Programs and Injecting Equipment Access for People who Inject Drugs* identifies more detailed areas requiring reform, such as:

- lack of coverage of exemptions for non-injecting equipment,
- aiding and abetting offences,
- disposal offences,
- limits on the number and size of syringes, and
- new user pay principles.

We heard similar information from speakers - Fiona Poeder, Jack Wallace and Greg Denham - at an excellent session yesterday on 'Law: what is it good for?'

Legal Working Group - Ministerial Advisory Committee on Blood Borne Viruses & STIs

As you know from the Chairperson Professor Michael Kidd, MACCBVS guided the development of the five National Strategies approved by the Australian Health Ministers' Conference. He noted that three Strategies stated that:

'In view of the well documented return on investment and the effectiveness of Australian community-based NSPs, it is appropriate ...for state and territory governments to identify opportunities for trialling this approach in Australian custodial settings. This is also supported by the international evidence demonstrating the effectiveness of prison NSPs.'

In my view the ACT is more likely than other jurisdictions to pilot an NSP in its new prison, and in 2007 the ACT Human Rights Commission recommended such a trial.

I can briefly outline the work of the new Legal Working Group co-chaired by Bill Bowtell and myself. The Group held its first teleconference on 25 June 2010, will have a first face to face meeting on 28 October and operate for 12 months. It plans to work in two main areas:

- Discrimination, including on the basis of disability, sexuality and race; and
- Barriers to NSPs, as well as criminal law, public health, drug control and immigration.

It will monitor the work of the new Global Commission on HIV and the Law, and its Technical Advisory Group - Michael Kirby (former Judge of the Australian High Court) is a member of both bodies. The Global Commission held a meeting in October 2010, and will next meet in July 2011 to consider a Report to be issued at the end of 2011. The TAG met on 17 June 2010 and will hold future meetings in January and July 2011, with four regional hearings chaired by Michele Sidibe to be scheduled during February-June 2011. TAG has two other Australian members, Cheryl Overs and Annie Madden (representing the International Network of People Who Use Drugs).

Human rights Audit of ACT detention facilities

The power of government is at its greatest where residents are detained in closed institutions by the state. People in detention are extremely vulnerable to abuses of power, and this power imbalance imposes a continual legal and moral duty on authorities and officials to act justly, to prevent abuses of power, eg Abu Ghraib. Deprivation of liberty is an extremely severe penalty and creates an obligation to ensure that other rights are not also curtailed more than absolutely necessary. People in detention are drawn disproportionately from sectors of society that are already vulnerable, such as the mentally ill, indigenous communities, and women who have experienced violence and often sexual violence. A very high proportion of these detainees have already been victims of abuse or neglect whilst growing up, and we as a society should aim to halt this intergenerational cycle.

The methodology for the 2007 Human Rights Audit of ACT adult detention facilities was developed in 2005 when the juvenile detention facility, Quamby, was audited. The Audit involved looking at all aspects of life in detention - legislation and policies governing the remand centre, physical layout and conditions. Interviews were conducted with detainees, as well as custodial and other staff, in order to get an understanding of the operational framework and culture, and we held forums with stakeholder groups. The Commission also surveyed some of the corrections documentation and video footage concerning critical incidents, for example uses of force. Other ways of obtaining information was through detainees ringing the Commission about systemic issues.

The timing was strategic, as the ACT Government had already made the decision to build the new prison, the Alexander Maconochie Centre (AMC). The Audit was a chance to benchmark existing facilities, and prevent the transfer of a negative culture to the new facility. Several earlier inquiries had already found that ACT remand facilities were worse than prison, especially the lack of space and activities. We found that the majority of staff were professional and committed to their work, but there was evidence of a bullying culture (which the ACT Government challenged). A human rights compliant prison requires more than a new building and new legislation – there must be a human rights culture, especially in management and staff. The Audit had 98 Recommendations, with the Government agreeing in full with 70, agreeing in principle with 10, agreeing in part with 4, noting 10 and not agreeing with 4.

The most controversial recommendation in the health care and services area in the Audit was to pilot a Needle and Syringe Program ('NSP') at the new prison. The recommendation is based on a harm minimisation approach that protects the rights to life and health. There was also a back-up recommendation that a 'safe injecting room' would be an alternative if the NSP was not possible, eg if staff, management and/or unions opposed the NSP. However, there is no current ACT community facility as exists in Sydney, the Medically Safe Injecting Room, described so well yesterday by Dr Marianne Jauncey. We also suggested that staff and union representatives visit prisons to meet with peers in Europe that operate NSPs, such as Spain.

The focus at the AMC has been on reducing the supply of drugs through security – electronic body scanning (SOTR), searches, urinalysis and sniffer dogs. Drugs and equipment have, not unexpectedly, already been found in the AMC. We know that injection of drugs usually correlates with higher levels of addiction, and that there is a risk of transmission of blood-borne diseases such as Hepatitis & HIV/AIDS in prisons. The rate of Hepatitis C for male inmates is about one third, and for female inmates is about two thirds. The rate of spread could be exponential when you consider that detainees return to the community fairly quickly – the average length of stay is only 7 months. The Third National Hepatitis C Strategy recognises that detainees are forty times more likely than the general community to test positive for Hepatitis C. It also notes that indigenous people are over-represented in correctional settings, so prevalence is about

three times higher than for the non-indigenous population. According to a recent NSW study, one in three prisoners are infected by Hepatitis C annually.¹

A strong human rights argument is that of 'equivalence' - there are already ACT community-based needle & syringe programs, and numerous studies, such as those described by Professor David Wilson yesterday, have demonstrated the efficacy of exchanges in communities around the world, as well as prisons in some countries. To deny protection against disease transmission in such a high-prevalence and closed population in prison may be viewed as inhumane. Current research shows that bleach is not as effective in killing Hepatitis C, as HIV. Evaluations of NSPs show reduction of needle sharing and infections, and do not increase drug consumption or demand. NSPs are also an opportunity to include safer sex education & means (eg condoms, dental dams). In the prison context they can be tailored to suit individual prison, eg Spain excludes violent prisoners. Nine countries have NSP programs in about 50 prisons – Spain, Switzerland, Germany, Luxembourg, Moldova, Kyrgyzstan, Armenia and Iran. The ACT has Methadone maintenance programs similar to those in the community.

The official ACT Government response was 'ACT Government policy does not support a needle & syringe exchange at this time. It is an ongoing matter for policy consideration' (18 months after AMC in operation from mid-2009, ie end 2010). Some unions, staff and others oppose the NSP due to occupational health and safety concerns, based on the assault of the prison officer Geoff Pearce in 1990 at Long Bay (but no NSP was in operation then). A term of the current Corrective Services staff Certified Agreement is that there must be consultation if the ACT Government is considering introducing an NSP.² The political driver for change may be not only be the Human Rights Act, but the legal duty of care to detainees if infection cases are proven, ie if a detainee tests negative on admission, but positive on release. This was the case in NSW where a negligence class action by prisoners in the mid-1990s concerning access to condoms led to reform.³

The ACT Greens issued a document 'Implementing an NSP at the AMC' in July 2010. There is a general review of the AMC being conducted by a team of consultants headed by Keith Hamburger, as well as an evaluation of drug policies and services by the Burnet Institute. The ACT was the first jurisdiction to allow distribution of condoms to detainees, but in Victoria condoms are still contraband, despite the Victorian *Charter of Rights and Responsibilities Act 2006*. The media has already noted the documentation of a detainee on remand who has contracted Hepatitis C at the AMC.⁴ The ACT Health Minister, Treasurer & Deputy Chief Minister, Katy Gallagher, at an Estimates Committee on 17 May 2010 stated that from a health point of view an NSP at the AMC is a 'no

¹ K.Dolan, S.Teutsch, N. Scheur, M. Levy, W.Rawlinson, J. Kaldor, A. Lloyd and P. Haber, 'Incidence and risk for acute hepatitis C infection during imprisonment in Australia', *European Journal of Epidemiology*, published online 19 January 2010.

² ACT Government, *Department of Justice and Community Safety Union Collective Agreement 2007–2010*.

³ M. Levy and D. Mogg, 'Moving beyond non-engagement on regulated needle-syringe exchange programs in Australian prisons', (2009) *Harm Reduction Journal* 6:7.

⁴ 'Hep C-infected inmate could sue Govt', *Canberra Times*, 19 May 2010.

brainer'. The Chief Minister, Jon Stanhope, was reported to have said to the media that, given drugs have been found at the AMC, 'I am now more inclined to believe that a needle exchange as a minimum is something that I would accept'.⁵

International law protection

At the international level there are many UN Standards etc relevant to humane detention:

- International Covenant on Civil & Political Rights (**ICCPR**) – eg humane treatment in detention;
- International Covenant on Economic, Social and Cultural Rights (**ICESCR**) – eg right to the highest attainable standard of physical & mental health;
- United Nations **Basic Principles** for the Treatment of Prisoners – eg Principle 9 'prisoners shall have access to the health services in the country without discrimination on the grounds of their legal situation';
- United Nations **Body of Principles** for the Protection of All Persons under any form of Detention or Imprisonment;
- **Standard Minimum Rules** for the Treatment of Prisoners;
- **International Guidelines on HIV/AIDS and Human Rights** – 'prison authorities should provide prisoners with access to the means of prevention (condoms, bleach, clean injecting equipment)'; and
- **WHO Guidelines on HIV/AIDS Infections in Prison** – 'all prisoners have the right to receive health care, including preventative measures, equivalent to that available in the community without discrimination...Consideration should be given to providing clean injecting equipment during detention...'

The Optional Protocol to the Convention Against Torture ('OPCAT') was signed by Australia in May 2009, and ratification is now due – this is an improvement from Australia voting against it at the UN in 2002. The OPCAT monitoring regime requires each State Party to establish or designate its own inspection body, called a National Preventive Mechanism, eg the Australian Human Rights Commission. It will establish a system of regular visits to places of detention by independent experts order to prevent torture and other forms of ill-treatment from occurring. The inspection arrangements must cover all 'places of detention' within all parts of Australia, such as prisons, juvenile detention institutions, police stations, locked psychiatric wards and immigration detention centres. It also extends to prisoner transport, court security, military detention facilities and aged care hostels where residents are detained involuntarily.

The Shelley case of a UK prisoner complaining about lack of access to a NSP failed in the European Court of Human Rights in 2008, mainly because there was no evidence that he was an injecting drug user himself, as well a technical legal issue that is not applicable to UN jurisprudence (the doctrine of the 'margin of appreciation' which allows countries a large amount of latitude in the practical implementation of human rights).⁶

⁵ *Canberra Times*, 16 September 2010.

⁶ *Shelley v UK* 4 January 2008 (23800/06).

The recent Vienna Declaration at the XVIII International AIDS Conference in July 2010 has called for the incorporation of scientific evidence in formulating drug policies, and recognises the harm that the 'war on drugs' can inflict, and its potential to waste valuable funds. Dr Caitlin Hughes presented an interesting case study yesterday on the decriminalisation of drugs in Portugal, but I think Australia is a long way from considering such a proposition.

Conclusion

The development of human rights culture consistent with harm minimisation in the ACT is a long term process of step by step continuous improvement. It is important that people know what their rights are, such as the right to life, equality and humane detention, and that agencies know exactly what their responsibilities are. The AMC is a unique opportunity to design a human rights compliant prison, which has been an arduous, but worthwhile process. The 2007 Human Right Audit recommendation to pilot an NSP requires partnership between staff, unions and management, the community, government and experts (eg public health and drug & alcohol). I am optimistic that a pilot NSP may occur in the ACT, probably implemented by an NGO, following relevant evidence based research.