

HIV/AIDS and Australian Prisons

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Much attention has been devoted recently to the plight of HIV positive prisoners. The primary reason for this interest is the fear that prisons are 'incubators' for the transmission of the Human Immunodeficiency Virus (HIV), the accepted cause of AIDS. The prison is seen as a bridge in the transmission of HIV from the recognised high-risk groups to the community at large. Put simply, the argument is as follows.

Prison populations include a disproportionate number of people who engage in high-risk activities associated with the transmission of HIV - intravenous drug users (IDUs) and men who engage in homosexual activity, often temporarily for the period of imprisonment. Prisoners are thus seen as a high-risk group for HIV infection upon admission, for the transmission of HIV infection within the prisons and for further transmission in the general community upon release.

The majority of prisoners are sexually active young heterosexual males who will resume or establish sexual relationships with wives or girlfriends upon release. The female sexual partners of prisoners who may have been infected with HIV in prison would be at risk of infection, as are the children conceived in such relationships.

The Popular Solution

In Australia there is a widespread belief that the solution to the problem of HIV transmission in prisons is a simple one: identify and isolate infected prisoners. Such a simple solution is often advocated in the popular discussions of HIV infection in prisons. The key features of the 'solution' are that all prisoners should be tested for HIV antibodies upon admission and streamed according to the result. HIV positive prisoners should be segregated in part of the prison and special services developed for them. Life in the HIV negative part of the prison goes on as normal.

This 'solution' will not stop the spread of HIV infection. It is impossible to guarantee that the HIV negative part of the prison is in fact HIV free because:

- reliance on antibody test results alone may not detect all infected individuals as there is a lag time between infection and the appearance of detectable antibodies. This means that despite the best attempts to screen and segregate there may be HIV-infected prisoners in the HIV negative part of the prison.
- the prisons are not closed institutions, nor should they be. Because the majority of prisoners are released back into the community it is widely recognised that

pre-release education and work release programs are of value in rehabilitation and social readjustment. A significant number of prisoners leave and return to the prison each day. Other prisoners attend the prison on weekends only (weekend detention). Unless the antibody status of each prisoner re-entering the prison is known conclusively at each re-entry, there is a risk that recent infection may have occurred. Again, the 'AIDS free prison' may not in fact be AIDS free.

The false sense of security engendered in regard to those prisoners labelled HIV negative and housed in the HIV negative part of the prison may lead to a more rapid increase in HIV infection than would otherwise occur. The only safe approach is to assume that all prisoners may be infected and to employ universal precautions and policies. The policies to deal effectively with high-risk activities are controversial and often at odds with the existing criminal law. Traditional attitudes and values are challenged by the need to contain the HIV infection and prison administrators will be placed under a great deal of pressure. Unfortunately there is no simple solution.

AIDS and HIV Prevalence in Australian Prisons

Information on AIDS and HIV prevalence and incidence in Australian prisons is not systematically collected, counted or analysed. In general, the data collected are fragmentary, and comparisons between the States and Territories cannot be made easily. Although similar observations were made in the 1989 report to the Australian Government the situation appears to have further deteriorated (Heilpern & Egger 1989). The information available from the prison systems is inadequate to monitor the HIV epidemic in Australian prisons. Valuable resources allocated to the HIV testing of large numbers of prisoners are being wasted by the failure to establish a proper statistical collection. The following information was collected from the seven different State and Territory corrections departments in Australia.

HIV testing in Australian prisons

Compulsory testing programs currently operate in South Australia, Queensland, Northern Territory and Tasmania for all prisoners and remandees (detainees) entering the prisons. In NSW, mass compulsory screening is being introduced from November 1990. In Victoria, prisoners are encouraged to volunteer for the HIV test as part of the reception program. Reluctant prisoners are counselled and encouraged to volunteer. The compliance rate is 99 per cent.

In Western Australia the testing program is voluntary but few prisoners seek testing. If, however, a prisoner is assessed by medical staff at reception as having participated in high-risk behaviours HIV testing is compulsory. High-risk behaviours are defined as unprotected sexual intercourse with an infected person, and sharing injection equipment. Prisoners who exhibit high-risk behaviours within the prison are also compulsorily tested. The criteria adopted to identify and classify high-risk prisoners are open to criticism as being subjective and incomplete.

The compulsory testing of staff is not undertaken in any State or Territory.

When testing occurs

In Victoria, and those administrations utilising compulsory testing, the initial test is conducted at reception. In Queensland, the Northern Territory, South Australia and Tasmania prisoners are retested after three months to detect those seropositives missed due to recent infection (the 'window' period). In Western Australia retesting of seronegative high-risk prisoners occurs after three months. In Victoria retesting is only available on request. In New South Wales retesting will be conducted prior to release. In Queensland all prisoners are also retested at twelve monthly intervals and prior to release. Queensland is thus the only State to address the problem of seroconversion within the prison. Table 1 summarises the testing programs in operation in each State and Territory.

Results

The results from the present survey conducted in October-November 1990 found that there has only been one prisoner with AIDS housed in an Australian prison, in Queensland. Seropositivity is reported in Table 2. The cumulative total of known HIV positive prisoners from 1985 to October 1990 was estimated to be 206. On 9th November 1990 there were a total of thirty-nine known HIV positive prisoners in Australian prisons (Table 2). Seroprevalence (the proportion of HIV positive prisoners as a percentage of the number of prisoners tested) could not be estimated from the data available from Queensland (no information on the number of persons tested each year and no information on women prisoners), Victoria (no data on women prisoners), Western Australia (no information on the number of persons tested per year, nor on the number of seropositive prisoners per year), and New South Wales (no information on the number of known HIV prisoners per year, nor the number of persons tested per calendar year). The only States able to provide data upon which seroprevalence could be calculated were South Australia, Tasmania and Northern Territory where seroprevalence ranged from 0 to 0.4 per cent.

No information was available as to the risk factors associated with seropositivity in Australian prisoners. The only Australian State to collect data on seroconversion, Queensland, reported no seroconversions.

The aims of HIV testing

In the 1989 study each State and Territory was asked to describe the objectives of their testing programs (Heilpern & Egger 1989). The provision of effective medical care, the monitoring and management of HIV positive prisoners, and the collection of statistics on the epidemic were nominated as the most important aims by most States. The data collected for the present research demonstrate that the latter two objectives are not being met by the testing programs.

Deficiencies in the data collected

The deficiencies were numerous and, apart from lack of comparability of different screening methods include:

- Testing programs do not test all prisoners. The numbers tested appear to comprise only 60-80 per cent of receptions. In 1987-88, 3356 prisoners were received into South Australian prisons but according to the South Australia Department of Corrections 1975 HIV tests were conducted in the same period. This constitutes only 59 per cent of receptions. The Victorian Department of Corrections informed the present authors that in 1988, 3300 male prisoners were tested for HIV which was 78 per cent of receptions. In South Australia the testing program is only directed at prisoners serving more than seven days. In Victoria prisoners regarded as 'walk through' are not tested. As the testing data indicate, the prisoners not subject to HIV testing form a modest proportion of

receptions. 'Management' decisions based on HIV status are thus based on incomplete data. Similar problems arise in relation to monitoring the HIV epidemic.

Only the Queensland program addresses the problem of the testing of existing long-term prisoners and the problem of seroconversion within the prison. In the other States and Territories a change in HIV status of prisoners may simply not be known.

- The scientific goal of adequate monitoring was not realised in any State or Territory.

In many States or Territories the data collections could best be described as hand tallies, updated as new cases are diagnosed. Only the most recent cumulative tally of HIV positive prisoners was available from several States. Such data is inadequate to monitor temporal changes in the epidemic. At the very least a statistical collection should be established whereby certain base information is collected and recorded for all individuals tested.

- Information on risk factors is not systematically collected or recorded as part of the testing programs. Knowledge of the risk factors associated with HIV infection in prisoners (e.g. IDU, homosexual intercourse) is important to understanding and preventing HIV transmission within the prisons.

Antibody Testing and its Application in Prisons

Much has been said and written about the role of the antibody test in HIV prevention in the general community. The ethics and the value of mass compulsory screening has been debated extensively. Many of the same issues and dilemmas arise in the context of prisons. Because the prison is seen to be a closed institution where the liberties of the individual have already been infringed through the infliction of punishment by the state, it is often assumed that the ethical problems and the practical problems are fewer but the ethical and practical problems involved in the applications of the antibody test are as great in the prison as elsewhere. Testing is not an end in itself. The relevant and important questions are whether the testing is voluntary or compulsory, the purpose of testing, by whom the test is conducted and the uses to which the test results are put.

A case is often made for the compulsory testing of all prisoners in order to implement different imprisonment regimes for seropositive prisoners in the belief that such measures will contain the HIV epidemic.

But the cost of complete segregation is high in financial and human terms. As the number of seropositive prisoners admitted to the prison system increases, the task may become one of segregating the seronegative prisoners. Segregation also makes it difficult to classify and stream prisoners with different security classifications. Very few prison systems in North America or Europe have been able to sustain HIV segregation programs as soon as the numbers of seropositive prisoners started to increase. Segregation is currently favoured in several Australian jurisdictions but the number of infected prisoners is still very small. The ability to be able to maintain this policy in the future must be in doubt. Mass compulsory screening is the single most controversial issue within the prison debate. Compulsory screening alone does nothing about seroconversion within the prisons and is not the best way to monitor the epidemic. The World Health Organization (WHO) has recommended against compulsory testing in prisons (Harding 1987, p. 1263):

Prisoners should be treated in the same way as other members of the community, including the same right of access to:

. . . testing for HIV infection on request, confidentiality of results, and timely pre-test and post-test counselling and support from appropriately trained people acceptable to the prisoner; . . .

Prisoners shall not be subjected to any discriminating practice, relating to HIV infection or AIDS, such as involuntary testing, unnecessary segregation, or isolation, except where that is required for the prisoner's own well being.

A similar position has been adopted by the Council of Europe (1988). In Australia, prison administrators have not yet answered some difficult questions which arise from the compulsory mass screening of prisoners:

- what role does mass screening play in disease prevention?
- in what way does mass screening improve medical monitoring and care?
- do mass screening and segregation undermine the effects of education and prevention?
- are there better ways to monitor the course of the HIV epidemic within prisons?
- do the costs of compulsory mass screening outweigh the benefits? Could this money be put to more cost effective prevention programs?
- should correctional systems be taking steps not taken in the general community?

The answers to these questions will determine many of the future policy decisions made by prison administrators in Australia.

Policies to Deal with HIV Transmission within the Prison System

Education

Education and training programs represent the keystone of efforts to prevent transmission of HIV infection in prisons and gaols, as well as in the population at large (Hammett 1988, p. 63). The study conducted by Heilpern and Egger (1989) found that all States and Territories have accepted the importance of education on AIDS and HIV infection in the prisons. Although all have introduced some form of training and education, programs differ in key areas such as:

- the point at which prisoner education occurs and the extent to which it is repeated;
- whether attendance is voluntary or compulsory;
- whether prisoners with special needs are considered (e.g. Aborigine, women, non-English speaking backgrounds);
- the content of the education (e.g. whether information on safe sexual practices and techniques for needle cleaning is provided); and
- the extent to which the education programs are evaluated and monitored.

Many of the same issues arise in the context of staff education and training. A detailed review of the content of the AIDS education programs in each State and Territory is beyond the scope of this paper. For a more detailed review of education programs see Heilpern and Egger (1989).

Accommodation

The housing of asymptomatic HIV positive prisoners or those with HIV related illnesses not requiring hospitalisation is a difficult problem for prison administrators. Prisoners in the terminal stage of AIDS are critically ill and require the same medical care as anyone else.

Segregation is not justified on medical grounds (Dwyer 1988). For these reasons, WHO has recommended against segregation and this position has been adopted by the Council of Europe.

The arguments for and against the segregation of seropositive prisoners who are not ill are similar to the arguments which have arisen in relation to compulsory mass screening.

The arguments for segregation include the following:

- segregation is necessary to protect HIV negative prisoners from HIV-infected sexual predators or violent prisoners;
- segregation is necessary to avoid transmission through the sharing of needles;
- segregation allows specific education and counselling services to be provided to the segregated prisoners;
- there is a risk of violence to HIV positive prisoners.

The arguments against include:

- segregation imposes a further and unreasonable punishment on a prisoner;
- segregation makes it impossible to maintain confidentiality of the prisoners HIV status;
- sexual predators and violent prisoners should be removed and isolated regardless of whether they are HIV-infected;
- the threat of violence to seropositive prisoners has been overstated and is not supported by the South Australian experience;
- segregation undermines education programs which emphasise that transmission does not occur through casual contact;
- segregation may actually increase the risk of infection because prisoners and staff in the areas reserved for seronegative prisoners may be less vigilant in protecting themselves.

Accommodation of seropositive prisoners in Australian prisons

South Australia, Tasmania and New South Wales have policies which integrate seropositive prisoners into the general prison population. But the Australian experience of an integration policy is largely limited to the South Australian prisons.

In Victoria there is a policy termed 'reverse integration'. HIV positive prisoners are segregated and accommodated with selected volunteers who have a history of intravenous drug use. Queensland has a similar partial segregation policy in which infected prisoners are placed with intravenous drug users. This policy is aimed at reducing the isolation previously experienced by segregated seropositive prisoners and alleviating the financial costs of maintaining a separate AIDS unit.

In Western Australia HIV positive prisoners are segregated in the medical facilities at Fremantle Prison (males) and Bandyup Women's Prison (females). The Northern Territory prison administration has a policy of segregation in a separate infectious disease unit located within the prison system.

It was reported that no seropositive prisoners have been assaulted or threatened in Tasmania, Queensland, Western Australia, Northern Territory or New South Wales because of HIV status. In South Australia, with its integration policy, assaults on seropositive prisoners were rare.

The NSW prison administration is implementing a change in housing policy from segregation to integration. A segregation policy was adopted in 1985 and prison administrators are now confronting the industrial concerns which led to segregation. Custodial officers have expressed concern that without segregation they would not know who was seropositive and would thus be unprepared in emergencies. Occupational transmission is a major concern and negotiations are continuing on this issue. The former segregation unit will be used to give HIV positive prisoners 'time out' to adjust, or where a seropositive prisoner is engaging in problem behaviours.

A full integration policy was introduced in South Australia in February 1986. The integration system appears to work well with little adverse reaction from either staff or prisoners. South Australia has a tagging system whereby any prisoner with a transmissible disease (including HIV) has a notification to that effect on his or her file without identification of the actual disease. There is a similar scheme in operation in the UK.

In conclusion, segregation is the favoured option in Australia, partly because of the very low numbers of seropositive prisoners. The difficulties associated with segregation have not been experienced yet. Full segregation is unable to achieve the primary goal of preventing seroconversion but it is often regarded simplistically as the 'solution' in the popular debate. Pressure from many sources is exerted on prison administrators to implement segregation regimes without a full understanding of the problem.

Confidentiality

Releasing information that a prisoner is seropositive can have adverse consequences for the individual both within the prison system and outside. While in the prison, the individual may suffer ostracism, threats of violence, and actual violence. Upon release, the prisoner may face discrimination in employment, housing and other areas.

Given the known major causes of transmission, the knowledge that a person has the HIV infection often leads to the assumption that the person is either homosexual, bisexual or an intravenous drug user. This assumption alone may result in negative consequences for the individual.

It is often argued that knowledge of the HIV status of a prisoner is necessary for:

- administrators to make informed classification and programming decisions;
- custodial staff to take adequate precautions to protect themselves;
- medical staff to ensure proper treatment and preventative measures;
- administrators to discharge their ethical responsibilities to notify the spouse or sexual partners of inmates prior to leave or discharge;
- parole authorities to adequately supervise the prisoner after release.

The disclosure of test results

■ Within Correctional Administrations in Australia

In Victoria, only the Medical Superintendent receives information regarding the seropositive status of a prisoner, whereas at the other extreme, in the Northern Territory, all operational staff are informed, particularly those who might have direct contact with the infected prisoner. In most other States, the Medical Superintendent, Departmental Head and the Prison Superintendent are informed and there is limited dissemination to medical and custodial staff on a 'need to know' basis.

In South Australia, in order to advise staff concerning the appropriate management of an infected prisoner, the Prison Medical Service provides written medical advice which is available to staff. This advice merely indicates that the prisoner has a communicable disease but does not specify the precise nature of that illness.

■ Outside Correctional Administrations

In Victoria other agencies are not informed of a prisoner's seropositivity. In New South Wales, Tasmania and Western Australia health authorities are notified as HIV is a notifiable disease. In South Australia and the Northern Territory disclosure of the information is at the discretion of the prison medical services. The Northern Territory has indicated that such disclosure would be subject to the prisoner's consent. The State health authority in Queensland carries out HIV tests in prisons and is thus aware of a particular prisoner's antibody status. In South Australia, relatives are informed of a prisoner's HIV status if that prisoner applies, and is eligible for either home detention, unescorted leave, or a family visit in which the possibility of sexual activity may occur. This information is given with the prisoner's knowledge.

In Australia the issue of confidentiality has not assumed such a high profile as in the USA. This is partly because the segregation or other administrative policies in some States automatically mean full disclosure, and in other States the numbers have been so small that a case by case approach has been possible. This situation may change in the future and more carefully defined policies will need to be developed.

Counselling

In addition to meeting the needs of individual prisoners, counselling is an important weapon in controlling the spread of HIV by changing high-risk behaviour and in minimising the cost of care and treatment. According to the US Centers for Disease Control:

Our best hope for preventing HIV transmission rests on a strategy based on information and education. Counselling persons who are at risk of acquiring HIV infection and offering HIV antibody testing is an important component of that strategy (Centers for Disease Control 1987, p. 1).

The Commonwealth Government AIDS discussion paper also emphasises the importance of counselling:

Knowledge of whether or not one is infected may have some effect on the speed and direction of behaviour change, particularly if accompanied by professional pre-test and post-test counselling (*AIDS: A Time to Care, A Time to Act* 1988, p. 71).

There is growing evidence that the knowledge of HIV status and counselling are effective mechanisms in encouraging behaviour change. Counselling should be available to each prisoner before the antibody test, when the results of the antibody test are known, and subsequently. Pre-test counselling is aimed at clarifying problems and eliminating misunderstandings; at encouraging the prisoner to volunteer for the test (if it is voluntary), and at encouraging the prisoner to change high-risk behaviour.

Post-test counselling is essential for every prisoner regardless of the result of the test. It can be an important time for discussing and discouraging high-risk behaviour and for minimising any false sense of security which may arise from a negative result.

Counselling in Australian prisons

In all States, some pre-test counselling is provided. However, this is usually in the form of information about the test, rather than professional counselling on the medical, psychological and behavioural implications of a positive or negative result. Only in South Australia and Western Australia is post-test support/information provided to all prisoners whether they test positive or negative. In all other States post-test counselling is provided for seropositive prisoners only.

In all States nurses or psychologists act as AIDS counsellors. Most have completed a brief AIDS counselling course. In some states assistance is provided by community organisations such as AIDS Councils and Aboriginal Medical Services. In Victoria pre-test counselling is given by nursing staff. Post-test counselling to seropositive prisoners is conducted by the Medical Superintendent or Deputy Medical Superintendent. Counselling programs are not evaluated in any States or Territories.

In general, most Australian prisoners only receive counselling if they are found to be seropositive. The importance of counselling seronegative prisoners does not yet appear to have been recognised by Australian prison administrators. This situation may be contrasted with antibody testing programs in the general community. In these programs the value of

counselling both seropositive and seronegative individuals has been recognised and forms an integral part of the testing protocol.

High-risk sexual activity

Australian policies

No Australian State permits the issue of condoms or provides conjugal visits widely. However, in South Australia, private visits at a minimum security institution are allowed, and resocialisation leave programs are available to long-term prisoners approaching the end of their sentences. In Victoria, private visits are allowed at two prisons. In many of the education programs there is a reluctance to deal with sexual activity in the prisons. In South Australia and Western Australia, for example, information on safer sexual practices is provided only as part of a prisoner's pre-release program. In the Northern Territory the prison service distributes brochures and posters on safe sex practices.

The only positive steps which are taken in most States and Territories to minimise homosexual activity are the provision of single cell accommodation and increased supervision at such perceived high-risk locations as communal showers. Single cell accommodation is available for all men and women in Tasmania, and for almost all men and women in Queensland. In Western Australia, single cell accommodation is available for approximately 1000 of the 1700 male prisoners in the system and for almost all women. Some dormitory and multiple bed accommodation is being retained to meet the needs of Aboriginal prisoners. In the Northern Territory approximately 70 per cent of all accommodation is single cell. It is also proposed to retain some dormitory accommodation for Aboriginal prisoners. In Victoria, the majority of women prisoners, but fewer than 50 per cent of males are housed in single cells. In New South Wales there are few single cells.

In South Australia single cell accommodation is available for all women prisoners and for most male prisoners. In South Australia almost half the prison population have separate shower facilities. Communal showering facilities are the norm for the overwhelming majority of prisoners in all the other States and Territories.

Policies to minimise transmission through sexual activity

There are several policy initiatives which may reduce the sexual transmission of HIV infection. The policies are not mutually exclusive and an effective prevention program should involve all the measures discussed below.

- The provision of single cell accommodation for all prisoners and individual showering facilities.

While most Australian prison administrations would accept such accommodation, for many there would be insurmountable cost barriers. In some States it is claimed that there is a need to maintain dormitory accommodation for some prisoners. Aboriginal prisoners are believed to prefer dormitory accommodation.

- The distribution of condoms

Access to condoms has been vigorously opposed by prison officers in Australia. It is often argued that the distribution of condoms condones illegal sexual activity. It is also argued that condoms can be used as weapons, used to smuggle goods, and have a high failure rate when used for anal intercourse. Some also argue that the issue of condoms positively encourages homosexuality. In 1988 a pilot program was announced by the Health Department in New South Wales to distribute condoms in Bathurst Gaol. The Health Department also delivered condoms to Long Bay Gaol in the following year. Both initiatives were met by threats of strike by the prison officers and were not implemented. Thousands

of condoms delivered to Long Bay Gaol were subsequently destroyed, never having been made available in the gaol (Lake 1990).

However, failure to provide condoms may undermine educational programs and prevent prisoners from taking responsibility for safe sexual behaviour. Failure to make condoms available also ignores the fact that anal intercourse occurs and will continue to do so. That condoms should be obtainable readily and discreetly has been recommended in Australia (NACAIDS Prison Sub-Committee 1987) and overseas (Vaid 1986). The Council of Europe has formally adopted a resolution recommending the availability of condoms in prisons in its member states (Council of Europe 1988). Most prisoners are heterosexual outside the prison environment and prison authorities have an obligation to the community as a whole to ensure that HIV does not spread from the recognised high-risk groups to the wider heterosexual community through sexual activity. Eventually, the community may pressure prison authorities to accept this responsibility and allow prisoners access to condoms. Condoms are available to prisoners in twenty-one prison systems (from thirteen countries). Four States in the USA and sixteen prison systems in Europe provide condoms to prisoners (Harding, Manghi & Sanchez 1990).

■ Legalising consenting homosexual acts between adults

The illegality of homosexual activity is repeatedly raised as a problem for prison administrators in the dissemination of information on safer sex and the issue of condoms. The argument appears to be that prison administrators have a special obligation to observe the law and to be seen to do so. Transgression of the law by prison administrators is perceived to undermine the correctional aim of the prison. Whether this obligation is greater than the obligation imposed on other institutions is open to debate. In the general community, the seriousness of the HIV epidemic has led to the implementation of policies which have the same legal contradiction, and which would have been unpalatable only a few years ago. IV drug use is illegal and yet in many countries there are flourishing and successful needle exchange and distribution programs. There is little doubt that the HIV epidemic has forced a widespread reappraisal of our values and priorities in many areas. Homosexual activity in the prisons is another such area where the traditional values and approaches should be re-appraised in the light of the pressing need to contain the HIV epidemic. Where the illegality of homosexual activity in the general community and the prisons continues to create an impediment to the implementation of successful prevention programs, governments should seriously consider legislation to decriminalise such activity.

■ The provision of conjugal visits

The introduction of such visits may require an extensive education program to reduce opposition from custodial officers and minimise adverse community reactions. It may be argued that conjugal visits will increase the amount of illegal drugs passing from visitors to prisoners. However, the potential benefits of conjugal visits should not be dismissed readily. The provision of private visit facilities in South Australia and Victoria is a welcome development.

■ Other measures to minimise non-consensual homosexual activity

The provision of single cell accommodation and of individual showering facilities is likely to reduce opportunities for non-consenting homosexual activity. In order to reduce non-consensual homosexual activity further, administrators may need to be prepared to remove and segregate sexual predators and provide closer supervision and protection to younger and more vulnerable prisoners. Education programs in the prisons also need to be broad in scope. It is not enough simply to provide information on safe sex practices. Educational programs must come to terms with the complexity of prison sexuality and the role that it

plays in the culture. The relationship between sexual domination, the assertion of masculinity, and power and status in the prison should be recognised and programs developed which understand and challenge the values underlying coercive prison sexuality.

Intravenous drug use

Whilst there is little reliable data on the extent of IV drug use in prisons, it is clear there is a definite risk of HIV transmission due to needle sharing in the prisons. It is becoming increasingly difficult for prison administrators to ignore the issues of needle availability and needle cleaning. As one commentator has said:

In the light of the startling increase of HIV infection in the IV drug population both inside and outside jail, this controversial issue will soon be the most central issue on the agenda . . . We are engaged in an extraordinary war which demands extraordinary solutions (Norton 1988).

Australian policies

In New South Wales there is a program of random mandatory drug testing to minimise the amount of drug use within prisons. In 1987, over a three-month period, 2173 samples were taken and only 1.1 per cent of these were positive. In Victoria there is a mandatory urine testing program in the two program units housing seropositive prisoners and/or volunteer prisoners who have a drug or alcohol problem. In Tasmania, Western Australia, Queensland and South Australia, tests are only conducted on suspicion of drug use. In Queensland a mandatory testing program is under consideration. Random urine testing is also under consideration in the Northern Territory. A variety of penalties is imposed by administrations on prisoners found to have used prohibited drugs, varying from internal correctional sanctions to criminal charges.

Information on techniques for cleaning needles and syringes is provided by Victoria and New South Wales in face to face presentations to prisoners. In Tasmania and Western Australia pamphlets are provided which contain information on such techniques. No information is provided in the Northern Territory, Queensland or South Australia. In South Australia some information is provided as part of the pre-release program. Bleach/disinfectant is available for other purposes in most systems. No cleaning material is specifically provided for cleaning needles and syringes.

All Australian administrations reported that programs and counsellors are available to assist prisoners to overcome drug addiction. Methadone programs within the prisons are also available for some drug dependent prisoners in some States (e.g. New South Wales and South Australia).

Policies to minimise transmission through IV drug use

The policy options available to prison administrators are controversial, and, as with homosexual activity, there is a contradiction inherent in the official recognition of an activity which is illegal.

- The provision of information on cleaning needles and syringes

It is often argued that the provision of such information implies that the administration is condoning an illegal act which has contributed to many prisoners being incarcerated in the first place. It is also argued that such information may encourage non-users to experiment with intravenous drug use. On the other hand while avoidance of intravenous drug use must always be emphasised, the importance of preventing the spread of the disease makes it essential that information on cleaning drug equipment be provided. This general principle has been accepted in the wider community and many State governments have provided needle exchange and distribution programs.

- The ready availability of cleansing agents

The arguments for and against this option are similar to those above. It may also be argued that it can be used as a weapon against staff, but bleach has been available for a long time without any suggestion of abuse until it became associated with the sterilisation of IV drug use equipment.

- The introduction of a needle exchange program

Again, the arguments outlined above apply to this option. In addition, needles can be used as a dangerous weapon and custodial officers would no doubt vigorously oppose any such schemes. As against this, provided it was strictly a needle exchange program, no additional needles need be placed into circulation. The Council of Europe have recommended that this option may be necessary as a last resort.

- The upgrading of the quality of drug rehabilitation programs to encourage IV drug users to stop injecting themselves

This issue is particularly important within a prison setting as IV drug users are recognised as difficult to reach in the outside community. Increasing the number of places available for methadone treatment in the prisons should also be considered as a matter of urgency for HIV positive drug dependent prisoners.

Occupational transmission

The protection of staff against the risks of HIV transmission is also an important obligation borne by prison administrators. Employees in all industries whose work involves a risk of injury or disease have a right to protection. Such protection is usually achieved by the provision of appropriate equipment, the adoption of policies which minimise risk situations and the adoption of certain procedures under specified risk situations. There is a clear need for occupational health and safety guidelines for people whose work may involve them in interactions with HIV infected people in potential transmission situations. The primary group who are at risk in this sense are health workers and custodial staff.

Occupational contact with infected prisoners can occur during activities such as conducting body and cell searches; performing emergency first aid in the presence of blood or other body fluids; combating prisoner disturbances and controlling aggressive prisoners; responding to homicides and suicides; and supervising the cleaning of blood and body fluid spills.

Until July 1990 there were no known cases of occupational transmission amongst correctional staff anywhere in the world (Hammett 1988). In Australia the present authors were informed of four known cases of seropositivity amongst prison staff (three in New South Wales, one in Queensland). In three of these cases risk factors external to the workplace were believed to be responsible. In the remaining case in New South Wales occupational transmission is alleged and the matter is now the subject of criminal proceedings. It is alleged that a twenty-one year old prison officer was stabbed in the buttocks by a prisoner with a blood filled syringe at Long Bay Gaol on 22 July 1990 (*Sydney Morning Herald* 23 July 1990). HIV tests were conducted on the officer and in late August a positive result was reported. The prisoner has been charged with malicious wounding occasioning grievous bodily harm and proceedings are pending.

A detailed discussion of the circumstances leading up to the alleged assault in this case is prohibited at the present time by the law of contempt. Within these constraints certain observations may be made.

Firstly, the case cannot be regarded as a needlestick injury, where the worker is jabbed accidentally whilst handling a syringe, often hidden amongst bed linen or other objects.

Secondly, (without making any comment on the particular case in NSW), in order to minimise occupational transmission which may hypothetically arise out of an assault, attention must be directed at the circumstances surrounding the assault.

The measures directed at preventing needlestick injuries arising out of cell searches and body searches (e.g. heavy gloves) are quite inappropriate to deal with a deliberate assault on an officer or a prisoner where a contaminated syringe is used as a weapon. Careful consideration must be given to identifying prisoners whose behaviour constitutes a risk to staff and prisoners. Violent prisoners may need to be segregated in circumstances where precautions can be taken to minimise the opportunity for assault and where access to weapons is reduced.

Finally, the HIV status of a prisoner in a situation of assault with a syringe is irrelevant. Motives for assault, access to syringes (and other weapons) and aggressive behaviour are not confined to seropositive prisoners.

The tragic case in New South Wales underlines the need for a careful review of policies and procedures within the prisons. What precautions can be taken to prevent syringe assaults? What warning signals should be acted upon? Knee-jerk responses such as the calling for the segregation of all seropositive prisoners, or the confiscation of property from all prisoners will not help to save lives in the future.

New South Wales: A Case Study

Within Australia, New South Wales is the State most likely to have a significant HIV problem in the prisons. New South Wales has the highest number of HIV positive people in the general community and the highest number of IV drug users. It also has the largest prison population. The need for effective policies is thus more acute than in the other States. A brief review of events in New South Wales over the last few months demonstrates the failure of the Government to come to terms with the urgency of this need:

- the introduction of compulsory HIV testing in November 1990 with no clear idea as to how the test results will be used to stem the epidemic. The Minister in his second reading speech referred to the fact that the testing program will provide 'a basis for informed decision-making by medical and prison authorities as well as prisoners' (New South Wales Parliament Hansard, 19 May 1990). No information is provided as to which decisions will be based on the test results. Other goals of the program are to 'assist prison authorities in better carrying out their duty of care towards infected and non-infected prisoners' and to enable 'scarce resources . . . [to] be concentrated on those people most in need, that is those who are found to be HIV positive' (New South Wales Parliament Hansard, 10 May 1990). It is unclear how testing will assist in achieving these objectives, nor the precise resources to be allocated.
- the implementation of universal compulsory HIV testing of receptions without sufficient procedures to enable statistical or scientific monitoring of the epidemic.
- the introduction of 'confidentiality' provisions which rather than protecting confidentiality create a broad regulation making power 'authorising the disclosure of information obtained in the course of testing' (Prisons (Medical Tests) Amendment Bill 1990, Schedule 1, s. 50(a)(15)).
- the introduction of an HIV testing program which will be of limited value in identifying all HIV positive prisoners. It is not intended to retest prisoners after three months to detect those HIV positive prisoners in the 'window period' at reception testing. Furthermore there are no plans to test existing prisoners whose HIV status will thus remain unknown.
- the confiscation of the personal property of all prisoners in order to prevent syringe assaults. Under the new policy cell property for all prisoners is restricted, for example, to three pairs of underpants and socks, six unframed photographs, two books and a limited quantity of legal documents. Banned property includes

religious ornaments, thongs, hats, posters, curtains, caged birds, wedding rings, ear studs. The Premier subsequently stepped in to allow wedding rings. 'Quite how some of these items might be used to secrete needles and drugs, the professed aim of the policy, was not immediately clear and cartoonists and satirists had a field day' (Brown 1990).

- the response to the new policy has been disturbances and riots in prisons throughout the state. Prisoners and prison officers have been injured and property damaged. 'President of the Prison Officers Union, Mr Dick Palmer, puts the damage at "conservatively" \$35 million, comprised of the damage to cells at a number of prisons, loss of 300 cells at Parklea, and loss of \$10 million income and contracts because prison industries have been virtually idle in key prisons throughout September and October . . . Far from protecting prison officers, the alleged aim of the confiscations following a needlestick injury to a prison officer who later tested HIV positive, the build up of anger and violence has put prison officers at far more risk than before (Brown forthcoming).

The current policies in New South Wales not only fail to come to terms with the problem but are actually creating a situation which is dangerous to both staff and prisoners. The responsibility owed by the prison administration in New South Wales to the community at large appears to have been forgotten. Law and order policies should not override issues of public health. The New South Wales Minister for Corrective Services has stated that he 'would like to be remembered as someone who has put the value back in punishment' (*The Independent Monthly*, October 1990). It is to be hoped that the cost of his aspiration is not an increase in HIV infection in the prison and in the general community.

Conclusion

In conclusion, whilst the policies to deal effectively with risk to prisoners and staff may challenge our traditional values, they cannot be sidestepped. As Justice Kirby has said:

I therefore hope that we will go back to the WHO guidelines on prisons. And, that we will see less show-biz politics and fewer empty gestures - and more real concern to protect prisoners, and ourselves. Only in that way will we halt the needless spread of this most terrible virus . . . (Kirby 1990, p. 29).

Appendix - Tables

Table 1

HIV Screening and Management in Australian Prisons

State	Testing Program	Management of Seropositive Prisoners
QLD	Compulsory mass screening of all admissions. Retest: three months, annually, and prior to release.	SEGREGATED
SA	Compulsory mass screening of all admissions serving > 7 days.	INTEGRATED (unless for specific medical or security reasons).
NT	Compulsory mass screening of all admissions. Retest: after 3 months.	SEGREGATED
TAS	Compulsory mass screening of all admissions. Retest: after 3 months.	INTEGRATED (depending on medical and security assessment).
WA	Voluntary but compulsory for high-risk prisoners. Retest: high-risk prisoners after 3 months, only if seronegative.	SEGREGATED
VIC	Voluntary. Retest on request.	SEGREGATED with voluntary IV drug/ alcohol user prisoners.
NSW	Compulsory mass screening introduced November 1990. Retest: prior to release.	SEGREGATED: moving to a policy of integration.

Table 2

The Number of HIV Positive Prisoners in Australian Prisons on 9 November 1990

	Number	Prison Population ¹ for June 1990
NT	0	405
WA	1	1 807
SA	11	930
VIC	8	2 312
NSW	16	5 321
QLD	2	2 205
TAS	1	226
Total	39	13 206

¹ Australian Institute of Criminology, *Prison Trends* No.169, June 1990

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