



No.21

AIDS and Prisons

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The possible transmission of HIV/AIDS throughout the community is a serious issue. The nation's gaols, with their changing population, are of particular concern. This concern is reflected in some recent government initiatives: the New South Wales State Cabinet is planning to empower magistrates to order carriers of the virus to undergo medical treatment, counselling and surveillance; the Queensland Health Department is funding a research project which aims to detail the extent of drug-taking and sex among prisoners.

It is important that public debate is well informed about HIV/AIDS and its prevention. This Trends and Issues summarises the policies relating to HIV/AIDS at present in place in Australia's prison systems, canvasses some important issues relating to its prevention in the prison environment, and stresses the need for effective educational programs.

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What is AIDS?

Acquired Immunodeficiency Syndrome (AIDS) is a condition caused by the Human Immunodeficiency Virus (HIV) in which the body's disease-fighting mechanism (the immune system) is weakened. As a result, a person with AIDS is prone to particular diseases and infections such as Kaposi's sarcoma, pneumocystis carinii pneumonia, tuberculosis, and several others. AIDS is the end-stage of HIV infection.

How is HIV Transmitted?

As its name indicates, AIDS is an acquired disease. The HIV virus can be transmitted through body fluids such as blood and semen, and possibly through saliva, urine, faeces and breast milk. Thus, HIV can be spread by sexual intercourse, both anal and vaginal, and sharing needles and syringes. It can be transmitted from mother to foetus before birth, and possibly during labour. HIV can also be spread through the use of infected blood, although the risk of this occurring in Australia has been virtually non-existent since the introduction, in 1985, of testing all donated blood for the presence of HIV antibodies. Finally, it is possible to acquire HIV infection through the use of infected human organs or tissue.

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HIV is far less contagious than more common viruses such as influenza, colds and measles. Despite persisting popular misconceptions, it is not transmitted as the result of casual social contact. In fact, a United States survey of 60,000 reported AIDS cases showed no recorded instances of the relatives and friends of AIDS sufferers contracting AIDS through their contact, much of it close and prolonged (Margolis 1988).

Mortality Rates and AIDS

Because AIDS was not recognised until 1981, it may still be too early to state conclusively how many of those with HIV antibodies will go on to develop the full-blown disease. The US Center for Disease Control estimates that at seven years after HIV infection, 30 per cent of individuals will have developed AIDS and that a further 49 per cent will have developed AIDS-Related Complex (ARC), leaving only 21 per cent asymptomatic (personal communication, Dr Bruce Whyte, NHMRC Special Unit in Aids Epidemiology and Clinical Research). The case fatality rate for AIDS in Australia is 48.2 per cent (Heilpern & Egger 1989). Although new antiviral drugs such as Zidovudine (AZT) have increased the survival period between the diagnosis of AIDS and death, there is at present no cure for AIDS and no vaccine to prevent it.

Epidemiology of HIV/AIDS

It is impossible to state accurately the prevalence of HIV infection on the globe. Estimates are that there are some 5-10 million HIV seropositive individuals (National HIV/AIDS Strategy 1989). As at 5 May 1989, 151,790 cases of AIDS had been reported to the World Health Organization (WHO 1989). This figure does not represent the total number of AIDS cases worldwide because not all cases of AIDS are reported to WHO. WHO estimates the

total number of AIDS cases to be three times this figure (WHO 1989).

AIDS was first diagnosed in Australia in 1982 with one case reported. To August 1989 the cumulative total of AIDS cases was 1,385. The growth in reported AIDS cases from 1982 to 1988 is shown in Figure 1. In contrast, there are no clear indications of the number of Australians who are infected with HIV. However, the NHMRC Special Unit in AIDS Epidemiology and Clinical Research estimates the number to be in the range of 15,000 - 25,000 individuals.

At the present time in Australia, AIDS is a disease which primarily affects the homosexual population. As at October 1988, some 87.7 per cent of reported AIDS cases were homosexuals or bisexuals, 6.0 per cent of cases could be traced to blood transfusions or haemophilia, 1.3 per cent of cases were heterosexuals, and in 3.3 per cent of cases intravenous (IV) drug use was involved with the possibility of sexual contact as an additional risk factor. In the remainder of cases the mode of transmission was not classified (AIDS: a time to care, a time to act 1988).

Importantly for the prison system, there is a risk of HIV infection from anal sex. The disease can also be

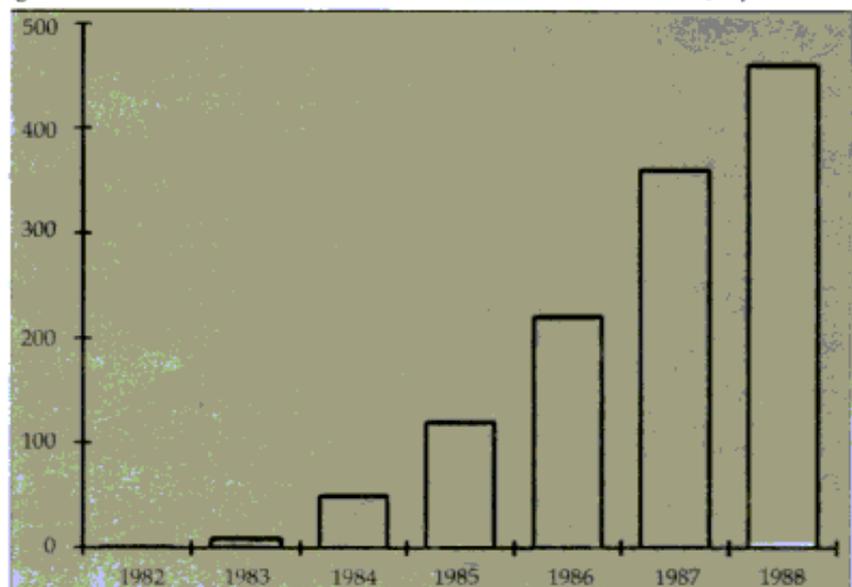
acquired through IV drug use. Statistics suggest that IV drug use does not have a significant association with AIDS in Australia. It must be emphasised, however, that this situation could change. 'Studies of historically collected blood samples from IV drug users indicate the potential for very rapid spread of the virus within the group. HIV infection among drug users in Manhattan, Edinburgh, Scotland and Italy had increased to 40 per cent just 3-4 years after the virus was first introduced to the group' (Norton 1988, p. 621).

HIV/AIDS in Overseas Prison Systems

As at October 1987, there was a cumulative total of 1,964 confirmed AIDS cases among inmates in the 70 United States correctional institutions which provided information to the US National Institute of Justice (Hammett 1988).

A number of States in the United States have HIV screening and testing programs. Recorded figures show seroprevalence rates among new, current, and about-to-be-released inmates in these mass screening jurisdictions to be between 0 per cent and 2.6 per cent (Hammett 1988, p. 29).

Figure 1 Annual incidence of AIDS cases in Australia at 31 July 1989



Source: Adapted from Figure 2, National HIV/AIDS Strategy. A Policy Information Paper, August 1989, Department of Community Services and Health, Australian Government Publishing Service, Canberra, p. 15. Commonwealth of Australia copyright reproduced by permission.

In the United Kingdom the HIV seroprevalence rate in gaols is between 0.7 per cent and 1.0 per cent (McMillan 1988). European surveys for HIV infection in prison were reported at the Fourth International AIDS Conference in Stockholm. 'For eight prison studies reported at the conference, the median infectivity rate is 15 per cent' (Norton 1988, p.621). Additionally, 'the overall infectivity rate in drug users is very high. For four prison studies reported at the conference, the median infectivity rate among drug users is 44 per cent' (Norton 1988, p.621). Differences in HIV seropositivity rates in overseas countries may be accountable in part by different survey methodologies.

HIV/AIDS in Australian Prison

There are no reliable figures for the prevalence or incidence of HIV infection in Australian gaols. Not only are there different testing regimes, some HIV infected prisoners were in prison before compulsory testing was introduced or were infected after intake and are not reflected in those figures which are available. At the time of going to press testing of prisoners on reception is compulsory in South Australia, the Northern Territory, Queensland and Tasmania. Testing is voluntary in New South Wales, the state with the largest prison population. At present, the refusal rate among New South Wales prisoners is estimated to be around 95 per cent (Heilpern & Egger 1989).

However, it was recently announced that compulsory testing both on reception and prior to release would be introduced in New South Wales prisons from 1 January 1990 (*The Australian* 14 September 1989). In Victoria, testing is voluntary, although officials report that the refusal rate is low - about 1 per cent. In Western Australia, testing is voluntary with the exception of those prisoners who, on reception, are categorised by medical staff as 'high-risk'.

Based on a survey conducted by Heilpern and Egger early in 1989, a cumulative total of 99 prisoners identified as HIV seropositive were in Australian prisons. Survey results for Australian jurisdictions (excluding the ACT where there are remand facilities but no prison) are contained in Table 1. Heilpern and Egger (1989) estimate that seroprevalence rates range from 0 per cent to 2.9 per cent.

Prisoners are not the only people at risk of HIV infection in the correctional system. Australian prison officers are not tested compulsorily for HIV so no figures exist to date. However, of two known cases of HIV infection in New South Wales prisons officers, both are believed to have been contracted outside the workplace (Heilpern & Egger 1989). The United States experience is similar in this regard. There are no known cases of AIDS being contracted in United States prisons as a result of occupational exposure (McGurk et al. 1987).

HIV/AIDS and the Prison Environment

It is generally recognised that the prison environment is a potential reservoir for the spread of HIV/AIDS. In particular, the threat exists of its spread into the heterosexual population by way of prisoners who are intravenous drug users and/or sexually active or sexually assaulted whilst in prison. This is especially so because of the high turnover of prisoners in the Australian prison system. On average, inmates are incarcerated for short periods - less than 6-12 months in New South Wales (Scagliotti 1988) - enough time to become infected and then carry the disease out into the community.

The closed, overcrowded, understaffed and stressful environment of the prison is conducive to a number of high-risk activities that are associated with transmission of the HIV virus:

Sexual transmission

It is impossible to establish how much sexual activity both consensual and non-consensual, takes place in prison. In addition to sexual activity engaged in by inmates who are normally homosexual or bisexual, institutional sex, practised by heterosexual prisoners, occurs. Homosexual rape also takes place. All of these practices may involve anal sex, which is associated with a high risk of HIV transmission.

Some idea of the extent of sexual activity in gaol is provided by a 1983 United States study by Nacci and Kane (1984), although it must be remembered that their findings may not be generalisable to Australian prisons. They found that 20-30 per cent of the 330 prisoners they interviewed in seventeen Federal correctional institutions engaged in sex while in prison. Only 9 per cent reported that violence had been used.

Intravenous drug use

Many inmates in Australian gaols are imprisoned for drug-related offences

Table 1 HIV positive prisoners in Australia: annual and cumulative totals

STATE	1985	1986	1987	1988	Cumulative Total	Tests Cumulative Total	Prison Population 30.6.88	Admissions Year Ending 30.6.88
Qld	-	1	3	7	11	15000	2418	6399
SA	4*	3*	7	8	22	2929	822	3356
NT	0	0	1	0	1	6373	381	1323
Tas	-	-	1	0	1	1100	304	1084
WA	1*	4*	4*	0	9	1600	1658	5802
Vic	2	7	6	11	26	10 100	2084	4719
NSW	-	3	20	6	29	1294	4287	11200

* voluntary testing program, prior to the introduction of the current program.

Source: Heilpern, H. & Egger, S. 1989, *AIDS and Australian Prisons: Issues and Policy Options*, Department of Community Services and Health, Canberra.

and may already be intravenous drug-users. Indermaur and Upton (1988) surveyed all receptees at seven Western Australian prisons between June and September 1987. They rated 24.4 per cent of males and 25.6 per cent of females as heavy or regular drug users (including cannabis). Another study conducted by Miner and Gorta in 1985 concluded that 79 per cent of New South Wales women prisoners had been drug users prior to incarceration. Undoubtedly, too, drugs are available in prison, although the extent of drug use is uncertain. A study conducted by Cicchini (1986) of self-reported substance abuse among inmates of Karnet Prison Farm in Western Australia, found that 40 per cent claimed to have used illicit drugs or alcohol while in prison. High rates of IV drug use based on anecdotal evidence are suggested by other experts. Speaking at the Third National AIDS Conference in 1988, Professor John Dwyer estimated that in Long Bay Gaol in New South Wales, about 60 per cent of inmates use intravenous drugs once or twice a week. Others have suggested that the supply of drugs in some Australian prisons is such that heroin is exported from gaols (Senator Peter Baume reported in the *Sydney Morning Herald* of 8 April 1989 about Pentridge Prison). The availability of drugs, and the general boredom in Australia's overcrowded prisons, also means that some inmates acquire a drug habit while incarcerated.

Sharing of needles and syringes is the major risk factor in the spread of HIV among intravenous drug users in correctional institutions. Not surprisingly, large numbers of prisoners share a small number of needles and syringes. According to the Working Panel on Intravenous Drug Use and HIV/AIDS (1989, p. 7) 'in one New South Wales prison up to 40 women had shared one 'fit' and in a Victorian prison 70 men had shared one 'fit'.'

Other risk factors

It is a commonplace that prisons are violent, dangerous places with riots, assaults, self-inflicted injuries, and murder occurring. For example, a prison inmate is three times more likely to be murdered than a member of the general public (Hatty & Walker 1986). In New South Wales, Scagliotti (1988) found that there were 125 reported assaults by prisoners on other prisoners between January and June 1988, and 47 assaults by prisoners on prison officers. It must be emphasised that there is probably a large 'dark figure' of unreported assaults, both physical and sexual. Riots, assaults, self-mutilation, suicide, and murder all involve the possibility of unprotected contact with human blood, although it should be noted that the risk of infection through open wound and mucous membrane exposure is extremely low (Hammett & Bond 1987).

Finally, the possibility of transmission from tattooing also exists. Tattooing is institutionalised but illegal in Australian prisons, so the likelihood of unsterile equipment being used is high. In 1988 Doll reported two United States cases of HIV infection in ex-prisoners who had been tattooed in gaol with unsterilised needles which had been used to tattoo other inmates. In one case, sex with prostitutes was an admitted risk factor, but in the other the patient denied homosexual activity, IV drug use, blood transfusions, and sex with prostitutes.

Preventing HIV/AIDS and the Prison Environment

It is generally accepted that mass screening of the community, and even routine testing for HIV of most high risk groups, is not warranted. Thus the National HIV/AIDS Strategy (1989, p. 41) stated recently that 'compulsory testing of the Australian population is not proposed because the risk of infection within the entire community

is relatively low'. The need to protect HIV infected individuals against discrimination has also been a concern of AIDS groups, civil libertarians etc. The National Strategy Policy Information Paper (1989) suggested the introduction of anti-discrimination legislation to prevent discrimination against HIV-infected persons in the areas of employment, education, training, accommodation or the provision of goods and services'. The Policy Information Paper (1989) also called for all governments to ensure that privacy laws were in place and foreshadowed a review of the Commonwealth Privacy Act in the context of the protection given to HIV infection information.

Consideration of testing, discrimination, and confidentiality have resulted in quite different conclusions in respect of the prison environment. The reasons have to do with the prison environment and the nature of HIV/AIDS itself.

- As a result of their lawbreaking behaviour, prisoners have already forfeited some civil rights. Further, prisons are regarded by many as places of punishment. The level of sympathy for prisoners and their 'rights' is, therefore, low. Consequently, prisoners have little power as political lobbyists.
- Prisons are violent and unpredictable places, where high-risk activities endanger prisoners and prison officers and, by extension, the families of both.
- The prison environment can be controlled in a way that the general populace cannot.
- AIDS is a disease with a high mortality rate, and associations with behaviour which is often socially unacceptable and illegal. For these reasons, considerable pressure exists to take any measures deemed necessary to prevent its spread to other inmates, prison staff, and the wider community.
- The measures sometimes suggested to control its spread in prisons, such as the distribution of

condoms, needles and syringes, are regarded by some as dangerous in themselves and as encouraging morally reprehensible or illegal behaviour.

- It can be argued that the supply of needles and syringes to drug users does nothing to break the cycle of addiction, crime, and imprisonment. In other words, such measures destroy the rehabilitative potential of prison, and contribute to high recidivism rates.
- Prisons are state institutions. It is suggested by some that as society's law maker, the state cannot condone and encourage practices in its own institutions which are illegal in the general community.

As a result, measures have been proposed in regard to HIV/AIDS in prison which in some instances are not medically justifiable, and are managerially questionable.

Testing

Arrangements in Australian prisons for testing on reception have already been described. Although mass screening of prisoners may have the attraction of a stern response to a serious problem, it is not a solution in itself because it may produce little in the way of behaviour changes. Compulsory anonymous testing gives an indication of the extent of the HIV/AIDS problem in the prison system, but does not accord the person tested information as to his or her antibody status. It also provides little incentive for lifestyle changes. For those who support the segregation of HIV seropositive prisoners, anonymous testing provides no information on which to base accommodation decisions.

Mandatory identified testing also has its problems. The first is the cost of testing, re-testing, and confirming positive results. There is the cost of testing all prisoners on reception, periodically or prior to release. Although the ELISA test is generally reliable, a positive result should be

confirmed by a Western Blot test - a further expense. In addition, HIV infection has an incubation period from three weeks to four months. Thus a test on reception will not identify all infected individuals. If periodic re-testing does not occur then accommodation decisions will be meaningless. Additionally, those prisoners who have tested HIV seronegative may well gain a false sense of security, bringing with it participation in unsafe behaviours.

The correctional system has a responsibility to prisoners who undergo testing, either voluntary or mandatory. Because of the enormous implications of an HIV seropositive result - social, psychological, and physical - and the possibility that a negative result will lead to unsafe behaviours, pre- and post-test counselling should be provided by appropriately trained workers. A measure of the devastating reactions to AIDS which occur is a study by Marzuk, Tierney, Tardiff et al. which found that AIDS sufferers in New York had a suicide rate 66 times higher than that of the general population (cited in Norton 1988).

Although a variety of counselling policies are in place in Australia, none is totally satisfactory. The only States to provide both pre- and post-test counselling, irrespective of the outcome of testing, are South Australia and Western Australia. Pre-test information is provided in all jurisdictions except the Northern Territory. Post-test counselling for HIV seropositivity is provided by all prison systems. At present no formal evaluation of counselling is carried out in any Australian jurisdiction (Heilpern & Egger 1989).

In addition, there is the question of the use made of test results. Accommodation is dealt with in the next section. Confidentiality of results also needs proper consideration. If results are known within the prison system, threats and abuse from other prisoners and staff may ensue. Furthermore, if information filters beyond the prison system,

discrimination in housing, and employment may occur when a prisoner is released.

If results are to be circulated, then the question must be answered - to whom? It is variously suggested that prison medical officers, medical administrators, prison administrators, and prison officers have a right or a need to know. Some would add that the state also has a responsibility to inform others outside the prison system who come into contact with HIV- infected prisoners, including their sexual partners. A range of policies is in place in Australian jurisdictions. At one end of the spectrum is Victoria where only the medical superintendent is informed if a prisoner is HIV seropositive. In the Northern Territory, on the other hand, all staff are advised (Heilpern & Egger 1989).

Finally, the implications of testing prior to release should be considered in the light of the decision in New South Wales to introduce such testing in 1990. Such a policy will give an indication of seroconversion in the prison system, although it must be remembered that due to the incubation period for AIDS some prisoners who have been infected with HIV will not test HIV seropositive prior to release. Many of the general comments about testing also apply to testing prior to release and are particularly important in this context. For example, if identified testing is to take place (surely important for the individual and his or her sexual partners in the community) whose responsibility will it be to ensure that adequate post-test counselling occurs? Does the state have a responsibility to inform a prisoner's known sexual partners of an HIV seropositive result and what safeguards will or should be in place to ensure that the information is kept confidential and does not impinge on an ex-prisoner's attempts to find work and housing?

Accommodation

There are many accommodation options available for dealing with HIV/AIDS in prison. They include total segregation and total integration, case-by-case decisions based on factors such as propensity to violent behaviour and progression of the disease, partial segregation involving participation in some or all prison activities, and single cell accommodation for all prisoners.

Integration of prisoners is practised in Austria, Denmark, France, Italy, Spain, and Switzerland. Violent HIV seropositives are segregated in Norwegian prisons (Harding 1987). In the United States almost three-quarters of state and federal correctional systems make decisions on the basis of assessment of individual prisoners (Hammett 1988). In the United Kingdom, known seropositive prisoners are segregated.

A range of policies exists in Australian prisons. In South Australia and Tasmania, a policy of integration has been pursued. In Queensland and Victoria, HIV seropositive inmates are housed with intravenous drug users. In Western Australia they are accommodated in separate medical facilities, and in the Northern Territory in a separate infectious diseases unit. In New South Wales, where a policy of segregation existed from 1985 until recently, integration is now being introduced (Heilpern & Egger 1989).

Those supporting segregation argue that HIV seropositive prisoners are liable to be attacked by other prisoners and are a danger both to other inmates and prison officers. Apart from attacks on HIV seropositive prisoners it has been said that '... inmates who want to regain a sense of power and control may use their diagnosis to manipulate or threaten others' (AIDS Inmates 1988, p. 100).

Despite the fears of inmates and prison officers, medical opinion appears to be that segregation is not

medically indicated, may well lead to a false sense of security, and is in conflict with educational strategies emphasising that HIV infection cannot be spread by casual contact. Further, according to some experts, it targets the wrong group '... Screening and segregating the population according to serological status does not specifically target the prisoners who engage in sexual acts or intravenous drug use. ... the challenge is to discover aggressive wrongdoers and to control their behaviour...' (Gostin et al. 1987, p. 43).

Apart from questions about the cost and effectiveness of segregation, the question of prisoners' rights and the implications of isolation of HIV seropositive prisoners have been ignored in much of the debate to date.

In the United States it has been suggested that segregation violates constitutional rights to freedom from cruel and unusual punishment. Other considerations are that segregation often precludes prisoners from engaging in prison activities such as prison workshops and work release; that it results in the unstructured mixing of prisoner categories - with maximum and minimum security prisoners confined in the same unit; and that it is psychologically damaging for HIV seropositive prisoners, who are usually mobile, often asymptomatic, and are thus fully able to participate in prison activities. For those whose condition has progressed to AIDS-Related Complex or AIDS, their ability to delay the progress of their disease will depend in part on their psychological fortitude and the social support systems around them. Prisoners are already disadvantaged in regard to the latter: those in segregation, doubly so. Said an inmate from the AIDS Unit (now closed) at Long Bay Prison in Sydney, 'The boredom was unbelievable. It makes you even more depressed, being locked up in a place where people are dying.' (*Sun-Herald*, 20 November 1988). Policies also need to be developed for those prisoners who are seriously ill. For example,

consideration should be given to admitting them to hospital or releasing those who are terminally ill and who would not be a danger to the community.

Segregation must also be examined as a managerial decision, with practical implications. For example, both prisoners and prison officers have protested about HIV infected prisoners being housed in the general prison population. In November 1988, prison officers in Maitland and Cessnock gaols in New South Wales went on strike over the admission of an HIV seropositive prisoner (*Newcastle Herald*, 15 November 1988). The fire at Jika Jika Section of Pentridge Prison in which five prisoners died was believed to be part of a protest at two HIV infected prisoners coming to the Section (*Melbourne Sun*, 22 November 1988). The experience in South Australia provides some hope, however. In that jurisdiction where a policy of integration is in place, assaults on HIV seropositive prisoners are rare.

The Working Panel on Intravenous Drug Use and HIV/AIDS (1989, p. 8) recommends that 'a prisoner with HIV infection [should] not have either their medical or prison regime worsened by the fact of their infection'. Not all HIV seropositive prisoners are a danger to others. If single-cell accommodation is not economically feasible, then it is suggested that decisions on accommodation be made on a case-by-case basis depending on considerations such as the prisoner's medical condition, and the threat that the prisoner constitutes to other inmates and prison officers, irrespective of his or her HIV status.

Condoms

Condoms do not totally protect against the AIDS virus, but when used correctly, significantly reduce the risk of HIV transmission.

Condoms are not presently available in Australian prisons. A major impediment to date has been the

attitude of prison officers who fear that condoms will be used as weapons or to conceal contraband in body cavities. A further impediment is the fact that homosexuality is a criminal offence in some Australian jurisdictions, and is illegal in the prison systems of South Australia, Northern Territory, Queensland and Tasmania (Heilpern & Egger 1989). In favour of condom availability it can be argued that the state has a responsibility to protect prisoners' lives, and that as institutional sex cannot be prevented, inmates should be able to practise it safely. In the three United States systems where condoms are distributed there are no reported cases of condoms being used as missiles (AIDS in Prison 1988).

Needles and Syringes

Even more controversial than the distribution of condoms is the distribution or exchange of needles and syringes in prisons. No needle exchange program is in operation in any prison in the world, although the Council of Europe has stated that it may become necessary.

In Australia, intravenous drug use is illegal, although needle exchange programs do exist. Arguments against needle exchange or distribution in prison are as follows. Infected needles can be used as weapons. There have been reports of HIV found in blood taken from needles and syringes. The risk of HIV infection, therefore, exists. However, it should be emphasised that the rate of HIV infection as the result of needlestick injury is low - less than 1 per cent in the case of a single needlestick exposure (Hammett & Bond 1987). Some also argue against a needle exchange program in prisons because intravenous drug use is illegal in Australia and prisoners may thereby be encouraged to persist in the same behaviour which caused them to be arrested in the first place.

A number of options exist, either singly or in combination, which could

be pursued to combat the problem of HIV transmission through the sharing of unclean needles and syringes. They are the continued prohibition of drug-taking equipment, the distribution of needles and syringes, exchange programs for needles and syringes, and expansion of methadone and drug rehabilitation programs. The potential negative consequences as well as the beneficial effects of these options must be considered. For example, there is opposition to the introduction of methadone maintenance programs. One of the grounds for such opposition is that methadone trafficking in prisons may result.

Other options are to ensure that prisoners know how to clean needles and syringes, and to provide bleach for cleaning drug-taking equipment. The Working Panel on Intravenous Drug Use and HIV/AIDS (1989) reported that not all prison administrations make bleach available to inmates. Unfortunately, drug use in prison remains a problem, and it is therefore in the interests of both prisoners and prison officers that needles and syringes are clean.

Education

None of the above strategies can be effective without educational programs. The need for ongoing and effective HIV/AIDS education is demonstrated by a recent incident reported in the Australian media concerning the treatment of a female AIDS prisoner. 'Prison officers were told that the AIDS prisoner was required to wash her own clothing, utensils and not to be given assistance by prison officers unless a medical officer was present.' (*Courier-Mail* 28 September 1988). The usefulness of education is demonstrated by the program conducted by the Worcester County House of Correction in the United States which reported that since HIV/AIDS education was initiated, there have been no episodes of violence, discrimination, or

segregation in its prison system (Norton 1988).

All Australian prison systems have HIV/AIDS education programs, although they vary in structure and regularity. Thus, in Victoria and New South Wales voluntary programs are run for prison officers and prisoners. An innovation in New South Wales prisons is the introduction of the HIV Prisoner Peer Education Program beginning in June 1989. In Tasmania, receptees and new prison officers are required to attend HIV/AIDS education courses. In South Australia, HIV/AIDS education is part of prison officer training programs, and is provided to new inmates. In Queensland, there have been no HIV/AIDS education sessions since 1986, but videos and pamphlets are available. In the Northern Territory voluntary education programs for prison officers and inmates were provided in 1987. Since then, HIV/AIDS education in the Territory has been confined to prison officers (Heilpern & Egger 1989). Western Australian prison officers are given compulsory HIV/AIDS education as part of their probationary training and prison medical and nursing staff receive annual in-service training on HIV/AIDS. Voluntary education programs are provided for Western Australian prisoners.

The problems of implementing HIV/AIDS education in prisons should not be trivialised. There are deep-seated anxieties about HIV/AIDS amongst prison officers and inmates, and firmly entrenched misconceptions to be overcome. Hostility exists between prison staff and prison inmates, and between prisoners and other prisoners suspected of having HIV infection. Although essential, effective education is an enormous difficulty, given the high turnover of prisoners in Australian gaols. There are problems of bringing persuasive and relevant information to a group who, as a whole, have little formal education, and may comprise a great variety of ethnic groups. There is low overall

priority given to education in the prison system. In addition, development, implementation, evaluation, and staffing of educational programs is costly. Last, is the fact that both prison staff and prison inmates can become complacent about the AIDS question, so that education programs need to be creative and innovative if their message is to be effective.

A simpler task is to identify the requirements of effective HIV/AIDS education in the nation's prisons. They are:

- a proactive rather than a reactive approach;
- a commitment to HIV/AIDS education from responsible government ministers, senior policy makers and prison administrators;
- the provision of compulsory HIV/AIDS education on reception into prison, and for new prison officers with regular, follow-up and pre-release sessions;
- the active involvement of prisoners and staff in learning, producing, and evaluating educational measures to ensure that HIV/AIDS education is relevant to their needs and concerns;
- the use of discussion sessions and video presentations, as well as written material, for maximum educational effect;
- the use of well-trained and committed HIV/AIDS educators;
- co-operation between jurisdictions and sharing of ideas and resources: and
- ongoing evaluation of the programs which are in place.

Summary

It is suggested that some of the current policies which have been implemented to contain the spread of HIV infection in prisons need to be re-assessed. Compulsory testing and segregation are cases in point. How effective are they in minimising HIV transmission?

Have their implications been properly examined? In the case of compulsory testing will all prisoners be advised of their HIV status; how often will prisoners be tested; what are the financial implications of testing; are there adequate pre- and post-test counselling facilities; who will be privy to the results of testing; what safeguards will prisoners have that information about test status will not become available outside the prison system; how will the information obtained be used? In the case of segregation of HIV seropositive prisoners, is segregation medically and administratively justified? What are the likely physical and psychological effects of segregation on HIV seropositive prisoners?

It is also suggested that recognition should be given to the fact that institutional sex, sexual assault and intravenous drug use do occur in Australian gaols. Single cell accommodation may reduce the incidence of sex, both consensual and non-consensual, in prison. Drug education may help reduce the use of drugs in gaol. Nonetheless it is unlikely that such measures will prevent the occurrence of drug-taking or sex in the nation's correctional institutions. For these reasons consideration should be given to the distribution of condoms and to the provision of bleach so that prisoners can clean their drug-taking equipment.

No matter what policies are implemented in our prisons it is vital that HIV/AIDS education for prisoners and prison staff be supported and that evaluative studies be undertaken of any HIV/AIDS policies that are in place so that their effectiveness and their ramifications can be assessed.

Conclusion

This Trends and Issues has attempted to raise some of the many issues associated with the prevention and management of HIV/AIDS in Australian prisons. Those issues raise

hard questions which have to be critically addressed so that comprehensive and effective policies can be introduced. The implications extend far beyond Australia's prisons, raising wider issues such as the need for the legalisation of homosexuality and drugs. They call for the commitment of resources, both human and financial. Based on what is known at present, the number of HIV seropositive prisoners in Australian gaols is probably small. However, this should not be used as an excuse to delay difficult decisions. The window of opportunity currently available will not remain open indefinitely.

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Glossary

- AIDS Related Complex (ARC) - combination of conditions symptomatic of HIV infection including swollen lymph nodes, weight loss and night sweats.
- ELISA - acronym for Enzyme-Linked Immunosorbent Assay. It is the primary test used to detect the presence of HIV antibodies in the blood.
- HIV seropositive/HIV seropositivity - exposure to the HIV virus resulting in the production of antibodies to the HIV. The presence of those antibodies can be detected by blood tests.
- Kaposi's Sarcoma - a previously rare cancer of the skin and endothelial cells characterised by multiple bluish red or brown nodules.
- Pneumocystis carinii pneumonia - a life-threatening form of pneumonia.
- Western Blot test - A test which identifies antibodies to specific protein molecules. It is considered more specific than the ELISA test in detecting HIV antibodies in blood samples.



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