Preface

The first national HIV/AIDS in prison conference held in Australia took place in November 1990. Demand, in Australia and overseas, has encouraged the Australian Institute of Criminology to print a second edition of the conference proceedings. Some of the developments which have occurred since November 1990 are outlined in this preface.

The communique issued by the conference was distributed by Professor Bob Douglas of the National Centre for Epidemiology and Population Health to all state politicians and to Federal Ministers with relevant portfolio responsibilities. Detailed reviews of the response to the communique can be found in papers delivered by Professor Douglas and by Dr Sandra Egger at the 'Window of Opportunity Congress' held in Adelaide in December 1991. An HIV/AIDS and Prisons newsletter was produced by the Australian Institute of Criminology in November 1991.

Progress has occurred around Australia in the areas of HIV/AIDS education for prison staff and prisoners, occupational health and safety, research and in epidemiological data collection. In September 1991 correctional staff and representatives from community based organisations from each state and territory participated in a National Train the Trainer Peer Education workshop held in Sydney. HIV/AIDS Coordinators have been appointed by corrective services departments in Queensland and Western Australia. 'Dead Set', a video scripted by prisoners addressing the issues of sexual assault and drugs in gaol was released by the New South Wales Department of Corrective Services. In South Australia, a Communicable Disease Policy and Procedure Manual has been prepared and 'Just Another Day', a video dealing with HIV health and safety issues for prison officers, was produced by the NSW Department of Corrective Services.

Funding has been provided in South Australia for research on the experiences of ex-prisoners with HIV/AIDS seeking accommodation after discharge from gaol; and for a study involving the partners of HIV seropositive prisoners. In an addendum to their conference paper, Dr Matt Gaughwin and his colleagues review recent overseas research on prisoner HIV risk behaviour.

Amongst the recommendations of the 1990 Conference was the establishment of an HIV in prisons database. The National Centre in HIV Epidemiology and Clinical Research, in conjunction with the National AIDS in Prisons Information Clearing House, commenced collecting data on HIV in Australian prisons in the first quarter of 1991.

The most challenging issues addressed in the conference communique have yet to be tackled—in particular, the recommendations for a trial of condom availability and disposal, and a pilot needle exchange program. The important issue of counselling, especially post-test counselling for all prisoners irrespective of HIV serostatus is, generally, still not satisfactorily addressed. Those jurisdictions which were segregating HIV seropositive prisoners solely on the basis of their serostatus continue to do so. Statutory immunity from legal proceedings conferred on prison administrations has not been removed. Finally, methadone programs are not provided in all jurisdictions. In New South Wales, where some 500 prisoners are on methadone, the prison methadone program is under review.

Some other matters should also be recorded. New South Wales commenced compulsory testing of prisoners on reception in three prisons in November 1990. Since that time, compulsory testing on entry has been introduced in all New South Wales prisons and testing on exit is also in place. Preliminary results show an HIV seropositive rate in New South Wales prisons of about 0.5 percent.

In a report released in April 1992 entitled *Discrimination—The Other Epidemic*, the New South Wales Anti-Discrimination Board recommended that prisons legislation be amended to provide prisoners with enforceable rights to reasonable medical care and

treatment. It also recommended the cessation of compulsory HIV testing and, in those limited circumstances in which a prisoner with HIV must be segregated, that he or she should have access to the same services as other prisoners.

The ability of HIV seropositive prisoners to avail themselves of the provisions of anti-discrimination legislation was addressed at the end of 1991 by the Western Australian Equal Opportunity Tribunal. In the case of *Hoddy v. Executive Director Department of Corrective Services*, the complainant, who was HIV seropositive, had been imprisoned in a minimum security facility. The facility made employment, recreation and educational programs available to its inmates but the complainant was not permitted to participate in them. Two preliminary issues were decided by the Tribunal. First, it held that the complainant's condition of persistent generalised lymphadenopathy constituted an impairment under the *Equal Opportunity Act 1984* (WA). Second, it held that the Executive Director of the Department was a provider of services and facilities. It was therefore open to the complainant to complain of discrimination under the Act. After deciding these preliminary matters, the important substantive question of whether the Department of Corrective Services had engaged in discriminatory conduct against the complainant, remained to be determined. However, a settlement negotiated between the complainant and respondent precluded a further hearing.

While governments have been slow to tackle the difficult questions raised during the conference, high-visibility, 'get tough' responses to HIV/AIDS in prisons persist. In New South Wales, the *Prisons (Syringe Prohibition) Amendment Act* was passed in 1991. Although prisons legislation has always contained penalties for contraband, this special legislation provides increased penalties for the introduction or supply of syringes in prison. The penalty is two years imprisonment and the onus is on the defendant to prove that the introduction or supply was lawful.

The last 20 months have witnessed some encouraging developments in the area of HIV/AIDS in prisons. However, the major challenges remain. Current low seroprevalence rates in Australian prisons should not be a cause of complacency or an excuse to avoid addressing complex issues or the wider questions which are posed by the issue of HIV/AIDS in prisons—including questions of illicit drugs policy, prison reform and prisoners rights.

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June 1992

*The views expressed are my own and do not necessarily reflect those of the Australian Institute of Criminology. My thanks to John Godwin for the information he provided.

Overview

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The topic HIV/AIDS and prisons has occasioned much public debate and was the focus of the first national conference on the subject organised by the Australian Institute of Criminology and the National Centre for Epidemiology and Population Health.

The conference brought together, in formal sessions and informal workshops, criminal justice and medical researchers, policy makers and administrators, prison officers, prison health workers, educators, social workers and members of community organisations. This diversity is reflected in the style and content of the papers published in this volume.

In his introductory paper, Professor Robert Douglas who is Director of the National Centre for Epidemiology and Population Health addresses the challenges presented by HIV/AIDS and prisons. Among the achievements of the conference was the consensus arrived at by participants which was reflected in a communique issued at the close of proceedings. A copy of the communique is appended to Professor Douglas' paper.

Among other things, the communique called for agreement between all Australian jurisdictions on the establishment of a common protocol for the collection of epidemiological data on HIV/AIDS in prisons, greater consideration of the use of non-custodial sentences for offenders convicted of drug-related crime, increased access to methadone in prisons, the provision of adequate compensation when HIV is occupationally acquired by prison officers and the implementation of universal infection control procedures.

Conference delegates agreed that sterilising agents should be made available to prisoners for the disinfection of drug injecting equipment. They also considered the vexed questions of condom distribution and needle and syringe exchange. A trial of condom availability was advocated and, in the case of needle exchange, 'a careful time limited evaluation of a strict needle exchange program' was recommended. A follow-up meeting to consider developments since the communique is planned for late 1991.

A United States perspective on HIV/AIDS in prisons epidemiology and policies was presented by Dr Theodore Hammett from the Massachusetts firm of Abt Associates. The long-standing experience of US correctional systems, where more than 5000 AIDS cases have been reported since 1981, provides valuable insights for Australians. US correctional administrators are now shifting their focus 'from short-term 'crisis' matters such as fear of casual transmission to 'long-haul' issues such as housing, programming, and medical care for prisoners with HIV disease'.

A review of HIV/AIDS policies in Australian prisons was provided in a paper delivered by Dr Sandra Egger, Senior Lecturer in Law at the University of New South Wales. Dr Egger also presented the results of a survey which revealed that the cumulative total of known HIV positive prisoners in Australia in the period 1985 to October 1990 was 206. She stressed, however, that present testing practices could not identify all HIV positive prisoners. For example, prisoners serving short sentences may not be tested and many jurisdictions do not retest prisoners during their sentence or prior to exit.

A conceptual approach to the development of HIV/AIDS policies in prisons was provided by Mr Justice Michael Kirby. He also spoke about the principles adopted by the World Health Organization Global Commission on AIDS, of which he is a member. The Commission has emphasised the special responsibility which prison administrators have to inform prisoners of the risk of HIV infection and has endorsed non-discriminatory policies, except when required for a prisoner's well-being. It also favours confidentiality of test results, possible compassionate early release for prisoners with AIDS and the provision of medical services equivalent to those available to AIDS patients in the wider community.

The Judge said that advice, education and counselling must be supplemented by access to the means of self-protection for those unable or unwilling to heed educational messages. And he urged the adoption of 'all proper steps to protect prison officers and prisoners alike. By protecting them we protect society'.

The subject of risk behaviours among prisoners has attracted much speculation but little research. Dr Matt Gaughwin from the National Centre for Epidemiology and Population Health presented a review of research to date. His paper highlights the importance of risk behaviours in developing an understanding of the epidemiology of HIV/AIDS in prisons, and in designing and implementing policies which will reduce the transmission of HIV, both in prisons and to the wider community.

Dr Gaughwin called for further research into the frequency and nature of the risk behaviours of seropositive and seronegative prisoners, both in and after prison. Such research will promote an understanding of whether the prison environment facilitates or inhibits risk behaviours.

Two researchers who have undertaken such studies were present at the conference. Ms Kate Dolan from the Centre for Research on Drugs and Health Behaviour in London described the findings of a number of studies of drug injectors in Britain. Drug injectors surveyed had an incarceration rate of 55-76 per cent. Importantly, some 23-30 per cent had injected in prison and 17-20 per cent had shared injecting equipment in custody.

Ms Dolan and her colleagues examined risk behaviours in prison and attitudes to harm minimisation measures - such as whether prisoners would use condoms if available. Interviewees were also asked about risk behaviours outside prison because such behaviours 'are an indication of the potential for the spread of HIV from prison to the community, should HIV infection be transmitted within the custodial setting'.

Dr Alex Wodak from the Drug and Alcohol Service at St Vincents Hospital in Sydney presented the results of a research study into the risk taking behaviours of Sydney male drug injectors. Some had spent time in prison, predominantly in the period 1985-87. Ex-prisoners were questioned about risk behaviours inside prison and on release. The study found that while the frequency of injection inside gaol is probably lower than outside, the risk per injection may well be higher due to more frequent sharing, inadequate cleaning and the possibility that sharing involves a greater number of people.

Dr Wodak and his colleagues reported a worrying level of risk behaviour including anal rape. On a more optimistic note the researchers found that prisoners were aware of AIDS and concerned about cleaning their needles. From the data collected, Dr Wodak raised the possibility that levels of high risk behaviour in prison may be declining but emphasised the need for further research to test this idea.

One approach to HIV prevention is the provision of methadone to drug users. Of some 5000 people on methadone in NSW, about 400 are in custody at any one time. The mechanics, costs, advantages and disadvantages of a prison methadone program were described by Dr Frank McLeod, Director of the NSW Prison Medical Service. The program recognises the existence of intravenous drug use in prison. Prison methadone was introduced in NSW primarily as an HIV prevention strategy rather than as a treatment for drug use. According to Dr McLeod there is evidence, in part from the results of urinalysis, that prison methadone does reduce IV drug use.

The law, HIV/AIDS and prison frequently intersect. Some examples are the liability of prison authorities for HIV transmission as the result of an assault, prison conditions for HIV positive inmates, and occupational health and safety measures for prison officers. Traditionally, prisoners have experienced many obstacles, both legal and practical, gaining access to the courts. In addition, legal issues associated with HIV/AIDS in prisons have rarely been addressed in Australia. Two conference speakers examined some of those issues.

In his paper, Mr John Godwin of the AIDS Council of NSW addressed the liability of prison authorities for HIV transmission incidents and the duties owed by them to prisoners, prison officers and third parties such as the sexual partners of prisoners. He called for the implementation of policies which adequately reflect duties to care for the health and well-being of prisoners and provide for a safe system of work for prison officers.

Prisoners rights were the subject of a paper by Ms Beverley Schurr of the Australian Council for Civil Liberties. She drew attention to the dearth of prisoners rights in Australia despite the existence of international conventions, United Nations and Australian standards. Australian courts have traditionally interpreted prisons legislation as providing no enforceable rights for prisoners. Among other things, Ms Schurr examined the situation of prisoners with regard to compulsory testing and treatment, and documentary confidentiality. She recommended the abolition of compulsory HIV testing of prisoners, the implementation of procedures to ensure consent is freely given to any testing that is carried out and the introduction of penalties for disclosure of test results.

A key plank in any HIV/AIDS platform is education for both prisoners and staff. Australian prison systems have been at the forefront of HIV/AIDS education in prisons. Speakers from NSW and South Australia gave their perspectives on the development and implementation of successful educational strategies. Given the traditional antagonisms which exist between prisoners and prison officers, Ms Kim Mannion (AIDS Coordinator with the NSW Department of Corrective Services) emphasised the need for the gradual implementation of HIV/AIDS education strategies. She also stressed the cost-effectiveness and credibility of peer education for both officers and prisoners, and the need for educational strategies to take account of the literacy levels and needs of the target audience.

Ms Eileen Adamson, a lecturer in AIDS Training at the NSW Corrective Services Academy, described the development of AIDS education for prison officers in NSW. She spoke of the early difficulties involved in convincing prison officers and administrators of the need for AIDS information, funding problems, and the difficulties of implementing occupational health and safety practices in the prison environment, due to peer pressure on new recruits from more senior prison officers.

In NSW the AIDS Management Course for prison officers aims to give educational programs credibility and lasting effect by training selected prison officers from each gaol in order to provide a "critical mass' and support mechanism to cut through the effect of peer group pressure'.

The importance of design and evaluation in HIV/AIDS education programs was emphasised by Ms Adamson who described the use of needs analysis, learning level assessment and post-course performance evaluation in the AIDS Management Course.

South Australian perspectives were provided by Mr Ollie Behrens-Peters, the State's Prison Health Project Officer. Experiential learning, emphasising participation in

and contribution to educational program development, has been used in South Australia. The approach has been to secure the support and commitment of prison officers to AIDS education before targeting prisoners. Inmates are then involved in developing the content and presentation style of educational programs. Mr Behrens-Peters also spoke of the need to include HIV/AIDS education in programs dealing with communicable and sexually transmitted diseases generally, in order to combat 'boredom' with the AIDS issue.

Ms Helen Close of Helen Close Research, a Western Australian firm, addressed the importance of determining information levels, fears, preferred educational methods and views on segregation and testing, as a prerequisite to developing AIDS policies and educational strategies. She remarked that these perceptions 'rather than an imposition of conceptual frameworks by outside parties, provide a critical basis when formulating effective guidelines and strategies for the effective implementation of AIDS prevention measures and AIDS educational programs in prisons'. In order to assess these perceptions her firm surveyed prisoners, prison officers and other prison staff in seven metropolitan prisons.

Management issues, both administrative and medical, were addressed by a number of speakers. Details of the NSW Government's response to HIV/AIDS were presented by Mrs Frances Buckeridge who delivered a paper on behalf of NSW Corrective Services Minister, Mr Michael Yabsley. The paper referred to the need to restrict prisoners' property in gaols in order to reduce the amount of contraband, and the potential use of condoms as weapons and as vehicles of violence and victimisation. NSW has Australia's largest prison population and introduced compulsory HIV testing from 5 November 1990. The NSW Government has introduced testing in order to monitor the HIV/AIDS epidemic and to discharge its responsibilities to the community.

The Director-General of the Victorian Office of Corrections, Mr Peter Harmsworth traced the development of HIV/AIDS policies in Victoria. Victoria has adopted voluntary testing, which has a compliance rate of about 99 per cent, and uses reverse integration. Reverse integration means that HIV positive prisoners are accommodated in a special unit in 'K' Division in Pentridge Prison with volunteer mainstream prisoners who are participating in a drug and alcohol program. The aim of the policy is to ensure that HIV positive prisoners are not isolated from other prisoners and are accommodated in a safe, secure and supportive environment.

The underlying philosophies and day-to-day operations of the special unit were detailed by Mr Paul Hamilton, Program Coordinator of 'K' Division in Pentridge Prison. A community ethos has been fostered and mutual goal setting used to produce a set of behavioural norms which are supported by both staff and prisoners. Mr Hamilton attributed the lack of violent incidents in the unit to this approach, despite the fact that it houses prisoners who pose management problems.

South Australian management approaches were provided by Ms Ann Bloor, Coordinator of Health and Welfare in the Department of Corrections. Compulsory HIV testing and integration are in place in South Australian prisons. Ms Bloor referred to the specific management problems posed by violent prisoners, promiscuous and attractive HIV positive prisoners, and HIV positive prisoners who spit or bite. She stressed the role of careful placement of prisoners by the Prisoner Assessment Committee in the success of integration.

Management from a medical viewpoint was the theme of a paper by Dr Christopher Liew, Director of the South Australian Prison Medical Service. Dr Liew highlighted the benefits of compulsory testing in the context of early diagnosis, the efficacy of AZT and the availability of preventive medication for opportunistic infections.

Industrial disputation has been a problem in the context of HIV/AIDS and prisons. As part of an attempt to promote good industrial relations, the South Australian Government has sought to convince prison officers that it is committed to protecting them. One strategy in this campaign has been to provide a hepatitis B vaccination program for prison officers. The program has been extended to prisoners.

One of the issues involved in HIV/AIDS and prisons is the relationship between health and corrections. This was the subject of a panel presentation and discussion involving corrections and health personnel from a number of jurisdictions. The two most frequently encountered models of health care in prisons are the provision of health services by medical staff employed by corrections authorities and the use of medical staff employed by health authorities. To overcome possible tensions between correctional and public health perspectives, a Corrections Health Board has been established in Victoria. Mr Stephen Kerr, Manager of the Corrections Health Board, outlined the functions of the Board. It consists of senior personnel from corrections and health departments.

The Conference also considered the needs of particular groups in the context of HIV/AIDS and prisons. NSW AIDS Education Officer, Ms Tracie Walsh, spoke about women prisoners and HIV/AIDS. She pointed to the drug-taking backgrounds of many women prisoners, the risks of woman-to-woman sex, and the possibility that the male sexual partners of women prisoners have also served prison terms. Particular difficulties identified by Ms Walsh in AIDS education for female prisoners were low self-esteem and the paucity of literature on safer woman-to-woman sex. She called for access to dental dams in prison to facilitate safer sex for women prisoners.

Aboriginal and Torres Strait Islander issues were presented by Mr Stanley Nangala, Chairperson of the Communicable Diseases Advisory Committee in the Aboriginal and Torres Strait Islander Commission. Of particular importance to Aboriginal and Torres Strait Islander prisoners who may acquire HIV is their generally low health status. Cultural and educational factors, which may reduce the usefulness of AIDS educational programs developed for other Australian prisoners, also need to be recognised. Mr Nangala drew the attention of Conference participants to the over-representation of Aboriginal and Torres Strait Islander peoples in Australian prisons and called for greater use of non-custodial sentences.

Institutionalised juveniles are another group whose needs are only just beginning to be addressed in Australia. Ms Lisa Ward and Mr Gerard Jones from Community Services Victoria spoke about the policy development process in relation to HIV/AIDS and juvenile corrections. The development and implementation of effective policies are important because young offenders may be at risk of HIV/AIDS due to their involvement in drug use and prostitution.

The emphasis in juvenile corrections in Victoria is on care. Detention is regarded as a good opportunity to teach risk minimisation. It is recognised that in the graded release system provided for juvenile detainees, risk behaviours may occur. Condoms and needles are not distributed at youth training establishments but information on their use and availability is provided.

Mr Tony Clunies-Ross from the Office of Corrections in Victoria outlined the Office's policy on HIV/AIDS and community based corrections. The number of known HIV-infected clients in Victoria is small - about eighteen in a total of 5 600 as at October 1990. However, according to Mr Clunies-Ross, a large number of offenders on pre-release, parole and community based orders are intravenous (IV) drug users. Community based corrections staff provide safe behaviours counselling and bleach sachets, and attempt to put HIV-infected clients with specialist community resources. This last aspect of their work can be a particular problem with clients who live in the country away from specialist services in metropolitan areas.

Conference delegates were fortunate to be addressed by a prison officer, Mr John Doyle, who is a union representative with the NSW Prison AIDS Project. Mr Doyle was seconded to the Project in 1990 to provide credible AIDS education and information to NSW prison officers. He also developed an occupational health and safety kit for use in prisons.

Mr Doyle spoke of the unpredictability and stressful nature of employment in a prison. He described the effect on prison officers of the recent alleged assault on a NSW prison officer who subsequently tested HIV positive. Provision of trauma counselling was recommended to assist prison officers who are exposed to body fluids as a result of

accidents, self-mutilations by prisoners, suicides and murders. Given the problem of drug use in prison Mr Doyle called for more effective drug surveillance and control measures, and for harsher penalties.

The Conference program would not have been complete without a prisoner's point of view. Fortunately, delegates were addressed by a serving HIV positive prisoner who had been granted special leave by the South Australian Department of Correctional Services. The prisoner drew delegates' attention to the problem of street kids, their involvement in IV drug use and prostitution and the potential they have to become HIV carriers in the prison system. He stressed the need to segregate dangerous HIV positive prisoners in order to protect everyone who comes into contact with the prison system; gave a prisoner's view of the frustrations and anxieties experienced in prison, and urged all interested parties to work together '. . . where this virus is concerned, if we don't pull together and get together, we lose . . . It's life. It's not something you play with. It's someone's life.'

WHO Global Commission, AIDS Recommendations and Prisons in Australia

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Commissioner of the World Health Organization
Global Commission on AIDS
Trustee of the AIDS Trust of Australia
Commissioner of the
International Commission of Jurists
President of the Court of Appeal
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My special concern to address the issues of the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in prisons derives from three sources.

First, as a judge I have the responsibility of sending people to prison. As an appellate judge this responsibility arises on the confirmation of convictions which are challenged and on resentencing of a convicted offender, whether on an appeal which that offender has brought or on an appeal against leniency of sentence brought by the Crown. The obligation to send a fellow human being to prison, at a time when HIV/AIDS may lie in wait there, haunts any person of moral sensibility. The law may say that conditions in prison are the responsibility of the executive Government (for example, *R v. Perez-Vargas* (1987) NSWLR 559 at 565). The law may exonerate a judge of moral blame. He or she may see the judicial function as purely mechanical: an instrument of the law. Yet the law presents judges with choices. The privilege of choice carries with it the necessity to evaluate the consequences of the choice made. Where that choice involves sending a person to prison the risk that the person will there acquire HIV ought not to be banished from the mind by ignorance, indifference or resignation. It is a new factor in the equation when this mode of punishment is considered. It is yet another reason why imprisonment is a punishment truly of last resort. There is also legal authority which suggests that the fact that a prisoner has already been exposed to HIV may be a reason for reducing the time spent in prison and increasing the time served on parole or early release (*R v. Michael Smith* 1987 27 A Crim R 315). So the advent of AIDS in prison necessarily concerns me as a judge.

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[1] Personal views only. This address is an adapted and updated version of the South Australian Justice Administration Foundation Oration 1990 Annual Oration, 'AIDS Strategies and Australian Prisons'.

My second concern arises from my membership of the Global Commission on AIDS at the World Health Organization (WHO). That body, established in Geneva, comprises twenty-five Commissioners from different regions and with different expertise. It is established to advise the Director General of WHO (Dr H Nakajima) on worldwide strategies to combat the spread of the AIDS epidemic. Among the Commissioners are the two scientists credited with the isolation of the HIV virus which is the cause of AIDS: Dr Luc Montanier of France and Dr Robert Gallo of the United States. Membership of the Global Commission has given me a privileged insight into the battle against a global epidemic of truly frightening potential. In that battle, legal measures have but a small role to play.

A fellow Commissioner in the Global Commission is Dr June Osborn, Dean of the School of Public Health in the University of Michigan. Professor Osborn is also the Chairman of the United States Commission on AIDS. One of the high priorities which has been adopted by that Commission in its attack on HIV/AIDS in the United States concerns the spread of the virus in United States prisons. That Commission has just received submissions on the subject from health and correctional personnel from around the country. Partly because of the 'war on drugs' in the United States, and the extensive use of incarceration as a weapon against individual users of drugs, the United States prison population has increased rapidly over the past decade. The buildings and facilities have not kept pace; on a per capita basis the budgets for personnel have actually decreased. The result has been a very serious state of health in United States prisons. Where, a decade ago, the usual reason for a sick call in prison was influenza, now it is pneumocystis pneumonia in its early stages or oral thrush with its ominous implications. In the New York State Prison, the Commission has received an estimate that 10 per cent of prisoners are critically ill from HIV/AIDS related illness. The potential for public health contributions through the use of the rapidly changing prison population has been unrealised. For many people in disadvantaged social or racial groups in the United States, the corrections system may actually be the main or sole opportunity for purveying education about HIV/AIDS to the populations amongst those most at risk. It is the realisation of that potential which may cause significant changes to be made in the United States, via the correctional system. By a strange irony, typical of the United States where there is no general publicly funded health care system, the United States courts have ruled that medical care is a right for incarcerated people by reason of the 8th Amendment. That is the constitutional provision which proscribes cruel or unusual punishment. The result is that prisoners must be treated for HIV/AIDS infection where it is identified, even though, once they leave prison, no such right exists. One prisoner recently testified to the United States Commission that recidivism amongst HIV positive prisoners runs as high as 90 or 95 per cent because the deprivations and neglect of homelessness and poverty can then be replaced by security and treatment within the prison walls (personal communication, Dr June Osborn, 20 August 1990).

The Global Commission on AIDS is one unit in the global program on AIDS of WHO. Within that program a large number of consultations and meetings constantly take place to spread medical information, share public health intelligence and to devise international strategies and global standards. One such consultation, held in November 1987, concerned the prevention and control of AIDS in prisons (World Health Organization 1987). I conceive it to be part of my function in Australia, as a member of the WHO Global Commission, to call the important statement which followed that consultation to the notice of those responsible for correctional policy as well as to the attention of citizens generally.

The mention of the citizenry expresses the third capacity in which I have concern about HIV/AIDS in prisons. I, too, am a citizen of this comparatively free and prosperous country. Fair Australia will only be advanced if its citizens remain alert to the human rights of disadvantaged and even unpopular groups in the community. Winston Churchill's dictum remains true: the civilisation of a country can be judged by the way it treats its prisoners.

Recent Developments in Prisons

Our civilisation has been tested in recent weeks. A young prison officer in New South Wales alleged that he was jabbed in the buttock with a needle at Long Bay Gaol in July 1990 by a prisoner said to have been infected with HIV. This incident followed another one in which it was claimed that the prisoner, who had a history of drug offences, had concealed a needle in the padded toe of his sandshoe. The needle on that occasion was reported as clean, but not sterilised. It had no apparent sign of blood. There should be an 'absolute zero risk of infection' (Mr Michael Yabsley, NSW Minister for Corrective Services, quoted in *The Age*, 7 July 1990). The Minister, at the time of the second alleged attack said that prison officers trying to stop contraband getting into prisons were literally faced with 'finding a needle in a haystack ... Syringes and needles have now, in the most literal sense, become a new lethal weapon. Syringes and needles have to be purged from the system'.

Unfortunately, eight weeks later an antibody test performed on the prison officer allegedly jabbed in the buttock produced a positive reading. Following the shock of this news Minister Yabsley implemented a major campaign to remove prisoners' personal property from prison cells. It was his view that such property made it almost impossible to detect the contraband, including needles shared among prisoners and occasionally used against prison officers. The result of the removal of personal effects has been riots and even an investigation by Amnesty International. Yet the alleged attack on the prison officer has led to calls for the segregation of prisoners with HIV/AIDS (*The Australian* 8 September 1998) and editorials demanding that gaol officers need AIDS protection (*Melbourne Herald* 7 September 1990; *Sunday Telegraph* 2 September 1990). Whilst the Government has stood firm against calls for segregation, it is reported to be considering enacting specific offences and providing increased penalties for the use of syringes as threatening weapons (*Sunday Telegraph* 2 September 1990). The suffering of the prison officer and the consequent reaction within New South Wales prisons has put the subject of HIV/AIDS in prisons on the television, radio and in the newspapers of Australia. It is therefore a concern for every citizen.

Epidemics are not new. The history of humanity has been a history of epidemics. In this paper I propose to address my topic from the starting point of nature of the HIV virus and the knowledge we have about its modes of transmission. Good strategies, whether in prison or elsewhere, will depend upon good scientific knowledge. I will then address the international data about HIV/AIDS in prisons, for it is often suggested that prisons represent a potential incubator of the virus. Next I will examine the responses of Australian correctional authorities. Finally, I will address a number of strategies that can be taken before coming to the truly hard questions of screening of prisoners and making available to them condoms and bleach in the attempt to limit the spread of the virus in their midst.

The Virus and Modes of Transmission

A useful rule for the development of any law or policy - but imperative in the control of an epidemic such as AIDS - is the necessity to have a clear understanding of the features of the target. Good ethics, effective policies and just laws are more likely to emerge from a clear understanding of the features of the epidemic, its modes of transmission and its characteristics in the community than from preconceptions based upon fear, hysteria, religious conviction or other grounds. If we are truly serious about mobilising whatever fragile and imperfect assistance we can give to impede the spread of HIV and AIDS, it is self-evident that people with relevant responsibilities should be aware - at least in general terms - of the nature of the epidemic and of the virus which causes its spread. To ensure that we keep our sense of proportion, it is also useful to know something about the present size and projected enlargement of the problem. We should be aware of the available therapies and the prospects for a vaccine and cure. Knowledge of the latter reinforces a proper sense of urgency about developing effective policies and laws which protect society, and the individuals who make it up, from the spread of this life threatening virus.

AIDS is a viral infection which suppresses the body's immune system (Mutton & Gust 1983). In the worst cases it goes on to destroy that system, leaving the patient vulnerable to opportunistic infections which would otherwise be resisted. The HIV virus invades and kills the body's white blood cells (called T lymphocytes or T-cells). As this occurs, diseases which rarely affect a person with an immune system which is intact can prove seriously debilitating (and later fatal) to those infected with HIV. AIDS, caused by HIV, is thus the precondition of a serious and usually, eventually, a fatal illness. The end stage illness will typically involve one of a number of infections or malignancies, many of them otherwise quite rare.

The HIV virus has been isolated in most body fluids, including saliva, tears and urine. However, only blood and semen have, so far, been implicated by epidemiological evidence in the transmission of the virus from one human to another. Mosquito bites, sneezing, casual contact, social interaction and shared toilet seats can be ruled out as modes of transmission. Fortunately for humanity, the HIV virus is not easily acquired. It is important to make this point to repel the worst fears, sometimes held by people who should know better. Irrational fears about earlier epidemics have taken their toll in the past. At the turn of the 20th century, it was seriously thought in public health circles that syphilis (a condition then bearing many parallels to contemporary AIDS) was transmitted by the shared use of pencils, pens, towels and bedding. Naval regulations were promulgated during the First World War requiring the removal of doorknobs from United States battleships because of the belief that they caused the spread of syphilis amongst the sailors (Brandt 1988). We now know that the causes were something rather less impersonal than a doorknob.

AIDS represents the third, or end, stage of the progress of infection with HIV. Like syphilis, AIDS has a typically long period of latency, although this varies according to the subject's age, environmental factors, etc. The long first period of HIV infection may last indefinitely. However, typically, in the adult it lasts about eight years. The second stage (ARC) sees the development of 'AIDS related complex' - with the onset of certain physical signs and symptoms. These usually accompany a significant drop in the T-cell count. It is the third stage which is AIDS - a condition diagnosed by reference to a number of now internationally accepted criteria.

Although progress from one stage to the next, and from AIDS to death, can be interrupted or slowed in some cases by therapeutic drugs, the available therapies are imperfect. They are also expensive. The most effective of them (AZT) costs (depending on dosage) about $4000 per person per year. Obviously in poorer countries drugs such as AZT are simply not available, whether to prisoners or to other citizens. But even in comparatively wealthy countries, such as the United States and Australia, controversies have also arisen concerning the availability of AZT therapy. Some views have been expressed that even people in the first stage of symptom-free HIV infection would benefit from AZT therapy. The cost of providing such therapy would be enormous, particularly in the United States where it is estimated that more than a million persons are infected with the virus. Three thousand new cases are reported each month in that country. In Australia, complaints have also been made about the availability of AZT. However, at least we have a national health system and standard criteria by which therapeutic decisions on this and other drugs can be made with a measure of equity.

The dimension of the problem we are facing with AIDS is clearly presented by the fact that the number of reported cases of AIDS represents only a portion of those persons with the condition. There are still various pressures to ascribe illnesses and eventual death to the opportunistic infection rather than to AIDS. In this way the dimension of the problem continues to be under-estimated. And cases of AIDS represent only the tip of the iceberg of persons infected with the HIV virus. Various estimates have been given for the numbers in Australia. Those estimates have recently been revised downwards. But it seems likely that at least 30 000 Australians have been infected. Most of them are young, symptom-free, apparently healthy, at the peak of their economic and social utility. As such, these people provide no risk to other citizens with whom they come in contact. It is not people or groups who present a problem for the spread of HIV. It is particular behaviour.

At first, a significant mode of transmission of HIV in Australia was through contaminated blood products (especially blood transfusions). This source of the epidemic has been stemmed in Australia but not, appallingly enough, in many developing countries of Africa and Latin America. The remaining modes of transmission are well known. They are sexual intercourse, sharing of contaminated intravenous drug equipment and perinatal transmission. The last is now a major source of transmission of the virus in the United States and in parts of Africa. The first two represent the source of the challenge of AIDS in the context of prisons.

Prisons: An Incubator?

There are no reliable figures for the prevalence or incidence of HIV infection in Australian prisons (Strang 1990). However, a recent article on the subject has suggested that the prison environment, at least in Australia, is, by its very nature, a potential reservoir for the spread of HIV/AIDS because of the established incidence in prisons of high risk activities which cannot, responsibly, be ignored (Strang 1990).

The position in prisons overseas is better documented or estimated. In a recent paper published in the *Medical Journal of Australia*, Dr Jael Wolk and others referred to the spread of AIDS to the community by reason of infection acquired in prison:

> Needle sharing and unsafe sexual practices are both generally considered to be prevalent within prisons, although the extent to which they occur is unknown. In the United States the number of AIDS cases in prisons increased by 157% between January 1986 (766 cases) and October 1987 (1964 cases) and the majority of cases were [intravenous drug users]. Studies of HIV sero prevalence in Argentine and Brazilian prisons in 1988 showed that 17% and 18.3% respectively of inmates were infected and the majority of the infected prisoners [are intravenous drug users]. HIV sero prevalence ranged from 11% to 48% in European prisons in 1987/88. There is also evidence that HIV infection is occurring in prisons: 2 of 137 inmates incarcerated for 9 years in Maryland, USA, tested HIV positive as did 6 inmates incarcerated for between 4.6 and 7 years in New York (Wolk et al. 1990, p. 453).

Further statistical data on the presentation of HIV in prisons is collected in a paper on the topic of Hans Heilpern and Sandra Egger (1989, p. 21). Most of the data collected by them refers to Europe and North America. So far as Europe was concerned, the highest figure reported was from Spain where screening among high risk prisoners revealed that 25.7 per cent were seropositive. Other high figures were reported from France: 13 per cent (testing of 500 consecutive entries); Italy 16.8 per cent (screening of 30 392 prisoners in 1986); Switzerland 11 per cent and the Netherlands 11 per cent (screening of a sample of prisoners in Amsterdam). The low figure returned by the United Kingdom (0.1 per cent) was regarded as reflecting a low level of screening rather than a genuine low level of prevalence in that country.

On the basis of these and other studies, an estimate was put forward that the overall prevalence of seropositivity in European prisons was in excess of 10 per cent (Heilpern & Egger 1989, p. 23). Amongst IV drug users in prisons the level of seropositivity was much higher. In one study of IV drug user prisoners in Fresnes in France, it was found that 61 per cent were seropositive. More recent research in France paints a still grimmer picture of the French prisons surveyed. Twelve per cent of prisoners admitted in 1987 admitted to drug dependence; an estimated 50 per cent of IV drug user prisoners were deemed HIV positive. The overall HIV seropositive rate in French prisons was estimated to be 6 per cent - a rate 20 to 30 times higher than in the general population. Overcrowding was such as to exacerbate these difficulties. And perhaps the most telling statistic was the rapid

increase in the rate of HIV seroprevalence. In one Spanish prison, for example, it almost doubled in one year from 24 per cent in 1986 to 46 per cent in 1987.

Similar patterns emerge from studies in the United States. Two national prison project surveys in 1985 and 1987 showed a 293 per cent increase in the number of cases of inmates with AIDS (420 to 1650). In both cases the death rate within a year was approximately 50 per cent. At October 1987, there had been a cumulative total of 1964 AIDS cases amongst prison inmates in the United States. Five per cent of the inmates with AIDS were women. The correctional administrators attributed approximately 66 per cent of the male cases to pre-prison homosexual activity. However, other opinions expressed the view that IV drug use is a much more important transmission category in correctional AIDS cases than in the population at large.

WHO Principles

Against the background of accumulating data on the incidence of HIV in prisoners in many countries - and the perceived importance of the issue to the future course of the AIDS pandemic - the World Health Organization convened its meeting on the subject in November 1987 in Geneva. Thirty-seven specialists from twenty-six countries participated. They included experts in public health, prison and medical administration, prisoner care, occupational health and safety, epidemiology and health policy. At the end of the consultation a statement, reached by consensus, was approved (World Health Organization 1987). This is a common procedure adopted by WHO to provide guidance to member countries from the international pool of talent and expertise available in dealing with major world health problems, including AIDS.

The WHO experts stressed the need to perceive control and prevention of HIV infection in the context of the larger obligation significantly to improve overall hygiene and health facilities in prisons. They recognised that in many countries there 'may be' substantial numbers of prison inmates who have a history of high-risk behaviours such as intravenous drug use, prostitution and 'situational homosexual behaviour' in the prison environment. These considerations imposed upon prison authorities a 'special responsibility' to inform prisoners of the risk of HIV infection. Many of the persons making up the prison population were thought to be 'unlikely to have received such education in the general community'. If there is ignorance about AIDS and its transmission in the general community, it may fairly be assumed to be a still larger problem in prisons. There, socially deprived persons with lower than average education tend to predominate. The experts urged that policies of prison administrations to deal with HIV/AIDS should be developed 'in close cooperation with health authorities'. They stressed the need for independent advice in the interests of prisoners by prison medical services. They urged the adoption of prison policies along the lines of guidelines which took into account a number of considerations. These included:

- the responsibility of prison administrations to minimise HIV transmission in prisons; and
- prisoners' rights of access to educational programs, voluntary testing, confidentiality of results, availability of counselling, medical services equivalent to those available to AIDS patients in the community at large and information on treatment programs.

The WHO report suggested that prisoners with AIDS should be considered for compassionate early release 'to die in dignity and freedom'. The need to prevent discriminatory practices relating to HIV infection or AIDS 'such as involuntary testing, segregation or isolation, except when required for the prisoner's own well being' was clearly stated. The necessity to provide prison staff with up-to-date information and education was also stressed. The experts went on:

> Homosexual acts, intravenous drug abuse and violence may exist in prisons in some countries to varying degrees. Prison authorities have the responsibility to ensure the safety of prisoners and staff and to ensure that the risk of HIV spread within prison is minimised. In this regard prison authorities are urged to implement appropriate staff and inmate education and drug user rehabilitation programs. Careful consideration should be given to making condoms available in the interest of disease prevention. It should also be recognised that within some lower-security correctional facilities, the practicability of making sterile needles available is worthy of further study.

Perhaps most boldly the experts urged that governments:

> May also wish to review their penal admission policies particularly where drug abusers are concerned in the light of the AIDS epidemic and its impact on prisons.

Australia's Reaction

Against the background of these internationally stated guidelines, it is relevant to examine the response by governments and prison administrators in Australia where prisons are generally a State responsibility. Recent developments in New South Wales illustrate the fact that it is difficult to be sure of the most up-to-date information on this score. Certainly, compulsory testing of all prisoners, including unsentenced prisoners, entering the correctional system is undertaken in Queensland, South Australia, Tasmania and the Northern Territory (Heilpern & Egger 1989, p. 29). Compliance with the obligation is obtained through the use of what are described as 'correctional sanctions'. In South Australia and Tasmania, a repeat test is undertaken after three months of imprisonment. The purpose of this test is to overcome the possible inaccuracy of the initial test based upon the established numbers of false positives and false negatives (due to imperfections of the test) or the possibility that the prisoner was in the window period at admission, when first tested. As is now widely known, the test commonly in use to establish the presence or absence of HIV infection responds to the antibodies produced following exposure to the HIV virus. These antibodies take a time to present in sufficient degree to produce a positive test result. Estimates of the window period vary. However, three months would appear to be safe for the purpose of catching cases missed in this way. In Queensland, retesting is conducted at twelve-monthly intervals. It may also be repeated on prisoners assessed as possibly engaging in 'high risk behaviour' (Heilpern & Egger 1989, p. 30).

In the other States, at least until recently, voluntary testing programs were offered and indeed encouraged. In Victoria, all prisoners are offered the opportunity to be tested upon admission. Reluctant prisoners are counselled and encouraged to volunteer. A very high compliance rate (98 per cent) is reported (Heilpern & Egger 1989, p. 30). In Western Australia, a voluntary testing program was offered; but few prisoners were reported as seeking to be tested.

Until mid-1990, the policy of New South Wales prisons was to provide for voluntary tests only. At least until 1989 the number of prisoners volunteering for the test was quite low (estimated at 5 per cent). This was because of the consequences of a seropositive result. Prisoners found to be HIV positive were segregated. They lost the opportunity to participate in many prison activities, for example industry, education, and work release. In these circumstances it was little wonder that the volunteers were few. Their number reportedly increased upon the abandonment of segregation. As well, prison authorities provided much information to prisoners about HIV/AIDS. In-house prisoner newsletters

also contained much beneficial discussion of the subject and of the special risks presented by prison life.

The results of the testing systems outlined above are not (as has been said) entirely satisfactory. By the beginning of 1989, the cumulative number of HIV positive prisoners in Australia revealed by such testing procedures was 99. As the total Australian prison population at any given time is of the order of 11 000 and as total annual admissions amount to about 33 000 prisoners, it can be seen that the present testing procedures reveal quite a low incidence of HIV in Australia's prisons. But these figures obviously mask a larger problem. Sources of the problem, and of the unreliability of the available statistics are:

- the numbers of false negatives/positives in jurisdictions where tests are not repeated;
- prisoners in the window period where tests are not repeated;
- self-selection and exclusion in jurisdictions where tests are voluntary; and
- exclusion of long-term prisoners in systems reliant upon more recently introduced testing on admission.

There seems little objective reason why Australia's prisons should be immune, at least in the long run, from the kinds and levels of infections revealed in Western Europe and North America. The same phenomena exist to give rise to the same problems, namely:

- High levels of drug using persons who -
  - are imprisoned for drug related offences, or
  - gain access to injected drugs in prisons; and
- High levels of young male prisoners, deprived of heterosexual outlet, thrown together often in crowded conditions which may give rise to situational homosexual conduct at levels significantly higher than would exist in civilian life.

It is in these circumstances that HIV is specially relevant to prisons. For these features of prison life mirror, unfortunately, the major known modes of transmission of the HIV virus.

The precise levels of access to injected drugs in prisons in Australia is unknown. Professor John Dwyer estimated in 1988 that in Long Bay Gaol in Sydney, about 60 per cent of inmates used intravenous drugs once or twice a week (Norberry & Chappell 1989). If this is even partly right, it represents a very high exposure rate to the risk of infection from unsterile injecting equipment. The figure may seem very high to a casual observer of the problem. In any case, figures in Sydney, the major port of entry into Australia of illegal injected drugs, may make figures in New South Wales prisons unrepresentative of prisons in Australia generally. But that drugs do enter the prison system is indisputable. It is proved by the occasional cases of criminal charges brought against prison officers and prisoners. It is established by reliable anecdotal evidence. It reflects, in part, the fact that a very high proportion (said to be more than 70 per cent) of all persons sent to prison in Australia have some civilian contact with illegal drugs. Because of mandatory or otherwise high prison sentences for drug related offences, it is inevitable that, at any time, many prisoners, in Australian prisons, will have had exposure to illegal injected drugs before admission. It is also true that many non-drug offences, particularly of larceny and robbery, can be traced to crimes committed, allegedly, to provide funds to feed an illegal drug habit. Likewise male and female prostitution are in some cases associated with that need. It is enough to say that the preconditions for the high increase in HIV through drug injection exist in the very nature of the client population of Australian prisons. Lack of effective alternative programs, lack of motivation to escape drug use, lack of resources to ensure adequate surveillance, the limits, in any case on complete surveillance and the advantages which can sometimes result from addicted prisoners who have access to their drugs all conspire to provide the environment in which even honest and vigilant prison officers may fail to eradicate drug use in prisons. To some extent it is, as Minister Yabsley has said, literally like looking for a needle in a haystack.

Overseas studies report that 20 to 30 per cent of prisoners engaged in sexual activity at least once whilst in prison (Nacci & Kane 1984). A 1989 study of a sample of prisoners in the South Australian prison system reported that about 42 per cent of prisoners engaged in risk behaviour at least once whilst incarcerated. Thirty-seven per cent were estimated to use drugs intravenously. Twelve per cent were reported as having engaged in unprotected anal intercourse (Douglas et al. 1989). There are numerous constraints upon accurate investigation of this phenomenon, including the cultural norms typically prevailing in men's prisons. Some cases of non-consensual sexual intercourse come to notice when charges are laid. It is reasonable to infer that these represent but the tip of the iceberg. Quite apart from violent activity of this kind, consensual homosexual acts undoubtedly do exist. The debate is thus about the level of prevalence.

What Can Be Done?

What then can be done to protect prisoners from infection with HIV whilst in prison? About some matters there need be little debate. Few observers would dispute the need to:

- provide information, education and training to prisoners and to prison officers, administrators and all those responsible for prisons about the special risks of HIV/AIDS in the prison context;

- provide facilities for antibody testing on a voluntary basis whenever a prisoner reasonably wishes to undergo the test;
- provide for strict confidentiality in the results of the test and for counselling both before and after testing is conducted. Discovery of seropositivity, particularly in a prison environment with a lack of support that may be available outside, add to the need for understanding and assistance to prisoners found to be HIV positive. Prolonged periods of idleness, and the absence of the distractions available to a person pursuing an ordinary life in the community, mean that the impact of knowledge of seropositivity will be even greater in the case of a prisoner than otherwise;
- pay attention to tattooing by unsterile tattooing equipment which is another special concern in the Australian prison culture. It provides a reason for the provision of bleach or other cleaning materials so long as in house tattooing occurs;
- provide facilities for treatment, including AZT, therapy and therapeutic counselling from prison medical staff to seropositive prisoners. Such staff should be provided with information about HIV/AIDS with the latest medical and non-medical supports available to persons infected; and
- collate appropriate data for the purpose of tracing the problem and constantly reviewing policies. Epidemiological data on the incidence of HIV among prisoners, provided on a purely statistical footing, should be pooled and distributed to correctional authorities throughout the country. Personal identifiers should be removed from such data.

Fortunately, certain studies including some on South Australian prisons, reveal relatively high levels of accurate knowledge about HIV and its modes of transmission within prisons (Gaughwin et al. 1990, p. 61). The bad news, however, is that, despite this information, prisoners and prison officers believe that there has not been a resultant substantial reduction in risk behaviour, particularly in respect of intravenous drug use (Gaughwin et al. 1990, p. 63). Clearly, prison journals should be used and prisoners themselves consulted on ways in which information can be effectively disseminated in the prison environment to ensure necessary behaviour modification.

Testing, Condoms and Bleach?

Mandatory screening

This leaves three issues of controversy upon which there is no unanimity. The first is whether compulsory testing of prisoners should be supported. Its introduction in New South Wales was accompanied by considerable debate including, apparently, within the Government. There is a tendency with AIDS to resort to mandatory screening. The Government is then seen to be acting. It is usually directed at powerless, voiceless groups (such as prisoners, overseas migrant applicants and members of disciplined services). It has the colour of a medical response to a medical problem. We remember the widespread useful testing for tuberculosis. It is relatively cheap. It has some epidemiological utility. It may also provide prisoners with some proof in the event that they later wish to bring an action for negligent care against the government or prison authorities.

The arguments in favour of mandatory testing of all prisoners for purely statistical data are strong. But, as introduced in Australia, identifiers have not been removed. Confidentiality has not been observed. In some prisons, the prisoners are segregated and lose valuable rights. In others, their confidences have been betrayed, as when one prison

officer told a family member that his father would take a time to get to the interview room because he was 'in the AIDS wing'. Testing leads to no cure. Unless accompanied by strict confidentiality (which is difficult anyway to maintain in a prison environment) it leads to discrimination, hatred and even retaliation out of fear. Unless a strict policy of separate prisons and segregation is adopted the testing leads, effectively, nowhere. As well, it is subject, unless constantly repeated, to the defects of false positives and negatives and to the window period. It may lead to false confidence about HIV status. It does not have the advantage which 'encouraged' voluntary testing presents as a first step in personal responsibility and behaviour modification which are essential for the containment of the HIV epidemic - especially in the artificial environment of prisons.

Whilst, therefore, I understand the political forces which lie behind compulsory testing of prisoners, I do not believe that it can be justified as an effective strategy against the spread of HIV in prisons, at least as presently undertaken. It is, I regret to say, politically attractive in part because it is cheap and has little consequence but involves doing something. I consider that the WHO guidelines which exclude such involuntary screening show greater wisdom.

Condoms

The provision of condoms in prisons has been opposed by prison officers' associations. In New South Wales, they even threatened to go on strike if any condoms were distributed in prisons (*Sydney Morning Herald* 14 June 1990). As a result of this threat it was agreed that the proposal would be 'kept on ice' for the time being. The *Sydney Morning Herald* reported that it was understood that 'Ministers feared that any unexpected confrontation with prison officers would seriously jeopardise legislation aimed at introducing compulsory AIDS testing for all New South Wales prisoners'.

A number of arguments are raised against the provision of condoms in prisons. Some of them are based upon the assertion that homosexual activity does not exist. This is a factual issue. It appears to defy such anecdotal and research information as is available. In some cases it is opposed on the basis that the provision of condoms would condone sexual activity, to the decline of prison discipline. However, in many of the responses to the AIDS epidemic, authorities have had to face cold reality. In the name of the higher good of preventing the spread of a deadly condition, which should certainly not be acquired whilst a person is the responsibility of a State in a prison, steps have been taken which, even recently, would have been considered unthinkable. The most obvious of these involves the needle exchange scheme.

It is said that prison officers should not be demeaned by handing out condoms. I entirely agree. Such a procedure would, in any case, greatly discourage their use. Condoms should be readily available from medical services. At the least they should be available from vending machines or prison stores. Prisoners cannot walk into a pharmacy and purchase them, as ordinary citizens may. They should not, by reason of their imprisonment, be exposed to the risk of a deadly condition which can be avoided (or the risk greatly reduced) by the use of condoms.

Then it is said that condoms will break and are not suitable to anal intercourse. New and safer condoms have been developed. Furthermore, it is not only for anal intercourse that condoms should be used. Condoms reduce the risk of sexually transmitted diseases spreading by other means of sexual intercourse. No-one suggests that condoms are a complete answer to sexual transmission of HIV. But they clearly reduce the risk very substantially. They would not be likely to be used in violent sexual acts, for example rape in prison. But for reducing the transmission of HIV in prisons at least by consensual sexual activity, condoms should in my opinion be made available free of charge. Whilst it is true that there is some risk that they may be used for secreting drugs or other objects, it is necessary in HIV prevention to balance risks. One thing is sure about HIV: once acquired

there is no cure. In most, if not all, cases, it leads to death. I therefore find myself in agreement with the leader of the *Sydney Morning Herald:*

> [T]here are more private ways of distributing condoms. In other countries condoms are simply sold across the counter in prison canteens or from vending machines. For six years, NSW Prison Officers have maintained that they will not accept the State-sanctioned introduction of condoms. This obstruction is a major political problem ... there is ... a fear that condoms would be used to conceal contraband in body cavities. This is indeed a risk. But it is less serious than the dangers of the spread of AIDS in NSW prisons and its implications for society outside the prisons (14 June 1990).

IV drug use

The most controversial issue is whether sterile syringes should be made available to prisoners or, at the least, bleach and other cleaning material to reduce the risk of spreading HIV through unsterile needles infected with contaminated blood. That risk is greater in the prison context because of the likelihood that, if illicit drugs are available, they will be administered with equipment which must be repeatedly used and shared amongst many users. To the subcultural forces which promote sharing of unsterile needles in civilian society, is typically added the imperative of unavailable alternatives in the prison context. It is not as if the prisoner can participate in the needle exchange scheme which has been introduced. He or she, if addicted, will usually have access only to imperfect equipment: just the kind likely to provide the perfect vehicle for the spread of contaminated blood.

I can understand the attitude of politicians and prison officers who resist the notion of providing sterile needles or even cleaning materials in a prison context. To many this would seem the final abandonment of the 'war against drugs' and in a disciplined context. It would appear, in an environment designed to uphold the law, to condone illegal drug use: a contradiction in terms. Many of these arguments were presented by analogy, when the proposal for needle exchange was made. In a rare and bold move with bipartisan support, governments in Australia, New Zealand and elsewhere have concluded that the risks of HIV/AIDS, and the usually fatal result of the infection, require radical and even unpalatable steps to be taken.

It is my belief that in due course even more radical steps will be needed as the AIDS epidemic penetrates Western societies by the vectors of drug infected heterosexual males and females. Already we are beginning to see serious calls to address the problems of drug addiction by the techniques of public health rather than the imperfect mechanisms of law and order (for example, Australian Parliament 1989; Wodak 1990; Kaplan 1988). But this will remain a long-term strategy - one of great significance for the prison system. In the short-term, in prisons, as in society, contradictions must be tolerated precisely because HIV once acquired has such devastating, horrible consequences. Offenders are imprisoned as punishment and not for punishment. They certainly do not go to prison to be exposed to the risk of acquiring a fatal condition there. Unless governments, and prison administrators can absolutely guarantee a totally drug-free environment, it is their plain duty to face up to the risks of the spread of HIV infection by the use of unsterile injecting equipment in prisons. If it is too much to adopt a similar exchange system (unused for used needles) at the very least cleaning bleach should be provided in discreet ways for use by prisoners. Such provision must be backed up by education about the great dangers of IV drug use today. It must be supported by the expansion of methadone and drug rehabilitation programs both within prison and afterwards (Strang 1990; Victorian Ombudsman reported in *The Age* 20 July 1990). Again, I agree with the *Sydney Morning Herald* leader of 14 June 1990:

> Dr Alex Wodak, Director of the St Vincent's Hospital Drug & Alcohol Service said this week [that] prisoners [should be supplied with] condoms and provided with bleach for cleaning needles. It is advice to which [the Minister] should listen.

Conclusions

The subject of this essay has illustrated the challenge to our correctional policies and institutions posed by an epidemic which was completely unknown and unexpected fifteen years ago. However, it is now upon us. As overseas experience shows it has special significance for the Australian prison system. We must ready ourselves, as a civilised community, to ensure that prisoners are not unnecessarily exposed to acquiring a fatal condition whilst in prison. If we do not take proper steps, we will stand condemned as irresponsible and morally negligent in the safekeeping of prisoners.

The World Health Organization has provided sensible guidelines. It is unfortunate that Australian politicians and prison administrators have not adhered to them. Not enough has been done to spread and repeat educational messages to the constantly changing prison population. Political gestures, such as mandatory testing, have been made with little practical utility in addressing the real problems of HIV infection in prison. Prisoners found to be infected are not isolated. The only advantage of this testing is that it will provide evidence upon which prisoners will be able to rely in actions against governments in negligence in other respects to HIV acquired in prison. I rather doubt that this was the policy which lay behind the strategies of mandatory testing of prisoners. As is usually the case, those strategies are based either on ignorance or prejudice or real indifference to the true problems of containing the AIDS epidemic.

In the potential incubator of prisons those true problems derive from the established modes of transmission of the HIV virus. These are by IV drug use and unprotected sexual intercourse. Advice, education and counselling (including to the point that the highest protection exists in avoiding entirely risky activities) must be given. But for those who cannot, or will not, take such advice, practical steps must also be taken. These include the availability of condoms and of cleaning agents or bleach to prisoners.

Death, as they used to say in the old road safety advertisements, is 'so permanent'. If overseas experience is any guide, many prisoners will become infected with AIDS in prison. They will mirror the sexual orientation of the general population. They could then become vectors for spreading a deadly virus through our population. We owe it to the prisoners - but if this is unconvincing, we owe it to our community - to protect prisoners from infection whilst in prison. This requires radical steps before it is too late. Just as we have taken them with the needle exchange scheme in civilian society. Such steps may seem unpalatable. The infection of any prison officer by the isolated act of a prisoner is most unpalatable. It is criminal conduct and morally outrageous. The infection of a person who is in the custody of society, because that person does not have access to ready means of self-protection and because society has preferred to turn the other way, is just as unpalatable. As a community we must take all proper steps to protect prison officers and prisoners alike. By protecting them we protect society.

I therefore hope that we will go back to the WHO guidelines on prisons. And that we will see fewer empty gestures - and more real concern to protect prison officers, prisoners, and ourselves. Only in that way will we halt the needless spread of this most terrible virus which imposes a great economic burden on society, strikes down the young, uses pleasure as its agent of spread and inflicts a long, cruel, one-way journey to death which causes great suffering to those infected and to those who, helplessly, see them die.

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AIDS in Australian Prisons
What are the Challenges?

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The Human Immunodeficiency Virus is a massive challenge to public health and is changing the human face of our planet. Nowhere is the challenge more complex than in the prison systems of the world.

The National Centre for Epidemiology and Population Health, has State, national and global commitments to the AIDS challenge. At the State level, we have been trying to understand the dynamics of the epidemic in South Australian prisons, and to identify rational approaches to epidemic containment. Nationally, a team led by our statisticians is working in close collaboration with the National Centre for HIV Epidemiology and Clinical Research, to improve our predictions about the way the epidemic will affect Australia in coming years. At the global level our demographers are trying to understand the dimensions of the calamity that is occurring in sub-Saharan Africa, including particularly the factors which facilitate transmission to women.

The issues we faced during this conference and about which conference participants formulated a series of recommendations to the Australian community, are biologically complex, but from the public health perspective they are relatively easy to understand. The public health facts have been shouted from the rooftops, in the media, and discussed extensively at scientific meetings. Transmission of the Human Immunodeficiency Virus occurs directly by exchange of bodily fluids. Exchange can occur by transfusion or injection of blood and by means of seminal fluid. If these simple processes could be stopped, the epidemic would cease.

Of course, what makes the challenge an immensely difficult one is not these public health facts, but their social and behavioural ramifications. Human sexuality and the intravenous injection of drugs, are two areas of great social sensitivity. Until the permissive 1970s we did not discuss them much at all. Even now in the 1990s they are subjects about which we are profoundly ignorant, and those facts which we do know, we would prefer to ignore, rather than face their implications.

Punishment and imprisonment are also taboo items. Societies like to see things in black and white, and prisons are the simplistic solution for punishing those who step beyond the conventional view of what is right. The public at large does not particularly want to explore the grey areas of this issue either. Any public debate on the question whether or not society's interests are best served by incarceration of huge numbers of individuals, and by a

system of retribution rather than rehabilitation, quickly get swallowed and replaced by concerns for security and control.

Small wonder then, that it took so long to hold a national meeting about HIV infection in prisons. All of the issues discussed in these pages are uncomfortable and sensitive ones. All of them infringe social and cultural taboos. In consequence, public policies which bear upon them are laced with inconsistencies and strong disagreement among policy makers.

What makes it imperative that we now face these inconsistencies and develop a unified approach to them across Australia, is that we are now at a critical point in the AIDS epidemic where concerted action could significantly influence its future direction, having effects on the health, not only of the population of prisoners, but indeed the entire population of Australia. What goes on in the prisons could materially influence the course of the epidemic outside prison.

There is a large turnover of prison populations. Intravenous drug users, because of current attitudes to this form of substance use, constitute a substantial proportion of the prison population. Presently, HIV infection is only slightly established in Australian drug users. But experience in other parts of the world shows that it can rise rapidly and that if it does so, and if shared needles are widely used, the increase in rate is exponential. If it rises significantly, the chances of heterosexual spread of the epidemic are considerably enhanced, and the problems in prisons - already very serious - will multiply.

It has become very important then that we develop a national strategy for containing the spread of the epidemic in the prison setting, and that we have the support of the entire community in developing that strategy. Because sexuality, substance abuse, and imprisonment are such taboo issues, most of our politicians would prefer to avoid them. They are the stuff of which scandals are made and the journalists love them. A lack of policy in this area is the consequence.

This Conference was unique. It gathered together many of Australia's influential decision makers, researchers and opinion leaders on the 'AIDS in Prisons' issue. Some of the world's leading researchers in the area came to the Conference and gave of their experiences and advice freely.

As the Conference progressed it became apparent that there was an extraordinary willingness to consider the issues and problems seriously, to cooperate and develop a meaningful statement of a way forward to deal with HIV and AIDS in prisons. The communique is the product of that cooperation and consideration.

Immediately after the meeting, the statement was sent to every State and Territory politician in Australia and to appropriate Federal Ministers. It has stimulated wide discussion on attitudes and practices, and many of the Conference participants are working to see the recommendations implemented.

The jury's verdict is awaited. At stake may be the future outcome of the Australian AIDS epidemic.

Communique - HIV/AIDS and Prisons Conference

The first national HIV/AIDS and Prisons Conference held in Melbourne from 19-21 November 1990 was attended by a widely representative group of 150 individuals from across Australia including senior prison administrators, prison officers, prison medical officers, academics in law, social welfare, medicine and public health, prisoners and former prisoners, church and welfare workers, juvenile justice workers, criminologists and interested citizens. The meeting was jointly organised by the Australian Institute of Criminology and the National Centre for Epidemiology and Population Health, and received sponsorship support from the Commonwealth Department of Community Services and Health and the National Centre for HIV Social Research.

The Conference heard papers on many aspects of the problem of HIV/AIDS and prisons both in Australia and overseas, and paid careful attention to a number of controversial questions which have not been resolved previously in Australia. The following statement was endorsed by those attending the final session of the meeting after a series of

workshops had considered its practical implications, and is being widely distributed to politicians, journalists and the community-at-large because the Conference believes it vitally concerns every Australian.

Influence of HIV/AIDS in prison on those in the wider community

What happens now in the Australian prison system could materially influence whether the HIV epidemic will extend to the wider community in the future, or will be contained. The future direction of the epidemic depends greatly on the extent to which the virus becomes established in those who inject drugs in the wider community. At this stage, intravenous drug users in Australia have relatively low rates of infection, a situation which could quickly change as it has done in many other countries. A high proportion of regular intravenous drug users pass through the prison system and back into the general community. With their incarceration. they carry into the prison environment their dangerous risk behaviours which become even more dangerous inside prison. In prison, under current circumstances they heighten the danger to those already incarcerated.

Recognising the realities of prison life

Conditions in Australian prisons are conducive to the spread of HIV. Shared needles and failure adequately to clean injecting apparatus are the norm in Australian prisons and injecting of drugs of various kinds is common. Anal intercourse is less common than intravenous drug use, but when it occurs it is nearly always unprotected and sometimes accompanied by violence and lack of consent. Overcrowding of prisons is a growing problem which favours these activities. While these problems should be addressed regardless of HIV, its presence in the prison population makes action particularly urgent. The Australian community ignores this urgency at its own peril.

Prison officers and administrators are placed in an impossible situation when prisons are overcrowded, when resources are inadequate, and they are expected to stamp out illegal sexual and drug using behaviour. The fact is that they are unable to do so, and this difficulty they share with every prison system in the Western world.

Under these circumstances, there must be a recognition of the need to minimise harm. A lesser of two evils approach recognises that illegal activities are going on in prisons and that prisoners ought to have both the knowledge and the capacity to protect themselves against HIV infection. There is, both for society and for individual health and prison workers, a serious practical dilemma in making the means available to prisoners to do this without appearing to sanction what is very often illegal behaviour. And yet, if the public health problem is to be seriously addressed, those engaging in these behaviours in prison should have access to condoms and to bleach for cleaning injecting apparatus.

Sexuality in the prison setting

Attitudes towards sex in prison vary widely in the community, and among prison staff. Further education of prison staff in the area of HIV transmission risks and attitudes towards people with HIV infection should occur.

It is recognised that sex does occur in Australian custodial institutions and that it may not always be consensual. But the nature and extent of these activities is not well understood, and further research is needed. Some sexual activities are safe or safer than others with respect to HIV transmission, and prisoner education should include specific information on the relative safety of different sexual practices, with a view to discouraging high risk activities when, and if sex does occur. It is recognised that single cell accommodation may reduce sexual activity in prison and we believe that single cell accommodation should be available for all prisoners.

Appropriate use of condoms and other barrier methods, will substantially reduce HIV infection. Before advocating widespread condom availability in Australian prisons, we

believe that a trial program should be instituted in one or more jurisdictions, including an evaluation of used condom disposal. They should be made available as part of health services aimed at reducing disease transmission in prisons.

Incarceration in prison does not necessarily involve cessation of the right to interpersonal social contact, but such contact (for example conjugal visits) will depend on the nature and level of security of the institution.

The management of transsexual inmates requires special consideration, and policies should be developed in consultation with appropriate community groups.

Drug use in prison

Intravenous drug use occurs in Australian prisons and as a consequence, those who share needles are at risk of transmitting HIV. We believe that tangible means should be available to reduce exposure to risk without condoning or facilitating these activities. The measures should include peer and professional education programs, and measures to ensure that the risks of intravenous drug use are fully understood.

A range of education and therapeutic options should be made available to all prisoners who wish to reduce the adverse consequences of their drug use. In efforts to reduce unsafe injecting practices, methadone programs should be made more widely available and be consistent with the principles incorporated within the national methadone guidelines.

It is clear that urinary drug screening within prisons is used by both health and correctional services. Urinary drug screening, undertaken as part of a therapeutic endeavour, should remain confidential. Where mandatory screening is undertaken in an effort to identify the size of the drug problem, screening should be confined to injectable drugs.

Bleach should be available throughout the prison system as a general disinfectant for those who engage in intravenous drug use, and all prisoners should have access to information which tells them how best to use it to disinfect injecting apparatus.

Needle exchange programs have proved to be an effective means of protection against transmission in community programs but have obvious dangers in the prison setting. Isolated overseas reports of successful needle exchange programs in the prison lead us to suggest that consideration should be given to, a careful time limited evaluation of a pilot strict needle exchange program [to] be undertaken somewhere in Australia in order to maximise the range of strategies available to contain the epidemic.

Judicial authorities should consider the use of non-custodial sentence[s] for individuals who come before the courts with drug related crime. Such an option may be in the best interest of both the community and the individual concerned.

Education

Appropriately targeted education strategies for all staff and all inmates is the key initiative in preventing the spread of HIV infection through the prison system and out into the community. The development of these strategies must start with an understanding of the language, literacy, knowledge, attitudes and values of the target group.

Education should provide an understanding of how the virus works and how it is transmitted, and should provide practical understanding on how infection can be prevented. All Australians should have this information, and prison staff and inmates are no exception.

All education should be conducted in clear and unambivalent language, assisted by graphics, and adapted to meet the requirements of the target group. All educational strategies must be evaluated to ensure that they are effective.

Detection and management of HIV-infected prisoners

Testing for HIV infection has two purposes; first the monitoring of the status of the epidemic both in the prison population and, because the prison population is a special subset of the general population, in the community at large. Linked testing is not necessary for the first

purpose. Its second purpose is as part of a therapeutic regime. It is particularly important that where testing is done for the second purpose, that it is done voluntarily.

The conference believes that where HIV testing is being done, whether as a mandatory requirement or on a voluntary basis, quality counselling both before and after testing must be provided. Pretest counselling should target all inmates and should encourage all to become actively involved in the testing program. If the test is negative, counselling should focus on positive reinforcement and encouragement for the individual to become involved in an infectious disease education program.

If a test is positive, individual counselling should be oriented toward the ongoing management of the disease and support for the individual and their family. Specific facilities providing specialised medical services, lifestyle education and peer support should be made available and voluntarily accessible to all inmates. The principles of normalisation for people infected with HIV should be applied.

The normal processes of prisoner classification should apply regardless of HIV status. HIV infected prisoners should have access to the same range of services and programs as uninfected prisoners subject to the same limitations as apply outside prison.

After prison

Even under ordinary circumstances, an offender who has spent time in prison will encounter bias, discrimination and prejudice as he/she attempts to re-establish him/herself within the community. If the same offender happens to be HIV positive, the odds stacked against them may at times appear to be insurmountable. Correctional authorities should be proactive in supporting the establishment of self-help groups for HIV/AIDS infected persons and particular help will be needed by those who reside in rural and remote communities. The needs of families and partners of prisoners who are HIV positive are particularly acute, and special counselling and education should be provided about safe practices.

State Correctional authorities should accept responsibility for developing strategies which ensure continuity between HIV/AIDS counselling and support received both within and out of prison. HIV/AIDS testing should be available to prisoners four months prior to their anticipated release and again one month prior to release.

HIV information kits should be provided to prisoners upon release which contain bleach, condoms and information on how to use and obtain these products.

Occupational health and safety

The risks to prison workers from routine contact with prisoners with HIV is no greater than the risk posed by HIV in the community in general. The principal risks to be considered for prison workers are exposure to blood during violence, from prisoner inflicted injury and [from] accidental needle stick injuries acquired during cell searches. Prisoners with access to HIV may use HIV to intimidate other prisoners and prison workers.

There will be some areas in which the legitimate interests of prisoners will constrain the extent to which the threat of HIV can be removed from prison workers. It is accepted that prisoners have a legitimate interest in rehabilitation in humane surroundings. Strategies which reduce the transmission of HIV between prisoners will reduce the risk to prison workers.

Prison workers have a right to expect that all reasonable measures will be taken to provide safe working conditions, but it is recognised that the threat of infection in this environment can be reduced but cannot be totally removed.

The aim of prison worker education should include elimination of misinformed fear and should also include specific education on adverse exposure to HIV with particular reference to usefulness of drug treatment. AZT or such other drug as may be the treatment of choice, should be immediately available and on the prison premises.

All prisons should provide adequate equipment for dealing with exposures to blood and bodily fluids. Universal infection control procedures should be mandatory in all corrective services institutions.

The advent of HIV infection adds urgency to the need to isolate prisoners who are violent or sexual predators, regardless of their HIV status. Isolation should be reviewed regularly. The use of HIV blood as a weapon should be subject to severe penalties.

Provisions for compensation of prison officers who become infected in the course of their duties should be investigated to reduce delays and to ensure their adequacy. The practicability of providing first party personal accident insurance covering HIV infection to all prison workers would be investigated.

Collection of epidemiological information

The Conference believes that although a great deal of testing is being done in prisons, the information that it provides is not being adequately used, either to measure the HIV infection present, or to evaluate the impact of preventive and control activities. These deficiencies can, and should be remedied.

We believe that Australian prison jurisdictions should agree to a common protocol for collection of basic information on HIV infection in prison, and develop mechanisms for funding and systematic review of procedures. Jurisdictions should share data on HIV in prison on a regular basis among themselves and with other appropriate bodies, and should make use of this information in the evaluation of HIV prevention measures as they are implemented.

Legal obligations of prison authorities

The obligations of prison authorities to provide prisoners with access to reasonable medical care and treatment necessary for the promotion and preservation of health should be set out in legislation.

In developing supporting policies, the following issues need to be included:

- provision of extensive and continuing education about HIV transmission to prisoners and prison officers;
- prisoner access to condoms combined with appropriate condom disposal systems;
- provision of access to appropriate sterilising material and information about sterilising injecting equipment;
- access to a range of drug treatment programs including methadone;
- provision of access to medical treatment at the same standard as that available to those outside prisons; and
- information on HIV status should be recorded separately from other prisoner details. Prison authorities should be responsible for devising systems to keep this information secure.

Prison authorities should not be immune from liability for breaches of common law or statutory duties.

HIV/AIDS in US Prisons and Gaols: Epidemiology, Policy, and Programs

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Acquired Immune Deficiency Syndrome (AIDS) remains one of the most difficult and complex public health problems in the United States and worldwide. Over 150 000 cases have been reported in the United States since AIDS was first identified in 1981. Over 75 000 of these have been reported to the US Centers for Disease Control in the past two years.

AIDS also continues to be a major policy and management issue for correctional administrators in the United States. Correctional institutions are a focus of public concern about this disease. This is due to perceptions that prisons and gaols hold high concentrations of individuals at risk for Human Immunodeficiency Virus (HIV) as a result of prior intravenous (IV) drug abuse and that within institutions inmates frequently engage in behaviours associated with transmission of HIV - particularly homosexual activity and needle sharing. Almost 7000 cases of AIDS have been reported among US correctional inmates since 1981.

While the crisis atmosphere surrounding AIDS in prisons and gaols seems to have dissipated somewhat in the US, the disease remains a serious issue for correctional administrators. Most correctional systems have adopted policies regarding HIV/AIDS. Certain principles, such as the importance of inmate and staff education on AIDS, are still indisputable. However, concern among correctional systems has shifted significantly from short-term 'crisis' matters such as fear of casual transmission to 'long-haul' issues such as housing, programming, and medical care for prisoners with HIV disease. Resolving these issues is often complicated by political, legal, and cost considerations

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In response to the continuing needs of correctional administrators for up-to-date information as they address these difficult and complex policy issues, the National Institute of Justice (NIJ), a research branch of the US Department of Justice, has sponsored five annual reports on *AIDS in Correctional Facilities: Issues and Options*. These reports summarise the latest medical information on AIDS, present statistics on the prevalence of HIV infection and AIDS in correctional facilities, and enumerate the key policy issues and options facing correctional administrators as they formulate policy responses. This paper summarises the major findings and conclusions of the 1990 update of the report.[2]

HIV Infection and AIDS in the Correctional Population

The 1990 NIJ study included the Federal Bureau of Prisons, all fifty State correctional systems, and twenty-seven large city and county gaol systems in the United States. Responses revealed a cumulative total of 6985 confirmed inmate AIDS cases between initial reporting of the disease in 1981 through October 1990. Of these, 4519 cases have been confirmed among inmates in forty-five State and federal correctional systems. In addition, twenty-five large city and county gaol systems reported a cumulative total of 2466 cases of AIDS among inmates. Due to incomplete, inconsistent and under-reporting, these should be considered minimum estimates. No job-related cases of HIV-infection or AIDS, have been documented among US correctional staff, although one such case is alleged to have occurred in Australia.

Cumulative total inmate AIDS cases in the United States have increased by over 800 per cent since the first NIJ study in 1985 and 29 per cent since the fifth survey in 1989. As shown in Table 1, between 1988 and 1989, for the first time since the NIJ surveys were initiated, the percentage increase in total US correctional cases (72 per cent) exceeded the increase in cases in the population at large (50 per cent). This jump in correctional cases may reflect, in part, improved reporting and record-keeping in several correctional systems. In any case, the relationship was reversed between 1989-90, when cases in the total population increased by 38 per cent compared to a 29 per cent increase in correctional cases.

These figures represent cumulative total cases from when the responding jurisdictions began keeping records. As for current cases, as of October 1990, there were 1312 among State and federal inmates in thirty-nine systems and 560 among city and county inmates in eighteen large systems.

Data from the 1990 NIJ survey on demographics and exposure categories of AIDS cases are incomplete. However, studies performed by individual correctional systems suggest that demographic and risk factor patterns among prisoners with HIV infection and AIDS have remained stable. Inmate cases are primarily male, blacks and Hispanics are overrepresented relative to the outside population, and, in some cases, to the correctional population as well. IV drug use is the predominant exposure category.

The distribution of cumulative total AIDS cases throughout US correctional systems is still quite skewed (Table 2). No State or federal systems reported their first inmate cases in 1990. There remain five States which report never having had an inmate AIDS case. Forty-five per cent of all responding systems still have had ten or fewer cases. At the other extreme, sixteen State and federal systems and seven responding city and county systems have had more than fifty cases. Eight State and federal systems (16 per cent) and three of the city and county systems (11 per cent) accounted for more than three-quarters of the cumulative total AIDS cases in such systems.

Table 3 shows that the regional distribution of cumulative total AIDS cases remains uneven, both in State and in city/county systems. Among State systems, the share of the

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[2] The full report, 1990 Update: AIDS in Correctional Facilities, to be published in the spring of 1991, will be available from the NIJ AIDS Clearinghouse, Box 6000, Rockville, MD 20850, telephone 301-251-5500. The Clearinghouse can make available copies of numerous other NIJ publications on HIV/AIDS and law enforcement, criminal justice, and correctional systems.

Middle Atlantic States (especially New York and New Jersey) was 55 per cent. The overall regional breakdown of cases in State systems remained quite stable between 1988 and 1989. The regional distribution of city/county gaol cases also remained quite stable since 1989. The share of the Middle Atlantic region rose from 44 to 54 per cent and that of the Pacific region declined slightly.

AIDS incidence rates are predictably higher in the correctional setting than in the population at large because of the higher concentration among inmate populations of individuals with histories of high-risk behaviour, particularly IV drug use. The incidence rate of AIDS for the entire US population was seventeen cases per 100 000 population in 1990; the aggregate incidence rate for State/federal correctional systems was 181 cases per 100 000 inmates. However, there was an extremely wide range of incidence rates across correctional systems. In State and federal systems, incidence rates ranged from zero to 1047, with fourteen systems under twenty-five and only twelve with rates over 100. This wide range reflects the uneven distribution of cases across systems.

The aggregate AIDS incidence rate in responding city/county gaol systems was 560 cases per 100 000. Here, too, there was a wide range of rates across systems, from zero to 4027 cases, with ten systems below ten and twelve systems over 100. The figures for city/county gaol systems are problematic, however, due to extremely high turnover in these populations.

HIV seroprevalence rates among inmates in most correctional systems are still probably 1 per cent or lower, according to available data from mass screening programs and blind epidemiologic studies, shown in Tables 4-5. It should be noted, however, that most high-prevalence States have not undertaken mass mandatory HIV antibody screening of prisoners, but some of these jurisdictions have undertaken epidemiologic studies. Higher seroprevalence rates, mostly between 2 and 4 per cent, are found in correctional systems covering jurisdictions with larger numbers of AIDS cases in the outside population. A blind epidemiologic study among incoming New York State prisoners in late 1987 and early 1988 found an HIV seroprevalence rate of 17 per cent. A similar study a year later found an even higher rate among female prison entrants in New York State.

Although substantial debate continues, little hard data exists on the extent of transmission of HIV within correctional institutions. Data from several jurisdictions (Maryland and Nevada, in particular) suggest infrequent transmission. Logic and common sense indicate, however, that even in the best-managed correctional facilities, at least some transmission of HIV is occurring among inmates. Systematic studies of in-prison transmission are under way in the Illinois State correctional systems. Results will be available in the spring of 1991.

Correctional Policy Issues and Options

The major policy areas involved in the correctional response to HIV are education and training; HIV antibody testing and notification; medical care, psychosocial services, housing and correctional management issues; and legal issues. Trends and issues in these areas are summarised in the following sections.

Education and training

While the original crisis atmosphere around AIDS in prisons and gaols seems to be dissipating, a number of studies of individual correctional systems reveal continued and substantial concern. Education and training programs still represent the cornerstone of efforts to prevent transmission of HIV infection in prisons and gaols, as well as in the population at large. In fact, the actual and potential role of education affects decisions on virtually all of the other AIDS issues and policy options in correctional facilities. For example, the effectiveness of educational programs may play a major role in determining both inmate and staff attitudes on whether inmates with AIDS or asymptomatic HIV infection should be segregated.

Most correctional administrators feel strongly that AIDS education and training are not options but absolute requirements. Virtually all responding jurisdictions currently offer or are developing some live AIDS training or educational materials for staff and inmates (Figures 6-8). There remains some unevenness in the provision of AIDS education. Seventy-one per cent of prison and gaol systems provide live AIDS education to staff at all of their institutions. Over three-quarters of prison systems but just over half of gaol systems provide live training to inmates at all institutions. There is a serious shortage in programs and materials for Spanish-speaking prisoners and those with special needs, such as the hearing- or visually-impaired.

Ninety per cent of responding correctional systems have at least some mandatory AIDS training for staff, while two-thirds of the prison and gaol systems have at least some mandatory education for inmates. The percentages are higher for State/federal than for city/county systems. The discrepancy regarding inmate education is probably a result of logistical problems posed by high inmate turnover in city/county gaol systems. Ironically, because the high turnover may present the risk of transmission both within and outside institutions, some form of mandatory education for every gaol inmate, possibly as part of orientation or medical screening, is particularly important.

HIV/AIDS education has two basic objectives: to foster behaviour change, reducing HIV transmission, and to allay concerns regarding casual transmission of the virus. Inducing changes in firmly entrenched social, sexual and addictive behaviours pose serious challenges for AIDS educators and policymakers. Research is beginning to show clearly that simply providing information is insufficient. Behaviour change requires ongoing empowerment, support and reinforcement. However, the effort is worthwhile, since AIDS education has been effective in significantly changing behaviour among IV drug users and gay men in the community.

Ideally, HIV education and training should occur before widespread concern takes hold and is repeated periodically so that timely, updated information can be presented and new staff and inmates quickly reached. Programs should be mandatory for both inmates and staff. Inmates and staff should be involved in the development of educational programs and in the delivery of training to peers. The use of peer trainers along with knowledgeable and approachable professionals will help to build credibility, a critical element in the success of AIDS training. Peer education and support programs may be particularly useful in fostering and maintaining risk reduction among inmates. However, as shown in Table 6, less than one-fourth of State/federal systems and only 15 per cent of responding city/county systems have instituted such programs.

HIV education should be geared to the specific concerns of the audience, focusing on specific risks and precautionary measures for inmates and staff. It should be appropriate to the educational levels, racial/ethnic composition, and special needs of the population, and avoid extremes of alarmism and complacency. Finally, all training and education should be documented so that its provision can be proven in the event of future lawsuits.

As knowledge about HIV education increases, educational strategies become more sophisticated. Some correctional systems are moving to develop and implement more comprehensive educational strategies which may involve counselling, HIV antibody testing, ongoing support groups, drug treatment opportunities and other components. Several examples exist of consortia of community organisations that are successfully working with correctional administrations to bring such programs to inmates. Drug treatment programs are a particularly important component of a comprehensive correctional response to AIDS.

HIV testing and counselling

Advances in treatment regimens for HIV infection have resulted in an increasing emphasis on early identification and intervention. Therefore, in the world outside correctional institutions, testing is now viewed more and more as an integral part of medical treatment. The situation is not quite the same in correctional facilities, where testing is still considered by some to be an infection control tool. But many correctional systems are now offering voluntary or on-

request testing. This trend is at least in part responsive to the movement toward early therapeutic intervention.

The major applications of HIV antibody testing in correctional inmate populations are mass screening, 'risk-group' screening, testing in response to potential transmission incidents, voluntary testing, testing on request, testing in support of blinded epidemiological studies, and testing in the presence of clinical indications or symptoms. Testing of staff may also occur in limited instances - such as in response to possible transmission incidents. Mass screening (the mandatory testing of all inmates, all new inmates, or all releasees in the absence of clinical indications) continues to be a controversial testing application.

The trend toward mandatory mass screening evidenced in correctional facilities between 1986 and 1987 has abated somewhat, although some systems still strongly avow such policies. As of October 1990, seventeen State systems and the Federal Bureau of Prisons but no city/county or Canadian systems had mass screening policies (Figure 9). This represents a net increase of three systems since 1988. The majority of jurisdictions currently conducting mass screening are small States with few correctional AIDS cases.

Several State systems which have discontinued policies of mandatory mass screening have done so for a number of reasons, including funding shortages and the realisation that mass screening was creating more problems than it was intended to solve.

Because of the recent findings regarding medical intervention for asymptomatic HIV-infected inmates, the importance of offering voluntary/on-request testing has increased. However, only about two-thirds of prison and responding gaol systems make testing available to inmates on request. Table 10 shows that less than half (41 per cent) of State/federal systems and just under two-thirds (63 per cent) of responding city/county gaol systems have testing policies based on a voluntary/on-request model.

There is evidence that voluntary testing of inmates serves the needs of both inmates and correctional systems. Results of some carefully controlled studies show that voluntary testing can capture a significant percentage of IV drug users and seropositive inmates.

Appropriate and sensitive pre- and post-test counselling are also critical. Survey results show that all prison and gaol systems report making at least some counselling available to inmates. It is particularly important that counselling sessions be used as important occasions for education. In addition, post-test counselling should be provided on an individual basis for those who have both positive and negative results.

Policymaking regarding the confidentiality and disclosure/notification of an inmate's HIV status remains a controversial and difficult issue for correctional systems. Many States have laws protecting the confidentiality or anonymity of individuals tested for HIV antibody. While almost all prison and gaol systems notify the inmate and attending physician or health-care worker of an inmate's test results, only a small fraction of systems have official policies of notifying correctional officers (Table 11). However, it is apparent from lawsuits filed by inmates that news of a particular inmate's positive test results or seropositive status travels rapidly through an institution. Breaches of confidentiality are alleged to occur frequently.

Continued staff education on the low-risk nature of most staff-inmate contacts and training on following universal precautions is necessary to ease staff concerns about transmission which prompt demands for widespread disclosure of inmates' HIV status. Such disclosures may, in fact, lull correctional officers into a false sense of security, leading them to believe that all infected prisoners have been identified. False negatives do occur on the antibody tests, and because of the sometimes long 'window' period between infection and appearance of antibodies, no testing program can guarantee the identification of all HIV-infected prisoners. Since disclosure has potentially serious consequences, it is essential that correctional systems adapt and enforce clear policies on the issue.

Medical care, psychosocial services, housing and correctional management issues

In responding to HIV/AIDS, correctional administrators must address both medical and psychosocial considerations and complex management factors, such as housing and precautionary measures.

Medical care Costs of medical care have escalated dramatically in recent years and represent a major budget item for correctional systems. In many correctional systems, the increasing numbers of prisoners with HIV infection and AIDS have rendered medical care costs an even more severe financial strain than was already the case. In these constrained circumstances, correctional systems are, and will continue to be, under pressure to contain medical care costs. However, cost containment should not come at the expense of reducing standards of care for HIV-infected prisoners.

As discussed earlier, there have been significant recent advances in medical treatment of HIV-infected persons. These include findings regarding the effectiveness of AZT in delaying disease progression in asymptomatic HIV-infected patients and of aerosolised pentamidine in preventing and treating *pneumocystis carinii* pneumonia. These and other therapeutic advances have prompted optimism that in many patients HIV infection may be manageable as a chronic disease and that life expectancy for AIDS patients may increase. Virtually all prison and gaol systems report providing AZT to inmates. However, not all correctional systems are providing AZT to all HIV-infected inmates with CD4 counts below 500 (the US government standard) even after the release of data in 1989 showing the drug's effectiveness in asymptomatics. Because AZT is an expensive drug, it may represent a serious budgetary strain for many jurisdictions.

Many of the improvements in treatment depend upon early identification and ongoing monitoring of HIV-infected persons. For this reason, it is important that all correctional systems offer HIV antibody counselling and testing to all inmates on request.

Psychosocial services It is increasingly well established that there is a close link between psychological and physiological health in HIV-infected persons. Therefore it is critical that they be provided with a range of supportive services. Correctional and public health officials, as well as AIDS advocacy groups, have established programs of supportive services for HIV-infected prisoners in several jurisdictions. Inmates in a few systems have initiated innovative peer support services.

Inmates with HIV infection and AIDS who are about to be released into the community also require important services. First, they need intensive counselling on their responsibility to notify their sexual partners of their medical status and to avoid any behavior that may transmit infections to others. Second, pre-release planning should include notifying and referring inmates to all government benefit programs for which they may be eligible - such as Medicaid and Supplemental Security Income. Of course, pre-releasees should also be referred to appropriate sources of hospice care, hospitalisation, outpatient care, counselling, and other support services in the community.

Housing and programming policies It appears that the trend in presumptive housing policy in many systems is away from blanket segregation of HIV-infected prisoners toward 'mainstreaming' - that is, maintaining all categories of HIV-infected prisoners in the general population. Many other systems are following a policy of case-by-case determination of housing, basing decisions on the specific medical or security needs of individual infected inmates.

Table 12 summarises housing policies according to mutually exclusive combinations and shows how these policy combinations have changed since 1985. Only nine State/federal systems still segregate/separate all AIDS patients. However, more than three-quarters of prison systems now make housing decisions for HIV-infected prisoners based on presumptive mainstreaming or case-by-case determination. Indeed, in recent years, presumptive general population housing seems to have overtaken case-by-case policies. City/county jail systems are also moving away from blanket segregation policies and reviewing the option of implementing case-by-case determination policies.

The trends in housing policy for HIV-infected inmates reflect a combination of factors, varying from system to system. Both presumptive general population housing and case-by-

case decisionmaking policies are more in accordance with offender classification schemes, which may be overridden when systems decide to base housing decisions solely on HIV status. Other factors include a less fearful and more compassionate attitude on the part of inmates and staff towards individuals with HIV disease, increased costs of hospitalising inmates, and class action lawsuits filed by segregated inmates. Segregated prisoners generally have only severely restricted, if any, access to institutional programming and recreational activities. However, most HIV-infected persons, and even many with AIDS diagnoses, are able to lead perfectly normal lives for long periods. It can be very damaging psychologically to be isolated from one's peers. Less restrictive housing also follows the realisation among correctional systems that, due to the increasing numbers of inmates with AIDS or HIV infection, segregation/separation may be impractical and unfeasible, as well as unjustly discriminatory.

Precautionary and preventive measures

Correctional systems continue to face the challenge of protecting their staff and inmates from HIV infection without raising suspicions or exacerbating fears through extreme precautionary measures. To address the issue, correctional agencies have instituted a wide range of precautionary measures to control the spread of AIDS within institutions. While most systems have instituted infection control measures to help staff and inmates protect themselves, only a handful have taken the much more controversial step of making condoms available to inmates in institutions.

Virtually all correctional systems have established some infection control policies in response to the HIV epidemic. In 1989, the US Centers for Disease Control released guidelines for the prevention of HIV transmission to health care and public safety workers, including correctional officers. These guidelines encourage institutions to tailor their infection control procedures to their unique needs, within the framework of 'universal precautions' - i.e., treating all persons as if they are infected. Precautionary measures should always be commensurate with the risk involved. Obviously, correctional personnel cannot predict with certainty when they will encounter blood or body fluids in the course of their duties. Many situations involve the potential for such contact. Staff members must exercise their professional judgment in using gloves, airways, infectious waste receptacles or other protections.

Precautionary measures addressing very rare or casual modes of contact, even if implemented in a good faith effort to reduce the fears of staff and inmates, may ultimately increase those fears by encouraging the view that HIV infection is transmitted by unusual or casual contact. Such a conflict between educational messages and practical measures may not only increase fear within the institution, but also foster suspicion of the correctional system for, in effect, saying one thing about the transmission of HIV but doing something else. Hence, correctional systems should be extremely cautious in adopting precautionary measures beyond those recommended by the Centers for Disease Control.

The issue of condom availability in correctional institutions continues to evoke argument. Only five US correctional systems - those in the States of Vermont and Mississippi and in the cities of New York, Philadelphia, and San Francisco - make condoms available to inmates while in the institutions. In these systems, condoms are dispensed either through medical staff (with counselling) or at institutional canteens.

Most correctional officials continue to believe that making condoms available, in effect, condones conduct that is prohibited by correctional regulations and, perhaps, by State law as well. By contrast, the few systems that make condoms available have essentially acknowledged that sexual activity occurs in correctional facilities despite its prohibition and determined that the importance of increasing the possibility of preventing HIV transmission outweighs any appearance of 'condoning' proscribed activity. These systems emphasise that they are not condoning the conduct, but rather taking what they believe to be a reasonable step to help inmates protect themselves against a deadly disease.

Legal issues

In late 1985, when the first edition of the NIJ study was prepared, most legal issues regarding AIDS in correctional facilities remained theoretical; few actual cases had been filed. Since then, however, numerous cases have been filed by inmates, and many have reached disposition. Most cases have been filed in United States District Courts, although some have been filed in State and county courts as well.

AIDS-related issues continue to produce substantial litigation involving correctional inmates and staff. Several major cases are moving toward decision or settlement. Recent developments this year include the first successful challenges to correctional systems' policies on segregation, medical care and AIDS education. However, there remains a good deal of uncertainty on the legal status of other important correctional policies related to HIV infection and AIDS.

The main types of cases brought by inmates have involved challenges to mandatory HIV antibody testing and to segregation and conditions of confinement for persons with HIV infection or AIDS. Lawsuits also include allegations of inadequate medical care for persons with AIDS, breaches of confidentiality, and inadequate AIDS education.

Three major AIDS-related lawsuits have recently been concluded. In *Walker v. Sumner*, a Nevada case, a State prison system's mass mandatory HIV screening policy for inmates was overturned by a court for the first time. The US Ninth Circuit Court of Appeals ruled that the Nevada system had provided no evidence that its policy served a legitimate penological interest (the precendential standard). On the contrary, the court held, the testing policy violated prisoners' constitutional rights under the Fourth, Eighth, and Fourteenth Amendments.

On the other hand, a US District Court judge upheld a policy of mandatory testing and segregation in *Harris v. Thigpen*, a case brought by Alabama inmates. The plaintiffs also alleged that the medical care provided to prisoners with HIV infection and AIDS was inadequate. In January 1990, the case was decided in favour of the correctional department. The court held that the State's policies represented reasonable measures taken in pursuit of a legitimate penological interest and that the right of uninfected prisoners to be protected from potential exposure to HIV-infected prisoners outweighed the claims of the latter group to be free from discrimination on the basis of their HIV status. The case is still on appeal.

A California case, *Gates v. Deukmejian*, challenged the State's policy of segregating all HIV-infected prisoners in a locked unit at a correctional medical facility. A settlement has been negotiated and approved by the judge, under which a one-year pilot project has been established for 20-30 HIV-infected inmates to live in a separate but not closed unit of the institution and participate with general population inmates in all programs and activities.

Prisoners and staff have initiated both civil and criminal actions arising from incidents, such as biting, in which transmission of HIV could allegedly occur. As yet, however, there have been no cases in which a plaintiff asserted that he or she became infected with HIV as a result of the incident. Several cases seeking expanded testing, disclosure of results, and restrictions on HIV seropositive prisoners are pending.

Many correctional systems are justifiably concerned about their potential liability should HIV infections occur among inmates while incarcerated and among staff while on the job. Such cases would face serious proof problems given the difficulty in linking infection with a particular episode. However, the most important actions correctional systems can take to minimise potential liability and maximise safety in their institutions are to intensify efforts to prevent sexual victimisation of inmates and provide all inmates and staff with clear and complete education and training on how to avoid becoming infected with HIV.

Conclusion

AIDS continues to pose complex and difficult problems for correctional systems. The only certainty is that these problems will not go away. With accumulating experience and

information, many correctional systems seem to be developing fair and reasonable policy responses to AIDS. But this is an evolutionary process. Correctional administrators and policymakers need up-to-date information on policy options and programmatic experience to continue the refinement and improvement of their HIV/AIDS policies.

Appendix - Tables

Table 1

Cumulative Total AIDS Cases among Correctional Inmates and the Population at Large, United States, 1985-90

	Correctional Cases[a]		Cases in Population at Large[e]	
November 1985	766		14 519	
October 1986	1 232		26 002	
% Increase 1985-86		61%		79%
October 1987	1 964		41 770	
% Increase 1986-87		59%		61%
October 1988b	3 136		73 621	
% Increase 1987-88		60%		76%
October 1989c	5 411		110 333	
% Increase 1988-89		72%		50%
October 1990d	6 985		152 231	
% Increase 1989-90		29%		38%

a The figures in this and other tables represent inmate AIDS cases in the federal prison system, all 50 state prison systems, and a sample of 28-37 city and county gaol systems (depending on the year of the NIJ Survey).

b Figures for 1988 include 28 city/county gaol systems.

c Figures for 1989 include 32 city/county gaol systems.

d Figures for 1990 include 27 city/county gaol systems.

e Adult/adolescent cases only. Paediatric cases excluded.

Sources: CDC, *AIDS Weekly Surveillance Reports* - US, November 4, 1985, October 6, 1986, October 5, 1987, October 3, 1988; CDC, *HIV/AIDS Surveillance Report*, November 1990; NIJ Questionnaire Responses.

Table 2

Distribution of Cumulative Total Inmate AIDS Cases, United States, November 1985 and October 1990[a]

	State/Federal Prison Systems							
	November 1985 (N=51)				October 1990 (N=51)			
Range of Total AIDS Cases	Number of Systems	%	Number of AIDS Cases	%	Number of Systems	%	Number of AIDS Cases	%
0	26	51	0	0	5	10	0	0
1-3	15	29	24	5	5	10	10	0.2
4-10	5	10	30	7	6	12	39	1
11-25	2	4	42	9	16	31	241	5
26-50	1	2	33	7	3	6	96	2
51-100	1	2	95	21	8	16	547	12
>100	1	2	231	51	8	16	3 586	79
Total	51	100	455	100	5 1	101[b]	4 519	99[b]

	City/County Gaol Systems							
	November 1985 (N=33)				October 1990 (N=27)			
Range of Total AIDS Cases	Number of Systems	%	Number of AIDS Cases	%	Number of Systems	%	Number of AIDS Cases	%
0	13	39	0	0	2	7	0	0
1-3	10	30	16	5	4	15	9	0.4
4-10	7	21	43	14	3	11	17	1
11-25	1	3	12	4	4	15	63	3
26-50	1	3	40	13	7	26	195	8
51-100	0	0	0	0	4	15	299	12
>100	1	3	200	64	3	11	1 883	76
Total	33	99[b]	311	100	27	100	2 466	100

a The figures in this table represent the minimum number of correctional AIDS cases to date, since the NIJ survey does not include every United States county gaol system.

b Due to rounding.

Source: NIJ Questionnaire Responses.

Table 3

Regional Distribution of Cumulative Total Inmate AIDS Cases, United States (Federal Prison System Excluded)[a]

	State Prison Systems				City/County Gaol Systems			
	November 1985 (N=50)		October 1990 (N=50)		November 1985 (N=28)		October 1990 (N=27)	
Region	Total AIDS Cases	%	Total AIDS Cases	%	Total AIDS Cases	%	Total AIDS Cases	%
New England[b]	16	4	284	7	0	0	8	0.3
Mid-Atlantic[c]	327	75	2 315	55	222	71	1 329	54
E.N. Central[d]	6	1	258	6	8	3	31	1
W.N. Central[e]	0	0	35	1	1	0.3	15	1
S. Atlantic[f]	49	11	675	16	24	8	178	7
E.S. Central[g]	1	0.2	61	1	0	0	2	0.1
W.S. Central[h]	12	3	244	6	3	1	60	2
Mountain[i]	2	0.5	79	2	1	0.3	26	1
Pacific[j]	20	5	242	6	52	17	817	33
Total	433	100	4 193	100	311	101[k]	2 466	99[k]

a The regional divisions used in this table are standard geographic divisions and are not based on numbers of AIDS cases. The figures in this table represent the minimum number of correctional AIDS cases to date, since the NIJ survey does not include every United States gaol system. Recent tightening of case identification and recording may partially explain the large increase since last year, in correctional AIDS cases in certain regions.

b Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut

c New York, New Jersey, Pennsylvania

d Ohio, Indiana, Illinois, Michigan, Wisconsin

e Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas

f Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida

g Kentucky, Tennessee, Alabama, Mississippi

h Arkansas, Lousiana, Oklahoma, Texas

i Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada

j Washington, Oregon, California, Alaska, Hawaii

k Due to rounding

Source: NIJ Questionnaire Responses.

Table 4

Available Seroprevalence Data From Mandatory Mass Screening of Inmates, United States

	Correctional System	Dates	Number Tested		Number Seropositive		% Seropositive	
All Incoming Inmates	Alabama	10/89-10/90	7 306	M&F	88	M&F	1.2	M&F
	Colorado	10/89-10/90	3 093	M	20	M	0.6	M
			358	F	1	F	0.3	F
	Georgia	7/89-5/90	20 435	M&F	561	M&F	2.7	M&F
	Idaho	8/87-10/90	3 000	M	10	M	0.3	M
		1987-10/89	50	F	0	F	0.0	F
	Iowa	11/87-10/90	13 434	M&F	26	M&F	0.2	M&F
	Missouri	1985-10/90	24 284	M&F	127	M&F	0.5	M&F
	Nebraska	3/87-10/90	6 426	M&F	21	M&F	0.3	M&F
	New Hampshire	1/87-9/89	1 760	M	9	M	0.5	M
		10/89-10/90	92	F	6	F	6.5	F
	Oklahoma	6/87-11/90	19 120	M	51	M	0.3	M
			2 347	F	3	F	0.1	F
	Utah	7/89-11/90	4 000	M	33	M	0.8	M
			231	F	6	F	2.6	F
	Wyoming	1/90-10/90	181	M	1	M	0.5	M
			46	F	0	F	0.0	F

Table 4 continued

Available Seroprevalence Data From Mandatory Mass Screening of Inmates, United States

	Correctional System	Dates	Number Tested		Number Seropositive		% Seropositive	
All Current Inmates	Mississippi	7/89-10/89	7 743 310	M F	78 7	M F	1.0 2.3	M F
	Oklahoma	6/87 7 811 403	M F	34 0	M F	0.4 0.0	M F	
	Utah	8/89-10/89	2 579 136	M F	19 5	M F	0.7 3.7	M F
	Wyoming	1984-10/90	74 0	M F	0 0	M F	0.0	M
All Inmates at Release	Alabama	1987-1989	25 321	M&F	2	M	0.008	M&F
	Missouri	1985-10/90	16 435	M&F	33	M&F	0.2	M&F
	Wyoming	7/90-	34 0	M F	0 0	M F	0.0	M
	Federal Bureau of Prisons[a]	1989	14 643	M&F	224	M&F	1.5	M&F
All Incoming & All Releasees	Nevada	1/89-9/89 384	3 775 F 8	M	34 F 2.1	M	0.9 F	M
All Incoming & All Current	North Dakota	1987-11/89	460 40	M F	3 0	M F	0.6 0.0	M F

a Federal Bureau of Prisons, unpublished data.

Source (unless otherwise noted): NIJ Questionnaire Responses.

Table 5

Seroprevalence Data from HIV Antibody Testing of Inmates in Blinded Epidemiological Studies[a]

Correctional System	Dates	Number Tested		Number Seropositive		% Seropositive	
Arkansas	7/90	698	M	6	M	0.9	M
		23	F	0	F	0.0	F
California[b]	4/88-5/88	5 372	M	137	M	2.5	M
	(All Incoming)	807	F	25	F	3.1	F
Florida	1988 (Consecutive Intakes)	1 000	M&F	69	M&F	6.9	M&F
Hawaii	1/88-10/90	2 327	M	22	M	0.9	M
		142	F	0	F	0.0	F
Illinois[c]	4/89-6/89 (All Incoming)	501	M	20	M	4.0	M
Michigan	11/89-9/90	2 221	M&F	24	M&F	1.1	M&F
New York (State)	12/87-1/88d (All Incoming at Downstate Correctional Facility, Fishkill)	494	M	84	M	17.0	M
	10/87-1/88	500	F	94	F	18.8	F
North Carolina	11/89-4/90	7 942	M	238	M	3.0	M
		784	F	36	F	4.6	F
Oregon	9/90-10/90	437	M	4	M	0.9	M
		76	F	0	F	0.0	F
South Carolina[e]	4/88-6/88 (All Incoming at 1 Reception Centre)	457	M	8	M	1.7	M
		3	F	0	F	0.0	F
Tennessee	7/88-8/90	4 461	M	52	M	1.2	M
		448	F	1	F	0.2	F
Texas	9/89-10/89	1 226	M&F	30	M&F	2.4	M&F
Virginia[f]	6/89-8/89	1 287	M	30	M	2.3	M
Washington	8/87-1/88	796	M	5	M	0.6	M

Table 5 continued

Seroprevalence Data from HIV Antibody Testing of Inmates in Blinded Epidemiologic Studies[a]

Correctional System	Dates	Number Tested	Number Seropositive	% Seropositive
Wisconsin[g]	1/88-8/88 (All Incoming)	1 621 M	9 M	0.6 M
Maricopa County, Arizona	6/89-11/89	813 M	28 M	3.4 M
Los Angeles County, California	10/90	400 M 100 F	11 M 1 F	2.7 M 1.0 F
Santa Clara County, California	10/86-10/89	348 F	6 F	1.7 F
Fulton County, Georgia	7/88-12/88	160 M 40 F	11 M 3 F	6.9 M 7.5 F
New York City, New York	9/89	1 690 M 546 F	272 M 140 F	16.1 M 25.6 F
Quebec, Canada	12/87-10/90	520 M 248 F	44 M 19 F	8.5 M 7.7 F

a These studies are anonymous (not identity-linked) and conducted to determine seroprevalence rates in a population. Several systems did not specify the inmate category (for example, all incoming) tested in their study.

b J.A. Singleton et al., *HIV Seroprevalence Among Prisoners Entering the California Correctional System*, California Department of Health Services, January 1989.

c Illinois Department of Corrections and Abt Associates Inc., unpublished data.

d B.I Truman et al., HIV Seroprevalence and Risk Factors Among Prison Inmates Entering New York State Prisons, Presented at 4th International AIDS Conference, Stockholm, June 1988.

e M.C. Monroe et al., *Studies of HIV Seroprevalence and AIDS Knowledge Attitudes and Risk Behaviors in Inmates in the South Carolina Department of Corrections, 1988*, December 1988.

f Commonwealth of Virginia, Department of Corrections, *HIV Seropositivity Study*, October 1989.

g Wisconsin AIDS/HIV Program, Wisconsin Department of Health and Social Services, HIV Seroprevalence and the Acceptance of Voluntary HIV Testing Among Newly Incarcerated Male Prison Inmates in Wisconsin, May 1989.

Source (unless otherwise noted): NIJ Questionnaire Responses.

Table 6

Live AIDS Education for Inmates, October 1989 and October 1990[a], United States

	U.S. State/Federal Prison Systems				U.S. City/County Gaol Systems				Canadian Systems			
	October '89 (N=51)		October '90 (N=51)		October '89 (N=31)		October '90 (N=27)		October '89 (N=11)		October '90 (N=12)	
Live Education	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Provided[b]	46	90	49	96	21	68	20	74	9	82	11	92
In All Institutions	34	67	41	80	15	48	15	56	7	64	7	58
Mandatory	23	45	26	51	1	3	3	11	3	27	2	17
Sometimes Voluntary and Sometimes Mandatory	20	39	18	35	4	13	5	19	1	9	2	17
Peer Education Programs	7	14	11	22	0	0	4	15	0	0	0	0

a Live education involves the participation of a trained leader in some substantial part of a session.

b Includes programs in operation and under development.

Source: NIJ Questionnaire Responses.

Table 7

Live AIDS Education for Correctional Staff, October 1989 and October 1990[a], United States

	U.S. State/Federal Prison Systems				U.S. City/County Gaol Systems				Canadian Systems			
	October '89 (N=51)		October '90 (N=51)		October '89 (N=31)		October '90 (N=27)		October '89 (N=11)		October '90 (N=12)	
Live Education	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Provided[b]	48	94	50	98	24	77	26	96	10	91	11	92
In All Institutions	32	63	42	82	19	61	24	89	8	73	10	83
Mandatory	26	51	30	59	11	35	15	56	5	45	2	17
Sometimes Voluntary and Sometimes Mandatory	19	37	17	33	10	32	8	30	2	18	5	42

a Live education involves the participation of a trained leader in some substantial part of a session.

b Includes programs in operation and under development.

c Figures include systems that specified centralised training staff.

Source: NIJ Questionnaire Responses.

Table 8

AIDS Education in Correctional Facilities, October 1990, United States

	For Inmates						For Staff					
	U.S. State/ Federal Prison Systems (N=51)		U.S. City/ County Gaol Systems (N=27)		Canadian Systems (N=12)		U.S. State/ Federal Prison Systems (N=51)		U.S. City/ County Gaol Systems (N=27)		Canadian Systems (N=12)	
Procedures	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Distribute Written Materials	50	98	25	93	11	92	51	100	26	96	11	92
Use Audio-Visual Materials	48	94	20	74	10	83	50	98	26	96	10	83
Topics Covered in Education Program												
Safe Sex Practices	44	86	23	85	10	83	45	88	22	81	10	83
Cleaning Techniques for Drug Injection Equipment	31	61	18	67	6	50	28	55	17	63	6	50
Spanish Language Education Available	14	27	14	52	-	-	6	12	8	30	-	-
Distribute Spanish Written Materials	31	61	21	78	-	-	23	45	13	48	-	-
Education for Individuals with Special Needs (e.g. hearing, or visually impaired)	12	24	11	41	1	8	-	-	-	-	-	-

Source: NIJ Questionnaire Responses.

Table 9

Correctional Systems Conducting Mandatory Mass Screening of Inmates, October 1990[a], United States

U.S. State/Federal Prison Systems (N=51)	U.S. City/County Gaol Systems (N=27)	Canadian Systems (N=12)
Federal Bureau of Prisons	None	None
Alabama		
Arkansas		
Colorado		
Georgia		
Idaho		
Iowa		
Michigan		
Mississippi		
Missouri		
Nebraska		
Nevada		
New Hampshire		
North Dakota		
Oklahoma		
Rhode Island		
Utah		
Wyoming		

a Defined as mandatory HIV antibody testing, generally identity-linked, of all new inmates, all releasees, and/or all current inmates, regardless of whether they do or do not show clinical indications of HIV infection. In terms of correctional policy, this type of testing differs in purpose and method from blinded epidemiological studies. These studies are anonymous (not identity-linked) screenings intended to assess seroprevalence rates in a particular population.

Source: NIJ Questionnaire Responses.

Table 10

HIV Antibody Testing of Inmates, Mutually Exclusive Categorisation, October 1989 and October 1990[a], United States

	U.S. State/Federal Prison Systems October 1990 (N=51)		U.S. City/County Gaol Systems October 1990 (N=27)		Canadian Systems October 1990 (N=12)	
	Number of Systems	%	Number of Systems	%	Number of Systems	%
Mandatory Mass Screening (all incoming inmates, current inmates and/or inmates at release)	18	35	0	0	0	0
Voluntary/Inmate Request Testing	21	41	17	63	9	75
Testing if Clinical indications[b]	12	24	9	33	3	25
Other	0	0	1	4	0	0
TOTAL	51	100[c]	27	100	12	100

a Includes actual and planned policies. This is a hierarchical categorisation. That is, jurisdictions that do mass screening are placed in that category, regardless of whether they also do testing for other purposes; jurisdictions that screen identifiable inmates with histories of high-risk behaviours, but do no mass screening, are placed in the 'screening of high-risk groups' category regardless of whether they also do testing for diagnosis, incident involvement, or epidemiologic studies; and so on.

b In this table, clinical indications includes lowered CD4(T4) counts, opportunistic infections, and TB positivity or active TB.

Source: NIJ Questionnaire Responses.

Table 11

Policies regarding Disclosure/Notification of Inmates' HIV Antibody Test Results, October 1990[a], United States

	U.S. State/Federal Prison Systems (N=51)		U.S. City/County Gaol Systems (N=27)		Canadian System (N=12)	
Parties to be Notified during incarceration and/or at release according to policy[a]	Number of Systems	%	Number of Systems	%	Number of Systems	%
Inmate	51	100	27	100	12	100
Attending Physician or Health-Care Worker	51	100	25	93	11	92
Other Medical Staff (Community or Correctional)	30	59	13	48	5	42
Correctional Management - Central Office	29	57	8	30	5	42
Correctional Management - Institution	33	65	10	37	3	25
Correctional Officers (Security)	7	14	6	22	2	17
Public Health Department	44	86	19	70	5	42
Spouse/Sexual Partner(s)	8	16	1	4	2	17
Victims of Inmate (in community and/or in prison/gaol)	8	16	4	15	0	0
Parole Agency	17	33	2	7	2	17
Residential Placement[b]	4	8	3	11	1	8
Work Placement[b]	3	6	2	7	1	8
Other[c]	2	4	2	7	1	8

[a] Figures include both systems which specified the conditions under which disclosure/notification to certain parties could be made (e.g. only with inmate consent and/or on a 'need-to-know' basis) and systems which did not specify these conditions.

[b] Most systems view notification of residential or work placement as falling in the domain of parole agencies/divisions.

[c] This category includes public agencies, courts, and other parties unspecified by responding systems.

Source: NIJ Questionnaire Responses.

Table 12

Combinations of Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection, November 1985 and October 1990[a]

	U.S. State/ Federal Prison Systems				U.S City/ County Prison Systems				Canadian Systems			
	November'85 (N=51)		October'90 (N=51)		November'85 (N=33)		October'90 (N=27)		October'87[b] (N=12)		October'90 (N=12)	
Housing Policy Combination	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%	Number of Systems	%
Separate/Segregate AIDS Cases; ARC Cases and Asymptomatics Maintained in General Population	3	6	5	10	3	9	0	0	0	0	0	0
Separate/Segregate AIDS and ARC Cases; Asymptomatics Maintained in General Population	10	20	0	0	3	9	0	0	0	0	0	0
Separate/Segregate All Three Categories	8	16	4	8	13	39	2	7	3	25	0	0
No Separation/Segregation of Any Category	2	4	16	31	0	0	7	26	0	0	2	17
Combinations Involving Case-by-Case Determination (for at least one category)	16	31	24	47	10	30	17	63	9	75	9	75
Other Policy Combinations, No Policy, or Policy Unknown	12	24	2	4	4	12	1	4	0	0	1	8
TOTAL	51	101[c]	51	100	33	99[c]	27	100	12	100	12	100

a In this categorisation, 'separate/segregate' means that the basic policy is to hospitalise or administratively segregate, regardless of whether clinically ill inmates are returned to general population when the symptoms subside.This categorisation is mutually exclusive.

b October 1987 was the first year Canadian systems were included in the NIJ survey.

c Due to rounding.

Source: NIJ Questionnaire Responses.

Human Immunodeficiency Virus (HIV) in British Prisons: Problems, Risk Behaviours and Prevention

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London

This paper discusses the problems of HIV in British prisons in regard to risk behaviours such as syringe sharing, sexual behaviour and tattooing. It recommends ways to prevent the spread of HIV within the prison system.

The English and Scottish Health Departments responded quickly to HIV among drug injectors in the community. In 1987 they called for tenders to establish fifteen pilot syringe exchange schemes and stipulated that the schemes should be evaluated. The evaluation investigated risk behaviours of drug injectors who used syringe exchange schemes and comparison groups of injectors who did not. The data in this paper are drawn from the evaluation of syringe exchange schemes. The methods used to evaluate the schemes can be found in a report by Stimson et al. (1988).

AIDS Cases by Exposure Group (see Table 1)

The population of Britain is approximately sixty million and there were approximately 3500 cases of AIDS by August 1990 (Public Health Laboratory Service 1988, 1989, 1990).

The predominant spread of HIV, in the United Kingdom, as defined by the World Health Organization, is Pattern I; the majority of cases of HIV and AIDS occur among homosexual/bisexual men. However, the proportion of AIDS cases among injecting drug users (IDUs) is increasing. While the proportion of cases for homosexual/bisexual men has decreased by 2 per cent, the proportion of cases from drug injectors has nearly doubled, from 1.8 per cent to 3.4 per cent.

Prevalence of Drug Use and Injecting (see Table 2)

One of the main problems in trying to understand HIV infection among IDUs is that there are no good estimates of the number of them in Britain. Doctors are required to notify the Chief Medical Officer at the Home Office when they see a patient whom they suspect to be dependent on certain controlled drugs. Amphetamines are not notifiable. A government advisory body, the Advisory Council on the Misuse of Drugs (ACMD) has used information about drug users seeking help, information on arrests and drug seizures and reports of notifications to estimate the number of drug users.

The ACMD estimated there were up to 75 000 regular injectors and up to 150 000 users of notifiable drugs in 1986. They acknowledged there was also an unknown number of amphetamine injectors and people who inject occasionally. In this paper it is assumed that there are 100 000 drug injectors in Britain.

Prevalence of HIV among Drug Injectors (see Table 3)

The second problem is lack of data on prevalence and incidence of HIV among drug injectors. Evidence suggests that the prevalence of HIV among drug injectors in England is below 7 per cent. Seven prevalence studies have found a range from 1.5 per cent out of London in 1987 to 6 per cent in London in 1988.

The English Prison System and HIV Policy

There is no compulsory testing for HIV in the English prison system. All inmates identified as having HIV are subjected to Viral Infectivity Restrictions. All such inmates are located in single accommodation or accommodation shared with other HIV positive inmates. Also it is likely that there will be restrictions on the work they can do (Lakes 1987).

Drug Injectors in the Prison System

There are approximately 45 000 inmates in English and Welsh prisons at any one time and about 160 000 prison receptions per year. In 1988 approximately 3500 people received immediate custodial sentences for drug offences. The proportion of these who injected drugs is not known but drug injectors are also sentenced for non-drug offences (Dolan et al. 1990a).

Of approximately 10 000 addicts notified in and out of prison, 68 per cent were known to be injecting. We have found in one sample that 63 per cent of injectors in prison were known to have a history of injecting by the prison medical staff (n=104). So there is possibly a 37 per cent under reporting of notifications in prison.

Percentage of Drug Injectors who have been in prison (see Table 4)

Many respondents in our samples reported having been in prison. In three studies of injectors 55 per cent to 76 per cent of respondents had been in prison at some time.

Risk Behaviour of Injectors in Prison (see Table 5)

There are problems with obtaining information from prisoners about their risk behaviour while they are in prison. Our data come from interviews with drug injectors in the community about their past experiences in prison.

In the first four studies the number of people who had been to prison or had injected in prison was not known. In 1987, we found 7 per cent of 387 injectors reported that they had shared syringes whilst in custody the previous year. A follow up of 142 of these injectors found that 4 per cent had shared syringes in custody but that was in the three months prior to interview. In 1988, 220 drug injectors were interviewed and 17 per cent reported they had shared syringes while in custody in the year prior to interview. Another study of 106 drug injectors found 10 per cent reported sharing syringes in custody in the three months prior to interview. These findings prompted us to question drug injectors about their last custodial experiences.

One hundred and thirty-nine drug injectors who had been in custody were asked whether they had injected during their last imprisonment and this was reported by thirty-two

(23 per cent). Sharing needles and syringes in custody was reported by 24 of the 32 (75 per cent). Another sample of 113 drug injectors found 27 per cent reported injecting when last in prison, and of those injecting in prison, 61 per cent shared syringes at some time. The final study found 30 per cent had injected in prison, and 67 per cent of those injectors shared syringes during their last imprisonment.

Risk Behaviour of Ex-prisoners in the Community (see Table 6)

Our studies were not designed to compare risk behaviour in prison with risk behaviour in the community. However, prevalence of risk behaviours outside custody are an indication of the potential for the spread of HIV from prison to the community, should HIV be transmitted within the custodial setting. All respondents were asked about their injecting in the month prior to interview, and sexual behaviour in the three months prior to interview. Table 6 shows this information for the custodial sample and the subsample of those who shared syringes in custody. It indicates that almost one-half of each group had shared syringes in the community in the previous month, and that one-quarter and more than one-third respectively shared with two or more others. More than 80 per cent of each group had sexual partners in the three months prior to interview, many having more than one sexual partner. Half of the custodial sample and 29 per cent of those sharing in custody had a sexual partner who did not inject drugs.

Cohort Study

The most recent study has been an ongoing study of 207 drug injectors. In this group 55 per cent had been in prison, 4 times on average and for 37 weeks on average. The most common conviction was related to criminally raising money in order to obtain drugs. The main reason that over one-third gave for **not** injecting when last in custody was that drugs were not available. Reluctance to share syringes was given as a reason for **not** injecting, but only by one-fifth. In terms of cleaning syringes, 90 per cent of those who were injecting attempted some form of cleaning, but the usual method was to flush or rinse the syringe with water. Surprisingly, a few had managed to use bleach or an antiseptic (25 per cent) or alcohol (5 per cent) (Dolan et al. 1990b).

Sexual Behaviour In Prison

Six per cent reported that they had had sex when last in custody with an average of five partners. We asked those who were sexually active if they would use condoms, if available, and 50 per cent said they would. All those who were not sexually active said they would not have had sex if condoms were available. The prison department has argued that possession of condoms by prisoners cannot be allowed because it would condone homosexual acts (ACMD 1988).

Tattooing

Seven per cent of injectors who had been in prison had shared tattooing equipment during their last imprisonment.

Comparison of Basic Demographics of Samples (see Table 7)

The average age, sex ratios and proportion injecting heroin in our samples are very similar to the Home Office statistics for all notified addicts. However only current injectors were interviewed in this study whereas the Home Office figures include users and as well as injectors. But among 10 000 notified addicts in 1988, 68 per cent were known to be injecting (HOSB 1989).

Summary

In summary, there is still a low prevalence of HIV infection among drug injectors in the British community.

Many drug injectors spend time in prison, and when in prison, some will inject; from 23 per cent to 30 per cent injected when last in prison. The proportion of injectors in prison who shared syringes ranged from 61 per cent to 75 per cent. These rates are alarming.

It appears that drug injectors in prisons are trying to protect themselves from HIV infection, since many attempted to clean their injecting equipment.

Recommendations

The results of this research suggest:

- More information is needed about the number of drug injectors in prison and the community. Drug injectors need to be encouraged to come forward in prison. Lifting the Viral Infectivity Restrictions may help and providing drug-treatment services of equal standard to those available in the community may be an incentive.
- More information is needed about risk behaviours in prison, but it should be collected in ways which will not compromise prisoners. Although information can be collected from recently released prisoners, we must try to gather information while people are in prison.
- The prevalence of HIV in prisons should be known. The introduction of anonymous and voluntary HIV testing in the English prison system would be more feasible if the Home Office revised its policy of segregating HIV-infected prisoners and did not coerce certain inmates to take a test.
- Given that it is impossible to prevent drug injection in prison, an immediate examination of the feasibility of measures to prevent the transmission of HIV within the prison system is needed. The priority is to investigate whether inmates would accept and adopt ways to more safely clean needles and syringes and then provide them with suitable cleaning agents. The next priority would be to examine the acceptance by prisoners and prison staff of the trial provision of condoms.

- Serious consideration must be given to diverting drug injectors from prison. One way may be to investigate alternatives to custodial sentences.

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Appendix - Tables

Table 1

AIDS Cases by Exposure Category

Category	August 1988 (n=1730)	Sept 1989 (n=2561)	August 1990 (n=3548)
Homo/bisexual	82.0%	81.0%	80.0%
Drug Injectors	1.8%	2.8%	3.4%

Table 2

Prevalence of Drug Use and Injecting in Britain

Regular injectors of notifiable drugs	75 000
Users of notifiable drugs	150 000
Estimated number of injectors*	100 000

* (regular and casual injectors and injectors of non-notifiable drugs)

Table 3

HIV Rates among Drug Injectors

Location	Year	Rate	n	Source
London	1984	1.5%	269	Cheingsong-Popov et al. 1984
London	1985-86	0.7%	146	Webb et al. 1986
England	1985	2.5%	203	Mortimer et al. 1985
London	1987	5.7%	633	PHLS Working Group 1989
England*	1987	1.5%	2 562	PHLS Working Group 1989
London	1988	6.0%	121	Hart et al. 1989
England	1989	4.0%	192	Dolan 1990

* This excludes London

Table 4

Percentage of Drug Injectors who have been in Prison

	In custody	n	Year	Source
Non-attenders	76%	183	1988	Stimson et al.
Drug injectors	55%	207	1989	Dolan et al.
Attenders	61%	470	1990	Donoghoe et al.

Table 5

Risk Behaviour of Injectors in Prison

Imprisoned	n	Year in Prison	Injected	Sharing (per cent of total)	Sharing (per cent of those injecting)
previous year	387	1987	-	7%	
previous 3 mths	142	1987	-	4%	
previous year	220	1988	-	17%	
previous 3 mths	106	1988	-	10%	
last time (n=32)	139	1988	23%	17%	75%
last time (n=31)	113	1989	27%	17%	61%
last time (n=86)	286	1989	30%	20%	67%

Table 6

HIV Risk Behaviour of Ex-Prisoners in the Community

	Custodial sample (n=139)	Subsample sharing in custody (n=24)
Shared syringes in last month	46%	46%
Shared with two or more	24%	38%
Sex partner is last 3 months	83%	88%
Two or more sex partners	39%	54%
Non-injecting sex partner (% of those sexually active)	50%	29%

Table 7

Comparison of Basic Demographics

	Study Samples		Home Office *
Demographics	1987-88 (n=863)	1989 (n=205)	1988 (n=12 644)
Age (years)	27.8	29	28
Sex (male)	74%	74%	72%
Drug (heroin)	69%	77%	88%

* All drug addicts notified to the Home Office in 1988.

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 gaol 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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National HIV/AIDS in Prisons Information Clearing House

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HIV/AIDS has become a major policy and management issue for prison administrators in this country, as in the rest of the world. It places enormous stress on already overburdened correctional systems. This paper describes the work of the recently established National HIV/AIDS in Prisons Information Clearing House (NAIPIC). Timely and accurate information can place corrections professionals in a stronger position to address the problem of HIV infection among inmates. Timely and accurate information allows the development of reasoned and effective management policies that provide sound education and training to ensure equitable delivery of services to all. NAIPIC provides a central source of information on how HIV impacts on the work and workplace of corrections professionals.

Before turning to the specific aims and roles of NAIPIC it is worth while looking briefly at the history of clearing houses. Clearing houses originated in London in 1832. The first clearing house was established by bankers for the adjustment of their mutual claims for cheques and bills, by exchanging them and settling their balances. This concept was gradually adopted by other institutions and organisations and extended to mean a central office for the receiving and giving of information.

The domain in which an information clearing house functions efficiently, is in distinguishing useful information from that which is not. NAIPIC's function is to filter the mountain of data that HIV/AIDS research programs around the world generate.

NAIPIC has three main aims:

- to establish a cohesive national network in prisons with clear lines of communication and avenues of information gathering and distribution;
- to make timely and relevant HIV/AIDS information available to prison systems throughout Australia; and
- to acquire, organise, review, update and distribute current HIV/AIDS information in the form that best meets the needs of its users.

NAIPIC operated initially during the period 7 May to 7 November 1990. During this time a communication network was established, based in NSW, linking all Australian corrections systems in the following areas relating to HIV/AIDS:

- policy and projects; and
- current and future needs.

Much of NAIPIC's effort has been directed at collating current HIV/AIDS in prisons research and educational strategies and providing samples of educational material such as brochures, videos and T-shirts.

Australian prisons are relatively isolated from available HIV/AIDS information. They are independent with little tradition of sharing information. Because the virus has only a small visible presence in some Australian correctional systems, jurisdictions vary in their concern, preparation and resource allocation for HIV positive prisoner management.

In 1989 the Commonwealth AIDS in Prison survey (Heilpern & Egger) highlighted a desire to share educational strategies, information and research between jurisdictions. All jurisdictions acknowledged that this would reduce costs and accelerate the implementation process. It does not follow that a policy successful in one jurisdiction should work in another. However, communicating successful methods of managing HIV positive inmates in a way that contributes to efforts of others in their work against the spread of the pandemic is vital in Australian gaols.

After receiving a grant from CAWISE (NSW Department of Corrective Services, Prison AIDS Project), the initial approach to establishing NAIPIC was to view Australian prison systems as a marketplace. This allowed NAIPIC to develop a business plan to meet the needs of its various 'clients'. It was clear from the start that there were several distinct 'market segments'. These were identified as:

- directors-general and heads of departments;
- decision makers within corrections departments;
- State health departments; and
- heads of communicable disease units - including Inter-Governmental Committee on AIDS representatives.

After identifying key individuals and institutions with whom we had to communicate I began a series of visits to the States and Territories and collected a great deal of material. With this initial inflow of information from both Australian and international sources a database was created using the INMAGIC software package. Experience points to a three-tiered need for information by prisons. In order of priority these are:

- HIV/AIDS in prisons research in Australia and overseas;
- HIV/AIDS in prison education strategies in Australia; and
- general HIV/AIDS research including medical and educational material.

The costs and time involved have led NAIPIC to concentrate on the first two levels while providing information on community-based clearing houses for the third.

The clearing house was established against a background of no ultimate answers to the problem of HIV/AIDS. While much remains to be learned about HIV infection it is increasingly obvious that prison policy makers and administrators cannot delay action until medical science produces the ultimate answer. The problem must be addressed now.

While the prison environment is one not generally associated with education and care, it does offer a chance to give both uninfected and HIV positive prisoners education and care that enhances their own health and their sense of responsibility upon release. Viewed in this light, it is the whole community which will benefit from the effective management of HIV infection in prisons. Perhaps this concept is best illustrated with a comment made by the owner of the CNN television network, Ted Turner: 'If people receive intelligent information they will react more intelligently'. This axiom applies to both inmates and administrators alike.

What is the best way to communicate intelligent, useful information? Apart from the attributes already described, information clearing houses have many other advantages. The

motto of the United States National AIDS Information Clearinghouse (NAIC) encapsulates their mission very clearly: 'We're here to make things clear'.

NAIC's services are aimed at all health professionals and extend to minority populations, community-based organisations and the general public. Since its beginning in 1987 NAIC has compiled two extensive databases on HIV and AIDS service organisations and unpublished educational material. It has distributed over thirty-eight million free publications to users throughout the US and abroad. Among its other corrections-related activities, NAIC publishes short, non-technical summaries of AIDS-related correctional topics. The main point is that information is a vital ingredient in controlling the spread of HIV/AIDS. Information clearing houses such as NAIC and NAIPIC are among the most effective ways of delivering this information.

Unfortunately, the conclusion one is forced to draw is that Australia lags sadly behind the rest of the world in this area. However, NAIPIC is building a structure for the timely communication of information necessary to manage inmates in such a way that HIV infection is not a constant risk for either inmates or staff. NAIPIC does not dictate policy. It aims to provide information so that effective policies can be designed.

Where does NAIPIC go from here? As well as updating, maintaining and publishing its resource documents, NAIPIC proposes three main areas of activity for the future. Firstly, the development of background papers and analyses of issues relating to HIV in prisons, including occupational health and safety, education and training, management of HIV positive inmates and industrial issues. Secondly, collaboration with the National Centre in HIV Epidemiology and Clinical Research to develop strategies for improving the collection of epidemiological information on HIV infection in prisons. As yet there is no standardised collection of such information in Australia, and it would provide a useful basis for analysing issues which have implications for all prison systems. Thirdly, developing proposals for cost sharing between States in order to maintain the information system.

Prison populations have special risks and special needs. NAIPIC does not intend to become yet another AIDS bureaucracy. It aims eventually to do itself out of a job.

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Behind Bars - Risk Behaviours For HIV Transmission In Prisons, A Review

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Soon after the Acquired Immune Deficiency Syndrome (AIDS) was first described, prisons were recognised as places where individuals with the syndrome could be found (Wormser et al. 1983). The seven cases reported by Wormser all had a history of intravenous drug use (IDU) and all denied ever engaging in homosexual activity.

With the advent of an aetiologic epidemiology of the syndrome and in particular, serological testing for antibodies to the Human Immunodeficiency Virus (HIV), it soon became apparent that prisoners in many prison systems throughout the world were infected (Hammett 1987, Harding 1987, Heilpern & Egger 1989, Norberry & Chappell 1989).

It was also recognised early that prisons were places where, compared to the general population, disproportionately large numbers of individuals had a history of engaging in risk behaviours associated with AIDS and HIV infection. Infected prisoners were more likely to have injected drugs than engage in homosexual activity. In the USA, these patterns were consistent with the observation that the geographic distribution of AIDS cases among prisoners followed closely that among cases in the general community where intravenous drug use was the primary risk (Vlahov & Polk 1988).

This knowledge raised concerns that prisons might be places where transmission of HIV could occur more frequently than elsewhere but the limited evidence to date suggests that transmission within some prisons occurs infrequently (Horsburgh et al. 1990).

Whether HIV transmission occurs is a function of the interaction between risk behaviours and the prevalence of infection. To date, studies of HIV transmission in prison have occured in settings where the prevalence of infection has generally been low and the prevalence of risk behaviours unknown.

But it is now well-known that the prevalence of HIV infection among intravenous drug users (IDUs), can increase very quickly (Des Jarlais & Friedman 1989) so it would be premature to discount the possibility that prisons could be places where HIV infection

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occurs frequently. At least one author has implied a role for prisons in the rapid rise in seroprevalence of HIV among IDUs in Thailand (Dolan et al. 1990a).

While there should be concern about transmission in prisons, the wider issues of the occurence of risk behaviours among prisoners, former prisoners and those at risk of incarceration, risk to their partners, children and prison staff should be considered also. Prisons have a definite role to play in limiting the spread of HIV both inside and outside prisons.

Knowledge and surveillance of the extent and nature of risk behaviours among prisoners should assist this process. While there has been frequent anecdotal comment in the media, in particular, that risk behaviours are rampant in prisons there have been few systematic studies of risk behaviours of prisoners particularly studies in which prisoners have been interviewed during their imprisonment. There is a modest literature of studies which have investigated risk behaviours among prisoners at entry to prison or after they have left prison.

Better knowledge of risk behaviours is essential to an understanding of the epidemiology of HIV in prisons. It will help to direct and focus more sharply health and education services and could be used as a tool to monitor the risk of transmission and evaluate the effectiveness of HIV prevention programs.

Sources of Information

Sources of information which can be used to build a picture of risk behaviours among prisoners are shown in Figure 1 (*see* next page). These sources can be used to derive quantitative estimates of the prevalence of risk behaviours. But they do not necessarily provide information on important contextual aspects of risk behaviours which may, in some circumstances, have a greater influence on the likelihood of transmission than measures of aggregate risk. In the course of this study descriptions of the nature of some of these contexts have been noted and are presented here as anecdotal summaries.

Figure 1

Sources of Information which can be used to estimate Extent of Risk Behaviours in Prisons (sources used for this review are highlighted)

DIRECT AND INDIRECT QUESTIONING of:

PRISONERS

at entry to prison

while in prison

at discharge from prison

after discharge

PRISONS STAFF

OTHER METHODS:

urinalysis for drugs

blood tests (HIV, hepatitis serology)

medical examination (sexually transmitted diseases, injection sites)

incident reports (rape, drug overdose or intoxication)

records of offence categories (e.g. property crime, drug possession or dealing)

finds of drugs or drug implements

Characteristics of Prison Populations

The inhabitants of prisons are not representative samples of communities in general. People get to be in prison because their behaviour has transgressed accepted standards. These standards are by and large clear (if not widely agreed upon) but can vary from community to community. In most communities the use of illicit drugs, buying or selling them or engaging in other criminal activity in order to get money to purchase them can result in imprisonment. It is no surprise that intravenous drug users may be disproportionately represented in prisons. Thus, for example, a recent study of intravenous drug users seeking methadone in NSW estimated that about 50 per cent of men and 25 per cent of women had been in prison at some time (Bell et al. 1990). While the proportion of Australians who have ever been in prison is not known precisely it is most likely that it is nowhere near 50 per cent. The situation for homosexuality is less clear, particularly since in most communities it is not in itself illegal or necessarily associated with illegal activities. The other important characteristic of prison populations is their large turnover which in a year can be up to five times as great

as the population in prison at any one time. This rapid and large turnover also affects the characteristics of prison populations such that those in prison at any one time are more likely to be those who have been imprisoned for serious crimes (Walker 1989). Durations of sentences vary for particular crimes across Australia and this also may affect the characteristics of prison populations and, as a result, the likelihood of risk behaviours occurring.

The implications of such patterns for HIV risk behaviours and transmission are that prisons may tend to cause the association of large numbers of intravenous drug users and that those who may never have engaged in potentially risky practices may find themselves in an environment where those around them have.

Table 1 summarises results of some recent surveys of prisoners about the prevalence of risk behaviours at any time in their lives.

Fourteen studies conducted in prisons since 1980 reported lifetime or prior to incarceration prevalences of IV drug use which ranged from 20 per cent to 53 per cent. The mean of the estimates was 36 per cent (95 per cent CI 30-42 per cent). Seven studies which did not specifically describe IV drug use but rather, heroin use reported prevalences of 20 per cent to 42 per cent with a mean estimate of 29 per cent (95 per cent CI 20-35 per cent). The mean estimate of prevalence of homosexuality was appreciably lower. The value from nine studies was 9 per cent (95 per cent CI 2-16 per cent) but the range was large and showed a skewed distribution (3-28 per cent). The data from these studies (which are largely from male prison populations) support the contention that male prisoners are more likely to have engaged in IV drug use than in homosexual activity.

These estimates should be regarded as approximate only since the samples of prisoners varied widely in regard to offence categories, participation rates, type of study and other characteristics. For example, the mean prevalence of IV drug use or heroin use was greater for studies which were cross-sectional in design (41 per cent) compared to studies which sampled entrants to prisons (28 per cent). This difference was statistically significant ($t=3.00$ $P<0.01$). Such observations may mean that studies which sample entrants to prisons could underestimate the prevalence of risk behaviours of prisoners within prisons.

Few studies specifically address risk behaviours of female prisoners. Patel et al. (1990) found that 35 per cent of a sample of female prisoners in Michigan reported injecting themselves ever, compared to 23 per cent of male prisoners. In South Australia, 13 of 19 (68 per cent) women prisoners interviewed in 1988 volunteered that they had injected themselves at some time (not shown in Table 1) compared to 37 per cent of male prisoners. The United States National Institute of Justice (1990) described slightly greater prevalences of self-reported injection and positive drug screen by urinalysis among female arrestees compared to male arrestees in the USA. Miner and Gorta (1986) found that 65 per cent of a sample of ninety female prisoners in NSW had used heroin.

Studies of the Australian population of lifetime prevalence of injecting drugs or male homosexual experience have reported estimates of 2-5 per cent for intravenous drug use and 6-11 per cent for male homosexual experience (Ross 1988, Commonwealth Department of Community Services and Health 1988). Clearly, prisons aggregate intravenous drug users but not necessarily homosexual men.

Evidence for Risk Behaviours Occurring in Prisons

A straightforward way of finding out whether people engage in risk behaviours is to ask them. This approach, while desirable, involves practical and ethical problems in prisons because the behaviours are illegal and many prisoners may not wish to incriminate themselves. But assurances of anonymity and asking indirect questions are two ways of overcoming such problems. It seems reasonable to argue that if the results of prevalence estimates which have been obtained by different methodologies are similar and consistent

then it is likely that they are reasonably robust. Some investigators either because of the nature of their studies or their particular situation have not been affected by current constraints and because of this it has become possible to compare results which have been derived from data collected in different ways.

Since 1980 a few researchers either because of a primary interest in the behaviours or as a secondary interest associated with the investigation of communicable diseases have asked prisoners whether they or their peers have injected themselves while in prison and whether they have engaged in homosexual behaviour. The results of these studies are shown in Table 2. It is readily apparent that there are far fewer studies which have investigated the prevalence of risk behaviours within prisons compared to studies which have asked about lifetime risk behaviours. The considerable ethical and practical difficulties of working in prisons are probably the main reasons for this situation.

Despite these difficulties, different methodologies and few studies, there is striking consistency among the studies that about one-third of prisoners inject themselves while in prison and that estimates of the prevalence of homosexual activity are lower than those for intravenous drug use. The results are also similar to estimates obtained from one maximum security prison in Adelaide where both prisoners and officers were asked to estimate prevalence of risk (Douglas et al. 1989). In Federal prisons in the USA the prevalence of drug use detected by random urine drug screening in prison(4-7 per cent) is substantially lower than the prevalence estimate from drug testing at time of arrest (Quinlan 1987 reported by Heilpern & Egger 1989 cf National Institute of Justice 1990). This difference is consistent with behavioural data which suggest decreased prevalence and frequency of drug use in prison compared to outside prison.

When studies of risk behaviours of intravenous drug users while incarcerated are compared (Table 3) this consistency in the data remains. It is also strikingly apparent that in all studies a large proportion of intravenous drug users shared needles while in prison. Dolan et al. (1990b) commented that in the UK, needle sharing increases in prison among those who inject but it should be borne in mind that the total number of sharing events may decrease since the frequency of injection appears to be on average substantially lower than among regular intravenous drug injectors outside prison (Tables 4 & 5). A more precise answer to that question would help a better epidemiologic understanding of the risk of HIV transmission in prisons.

While these somewhat crude values give us an idea of the likely extent of the problem in prisons they do not shed much light on the more detailed aspects of behaviours which may well be crucial to transmission. For example, only the Australian and UK studies have collected data on how needles were cleaned in prison. The evidence is that the majority of injectors fail to do so adequately. Risk behaviours should be assessed from their contextual aspects also. Whether injection occurs in groups, whether bleach is available and whether a prison officer is likely to approach may all profoundly alter the nature and severity of the risk associated with injection.

Little is known about what happens to risk taking behaviours on discharge from prison and whether they are relatively safe or unsafe. There is some evidence that prisoners after discharge are more likely to suffer adverse health outcomes, particularly death from drug overdose (Harding-Pink & Frye 1988). Again, the challenge is to ensure that the transition from prison to the outside community is a safe one. In our studies of IDUs in South Australia the data suggest that on release from prison most returned to their pre-incarceration injection behaviour but that perhaps there is a reduction in the prevalence of needle sharing (Table 5). Some caution is required in interpreting behaviour after prison since most IDUs were recruited from drug treatment facilities. Dolan et al. (1990a) found that almost half of a sample of 139 IDUs who had been in prison shared syringes once outside prison and that 39 per cent had two or more sexual partners outside prison.

Prison sexuality requires special comment. While prevalence of male homosexual practices is estimated to be relatively low, the context of sexuality may have large implications for subsequent sexual behaviour and/or drug use. A young, powerless prisoner may be intimidated into engaging in quasi-consensual sexual activity which he may cope with

by using drugs in prison. There are insufficient data, qualitative or quantitative, to be confident about the extent and effects of such activities but the fact that individual prisoners and officers mention these special circumstances should alert prison authorities to be aware of the possibility of sexual abuse. Conolly and Potter's (1990) observations that 8 per cent of drug injectors in a random sample of 158 NSW prisoners commenced injecting in prison and that of 14 men who had a homosexual experience as an adult 11 commenced in prison (personal communication to the authors) are telling in this regard. Some of these aspects of sexuality have been reviewed by Heilpern and Egger (1989). It is clear that more well-designed studies in this area are needed.

Prisons are frequently places where physical violence occurs and the possibility of HIV transmission as a result should not be dismissed. Similarly, tattooing is a practice which occurs in prison and the needles which are used could transmit HIV (Doll 1988). Dolan et al. (1990b) found that the prevalence of sharing tattooing equipment was 4-9 per cent among a sample of IDUs who had been in prison.

Behaviour of HIV-Infected Prisoners in Prison

There is some reason to expect that HIV-infected prisoners may differ from non-infected prisoners in their risk behaviours. The fact that they are infected indicates high-risk behaviour at some time. An important question is whether their behaviour within prison is risky. Again, because studies are few and have in general been done in low HIV prevalence populations, there are few data to compare. They are shown in Tables 6 and 7. It is apparent that most of the individuals interviewed injected themselves and shared needles while a smaller proportion engaged in homosexual behaviour. Dolan et al. (1990a) found that HIV-infected prisoners were more likely to inject and share needles in prison than non-infected prisoners and those who did not know their antibody status.

After aggregating the data from these studies the consistent finding is that HIV-infected prisoners are more likely to have injected themselves when they were in prison compared to non-infected IDUs or those who did not know their antibody status. But both HIV-infected and non-infected IDUs who injected in prison were about equally likely to share needles (Table 7). One difficulty with these data is that some of those who reported themselves as HIV-infected did not know their antibody status during their imprisonment. And, other determinants of injection such as sentence length may confound the apparent association between HIV status and the likelihood of injection.

While there are too few data to generalise confidently to prisons as a whole, the data should sound two warnings. First, a great deal more information is needed about the risk behaviours of HIV-infected prisoners. Second, vigorous attempts should be made to assist HIV-infected individuals to reduce the risk they pose to others.

Evidence for Prison Environments Facilitating Risk Behaviours

Intravenous drug use by itself is not necessarily a risk behaviour for HIV transmission. Sharing of implements for injection and/or failure to clean previously used needles adequately are almost certainly high-risk behaviours. What might distinguish prisons from other environments is the availability of education, and methods to make potentially risky behaviours safe. In early November 1990 a telephone survey of correctional jurisdictions in Australia by this research group indicated that clean needles with which to inject, bleach to clean needles and specifically targeted education about how to clean them (as in the Gaolwize comic) were not available in most Australian prisons (Table 8). Data from a South Australian study of prisoners in a maximum security prison suggest that prisoners are concerned about HIV infection, feel they need to know more about HIV to protect themselves and, while they are of the opinion that most injectors have not reduced their

injecting because of HIV, they are also of the opinion that clean needles would reduce the risk of HIV transmission (Gaughwin et al. 1990). In the current climate of uncertainty surrounding the implications of distributing sterile needles, an appropriate measure would be at least to make bleach more widely available. If prisoners were adequately instructed to use bleach before and after injecting this would not only reduce risk to themselves but also to those officers who accidentally prick themselves while searching for contraband. Condoms are in the same category as bleach. They present no hazard to staff or prisoners and should be widely distributed.

These, of course, are not the only ways of approaching or dealing with the actual and potential problems of risk behaviours in prisons. Other approaches such as education, counselling and drug treatment programs are just as important. But a certain amount of pragmatism is called for in the current climate of risk. One outstanding generalisation from the research which has investigated the relationship between intravenous drug use and HIV infection is that prevalence and presumably transmission of infection can change very rapidly. The reasons for such rapid change are by no means clear. This behoves us to be vigilant in our surveillance of both infection and behaviours which might transmit the virus and to be vigorous, innovative and pragmatic in our approaches to reducing the risk of transmission. We have a number of choices. We can deny the behaviours exist, we can proclaim their illegality or we can attempt to do something about them. Prisoners know about AIDS and are concerned for themselves (Gaughwin et al. 1990a) but they need responsible assistance from those who control and manage them to lessen their risk of infection.

The Possible Future of HIV Infection in Prisons

The HIV epidemic in Australia continues with new infected individuals being detected. There is insufficient information on HIV seroprevalence and transmission among intravenous drug users in Australia to know precisely whether transmission is increasing, stable or decreasing. Seroprevalence of HIV in South Australian prisons was low (about 0.8 per cent) and stable during 1989 (Gaughwin et al. 1991) suggesting that there has not yet been the rapid increases in infection among IDUs that have been observed elsewhere in the world. But the total number of infected persons detected is increasing and, as treatments become better, we can expect those infected to live longer, some to be imprisoned and some to be infectious to others. Prison administrators can expect an increased burden of caring for and managing HIV-infected prisoners in the coming years. The somewhat peculiar characteristics of population dynamics in prisons mean that there is an opportunity to regulate to some degree the exposure of non-infected prisoners to HIV. But to do this effectively will require a commitment to adequate surveillance of infection and risk behaviours and provision to prisoners of optimal opportunities to reduce risk to themselves. The extent of the likely worst-case scenario might be gleaned from information which is available about the seroprevalence of hepatitis B infection among prison populations. Transmission of hepatitis B is thought to be more efficient than HIV and natural immunity occurs unlike HIV. Measurement of the prevalence of any markers of infection can be used as a surrogate indicator of the potential extent of HIV infection. The prevalence of hepatitis B serological markers in USA prison populations (there are no recent Australian studies) is shown in Table 9. It can be seen that up to almost half of some prison populations have been infected. If this occured for HIV, the economic, administrative, social and health burdens would be profound. Far better for us to act now so that it never does. Risk behaviours are occurring in Australian prisons. If we are to avoid a catastrophe definite action will need to be taken. We cannot just hope that the situation will get no worse than it is now.

It is important to sound a note or two of caution about the data which is available on which to evaluate risk in prisons. Ethical restrictions have severely limited the collection of detailed data from prisoners while they are in prison and in our own situation in South Australia the indirect methods we have used have not allowed us to estimate the biases that may be present in voluntary samples. Studies of former prisoners are clearly biased to males with histories of significantly dysfunctional drug use. A large proportion of respondents are

relatively old and, in Australia, there are no published data which describe risk behaviours of Aboriginal prisoners.

The evidence from this review leaves little doubt that prisons are risky places. Circumstances of prison life may fortuitously decrease the risk of HIV transmission in prison but the situation is a fragile one with inherent instability. Such a situation requires vigilance. It would be gratifying to come back in three to four years time and observe that prisons in Australia have contributed significantly to stemming the transmission of HIV. This hope is neither naive nor idealistic. It is possible and the challenge is to make it happen.

Postscript

Since this paper was published, a number of important articles have been published which add to our knowledge of risk behaviours for HIV infection in prisons. In general, these papers echo the main findings and conclusions of our review paper but a number of important contrasts are evident.

Large studies in England (Turnbull, Dolan & Stimson 1991) and Scotland (Power et al. 1992) have supported the observation that the prevalence of injection while in prison among those with a history of injecting drug use (IDU) is lower than the prevalence outside prison. But both these studies report prevalences of injection inside prison modestly lower than the mean prevalence reported in IDUs in our paper. Such differences should be expected as the number of studies increases principally because prison systems around the world are different, as are the judicial systems which determine whether an IDU will be imprisoned for a particular offence. The nature of samples in studies will assume increased importance and multiple regression techniques - which take account of many factors which may influence the likelihood of injection in prison - should be used.

Most studies do not allow calculation of the relative risk of engaging in risk behaviours in prison compared to outside prison principally because questions asked did not allow determination of the number of risk-taking events per IDU per unit time. Such estimates are important, and the value of developing suitable questionnaires for such research is clear.

An example of such a situation is seen in a study of IDUs at a Glasgow needle exchange (Kennedy, Nair, Elliott & Ditton 1991) which found that about 70 per cent of respondents had a history of imprisonment: of these about 50 per cent injected while in prison and slightly less than 50 per cent of those who injected shared needles while in prison. But information which would allow comparison of, for example, the number of times needles were shared in and out of prison per unit time was not reported.

While studies of former prisoners have predominated in recent literature, a few studies from within prisons have been published. One study from within the Saughton prison in Scotland (Dye & Isaacs 1991) which had a 32 per cent response rate reported a prevalence of injection among inmates outside prison of 35 per cent and an in-prison injection prevalence of 24 per cent. Among those who did inject while in prison, needle-sharing prevalence was 76 per cent. Prevalence of injection and HIV status varied by type of prison, but response rates varied substantially by prison also.

A study of New Zealand prisons (Patten & Gray 1991) conducted within prisons found that 26 per cent of 190 inmates surveyed had injected themselves in prison while 17/190 had engaged in any sexual activity and 2/190 in anal intercourse.

Remarkably, Power et al. (1992), in a study of a stratified random sample of 559 prisoners from eight Scottish prisons, achieved a response rate to questioning about risk behaviours of 86 per cent. They found that only 28 per cent of inmates reported ever injecting themselves and about 8 per cent had injected while in prison. Of those with a history of injection, 97/154 had shared needles outside prison and 32/43 had shared needles inside prison. About 50 per cent of those who shared needles sterilised them routinely either inside or outside prison. The absolute estimates of injection prevalence are low compared with other studies conducted within prisons but consistent with studies of IDUs in that about 30 per cent of those prisoners who were IDUs injected while in prison. In another report of the same population they found only 1/559 inmates had engaged in sexual activity while in prison (Power et al. 1991).

Lower estimates of pre-imprisonment injection prevalence were obtained by Maden, Swinton and Gunn (1990; 1992) who reported a prevalence of 11 per cent among male prisoners and 23 per cent among women prisoners. Their study in male prisons was again remarkable in achieving a response rate of greater than 90 per cent. It involved a large random sample of 1751 and was conducted across all of England and Wales. These authors acknowledge the possibility of under-reporting of risk behaviours which must be considered seriously.

To reiterate the conclusions of our paper, prisons have responsibilities and power to make a substantial contribution to stemming HIV transmission. To accept such responsibility will require courage and the insight that they do not exist in a world which is apart from the communities in which they are located and that they need to address with their communities the welfare of prisoners both while they are in prison and while they are outside.

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Appendices - Tables

Table 1

Studies which Report Lifetime or prior-to-incarceration Prevalences of HIV Risk Behaviours

Author (*see* References)	Year of Study	N	Study Type	Country/ State	IV Use %	Heroin Use %	Homosex-uality %
Barton 1980	1980	10400		USA		30	
Nacci & Kane 1983		1982	330	CS	USA		28
Chaiken 1982	1982	2200		USA/3 States		28	
Hull et al. 1985	1982	455/659	CS	USA/ New Mexico	41		4
Decker et al. 1984	1983	759/6503	CS	USA/ Tennessee	47		22
Anda et al. 1985	1983	619/876	EN	USA/ Wisconsin	27		4
Indermauer 1985	1986	90	CS	Aust/WA		31	
Dobinson & Ward 1986	1986	225	CS	Aust/NSW		42	
Indermauer & Upton 1988	1986	926	EN	Aust/WA		20	
Johnson & Egan 1986	1986	402	EN	Aust/WA		21	
Glass et al. 1988	1986	818	EN	USA/Iowa	28		5
Conolly & Potter 1990	1989	158	CS	Aust/NSW	46		10**
Barry et al. 1990	1985	406/470	CS	USA Massachusetts	33		3
Andrus et al. 1989	1987/88	977	EN	USA/Oregon	53		3
CDC 1989	1987/88	459/600	CS	USA Massachusetts	52		
Vlahov et al. 1990	1987/88	1932	EN	USA Maryland	34		
Vlahov et al. 1989	1985-87	1488	EN	USA Maryland	37		
NIJ 1990	1988		EN	USA	26		
NIJ 1990	1988		EN	USA		heroin 21 cocaine 53	
Gaughwin et al. 1991	1988/89	373	CS	Aust/SA	37		
Hoxie et al. 1990	1988	989	EN	USA Wisconsin	25		
Patel et al. 1990	1988	802	EN	USA Michigan	20		4
MEAN					**36**	**29**	**9**
95% CI					**30-42**	**20-35**	**2-16**

*CS = Cross Sectional EN = Entrants **pers comm

Table 2

Studies conducted in Prisons of the prevalence of Risk Behaviours of Prisoners while in Prison

Author (*see* References)	Year of Study	Population/Study Type	IV Use (%)	Homosexuality
Decker et al. 1984	1983	random sample, 759 of 6503, Tennessee, USA direct questioning	28	18% unspecified
Nacci & Kane 1983	1982(?)	random sample, 330 from USA Federal prisons, (64% response) direct questioning		12% current prison 30% in any prison unspecified
Conolly & Potter 1990	1989	random sample, 158 in 6 of 26 NSW prisons Aust, direct questioning	32	9% unspecified 2% anal intercourse*
Gaughwin et al. 1991	1988/89	voluntary sample 373 of 791 Sth Aust prisoner's estimates	37	12% anal intercourse

*Pers comm

Table 3

Studies of Risk Behaviours of IDUs during past Imprisonments

Author (*see* References)	Year of Study	Country	N	Approx Age	Sex	Months in Prison	Per cent Injected	Shared Needles (% of injectors)	Cleaned Adequately (% of sharers)	Per cent Homo-sexual Activity
Carvell & Hart 1990	1989	UK	50	31	84%M	21	66	79		10
Hart et al. 1989	1986/7	UK	32	29	M&F		34	73		
Wolk et al. 1990	1987	Aust	54	28	M		50	100		13
Dolan et al. 1990a	1988	UK	139	28	69%M	65%<1mth	23	75	25	8
Gaughwin et al. 1991	1989/90	Aust	50	27	M	14	52	73	16	2
Gaughwin et al. unpublished	1989/90	Aust	9	28	F	8	67	100	33	
Dolan et al. 1990b	1989	UK	59	30	76%M	11	39	75	25	5
Dolan et al. 1990b	1989	UK	54	29	73%M	7	15		13	8
Donoghoe et al. 1989	1989	UK	286		>50%M		30	65		4
Connolly & Potter 1990*	1989	Aust	50		?M&F			94	30	
Mean				**29**		**12**	**42**	**81**	**24**	**7**
95%CI				28-30		5-19	28-56	72-92	15-32	4-11

*Imprisonment, interviewed in prison

Table 4

Studies which Estimate the Frequency of Injection of IDUs while Incarcerated

Author (*see* References)	Daily	Weekly	Monthly	Occasionally	Mean (inj/wk)
Decker et al. 1984 (USA, n=759)	|-------	23%	----------|	77%	
Gaughwin et al. 1991 (Sth Aust)					
1. Prisoners' estimates (n=200)	9%	30%	|----------	61% -------	|
2. IDUs (n=56)	14%	28%	20%	38%	1 (approx)
Dolan et al. 1990a (UK, n=26)					0.7

Table 5

Injecting Behaviour of South Australian male IDUs before, during and after their most recent Imprisonment

	6 Mths Before	In Prison	6 Mths After
Injected	39/50 (78%) **	26/50 (52%) *	34/46 (74%)
Frequency (daily or weekly)	34/39 (87%) **	3/26 (12%) **	28/34 (82%)
Shared Needles	28/39 (72%) ns	19/26 (73%) ns	18/33 (55%)
Cleaned Adequately	6/28 (21%) ns	3/19 (16%) ns	4/18 (22%)

Z test for proportions *P<0.05, **P<0.01, ns not significant

Table 6

Risk Behaviours of HIV-infected IDUs during their Imprisonment

Author (*see* References)	Injected	Shared Needles	Sex
Wolk et al. 1990	2/3 (66%)	2/2 (100%)	2/3 (66%)*
Gaughwin et al. 1991	6/7 (86%)	5/6 (83%)	1/7 (17%)
Dolan et al. 1990a	11/24 (46%)	10/11 (91%)	--------
Totals	**19/34 (56%)**	**17/19 (89%)**	**3/10 (30%)**

* Both homosexual

Table 7

Comparison of Injecting Behaviour during their Imprisonment of HIV-infected IDUs and IDUs who were not infected or did not know their Antibody Status

	Injected	Shared Needles
HIV Infected	19/34 (56%)	17/19 (89%)
HIV Negative or Unknown	66/209 (32%)*	53/66 (80%)^{ns}

* Chi square = 6.56, P = 0.01, ^{ns} not significant

Table 8

Availability of HIV Risk Reduction Measures in Australian Prisons, November 1990

	STATE						
	NSW	VIC	QLD	SA	NT	WA	TAS
Condoms	N	N	N	N	N	N	N
Sterile Needles	N	N	N	N	N	N	N
Bleach	Y	Y	N	N	N	N	N
Education	Y	Y	Y	Y	Y	Y	Y
Gaolwize Comic	Y	N	N	N	Y	N	N
Methadone	Y	YR	YR	YR	N	YR	N

Y yes, N no, YR yes but significantly restricted

Table 9

Prevalence of Hepatitis B Markers (antigen and antibody) in some USA Prison Populations

Author (*see* References	Year of Study	Study Type	Hep B Markers
Hull et al. 1985	1982	entrants	47%
Decker et al. 1984	1983	cross sectional	30%
Anda et al. 1985	1983	entrants	19%
Barry et al. 1990	1985	cross sectional	43%
Andrus et al. 1989	1987	entrants	36%
Mean			**35%**

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Minimising the Spread of the Human Immunodeficiency Virus Within the Australian Prison System

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It is a fact of prison life in Australia and indeed in most countries, that activities engaged in by prisoners may facilitate cross-infection with the Human Immunodeficiency Virus (HIV). Sexual intercourse between prisoners, `institutional sex', and the sharing of needles and syringes while injecting various drugs intravenously, are common practices and represent high-risk activity in the context of the current AIDS epidemic.

In most Australian prisons, life is harsh with much overcrowding and a staff to prisoner ratio which makes it impossible to develop surveillance mechanisms within the gaol that would prevent high-risk behaviour from occurring. Prisons, therefore, must be seen as potential incubators for the spread of HIV. The possibility that many prisoners leaving the gaol system will help disseminate the virus into the general community is real and demands the urgent establishment of programs that will minimise this risk.

We are now into the second wave of HIV infection in our community. It is largely related to the inadvertent passing of HIV from the bloodstream of one person to another as intravenous drug users (IDUs) share injection equipment. As a very high proportion of crimes in our society are drug related, many prisoners are IDUs, and those who are not will be exposed in the gaol system to people who use intravenous drugs and who may introduce non-users to the habit. As no authority believes it is possible to eliminate drugs, needles and syringes from our gaols, we must face the fact that HIV positive intravenous drug users in our gaol system may infect others.

In a survey carried out by the author in the metropolitan remand prison at Long Bay Gaol in Sydney, data thought to be reliable suggested that more than 60 per cent of 260 prisoners were using intravenous drugs three times per week. To do this they were sharing, at most, fourteen syringes and needles.

Rates of HIV infection among prisoners in Western gaols, particularly in the UK, USA and France, have increased alarmingly with, for example, 12.5 per cent of prisoners in French gaols being HIV positive. Even in countries where the incidence of HIV infection in the general community remains low, such as Belgium and Israel, approximately 7 per cent of prisoners are found to be infected with the virus.

Current moves in States such as NSW to restrict the property held by prisoners and thus deprive them of various forms of currency, are likely to do little to minimise the introduction of needles, syringes and drugs into the gaol system while contact visits are allowed to continue. While all reasonable efforts to prevent the entrance of drugs and the instruments for their use into the gaol system must be encouraged, a package of preventative measures needs to be introduced urgently and simultaneously if we are to minimise the potential for gaols becoming institutions where many non-infected individuals are infected during their short stay in prison and a major hazard for the spread of the virus into the general community is created.

Recommendation

The World Health Organization issued statements on the minimisation of the spread of AIDS in prisons after an international meeting which representatives of twenty-six countries, including Australia, attended. Two key statements were:

- control and prevention of HIV infection must be viewed in the context of a need to improve significantly the overall hygiene and health facilities in prisons;
- prison authorities have a special responsibility to inform all prisoners of the risk of HIV infection from high risk behaviour such as intravenous drug use and homosexual activity.

Education therefore becomes a key component of any campaign.

My survey of the educational material available to prisoners, prison officers and other prison personnel, suggests that even today no State has adequate material for the task at hand. Pamphlets from Commonwealth and State health departments are available within prison systems. However, there seems little doubt from my discussions with most educationalists that the most effective means of educating prisoners, and indeed prison officers, is by video presentations coupled with peer group discussions of the material presented. Most of the videos which have been made for prison systems around Australia are either out-of-date or unlikely to be effective. They simply supply a lecture from a moving head and are of such a quality that one can have no confidence that prisoners' interest will be established, let alone maintained.

It is obvious that educational material for prisoners must be created jointly by health professionals who fully understand the AIDS epidemic and by experts from corrective services' departments who understand the needs of prisoners. Educational material must be presented in plain language that prisoners understand. It is highly desirable that material be developed that can be used throughout the nation. Uniformity, apart from producing significant financial savings, minimises the controversies which currently exist and are fostered when prison systems have different views on the way AIDS-related problems should be solved. An example of the latter is the segregation or non-segregation of known antibody positive prisoners.

Currently, the best plans for an educational program generated by the Department of Corrective Services in NSW, involve a film on prison lifestyle which can be broken up into a number of discrete modules, each approximately ten minutes in length. These modules discuss numerous aspects of prison life. Sections are devoted to sex and sexuality within the gaol system and sexually transmitted diseases, specifically AIDS. The concept involves showing these modules to stimulate discussion among prisoners. At the end of each module, the tape can be stopped so that an appropriately educated group leader can use the material as a catalyst for a constructive debate in a reasonably small group setting.

A number of prisons allow prisoners to view sexually explicit movies. If this practice is to continue, then interspersed into the movie, in a `commercial-like' fashion, should be brief clips from educational modules or specifically prepared warnings emphasising the risk of contracting HIV and other sexually transmitted diseases from sexual activity within prisons.

In a number of gaol systems, closed-circuit television is available and, within those systems, educational material could be run frequently. Brief messages repeated many times are likely to have a much greater effect than a more elaborate message shown infrequently. Ongoing education and repetitive presentation of the most vital information in one form or another is clearly essential. While the material prepared for prisoners would no doubt be of educational value to prison officers, there appears to be a need to develop programs specifically for prison officers. Importantly, such educational material should involve detailed discussions about managing HIV-infected prisoners.

Counselling

Closely related to problems associated with the development of educational strategies are problems that relate to the lack of adequate counselling because of insufficient numbers of trained counsellors within the prison system. A general principle endorsed by the World Health Organization is that all those measures taken to educate, control and attend to HIV related problems in the community should be available within the prison system. Great efforts have been made in the general community to ensure that adequate counselling is available for high-risk individuals. It must remain a top priority within prison systems. While there is some variability from State to State, in general prison systems in Australia rely on current staff to supply one-on-one counselling where it is thought necessary. Often these counsellors are experienced only in drug and alcohol rehabilitation and there is little evidence that they are adequately trained to handle the sensitive and specific problems associated with the AIDS epidemic.

It is essential that prisoners who undergo HIV testing are counselled in a manner identical to that required for the outside community before being tested. The nature of the test, its limitations and the significance of a positive result in medical and social terms must be adequately explained. It is even more important that positive results are communicated to prisoners by knowledgeable and sympathetic counsellors who can answer accurately and immediately questions that are likely to follow the discovery that one is infected with the AIDS virus. Such counsellors must also be available to answer the questions which inevitably follow as a prisoner comes to grips with the information. Such counsellors, adequately trained, would be the ideal individuals to act as discussion leaders after the presentation of factual information by the video presentations described above.

Sexual Activity in Gaols

While it is nearly impossible to get accurate data on the number of violent sexual encounters that happen within gaol systems, such events undoubtedly occur. Far more common, however, is consensual sexual activity. This frequently involves anal intercourse and, within the prison system, is referred to as institutional sex rather than homosexual activity. Lack of single cell accommodation in almost all prisons and the impossibility of preventive surveillance, mean that tactics to minimise the spread of HIV through sexual intercourse within the prisons must be based on the acceptance of the fact that institutional sex will occur.

With the acceptance of this fact, supplementing the specific educational information described above to describe safer sexual practices becomes essential and condoms must be made available within prison systems. The distribution of condoms falls more naturally into the province of health care workers and AIDS counsellors rather than prison officers. Therefore, if vending machines are not installed, then condoms should be supplied freely and non-judgmentally by health care personnel. Clearly, whatever method is used in individual gaols, it must be possible to obtain condoms discreetly.

In States where sexual activity between consenting prisoners within the gaol is illegal the decriminalisation of such acts must become a major priority. Prisoners are less likely to worry about taking condoms, or being found with condoms, if sexual acts in prison between consenting males are not criminal offences.

In many gaol systems, transsexuals are allowed to dress in female clothing. A number of transsexuals are intravenous drug users and frequently have earned the money to buy their drugs from prostitution. They represent a particular hazard for the spread of HIV in prisons. Their psychological and physical needs and the minimisation of their role in the spread of HIV demands that they be housed in separate prison facilities.

In those gaols that do maintain AIDS units, females, especially female prostitutes, infected with the virus, must not be held in units with men infected with the virus or even transexuals similarly infected. Sexual activity has occurred between male and female inmates of AIDS units under such circumstances.

Problems Associated with Intravenous Drug Use

Intravenous drug use with shared needles and syringes provides the major risk for the rapid spread of HIV within the gaol system. The average prisoner in an Australian gaol is incarcerated for three to four months only before returning to sexual partner(s), who in most cases are of the opposite sex. The spread of HIV into the heterosexual community might thus be accelerated if frequent transmission occurred within prisons. While there is no doubt that data collected from the general community allows us to state confidently that needle and syringe exchange programs are helping to minimise the sharing of equipment by intravenous drug users in the community, it would seem impossible at the present time to implement such strategies in gaols.

Sterilising solutions should be made available within the prison system so that needles and syringes can be disinfected each time they are used. Instructions for safe disinfection of equipment should be widely available. While it may seem inconsistent with such policies, random, regular and compulsory urine testing for those drugs that can be administered intravenously - narcotics, barbiturates and amphetamines - has much merit. Each prisoner's urine should be tested at least three times a year. The institution of a urinalysis program would obviously be advertised to prisoners so that they would know that they face a risk of being detected as a drug user. Some form of punishment would be necessary for the program to have a deterrent effect. The loss, for a prescribed period, of the privileges associated with contact visits has been suggested as an appropriate deterrent. Most prisoners who use drugs intravenously in gaol are not addicted to drugs but rather use them as a way of minimising the harshness of their day-to-day lives. Such prisoners may well respond to the deterrent effects of routine urine screening.

It is essential that prisoners who are addicted to intravenous drug use be given all the assistance that would be available to them from the best drug rehabilitation centres established in the community at large. Methadone programs run within the gaol system by healthworkers expert in the administration of such programs, must be of sufficient integrity and size to accommodate all prisoners who need such a program. The running of such programs requires highly specialised skills without which inadequate programs can develop. It would be essential that those prisoners due for release within a reasonable time have a liaison set up with a community drug rehabilitation program to ensure a smooth transition from the prison methadone program to a program within the community.

Compulsory Blood Testing for HIV Antibodies

Nothing has been more controversial than the establishment of a program which would force prisoners on admission and at three monthly intervals to have their blood tested for the presence of HIV antibodies. It has been argued that the institution of such a policy will in no way help prisoners themselves and is, in fact, for administrative convenience within the prison. Information about a prisoner's HIV status, it has been contended, is useless if not shared and confidentiality is therefore a meaningless concept.

If the sharing of information about HIV positivity was the primary goal of testing, then compulsory testing does present many ethical dilemmas. However, clearly, the major aim of compulsory blood testing should be to identify those prisoners who are infected, counsel

them about the risk that they may pose to others, help them and thus minimise the risk that they will infect sexual partners once they leave gaol. World Health Organization strategies widely accepted in Australia indicate that the major defence against the spread of HIV in the community relies on the identification of high-risk individuals. Prisons offer an excellent opportunity to locate some individuals who might not otherwise come forward for testing in the community. While anonymous testing of prisoners would give us information, and valuable information at that, about the prevalence of HIV-infected individuals within the prison system, involuntary and confidential testing is a far more constructive approach.

Compulsory testing cannot be endorsed if prisoners whose blood contains HIV antibodies are segregated. Prisoners who do not have sex with each other or share intravenous needles and/or syringes are not in danger of being infected with HIV. Segregation is therefore a social rather than a medical issue within the prison system. My experience over a number of years of caring for isolated individuals in an AIDS unit at Long Bay Gaol, suggests that discontent, violent behaviour, inappropriately dangerous behaviour and attacks on prison officers are far more likely to occur in a segregated rather than non-segregated situation.

It has been argued that failure to segregate antibody positive prisoners might result in them being violently treated by non-infected inmates. It is true, that despite advice to the contrary, prisoners do discuss their HIV status with others. Nevertheless, experience overseas, particularly in New York where there is a major HIV problem, has shown that with appropriate education even those prisoners known to be HIV positive can be accepted into the general prison population without violence occurring.

Segregation emphasises to those prisoners placed in isolation the stigma that is attached to being infected with HIV. The psychological effects are damaging. This is especially so if segregated prisoners are not exposed to counselling and support measures available to similarly infected people in the community.

Antibody testing can help us to understand the nature of the AIDS problem in our prison system and to monitor the success or otherwise of prevention strategies. There are also a growing number of reasons why it is to the advantage of an individual infected with HIV to know this fact. Lifestyle advice, if followed, may decrease chances of the progression of an infection to AIDS. The availability of drugs such as AZT mean that it is perfectly legitimate to tell an individual that it is better to know rather than to not know their HIV status.

Advance Planning for Release from Gaol

It is essential that those prisoners known to be infected with HIV receive adequate education and counselling before release from gaol. This counselling must include appropriate members of the family. It is the responsibility of prisons to make sure that family members, particularly spouses and sexual partners, are fully counselled with the prisoner's consent. It is also highly desirable that prison counselling services hand over particular cases to community counselling services so that follow-up within the community can occur.

Despite the efforts of a number of individuals, we have not managed to hold a national meeting of corrective services Ministers and health authorities expert in AIDS which has developed a national policy for all prisons. We need to combine the resources of the Federal Government and State Governments to produce appropriate educational material and institute research into efficient ways of implementing an educational campaign and assessing its outcome. Continuing dialogue with prison officers, especially in the current climate where it is alleged that an officer was infected after an attack by a prisoner who was HIV positive, is absolutely essential if there is to be acceptance of the principles outlined in this paper.

A Pragmatic Approach to the Delivery of HIV Related Services to Prisoners

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One of the most interesting issues for those involved in prison health care has been the constant and sometimes deafening demand that, in regard to HIV/AIDS, prisoners are a priority group and should receive special attention and increased services. Needles, condoms, methadone, bleach, testing, education, counselling and conferences are all frequently suggested. This causes wry smiles amongst those who provide the normal range of health services within prisons and face a constant battle to supply basic medical, psychiatric and substance abuse services. We are, for once, inundated by interested parties seeking to provide support, grants, study and comment on our services. Why is this so, when usually opinions are that less rather than more be done for prisoners' health?

The answer seems to be the importance placed on the interface between prisoners and the rest of the community. The health sector and the general public have been lead to believe that prisons are incubators for HIV and will progressively infect the rest of the community. This is not necessarily an irrational belief, although such concern has not been realised as yet in Victoria. Since 1985 only forty-nine known HIV positive prisoners have been admitted into Victoria's prisons, and none has developed AIDS whilst in prison.

HIV policies in prison are not primarily based on concern for individual health, but rather out of fear of contamination of the general public. This point needs to be made because it provides essential background information for understanding some of the health policies suggested for the prevention of HIV infection in prisons. Such an approach is not necessarily a good basis for rational and humane decision making. Fear and stereotyping have been vigorously and successfully opposed by gay groups in the context of HIV policies for the general public.

Compulsory testing, segregation, breaches of confidentiality, and exclusion from particular workplaces have all been rejected as appropriate HIV policies for the general public. Such suggestions are now getting a full re-run in the prison community. To repeat, fear and stereotyping are not a good basis for rational decision making.

I want now to focus on the relationship between corrections and health organisations. It is usually an exercise whereby health services are provided by one group via the medium of another group to the patients. Despite elaborate theories of the competing goals and values of the different organisations - health and corrections - my experience is that the main obstacle to the provision of health services in prisons is the fundamental organisational difficulties that are encountered in prisons.

Prisons as organisations are quite good at providing the few basic and essential services by which they are most readily assessed. These are custody, shelter, food and basic medical services. Other areas that are less fundamental to the organisation's own existence are often frustrated by the exigencies of prison life. Programs for education, employment, pre-release planning, welfare, and psychiatric/psychological and substance abuse services are usually more difficult to organise and more prone to frustration and disintegration. These services demand flexibility of the organisation and a commitment to an individualised and caring model, both of which are luxuries within the prison system.

Prison administration is characterised by:

- inflexible work routines;
- difficulties in communication due to physical isolation of staff and shift work;
- high turnover of both staff and prisoners;
- lack of job definition beyond the provision of the basic services;
- little investment in ongoing training;
- low status and low morale; and
- poor industrial relations but strong industrial organisation.

It is these basic problems that make service provision difficult more often than any conflict of goals or obsession with security. When plans are frustrated in prison I usually counsel a belief in mistakes rather than conspiracies.

If this point is accepted it unfortunately makes one more pessimistic about achieving proper prevention and education strategies than if the problem were one of competing goals or values. This point must be emphasised to those who are unfamiliar with prison administration, so that they are made aware of the real difficulties associated with some of the suggested policies for HIV prevention in prisons.

With the community demanding policies based on fear rather than care and faced with an organisation which struggles to provide anything beyond basic custody and care, what can be done, and what has been done?

Health provision in corrections usually is done utilising one of two models. In the first the corrections department employs its own medical personnel. In the second, the health department or perhaps a large public hospital provides health services to the prison. There are difficulties associated with both models.

Victoria, after a number of years of dissatisfaction about the provision of health services to prisoners took the rather unusual step of forming a Corrections Health Board. This Board provides a method for achieving agreement on policy between the two departments - corrections and health. It was established in 1986 and provides a forum for senior executives from health and corrections not only to discuss issues but also to decide upon policy which will be binding on both departments. Its success relies on the involvement of managers who are sufficiently senior that they can make decisions, not simply recommendations back to their own department.

The Corrections Health Board was established primarily to address the perceived neglect and fragmentation of health services and policies in prison. However, soon after its establishment, HIV issues became one of the very dominant and persistent matters on its agenda.

An interdepartmental approach has given Victoria a good balance between the sometimes conflicting interests in HIV policy in prisons. It provides a forum for full and frank discussion of such issues as confidentiality, testing and segregation. This often means finding a compromise position, but compromise is the art of politics, and AIDS in prisons is

undeniably political. For instance, there has been a constant demand from some areas for needle exchange programs in prisons. Needle exchange programs are to be greatly commended in the community. They are an effective and courageous development for the community, but an unrealistic proposal for prisons. Prison staff cannot be expected either morally or on grounds of safety to accept such a development. It would be anomalous to devote extensive resources to preventing drug trafficking in the prison on the one hand and, on the other, to start distributing needles. Prison staff cannot be expected to keep people in custody for drug offences and then be asked to facilitate drug usage. Prison staff cannot be expected to distribute objects that may well endanger their safety.

Faced with a highly successful health initiative for the general public, but the impossibility of its implementation in the prison system, we opted for making bleach freely available in Victorian prisons for infection control. It is a compromise, but a successful one. Whereas some other jurisdictions have stalled on the issue of infection control amongst IV drug users in prisons, Victoria has proceeded with a policy that is effective and deliverable.

While a policy of freely available bleach has been introduced, ensuring that bleach is always available in practice in every prison is another matter. Generally, it is available, but sometimes prison staff `forget' to refill the dispensers. This highlights another key factor. Prison staff at all levels must have a commitment to the policies that management adopt, otherwise those policies will be frustrated.

The Corrections Health Board has established a Communicable Diseases Sub-Committee. This is a tripartite body consisting of public health and corrections officials and union representatives. It ensures that all policy recommendations are developed with the benefit of prison staff advice, agreement and ownership. This Sub-Committee, like the Corrections Health Board itself, survives by finding compromise and by ensuring that decisions are made after full and frank discussion from all sides.

The key factor in the establishment in Victoria of a balanced and effective set of procedures for HIV prevention and management has been the intensive AIDS education of a number of key personnel in the prison system. When the first HIV antibody positive prisoners were detected, procedures were inadequate and prisoners were confined to the hospital at Pentridge Prison. Over sixty key managers, union officials, health workers and prison officers were given a six day intensive AIDS course. Innumerable other officers and prisoners were given one to two-day courses. When this was completed re-evaluation of policies commenced. It was not until the appropriate personnel had a full knowledge of the issues that some rationality was injected into decision making. Attendance of large numbers of personnel at extended training requires commitment and cooperation from the corrections side, otherwise it cannot succeed.

Having discussed the linkages between the corrections and health departments and our attempts to involve prison staff at a base grade level - there is one other group that cannot be ignored - prisoners. Prior to the development of proper procedures for HIV management, HIV antibody positive prisoners were confined to the Pentridge Prison hospital. There was little to do there and increasingly these prisoners felt angry and abused. They became abusive and disruptive. If a humane and less isolated management regime had not been developed which supported such prisoners through the trauma of adjusting to being HIV positive then there is no doubt that prisoners would have used their antibody status in assaults against staff.

What does the Corrections Health Board see as the required policies? In brief, they are as follows:

- extensive education of both staff and prisoners, so that they fully understand the virus and maintain a humane attitude;
- extensive training and equipment of staff and prisoners for infection control;
- sound epidemiological information in regard to the prevalence of HIV in prisons;
- proper medical care of prisoners with HIV/AIDS; and

- humane and confidential management of prisoners who are HIV positive and have AIDS related illness.

While complete success has not been achieved in Victoria in relation to each of these matters, substantial progress has been made. It can only be achieved where there is constant discussion and negotiation between health, corrections, and prisoners. Finally, it is important to remember two things. First, that prison officers, prison management and prisoners will not be impressed by policies that emanate from public fear, if such policies are at the expense of their own legitimate interests. Second, that limitations of prison as an organisation be kept in mind when suggesting reforms.

Compulsory Testing and Integration

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My particular concern is for the prison population and the State of New South Wales. I am conscious of the difficulties which a term of imprisonment imposes on individuals and of the discomfort which is generally shared by the prison population. My administration is concerned with bringing about humane conditions within a closed environment, and at the same time fulfilling the requirements of the courts. I have a number of detractors in New South Wales, and indeed they may even spread further afield. It is not surprising that such a situation should prevail, for when real change is introduced, a number of people become threatened, alarmed and are imbued with feelings of insecurity and uncertainty.

Real change is taking place within the New South Wales prison system. Under numerous previous administrations there seemed to prevail an attitude of complacency, and the continuation of policies which dated back to the previous century. There was a general acceptance that certain criminal elements within the gaol system were the key operators. Their activities were condoned, as on the surface, it appeared that the gaols were quiet and that control was effectively being maintained.

Some disturbances have occurred within the New South Wales penal system in recent weeks. A brief allusion should be made to the necessary policy which restricts prisoners' private property. When the present administration came to Government, we found a prison system essentially dominated by the physically strong, by those who took on the role of predators and imposed a reign of terror against the weak. It was a system of fear and violence. It was a far cry from the basic requirement of having a humane and rehabilitative prison system which would cater for the needs of those many inmates needing to learn a disciplined way of life and acquire skills which would enable them to re-enter the community with a feeling of confidence.

It was discovered that a few prisoners were collecting large quantities of property, usually at the expense of other prisoners in the system. Property became a vehicle for exchange and, in addition, it was used to secrete contraband items including drugs, syringes and needles. The restrictions now imposed on prisoners property have provided a more equitable control of the prison system and have facilitated searching of cells with the subsequent reduction in the incidence of contraband.

A reign of deprivation has not been imposed on prisoners. The standard prison issue of clothing remains in place as it was previously. The approved cell property has been divided into three classifications; maximum, medium and minimum security prisoners.

What is the connection between the restriction of prisoners' private property and the attack that must be mounted against AIDS? Excessive property has been used for the secreting of needles. The use of those needles in prison is a major concern when considering the spread of HIV. While the incident in which it is alleged that a prison officer

was assaulted by a prisoner and became infected with HIV needs to be kept in perspective, part of that perspective must be an acknowledgment of what can happen.

Let me turn now more directly to the subject of AIDS in prisons. The New South Wales correctional system is the largest in Australia. The State's gaol population has increased and, at any one time, there are in excess of 5 700 people undergoing imprisonment with a yearly turnover in excess of 15 000. Over a period of several years this amounts to a large number of people who have had contact with the prison system, although recidivism rates would indicate that a number are returning to prison on a second or third occasion.

A total of twenty-eight institutions in NSW cater for maximum, medium and minimum security prisoners, remandees and periodic detainees. It is difficult to estimate the number of prisoners who have a drug-related background - some predictions suggest that as many as 80 per cent of prisoners have this particular problem. In addition, a recent Departmental study on sexual and IV drug use behaviour of prisoners suggested that prisoners share needles in gaol (Potter & Conolly 1989).

My Government, of course, will not facilitate illicit intravenous drug use or, in fact, any type of illegal drug use amongst the prison population. It will not provide a needle exchange system or any mechanism for the provision of needles for illegal purposes. There are those who would argue that this is inhumane, that it deprives the drug user of a means to which he/she is well-accustomed and that the likelihood of HIV infection is increased by denying this facility. I totally reject that proposition. Our aim is to prevent drug use and this certainly cannot be achieved by enabling the drug user to continue with the practice while in custody.

A similar situation prevails in regard to sexual practices within the prison. We are well aware that homosexual activities do greatly increase the probability of contracting the AIDS virus. We have carefully thought about issuing condoms and have rejected the idea. In the United States only seven States allow the distribution of condoms, and these are mostly in areas where conjugal visiting rights apply. The American federal system which accommodates 60 000 prisoners does not allow condoms in the prisons. Both the United Kingdom and France decided against the distribution of condoms. No Australian State distributes condoms to its prisoners. Significantly, the Dutch system allows condoms for conjugal visits only. Let me explore some of the reasons why the distribution of condoms has been rejected.

The issuing of condoms in prisons promotes the possibility of violence and victimisation of those who request or receive condoms. An increase in the incidence of sexual assault on prisoners is likely if condoms are made accessible. It might appear safer to the potential offender to violate his victim if he is afforded apparent protection by a condom. Condoms have been widely used for the carriage of illegal drugs into prison, a further reason why they have been banned. Condoms can be used as a weapon by prisoners, either against fellow prisoners or prison staff. They can be filled with water, sand or any substance and used as missiles.

A strong emphasis has been placed on education and training throughout the prison system. This is seen as the most effective means of preventing the spread of HIV. I have appointed four AIDS Coordinators who have established in each institution AIDS information sessions, AIDS Action Committees and peer education programs for staff and prisoners. The general aim is to have the staff and prisoners within each institution manage the AIDS problem. Regular information sessions are designed to keep AIDS awareness at a high level. The AIDS Action Committees are very important in each institution. They adopt a pragmatic approach to a serious problem and are responsible for the development of songs, videos, information stalls, brochures and fun runs as part of their AIDS education strategies. The Peer Education Programme has been very successful in distributing vital information. It has been accepted into the prisoner culture and has proved invaluable.

Legislation was recently passed providing for compulsory HIV testing within the prison system. This process commenced on 5 November 1990. Initially it will be directed to all new prisoners entering the system and to prisoners, several months prior to their release. Within a short period of time all prisoners will be tested. There has been some debate about

this particular issue, but the major concern revolves around the integration or segregation of HIV positive inmates.

In a recent address Professor John Dwyer said:

> The pivotal problem for most Departments of Corrective Services revolves around the question of segregation. If a policy is created whereby all individuals known to be infected with the HIV virus are to be isolated from the rest of the prison system, and confined with other prisoners similarly infected, then serious problems follow. Segregation is not justified on medical grounds.

Segregation of course imposes additional restrictions on prisoners. It has a tendency to create a leper colony in an environment which could be described as less than happy. It is not our intention to see inhumane activities operate within the system generally, and we have a particular sensitivity towards those unfortunate prisoners who contract this deadly virus.

A strong argument against segregation is the inevitable risk of creating a false sense of security from the virus amongst those in the mainstream of the prison system. One of the most forceful ways of discouraging high-risk behaviour is the fear of contracting the virus. I am firmly of the opinion that segregation would be at odds with this theme, and would be instrumental in creating a false sense of security amongst most prisoners.

What of the criticism that AIDS, like so may other issues relevant to corrections is being used for political purposes, or that the real health considerations take a poor second place to political considerations. Put more bluntly, the criticism is made that Governments seek to appeal to some base prejudice in order to justify predetermined political considerations. If that were true, segregation rather than integration would have been set in stone as the way to accommodate HIV positive prisoners.

The task of selling the reasons for integration has not been an easy one. There has been deafening silence from groups such as the Council of Civil Liberties on this issue. I suspect that, despite the merits of the issue, they opted to avoid the risk of being seen to support the individual.

The compulsory testing/integration strategy represents what the Government believes to be the best possible strategy to deal with a problem that has no comprehensive solution. In the absence of that solution, politicians, if they are being totally honest, will say that the decision has shades of what is least wrong, rather that what is most right!

A high degree of sensitivity is very much in the forefront of the introduction of HIV testing. It is also associated with the management of HIV positive prisoners. The Commonwealth AIDS Research Grants Committee report on AIDS in prisons recommended the introduction of compulsory screening with counselling. The necessary processes to conduct HIV screening are now in place in NSW. Any prisoner identified as being HIV positive will be provided with counselling by highly skilled professionals. The Commonwealth AIDS Grants Committee felt that `the prevention of HIV transmission within prisons could be most efficiently achieved by identifying those individuals who are positive for either HIV antigen or antibody and by concentrating resources on them'.

Prisons are often referred to as incubators for the AIDS virus and many in the community identify these institutions as places emanating danger. Certainly there is a tendency to have a congregation of HIV-infected inmates in gaol. However, rather than being an incubator, the prison is a funnel as many offenders tend to come from high-risk areas in the community. Intravenous drug users are obviously at risk and prisons contain a large number of prisoners from this category.

Clearly, it is important to establish the extent of the AIDS problem within the prison system. Not only do we have that obligation but we act in compliance with the Federal Government's National HIV/AIDS Strategy (1989) which recommends the compulsory testing of prisoners when they are discharged so that the spread of the AIDS virus from the prisons to the general community can be limited.

The window period is the time between infection with the AIDS virus and the appearance of antibodies in the blood. It will, therefore, be necessary for prisoners to submit to a blood test at any time during their period of imprisonment.

Let me say something more about the segregation of HIV positive prisoners. Integration is the policy which has been firmly adopted in NSW. It should be remembered that prisoners in the mainstream of the system are, and always have been segregated for reasons which include the good order and discipline of the gaol. Obviously if a prisoner exhibits disruptive behaviour or assaults another prisoner or prison officer, he or she will be subjected to segregation irrespective of whether or not he or she is HIV positive. Some have argued that optional segregation rather than integration best describes the course chosen in New South Wales. However, in a practical sense they mean the same.

In operating a compulsory testing program we are very conscious of the need for confidentiality. Results of tests will not be available to the ordinary prison officer, nor of course will the general prison population be informed.

Clearly, no system has yet devised a perfect management strategy for this deadly disease. We must decide on the best methods available to contain it while encouraging scientists to seek a cure and an effectual prevention for what has been such a devastating experience throughout the world. We remain ever vigilant in our search to provide the very best service that will ensure the containment of the virus, and I am absolutely certain that the structures we have put in place will greatly assist in preventing the spread of this deadly disease throughout our society.

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HIV/AIDS in the Victorian Prison System

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From my perspective as a correctional administrator, I would like to address Victoria's experiences in dealing with HIV positive prisoners, to reflect on current legislative requirements, to examine our current policies and finally to explore key strategies for the management of HIV in our prisons.

As early as 1985 the view was being expressed that prisons would become incubators for the AIDS virus. Concern was high that 'at risk' behaviours of prisoners, both prior to imprisonment and during their time in custody, would create an environment that would promote the rapid spread of the virus. While this has not been the case to date in Victoria it is helpful, I believe, to provide an historical perspective on the management of prisoners in Victoria.

Such a perspective is relevant as it will help explain how in Victoria we have moved from an initially suspicious, even hostile stance in 1985, to the current position of general acceptance, tolerance and positive support. This does not mean that all staff and all prisoners feel comfortable about working and living with HIV positive prisoners - but the feeling is vastly different from early 1985.

Prior to an identified HIV positive prisoner being received into custody in Victoria, a draft policy was prepared in early 1985, which was supported by both the Office of Corrections and the prison officers' union - the Victorian Public Service Association (VPSA).

In July 1985, the first identified HIV positive prisoner was received into a Victorian prison. As arranged, an officer escorted the prisoner to Pentridge Hospital. He had been assured that he would be safe from infection, but on arrival at the hospital he and the prisoner were met by a doctor who was fully gowned and masked. The doctor instructed the prison officer not to approach or touch anybody and ordered that the securing handcuffs and the officer's uniform be destroyed. The end result was that the prison officer undressed, left his uniform in a bag which was later sent to the tip, and went home in a distressed state, wrapped in a blanket. Not surprisingly, the incident caused quite a ripple throughout the prison system.

As a result of the rather memorable reception of the first HIV positive prisoner, the VPSA called for revised procedures to be established for working with prisoners who were HIV positive. Within a very short while revised policy and procedures had been developed as a joint effort by the Office of Corrections, the VPSA and the Health Department. The revised policy required HIV positive prisoners to be initially transferred to Pentridge Hospital for assessment, and then to be transferred to 'D' Division (a mainstream division).

In 'D' Division they were to be accommodated in a single cell and exercised in the 'D' Division hospital yard.

Although an agreed policy had been developed, prison officers continued to have concerns, and a number of stop work meetings were held during the remaining half of 1985 to discuss the AIDS problem. I might add management did little to allay these obvious concerns.

In 1986 the second prisoner found to be HIV positive, was received, duly counselled at Pentridge Hospital and subsequently was transferred to 'D' Division in accordance with the agreed AIDS policy. Prison officers were not accepting of the transfer. They sealed the prisoner's cell door and refused to interact with him in any way. Governors took over the role of prison officers but soon this process collapsed. The prisoner was returned to Pentridge Hospital.

In order to overcome the highly emotional reaction to the HIV problem, a number of initiatives were taken as a matter of high priority. First, there was the appointment of an AIDS educator. Apart from providing Office of Corrections management with a sound working knowledge of AIDS, the AIDS educator was appointed to establish education programs and information sessions on AIDS for prison staff and prisoners.

During 1986, this officer arranged a massive AIDS education program, running information sessions for staff and prisoners in all prisons. The first of a number of staff from each prison attended an intensive six-day course on AIDS at the Fairfield Infectious Diseases Hospital. These staff were to act as AIDS coordinators in each prison.

The AIDS policy and education programs developed by the Office of Corrections were not formulated in isolation. The Office of Corrections joined the AIDS Community Liaison Committee. This Committee consisted of individuals with expertise on AIDS and related issues, and met to consider relevant social, occupational and community matters. Represented on the Committee were both government and community groups, including the Education and Health Departments, the Haemophilia Society and the Royal District Nursing Service. It was considered important that the Office of Corrections should be aware of, and be part of, the range of services developed in the community for people infected with HIV. It was recognised that imprisonment in itself should not deny HIV positive prisoners access to services that were normally available in the community.

Another initiative was to reconvene the Communicable Diseases Committee. During the years 1984-1986 this committee had become moribund. Consisting of representatives from the Office of Corrections, Health Department and the VPSA it was given responsibility for developing a policy for prisoners with communicable diseases, which included of course, AIDS. This committee still meets and has played a major role in developing the strategies that have led to a cooperative approach to the management of HIV positive prisoners in Victoria.

The developments occurring with AIDS in Victorian prisons reinforced the need for both the Office of Corrections and the Health Department to establish a joint body to provide advice and direction in the development of a coordinated corrections health program.

The Corrections Health Board, consisting of senior members of both Departments, was subsequently established in late 1986. The Corrections Health Board continues to be responsible for coordinating the planning and management of general health, psychiatric, and alcohol and drug services for the corrections system.

In relation to the AIDS issue, the Corrections Health Board coordinated the development of an infection control policy and monitored AIDS research, as well as arranging meetings between the union executive and AIDS experts, including Professor Pennington, to discuss issues about AIDS in prisons openly and frankly.

Of all these initiatives, it has been the energy and resources devoted to education and training that have produced the most significant and lasting results. Much of the ignorance and previous high levels of fear associated with AIDS have now dissipated.

Legal Framework

Before discussing key strategies that the Office of Corrections now employs to deal with HIV in the prison system, I would like to take a few moments to consider briefly the legal framework and correctional philosophy which are relevant to HIV positive prisoners in Victoria. In Victoria, the *Corrections Act 1986* and Corrections Regulations place statutory obligations on the Office of Corrections to protect the health of prisoners. Section 47(f) of the Corrections Act details the right of prisoners to '. . . have access to reasonable medical care and treatment necessary for the preservation of health'. The Corrections Act also requires prisoners to submit to medical tests, both on reception and at any time thereafter (s.29).

The *Health Act 1958* and two recent amendments passed to deal with communicable diseases in Victoria (the *Health (General Amendment) Act 1988* and the *Health (General Amendment) (Amendment) Act) 1989*) also affect the management of HIV positive prisoners in Victoria, especially in relation to confidentiality. There is also the well-accepted common law responsibility of duty of care by prison staff. Duty of care requires that the Office of Corrections exercises reasonable care for the safety of prisoners in custody, and ensures that their health and well-being is protected.

The critical question for the Office of Corrections (and all correctional administrators) is therefore, what action is reasonable in the circumstances to prevent prisoners from contracting the AIDS virus.

Finally, the Office of Corrections also has a statutory obligation to staff under the *Occupational Health and Safety Act 1985*. Sections 21-25 specify the responsibilities of the employer to provide a safe work environment for staff.

Philosophy

Superimposed upon this legislative base, the Office of Corrections has adopted a correctional philosophy which has also strongly influenced the strategies implemented to manage HIV positive prisoners. The philosophy is reflected in eight guiding principles, incorporated in the Office's mission statement.

The important elements flowing from the guiding principles are:

- prisoners with HIV should not be further punished while in prison;
- such prisoners should have ready access to specialist services, treatments and programs normally available in the community;
- services, facilities, activities and programs should be based on the concept of individual management and designed to meet the individual needs of prisoners; and
- prisoners infected with HIV must not be discriminated against in the prison system.

Strategies Employed to Manage HIV in the Victorian Prison System

Against this background of historical developments, legislative framework and correctional philosophy it is appropriate to now briefly reflect upon the Office's current strategies for HIV positive prisoners.

Education

In line with the duty of care responsibilities of the Office of Corrections, the strategy devised to manage AIDS in prisons in Victoria has focused on an intensive education program. Education programs directed at both staff and prisoners commenced in all prisons in 1986. These programs have continued, and are directed at:

- prisoners - both at reception, on an ongoing basis, and as part of release preparation; and
- prison officers - a component on AIDS is included in the curriculum of all training programs for prison officers. As well, AIDS training is on-going at all prisons.

A number of officers and program staff in each prison have also participated in intensive AIDS training programs, to enable them to be primary information officers within the prison. The AIDS educator has also produced AIDS information sheets to keep prisoners and staff aware of current developments in the field. To add to the range of educational resource material, an AIDS informational video has been made for prisoners by the Corrections Health Service.

Testing

Victoria has a policy of voluntary testing on reception, and retesting on request. The exception to this policy is for occupational clearance. For infection control purposes, some occupations (for example, food handling positions) within the prison require prisoners to be retested. As part of the education program, prisoners are also encouraged to seek retesting after their release, if they believe that their behaviour has placed them 'at risk'.

It should be emphasised that Victoria's testing policy is totally voluntary. The success of the policy is reflected in a compliance rate, of 99.06 per cent. It is interesting to note that a recent study commissioned by the US Department of Justice's National Institute of Justice found that in the United States there is a strong trend away from mandatory mass screening in correctional facilities. There are now only a few systems with compulsory screening. About three-quarters of the prison systems and nearly all (90 per cent) of the gaol systems in the United States now have voluntary testing and retesting available to prisoners on request. The study concluded that the voluntary testing of prisoners serves the needs of both the prisoners and the system.

In Victoria, testing is performed on reception, during the routine medical examination. All prisoners are offered the test by a member of the medical staff and given the opportunity to make a choice. Reception staff report that a significant proportion of prisoners want to be tested, and actually ask for a test at reception.

Considerable effort has been put into ensuring that the concept of testing has been 'sold' to prisoners on the basis of something that is just for them, rather than as something just for the Office of Corrections. All prisoners who refuse a test are counselled by a member of the medical staff. It is worth noting that after counselling, few prisoners do not agree to be tested.

An important aspect of the testing program is the emphasis placed on counselling - particularly post-test counselling with prisoners who are found to be HIV positive. All prisoners who test HIV positive are informed of the result by the medical superintendent in an intensive counselling session. The medical superintendent acknowledges that these sessions are very difficult, but they have been found to be essential for the future treatment and management of the prisoner.

Accommodation

A special unit for prisoners who are HIV positive has been established in 'K' Division in the Metropolitan Reception Prison. The unit is shared with non-infected prisoners who volunteer for the unit.

After being informed and counselled of a positive result, prisoners are admitted to Pentridge Hospital for a period of further support, testing and general health maintenance. Following this they are transferred to the unit in 'K' Division.

The AIDS education program implemented over the last five years has been effective in facilitating the move from total segregation of prisoners who are HIV positive, to the current situation which has features of both integration and segregation. HIV positive prisoners are segregated, in that they live and work in a special unit, but they are integrated with non-infected prisoners who voluntarily share the unit. The unit was opened in February 1988, and has always been staffed by officers who have volunteered to work (and eat meals) with HIV positive prisoners. The emphasis is very much on managing a therapeutic community. There are consistent programs staff and prison officers, who are all involved in the delivery of an intensive program which has a 'healthy lifestyle' focus. Both staff and prisoners (that is HIV positive and non-infected prisoners) in the unit believe that the mixed unit works well.

Non-infected prisoners in the unit, who I stress are there on an entirely voluntary basis, tend to be young prisoners who wish to consider drug issues. They display no feelings of anxiety, nor do they present any management difficulties over their shared accommodation. The medical staff report that they are rarely asked to check any AIDS issues with them. From the Office of Corrections view, the unit in 'K' Division has been very successful.

Our existing policy provides HIV positive prisoners with accommodation that is not part of the mainstream prison system. It is anticipated that in the future, consideration will be given to having other placement options in each security level in mainstream accommodation.

The option that has appeal for me would be a corridor arrangement, whereby one or two selected prisons with graduated security levels would be used to accommodate prisoners who are HIV positive. The reasons I favour such an option are firstly, on equity grounds, that it provides security classification alternatives presently available to all mainstream prisoners. Secondly, it enables the more focused training of staff and the provision of scarce professional resources to provide the necessary support and counselling to HIV positive prisoners.

Infection control

To combat AIDS and other communicable diseases within Victorian prisons, a comprehensive set of infection control procedures has been drafted by the Communicable Diseases Committee. The procedures provide staff with a detailed set of guidelines to be followed should any contamination occur. The fundamental premise of these procedures is that staff treat all blood spills as potentially dangerous. Under the infection control procedures, bleach is now freely available to all prisoners in all prisons.

Condoms

Condoms are currently not distributed within Victorian prisons. The availability of condoms within prisons is a controversial issue that has attracted considerable debate both politically and industrially. Although not distributed in prisons in Victoria, condoms are included in a release package that has been developed by the Victorian Association for the Care and Resettlement of Offenders. This release package is given to all prisoners on their release from prison, as part of standard discharge procedures. There is no doubt that the issuing of condoms is a matter that will be the subject of ongoing discussion at both a political and industrial level.

Confidentiality

It is difficult to maintain the community standard with respect to confidentiality and HIV infection within prisons. However, it is essential that the principle not be ignored. In Victoria, all HIV tests and the results are coded and the coded results are sent direct to the medical superintendent by Fairfield Hospital. The policy of moving prisoners to the Pentridge Hospital in the first instance, and then later to 'K' Division, means that total confidentiality cannot be achieved. However, all steps are taken to ensure that information relating to HIV positive status is restricted, and, as much as possible, HIV positive prisoners are accorded the rights of confidentiality stipulated under legislation.

Professional support

Prisoners with HIV in 'K' Division receive close medical attention, from both the prison medical staff and specialists from Fairfield Hospital - the major treatment centre for AIDS in Victoria.

The prison medical superintendent visits all prisoners in the unit each week, and the prisoners are seen regularly by a consultant from Fairfield Hospital. The drug AZT is made available to assessed prisoners through Fairfield Hospital. Prisoners are assessed for AZT on the same basis as infected people within the community. In Victoria, we feel this supporting environment is essential to provide the most effective management of a group of prisoners coming to grips with a potentially fatal disease.

Conclusion

Since 1985, a total of fifty-nine prisoners have been found to be HIV positive. Nine were re-offenders. That is a total of fifty-nine from a grand total of in excess of 17 000 prisoners received into custody for the same five-year period. Not exactly the deluge predicted in 1985 when prisons were seen as the 'hot beds' for AIDS in society.

Over the past five years, a considerable amount of resources and energy have been spent by both the Office of Corrections and the Health Department, to ensure that a rational approach has been taken to the management and treatment of prisoners who are HIV positive in the Victorian prison system. I believe the policy and education programs developed to manage AIDS in Victorian prisons have been successful.

We have an HIV unit that functions well, which is staffed by officers who have a thorough understanding of HIV virus and who volunteer to work with prisoners who are infected with HIV. And most importantly, HIV-infected prisoners are well supported and hence are not angry with the 'system'. Consequently they do not pose a threat to staff or non-infected prisoners. We also have staff - uniformed, programs and medical - who are committed to providing HIV positive prisoners with the same support and medical treatment that is available to infected people in the community.

It is recognised there are differences between correctional jurisdictions in the way they manage HIV prisoners. There are various historical, political and industrial imperatives that have caused this situation to occur. It should be remembered that over five years significant changes have occurred, and I am optimistic about the future.

In particular, I believe the strategies adopted by Victoria, reflect an intelligent approach to dealing effectively with what is a most complex and potentially life-threatening problem. While I would not contend there is no room for complacency nor suggest we know all the answers, I do believe we have made a positive start to tackling the problem of AIDS in our prison system.

Managing HIV Seropositive Prisoners in South Australia: Some Successes and Failures

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The South Australian prison system is relatively small with a total of 966 prisoners accommodated in eight institutions ranging from a maximum security institution at Yatala Labour Prison (264 prisoners) to an open prison farm at Cadell (125 prisoners).

Initial fears in South Australia about HIV/AIDS were expressed as early as 1983 when a union shop steward wrote to the Manager of Yatala Labour Prison on the subject of 'suggested preventive measures to overcome officer exposure to AIDS disease'.

In 1984 information sessions and a video were made available to staff, but it was not until June 1985 that an identified HIV seropositive person was known to be in prison. Prior to this a voluntary blood testing program had been established by the Prison Medical Service with considerable success.

On 19 June 1985, after a series of industrial stoppages occurred, Dr Scott Cameron, Senior Specialist, Communicable Disease Control Unit, South Australian Health Commission, was asked to chair a committee of Health Commission, Correctional Services and union representatives to:

- examine the present practices for handling hepatitis B and AIDS in correctional services institutions; and
- recommend changes to existing practices where necessary.

The recommendations of the Cameron Committee did not include compulsory blood testing but did support voluntary testing. Other recommendations included education of prisoners, offering hepatitis B vaccinations and blood screening, formulation of an occupational health and safety program, special structured drug treatment and rehabilitation programs, provision of single cell accommodation, improved management of sexual predators and control of tattooing practices.

Subsequently, protective clothing was provided to prison officers including gloves for searching and a departmental instruction, 'Procedures and Practices for the Management of Prisoners with Communicable Diseases' (6.6.86), was prepared within a twelve-month period.

However, concern persisted, particularly in institutions such as the old Adelaide Gaol (now closed), where provision for medical facilities and ablutions was grossly inadequate. Again, it was obvious by mid-1987, that industrial trouble was looming.

On 21 May 1987, the then Minister of Health, Dr Cornwall, released a document entitled South Australia's AIDS Strategy which contained a range of policies endorsed by Cabinet. The implementation of this Strategy was the responsibility of the Minister of Health. The document specifically addressed prisoners and HIV/AIDS and was based substantially on the advice of the Crown Solicitor that compulsory testing would be necessary if the Executive Director of the Department of Correctional Services was to execute his responsibilities appropriately for the management and well-being of prisoners.

Prior to the introduction of compulsory testing, pressure had been building for the segregation of prisoners with communicable diseases but, for reasons which will be discussed later, the policy of integration was maintained in South Australia.

The introduction of compulsory testing in August 1987, and the reinforcement of the policy of integration helped ensure that HIV positive prisoners in South Australia stayed in the mainstream prison population. In South Australia as in other States, there was initially strong pressure to segregate on the one hand, and a strong lobby that opposed both segregation and compulsory testing on the other. Those advocating segregation displayed a very normal and basic reaction that often occurs in correctional systems in response to incidents. The traditional reaction to riots or incidents in prisons has been to segregate the prisoners concerned. Similarly, because HIV infection could be linked to homosexual or drug taking behaviours, which were and still are illegal in prisons, the response was predictably to demand segregation. When this perception was linked with the fear created by HIV/AIDS; with what has been characterised as the need to think of people with HIV/AIDS as other than a 'normal' community; and with the strong belief of many that 'medical problems' needed separate treatment, the impetus toward segregation was considerably strengthened. Lloyd (1990, p. 167) suggests that one of the crucial and challenging aspects of AIDS is:

> the way it makes visible some of the deeper aspects of our 'normal' thought patterns - our inability to cope with the fear of illness and death, without externalising these things as somehow other to ourselves.

In South Australia because compulsory testing was linked to integration, it became a tool that allowed staff to cope with the situation. Whilst it was recognised that most prisoners were serving short terms in prison and would not be tested, paradoxically perhaps, compulsory testing allowed staff to overcome their concerns.

Emphasising the similarities of HIV transmission patterns with those of other communicable diseases such hepatitis B was also helpful. This placed the AIDS virus in perspective and allowed the development of policy and procedures relating to communicable diseases in general, rather than for HIV/AIDS alone. The introduction of a hepatitis B immunisation program for prisoners and staff was seen as a positive step, therefore, in preventing communicable disease.

Current Policies in South Australia

The aims of current policies in relation to HIV/AIDS in prisons in South Australia are:

- to limit the transmission of HIV within the prison setting; and
- to manage HIV seropositive prisoners within an integrated prison setting.

The following strategies have been adopted in order to achieve these aims:

Non-custodial sentencing options

In addition to pursuing sufficient accommodation for prisoners to enable single cell accommodation to be provided for the majority of prisoners, it was agreed in the South Australian AIDS strategy that: 'The State Government will encourage the greater use of non-custodial penalties for those offences otherwise likely to attract only a short custodial sentence (South Australia's AIDS Strategy, 1987)'.

Although attempts have been made to reduce short-term sentences, particularly through the use of community service orders, South Australia still has a very high level of short-term prisoners. For example in 1988-89, of the 3892 persons who were released from prison, 2 387 (61.3 per cent) served seven days or less in prison. The consequences are that the Department's ability to provide single cell accommodation and special therapeutic units is reduced and the number of HIV seropositive prisoners undetected in the prison is potentially larger.

Compulsory blood testing for all persons in custody for more than seven days

Changes to the regulations made under the Correctional Services Act in 1987 enabled the Permanent Head of the Department:

> for the purposes of the assessment of prisoners under section 23 of the Act or of preventing or containing the spread of disease within correctional institutions, [to] direct that all prisoners, prisoners of a particular class or any particular prisoner undergo from time to time such medical examinations or tests as the Permanent Head specifies in the direction. [Regulations to the Correctional Services Act, r. 65(1)]

> There have been no difficulties in gaining prisoner compliance with compulsory blood testing.[1]

Modified quarantine for seropositive prisoners

This section of the Government's AIDS Strategy was intended to cover medically prescribed conditions and included, for example, the provision of a sewered single cell for accommodation. However, the Department, in its response to the unions stressed that consistent with prescribed medical regimes, prisoners who either demonstrated an assault record in relation to staff or prisoners, or had a history of sexual assault on prisoners could in consultation with the Prisoner Assessment Committee, be placed under a special management plan to protect staff and inmates. In practice this has meant that HIV

[1] Since August 1987 all prisoners serving a sentence of greater then seven days have been tested for HIV and of those imprisoned prior to August 1987, only one prisoner remains untested. Where prisoners have been reluctant to be tested - and this is only an occasional case - the prisoner has been willing to comply after being told that the Regulations state that a prisoner must not hinder or obstruct a medical practitioner in carrying out any such medical examination or test. Because approximately 61 per cent of prisoners in South Australia serve sentences of under seven days, it is impractical to initiate blood testing for these prisoners.

seropositive prisoners have been dealt with according to prison rules, as are other prisoners, and in some cases segregated for a period of time or transferred to another institution.

Retesting of longer term prisoners after three months

All longer term prisoners are retested after three months. Retesting is designed to overcome problems with the seroconversion or window period, although it is recognised that there still may be problems in some instances. It is also proposed, in the near future, to introduce exit testing. Such testing will give an accurate indication, at least for longer term prisoners, of the risks of seroconversion in the South Australian prison system.

Notification procedures - Department of Correctional Services

Currently the Executive Director of the Department of Correctional Services is informed of all cases of HIV seropositive inmates. His delegate, the Assistant Director (Programs), notifies the Manager of the institution, who ensures that staff are informed that the prisoner has a communicable disease. Staff are not told the specific communicable disease. This information would only be released on a 'need to know' basis. A medical regime is supplied by the Medical Officer within an hour of diagnosis, and correctional officers are expected to make themselves familiar with the requirements of that regime.

Notification of third parties

In implementing the South Australian AIDS Strategy, the issue of providing information to the wife of a home detainee, a sexual partner of a prisoner on leave, and in the private visit situation, was raised. This is a potentially difficult area because of concerns for both confidentiality and for the family of prisoners. Following legal advice, it was made clear that there is an obligation to advise third parties in a situation where there is a risk of the disease being communicated by a prisoner during leave. An option that was provided was to decline permission for a prisoner to enter home detention, receive a private visit, or participate in a day leave program if the prisoner objected to a third party being advised or if the third party declined to participate in the particular program when advised.

Education

The provision of education, first for staff and then for prisoners commenced in 1987 when an AIDS educator from the South Australian Health Commission was seconded to the Department of Correctional Services for a six-month period. In 1988, this role was undertaken by a Chief Correctional Officer and then again in 1990 by a staff member reassigned from the Health Commission.

Drug rehabilitation and counselling service

The Cameron Committee recommended the development of structured drug treatment and rehabilitation programs. It suggested that funding could be sought from the Federal Campaign and Strategy against Substance and Drug Abuse. Partly in response to this recommendation, the Department of Correctional Services and the Drug and Alcohol Services Council initiated the Prison Drug Unit which provides a counselling service for prisoners on a state-wide basis. A limited methadone program is also available for prisoners serving very short terms of imprisonment (who were on methadone prior to imprisonment), HIV seropositive prisoners and pregnant prisoners who are drug dependent.

Successes and Failures

In terms of current South Australian policies the major success has been maintaining HIV seropositive prisoners within the general prison population. Part of this success has also been the management of HIV seropositive prisoners with difficult behaviour. A major contributing factor has been the careful assessment and placement process carried out by the Prisoner Assessment Committee which has been facilitated by the relatively small numbers of HIV seropositive prisoners in prison, by the growing experience of correctional management and staff in the management of prisoners with communicable diseases, and by the commitment of the Government to provide modern single cell accommodation for prisoners. Single cell accommodation significantly reduces the risks associated with prisoners sharing cells.

On the other hand it is uncertain whether HIV transmission in the prison environment has been prevented. Anecdotal evidence suggests that needle sharing may constitute a major risk. Until measures such as urinalysis and exit testing are introduced which will provide more accurate data, it is not possible to gauge whether educational campaigns have significantly reduced high-risk behaviour.

On reflecting on our experience in South Australia, there are four major areas I would like to highlight. They are:

- the need to recognise the fear created by HIV/AIDS and to develop ways of overcoming it;
- communicating with staff;
- specific prisoner management problems; and
- concerns about the effectiveness of HIV/AIDS education in prevention.

Fear of HIV/AIDS

There have been several lessons we have learnt in trying to address the fear created by HIV/AIDS. Some of them have their origins in basic counselling strategies, others recognise the importance of involving staff and prisoners, others illustrate the need for staff to link the problems of HIV/AIDS to similar diseases, and others recognise the importance of all members of the prison community receiving the same factual information. Specifically, these lessons have been that:

- it is necessary to start with the individual and recognise the validity of his/her concerns. It is necessary to explore the reasoning behind the fears.
- prisoners should, whenever possible, be involved in the development of educational programs so that programs are credible and reflect the reality of the prison culture.
- recognition should be given to the contribution to prisoner education that some persons with HIV/AIDS can make.

- educational strategies must recognise that the prison is a system where staff and prisoners interact. It is important that both staff and prisoners receive the same factual information so that credibility gaps do not develop.
- the prison community can potentially assist the wider community in HIV prevention. If staff and prisoners are well educated about HIV/AIDS then they have a chance to prevent transmission amongst high-risk groups and can develop a sense of purpose and pride in this role. This role can be continued through community contacts.
- compassion for people with HIV/AIDS must be developed and encouraged and staff and prisoners assisted to recognise that they are potentially at risk.

Many of these lessons are also reflected in the experience of the gay community. Dowsett (1990) for example, in discussing successful education campaigns, points out that the culture of the gay community has been used to reinforce HIV prevention strategies by introducing information into normal community life, invoking a sense of gay pride to link gay men to the practice of safe sex. Similarly, in prisons, it is necessary to use the prison culture and develop a sense of pride in the work that both prisoners and officers can do to prevent HIV.

Communicating with staff

In communicating with prison staff in South Australia, it has been found that linking of hepatitis B and HIV/AIDS has enabled them to cope with, and better understand, the problems associated with communicable diseases and to place the problems engendered by HIV/AIDS into perspective. It has also been important that educational strategies have focused on staff education first and attempted to ensure that both staff and prisoners are given the same information. The latter ensures that staff credibility is enhanced. Similarly, efforts to ensure that staff are immunised against hepatitis B have reassured staff that the Department has genuine concerns about their occupational health and safety. The result has been lower levels of industrial conflict where HIV/AIDS is a major issue.

Specific prisoner management problems

In pursuing a policy of integration in South Australia, several aspects of prisoner behaviour or management have been of concern. It is perhaps unfortunate that the segregation-integration debate has overshadowed the need to look closely at how to manage HIV seropositive prisoners in specific situations such as:

- **Promiscuous or attractive homosexual HIV seropositive prisoners** The admission to prison of young homosexual males who wish to continue their lifestyle and who are seen as at high risk of transmitting the disease within prison, has been of major concern. Currently, it is possible to place such prisoners in smaller institutions or in an environment where their behaviour can be carefully monitored. Fortunately this situation has not occurred frequently, but if the numbers of prisoners who are HIV seropositive increases, then the capacity for such careful placement will diminish.
- **Prisoners who spit, bite etc.** The admission to prison of a prisoner who spits and threatens to bite is obviously of concern to correctional staff. Where such behaviour has occurred the prisoner has been segregated, but not on a long-term basis. It needs to be accepted that just as other prisoners' behaviour will be unacceptable at times, so will the behaviour of HIV seropositive prisoners. However, it needs also to be stressed that such prisoners will be returned to the general prison population and can, like other prisoners, modify their behaviour.
- **Use of syringes as a weapon against officers and prisoners** In South Australia, there have been allegations that prisoners have injected other

prisoners with HIV-infected blood. Obviously, we are aware of events in NSW where, it is alleged that an officer was injected with HIV-infected blood. The fear value of an attack with a syringe, coupled with current penalties for such an offence, are of concern as this may increase the chances of an attack.

- **Harassment of HIV seropositive prisoners** Harassment of HIV seropositive prisoners by other prisoners was initially of considerable concern with groups of prisoners deciding that they wanted HIV seropositive prisoners removed from the prison and making threats against them.

The lessening of these tensions has been evident since 1987, given the firm commitment of the Department of Correctional Services to a policy of integration, the support of managers and senior correctional staff in debating the issues with prisoners, the impact of educational programs, and the growing experience of both staff and prisoners of day-to-day contact with HIV seropositive prisoners.

- **HIV seropositive prisoners and drug use** Although HIV seropositive prisoners who are intravenous drug users can have access to methadone, there are still real fears that such prisoners will continue to use drugs and, potentially, share needles. The need to develop a more comprehensive drug strategy in South Australia is crucial as our options are limited in dealing with such prisoners. Consideration needs to be given to such measures as urinalysis, the use of therapeutic communities and improving the ability to detect drugs being brought into prisons. Penalties imposed on prisoners found to be involved in drug incidents need to be sufficiently severe to act as a deterrent.
- **Release of HIV seropositive prisoners** The release into the community of prisoners who have stated they will not practice safe sex is of concern. Although, legally, the Department of Correctional Services is not obliged to intervene, it raises issues about the capacity of community health services to prevent high-risk behaviour occurring.
- **Specific needs of HIV seropositive prisoners** Most HIV seropositive prisoners have conformed with prison regimes in South Australia but, nonetheless, have expressed concerns about access to special and vegetarian diets, the cost of vitamin tablets on a prisoner's wages, problems in coping with mood swings, and general depression as a result of the disease. Although there is an adequate prison diet, it is understandable that prisoners who want to maintain peak fitness and health are concerned about these issues.

The effectiveness of HIV/AIDS education in the prevention of HIV

Another major issue for South Australia has been whether educational programs will be effective in preventing risk behaviour among prisoners. Gaughwin et al. (1990, p. 63), for instance, whilst finding that prisoners in South Australia had some basic knowledge of HIV infection, also found that:

> they and prison officers, think that information about AIDS has not resulted in substantial reduction in some risk behaviours, particularly intravenous drug use. They also think that prisoners need to know more about AIDS to protect themselves adequately. These findings suggest that current information and counselling about AIDS are not meeting prisoners' needs and therefore should be reviewed.

These findings have affected the kind of educational programs offered in South Australian prisons. There has been a move away from using videos and lectures. Attempts

have been made instead to involve prisoners in discussion groups and workshops and to develop education that is relevant to the prison setting. Other methods range from the use of live theatre to the involvement of Aboriginal prisoners in designing posters with HIV prevention messages. However, there are still doubts whether education has reduced risk behaviour, particularly in relation to intravenous drug use.

Conclusion

In examining the management of HIV seropositive prisoners in South Australia, it can be concluded that there has been mixed success in achieving the aims of prevention of the transmission of the virus, and maintaining an integrated prison setting.

It has been possible to successfully integrate HIV seropositive prisoners, and to manage difficult prisoner behaviour. Importantly, there has been careful individual case management of prisoners by the Prisoner Assessment Committee and by institutional staff. This is aided by the fact that the numbers of prisoners who are HIV seropositive remains relatively small.

We have, however only recently started to grapple with the need to move away from looking at HIV/AIDS in isolation and to recognise the need to develop more comprehensive sex and drug strategies to address the main risk behaviours. We also recognise that the segregation-integration debate, together with its attendant industrial problems has diverted us from addressing these issues as quickly as we would have liked. A review of the South Australian AIDS Strategy is currently underway, involving representatives of the Department of Correctional Services, the Drug and Alcohol Services Council and the Prison Medical Service. It is hoped that this will provide an opportunity to reconsider current policies and, particularly, to re-examine our response to institutional sexual acts and the use of intravenous drugs.

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The Integrated Management of Human Immunodeficiency Virus (HIV) Infection in South Australian Prisons: The Medical Perspective

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The South Australian jurisdiction is a relatively small one with about 900 prisoners distributed over eight institutions (excluding James Nash House).

Three of these institutions, Adelaide Remand Centre, Yatala Labour Prison, and Northfield Prison Complex are in metropolitan Adelaide. The remainder are spread across the State, at Cadell, Port Lincoln, Mount Gambier, Murray Bridge and Port Augusta.

The Prison Medical Service (PMS) is a department of Modbury Hospital, assigned by the South Australian Health Commission to oversee the provision of health services to the State's prisons.

Development of a Policy of Integration of HIV-infected Inmates

The policy to maintain HIV-infected inmates in the prison mainstream, but with appropriate precautions, was a relatively simple one developed in the light of evolving knowledge about the virus between 1984 and early 1985. Since HIV infection was not known to be contagious, the policy assumed that spread of disease could be controlled by taking certain precautions and minimising the known risk behaviours.

Since then, this policy of integrating seropositive prisoners has remained largely unchanged except for the addition of compulsory screening in 1987.

When the first articles appeared in the *New England Journal of Medicine* in 1981 describing cases dubbed initially as GRIDS, scant attention was paid to them. But by 1983, when Sydney had already accumulated the first cohort of cases diagnosed in the country and it was clear that an HTLV virus was associated with AIDS (Bare-Sinoussi et al. 1983), we suspected it would be only a matter of time before the infection came our way.

Late in 1983, following consultation and in collaboration with the Institute of Medical & Veterinary Science, a survey was conducted at Yatala Prison and the then Women's Rehabilitation Centre to assess the number of people in the prison environment previously exposed to hepatitis B virus (HBV) infection. At the time, direct HIV screening was yet to be developed, and HBV infection was then the common model used to assess at-risk populations. It was felt that the attack rate of HBV would give an indication of the

susceptible population potentially at risk to HIV infection. This was based on the assumption that, except for identifiable racial groups, those exposed would roughly belong to the groups where the risk behaviours for HIV transmission would also apply.

The results, surprisingly, showed that the prevalence of seropositivity for HBV antibody was only three out of the 110 (2.7 per cent) who volunteered. This was not significantly different from the attack rate for the community as a whole.

However, we were aware that it was possible the survey was not a representative one, and suspected that a potential problem existed. We knew that risk behaviours instrumental in the transmission of HIV existed in the State's prisons. There was empirical evidence of intravenous (IV) drug use in prison, and personal admissions to consensual homosexual practices. There were also periodic requests for medical examinations of inmates suspected to have been sexually assaulted.

Volunteer testing

In October 1984, a commercial enzyme immunoassay kit to screen for HTLV-III (HIV) antibodies was introduced in the State, paving the way for mass screening and direct diagnosis of HIV infection. Preparations were therefore made for the introduction of a voluntary screening program for South Australian prisoners which commenced in April 1985. By July, 116 prisoners had volunteered for testing with three confirmed seropositives. They had each been in prison for periods of four, twelve, and ten months prior to diagnosis. There was a period of two months when all three were in one prison in 1984-85. All three were IV drug users. One of them had a wife, also an IV drug user, who was diagnosed HIV seropositive early in 1985.

A subsequent mass voluntary screening of 350 inmates and officers in July 1985 conducted by the South Australian Health Commission in response to industrial unrest and concerns of prison officers, revealed no additional cases. This reinforced our earlier impression that those who were engaged in at-risk behaviours had already volunteered for testing. We believed that we had a good rapport with those who may have been at risk and that compliance from this group had been good. Our experience was similar to that reported amongst intravenous drug-users with the lymphadenopathy syndrome overseas (Spira et al. 1984).

HIV infection in prison and industrial unrest

The initial identification of an HIV-infected prisoner in Yatala Prison prompted officer demands for segregation of all prisoners with communicable diseases and the compulsory screening of all inmates for all communicable diseases. It also led to a series of industrial actions. All these caused us to critically review the rationale behind the policy of integration. Whilst it put a great deal of pressure on correctional and health policymakers, the exercise helped us to crystalise our thoughts on the issue. With no precedents for us to go by from interstate colleagues, and no knowledge of overseas practices, we had to fully convince ourselves before we could convince others.

To allay officers concerns, a team of clinicians which was headed by Dr Scott Cameron, Chairman of the State AIDS Committee was appointed to look into the whole question of communicable diseases in prison. The PMS was represented on the Committee. This Committee essentially upheld the policy that had been advocated. A by-product of this episode was the conducting of a voluntary HBV and HIV screening program involving a number of the State's larger prisons.

Compulsory testing

Compulsory screening was initially felt to be unnecessary and unhelpful as voluntary testing appeared adequate. Furthermore, early on in the epidemic, a diagnosis did not confer on the individual any advantage in terms of curative treatment. In any case, many HIV-infected individuals were already identifying themselves during the court process, in the hope of getting non-custodial or less severe custodial sentences. Their status was thus known prior to entry into prison.

However, by 1987 there was increasing concern that, with IV drug use and homosexual activity existing in prisons, prisons could be 'incubators for AIDS'. Calls made for compulsory testing of all prisoners led to the introduction of just such a policy in South Australia in August 1987. The impetus for mandatory screening was perhaps prompted more by legal than public health concerns. Fortuitously, it came at a time when AZT was being introduced into Australia after its recognition as a drug of promise in prolonging life and duration of well-being in people with AIDS (Fischel et al. 1987).

Medical benefits of early diagnosis

The situation now, three years hence, is clearly different. Early diagnosis is now clinically beneficial to the infected person. In addition to the availability of AZT to people with AIDS, there is the prospect of delaying the onset of AIDS in asymptomatic HIV-infected individuals with AZT treatment (Volberding et al. 1990; Fischel et al. 1990). Furthermore, there have been advances in the prevention of opportunistic infections for those with significantly depressed immunity, for example, the use of aerosol pentamidine to prevent pneumocystis pneumonia (Armstrong & Bernard 1988). Thus, unlike the early years of the epidemic, there are now clear medical reasons for recommending early diagnosis as medical intervention at a number of levels is possible.

Compulsory testing and segregation

It is interesting that Osborn (1988) suggested that the idea of quarantining people infected with HIV must lurk in the minds of those who advocate mandatory screening programs. The reverse seems to be true in the case of South Australia. The introduction of compulsory testing seemed to satisfy the concerns of the officers to the extent that it helped relieve pressure on the State to segregate all HIV-infected individuals. It removed the threat of quarantine.

Testing and complacency

Nevertheless, there remains the worry that compulsory testing has, and will, continue to lull some into complacency. It must be constantly emphasised to all who work and live in the prison environment that blood and body fluid precautions should be exercised on all occasions, and at all times, regardless of whether a person is known to be a communicable disease carrier.

Some Issues in the Medical Management of HIV Prisoners

Supportive medical initiatives complementing the HIV policy

In recommending the integration of HIV-infected inmates into the general prison routine, the PMS was aware that the prevention of HIV spread was very much dependent on modifying risk-taking behaviours. Those individuals allowed to enjoy the full range of prison programs were expected to comply with the rules of the system. At the same time, such a policy also required staff to exhibit a high level of professionalism in carrying out their duties. They had to exercise effective personal precautions whilst maintaining effective supervision and surveillance of their charges.

At the same time, continued acceptance of the policy by staff and inmates was implicitly dependent upon reasonable efforts being made to promote and police public health in the prison environment. In this context, a number of health programs were introduced progressively as the picture of communicable disease in prison unfolded. These initiatives probably helped both inmates and staff to accept the policy, and included the following.

HBVAX program

The initial negative officer attitude toward communicable disease in prison lumped HIV and HBV infections together. Given that HBV was preventable by vaccination, a vaccination program for officers was promptly begun. This helped to soften officers' attitudes towards the policy of integration. A year later, beginning in December 1986, a similar program was commenced for prisoners with sentences of greater than six months duration. The arbitrary cut-off took into account the cost of the vaccine and also the need to ensure reasonable completion of the vaccination program. It had been our experience that inmates tended to ignore health follow-up appointments upon discharge.

When compulsory testing for HIV was introduced, voluntary screening for HBV was offered as well. There was almost 100 per cent coverage. This led to the discovery that there was a progressive rise in the HBV carriage rate in prison, from an average monthly prevalence of 9.4 seropositive inmates in 1988 to 21 in 1989. This, of course, meant an increasing reservoir for potential transmission. So, in 1989 the program was extended to every inmate admitted into prison. This was necessary given the large proportion of prisoners who were known to be IV drug users and therefore at risk of HBV infection. It also took account of the finding that, in America at least, vaccine programs had been most difficult to carry out amongst parenteral drug users (Hadler 1988). That being the case, to immunise offenders whilst they were in prison seemed most appropriate. Importantly, the program was possible only because by then the cost of recombinant vaccines was only a third of the cost of the previously available vaccine. Immunisation, therefore, became financially affordable.

Annual voluntary CXR screening

A routine annual chest X-ray screening for pulmonary tuberculosis commenced in 1988, again on a voluntary basis. Chest X-ray screening for all HIV seropositive inmates became a routine part of the protocol in 1989.

Standard management protocol for HIV-infected prisoners

A standard protocol was developed so that each inmate was medically reviewed on a three-monthly basis and in a standard format so that there was a consistency in the review process regardless of the prison to which the inmate was transferred. It also helped to set a minimal

standard of care, a necessity if there was to be a policy of integration where an inmate, regardless of HIV status, could progress through a prison plan set for him or her.

In practice, HIV-infected inmates were seen more frequently than required by the protocol. In a review of thirteen HIV-infected inmates in the prison system during the month of September 1990, it was found that they had an average of four medical and eight nursing consultations per month. These did not include consultations with medical specialists in public hospitals, or group sessions held at some of the institutions.

HIV and drugs in prison

As alluded to earlier, a policy to allow the free movement of HIV-infected inmates in prison requires that there be a number of safeguards in place. One of the imperatives is that there must be an energetic and aggressive effort to deal with the issue of IV drug use in prison. This is the main risk behaviour in the spread of HIV in prison and its incidence must be reduced if the transmission of infection is to be minimised.

Over the past twenty-four months there have been, on average, between ten and twelve HIV-infected inmates in the State's prisons daily. In the 1988 calendar year, the average monthly prevalence was 7.3 or 0.9 per cent (7.3 in 840) whilst in the 1989 calendar year, the figure was 11.7 or 1.3 per cent (11.7 in 900). We are currently running around the latter figure. The figure is low and it is important that every effort be made to maintain it that way.

To do so, prison and health administrations must face up to the real need for a significant expansion in drug treatment services if the number of IV drug users in prison is to be reduced. In an exit survey of 193 sentenced prisoners in 1988, 26 per cent gave a history of IV drug use prior to imprisonment (personal data). The criminal careers of IV drug-using prisoners tend to be recidivistic. Our data indicates that of the 32 HIV-infected inmates that have come through the South Australian prison system, 23 or 71 per cent had been in prison at least twice. Fourteen of the 32 or 43 per cent had been in prison on at least three occasions. The vast majority (81 per cent) of the HIV-infected prisoners who have come through the State's prisons were categorised as IV drug users and acquired their infection through that activity.

In having HIV-infected inmates integrated with the general prison population, the danger of spread of HIV infection among IV drug users within prison is the potential cost of the policy. Therefore, every effort must be made to modify drug-using behaviour so that transmission risk is minimised. Every effort must be made to deal with the drug problem including the 'demand' side of the equation.

There is also the 'supply' side. Unfortunately, since the appearance of HIV in prisons, it has been our empirical observation that the incidence of IV drug use in prisons has increased, not decreased. The main conduit of supply seems to be through contact visits. Greater stringency needs to be exercised in the processing of visitors into the prison as well as during visits. More can and should be done in prisons to limit this supply. It is a correctional issue with significant health implications. Improved correctional surveillance techniques, together with random urinalysis and testing on suspicion, linked to sufficiently severe sanctions as deterrents, must be considered.

Unlike the situation in a democratic community where combating the drug problem has many constraints, and the capacity to manipulate the environment is largely limited to public education and persuasion, the prison milieu is quite different, at least in theory. Prison administrations have the power and opportunity to exercise significant control over the prison environment, from restricting access to drugs, to structured and disciplined lifestyles, to productive prison programs to interventional support in times of crises. Or so it should be. Prison administrations should recognise that they have a unique opportunity unavailable to community services in addressing this problem. An integrated policy means that this opportunity must be exploited.

Homosexual activity in prison

This is the second significant risk behaviour in the spread of HIV infection in prison. In the context of HIV and prisons, whilst calls have been made for the need to facilitate 'safe sex' in prisons by the provision of appropriate educational material and the much publicised issue of condoms, surprisingly little encouragement has been given by health advocates to correctional efforts to minimise homosexual activity in prison. The vast majority seem unprepared to say that anal sex is contrary to good health.

From a public health perspective, it would seem logical to actively attempt to minimise anal intercourse, just as attempts should be made to minimise IV drug use, whether in the community or in prison. In the correctional context, it is sensible and desirable that policies be developed to minimise homosexual activities between inmates by reducing the opportunities for such contact and, importantly, to rethink policies on how sexual desires may be legitimately expressed. Control of homosexual activity in prison is about good correctional administration. Then only, at the next level should it be acknowledged that some prisoners will continue to engage in homosexual acts. For these prisoners there should at least be access to the lesser option, i.e. condom protection. It is a lesser option in that it does not completely eliminate the undesirable consequences that arise from anal intercourse, especially anal-receptive (passive) intercourse for the HIV-infected person.

There is available evidence suggesting that anal-receptive intercourse is associated with impairment of the individual's immunocompetence. Thus, continuing in the risk behaviour will further impair the immune status of the infected individual. It has been reported that homosexual men practising anal-receptive intercourse have impaired immunity and higher CD-8 and lower CD-4 lymphocyte counts than men practising no anal intercourse or being the active partner (Ratnam et al. 1986; Detels et al. 1983).

A number of factors have been proposed to account for this observation, including systemic exposure to infectious agents through breaks in the rectal mucosa, the lymphocyte inhibitory effect of seminal plasma and the immunosuppressive properties of antigens from seminal lymphocytes and spermatozoa (Gottleib 1986). Whilst their clinical significance has yet to be quantified, clinicians would be failing in their duty if they did not warn their patients of these possible untoward effects.

HIV and diets and vitamins

A common problem that medical staff in prisons encounter, and to which HIV-infected inmates are prone to is in the area of diets and vitamin supplements. It is sometimes quite difficult for PMS staff contending with requests for various changes to diets or requests for vitamin supplements.

It is said that HIV-infected individuals need to be given some choices; a patient without choices feels helpless. Inmates should be encouraged to adopt a positive attitude and be allowed to be more in control. But we do not agree with the practice of some agencies to use food and dietary supplements as an area of experimental exercise of choice. They see this as a 'soft option' area that does no harm.

We have difficulty with this. It is our view that having a positive attitude towards their infection also involves being realistic and accepting of many of their circumstances. This assists in avoiding disappointments arising from misplaced hopes. Prisoners with HIV infection should aim for some regular daily routine and a regular and balanced diet. Many of the ideas about food items suggested to HIV-infected inmates, through the prison grape-vine and lay magazines, are no more than fads that have no scientific basis. Furthermore, vitamins pills and capsules and the like are notorious vehicles for other types of illicit drugs in circulation in prison.

However, dietary supplements do have a place where clinically indicated. In this context we are concerned that those who restrict certain food items in their diet or are pure vegetarians do not develop malnutrition or vitamin B12 deficiency. The prison diet in South Australian prisons has been designed and checked by reputable nutritionists, and inmates are encouraged to use it.

HIV infection and equitable access to appropriate health care in prison

Central to the integrative policy is the access of prisoners to programs that help them towards a useful, productive life in the community. This means that the inmate is able to participate in a prison plan that usually involves time spent in country prisons. This would then require HIV-infected inmates to have access to as comprehensive a range of health services in the country as in the city. The problem is that health care services in country areas are not as wide-ranging and as readily available as those in the city. This situation will impact on the policy regarding transfers to outlying prisons when more HIV-infected prisoners become symptomatic.

At the same time, there is also a danger that the importance of and reliance on specialty clinics such as STD clinics may be overemphasised. This is especially so in South Australia where specialist services are concentrated in Adelaide. In the context of our policy, excessive centring of care would foster, in the mind of the HIV-infected inmate, the view that any place outside Adelaide is incapable of providing adequate and competent care.

This issue of relative levels of service is made less clear-cut by the 'softer', often less restrictive, more pleasant and often more supportive environment of country prisons. It is sometimes a difficult decision for the medical officer who has to clear a transfer, having to weigh ready access to health services against the better environment that country prisons generally provide. To date, it has not posed any real difficulties, but may do so when more symptomatic cases occur.

Education and counselling

As yet, PMS staff have not encountered any significant difficulty in getting inmates tested for HIV. Only a handful of prisoners initially refused but promptly changed their minds when spoken to by prison management. Education about HIV infection accompanied all testing and was repeated when test results were given out.

The difficulty has been in maintaining the same initial level of enthusiasm and comprehensiveness during counselling with the progress of time. The presentation of complete and accurate information is, needless to say, very important. Each new admission, after counselling, is also given a copy of the AIDS Report (published by NACAIDS, Canberra). This provides ready information for the inmate wishing to know more.

All PMS nursing staff have gone through an AIDS counselling course conducted by the main STD clinic in Adelaide. This, together with their professional access to, and knowledge of the inmates and the prisons provides a timely, appropriate and relatively uniform presentation of information and advice to the prisoners.

There was a time when counsellors from other agencies as well as PMS nurses and doctors participated in the counselling process. Inmates are generally suspicious and are quick to pick apparent discrepancies in information given to them from different sources. Problems arose but the potential for confusion and manipulation was resolved by making the PMS solely responsible for counselling.

Individual questioning of PMS staff at various times showed that after a while, the information they gave about HIV tended to be summarised. It became less than complete. This is something that health care staff need to be aware of and guard against. The message must be given concisely and yet adequately and accurately, and in such a way as to positively encourage the right behaviour.

The ultimate test for effective education and counselling is changed behaviour. Any other measure of outcome is only secondary. To this end, medical and nursing staff need to keep abreast of scientific developments. The challenge is for prison health administrators to facilitate on-going education to enable staff to enhance communication skills and keep in touch with the rapid advance of knowledge about HIV infection and AIDS.

HIV infection and the stress of imprisonment

Since the days of Galen, physicians have been aware of the link between stress and illness. The advent of HIV did, for a while, raise the issue of psychoneuroimmunology into prominence. The PMS was, on a number of occasions, called to give an opinion as to what possible fate would await an incarcerated HIV-infected person. Of particular concern was any deleterious effect that the stress of imprisonment could have on the health of the infected person.

There is a body of scientific evidence that links stress with disease through neuronal and hormonal pathways between the brain and the immune system (Lancet 1987; Schindler 1985). However, for the clinician, the difficulty lies in defining and then quantifying stress. As if that is not hard enough, it is just as difficult to quantify the clinical impact of stress on an individual's immunocompetence.

Any stress experienced in prison must be weighed against the stress that these same individuals would face engaged in their lifestyles in the community. Many would agree that the latter is not without significant stress. So to step into this area is to be like the proverbial fool walking in where angels fear to tread.

Nevertheless, it is apparent to us over the last five years that HIV-infected inmates coming into prison for a period of time more often than not leave the prison having put on weight, and looking more healthy than when they first came in. This would be an interesting area of research. It is our suspicion that the structured lifestyle, the relatively protected environment and the separation from their previous environment probably did them some good, at least in terms of physical health.

Industrial and occupational issues

Even in recent days there remains much apprehension and trepidation about HIV amongst correctional staff. This is not surprising, given similar reactions amongst ambulance drivers and even some health care staff in South Australia. Even in New York in 1988, where knowledge about AIDS is probably widespread, a survey by Link, Feingold et al. showed that 48 per cent of house officers reported moderate-to-major concern about acquiring AIDS from their patients. The reason is simple. AIDS is a fatal infection that is as yet without a cure. Whilst those working in certain hospitals, like those in New York, are obviously exposed to a greater risk, to correctional officers, to be at risk means to be in danger. Possibility is the same as probability to them.

In the context of an integrated policy, it therefore behoves policymakers to incorporate any new and significant developments into the process promptly to maintain credibility.

Despite two highly publicised reports on the failure of AZT to prevent infection after accidental exposure to HIV (Lange et al. 1990; Looke & Grove 1990), we are about to put in place an AZT prophylaxis protocol in accordance with recommendations of the Australian National Council on AIDS (1990). The protocol provides that staff accidentally exposed to possible HIV infection may commence on starter doses of AZT prophylaxis whilst awaiting initial telephone contact with an infectious disease physician. Subsequent appropriate medical supervision is then organised.

Confidentiality

In one sense, confidentiality about HIV infection does not exist in prison. Somehow, people in prison get to know those who are seropositive. In a number of instances, inmates have identified themselves as seropositive. Either this reflected their confidence in their colleagues and in the system, or they were 'persuaded' to reveal their status. If the former is the case, then it is an attitude perhaps fostered by an integrative policy. The latter does not appear to be common.

Nevertheless, the PMS maintains the same attitude towards the confidentiality of the inmates under our care as we would the other patients in our hospital. PMS staff make it a point to tell inmates that we are from a public hospital and independent of the Department of Correctional Services, and that we meticulously follow the rules of confidentiality. This assurance of confidence is necessary even though some may be already known to others in prison as HIV-infected.

Conclusion

This paper has detailed the experience of the PMS in coping with HIV infection in South Australian prisons over the past five years. The focus has been on the virus and how we contended with it. But the success of our efforts will be measured by the lives of the people who have been and may be affected by it.

On his deathbed in 1895 Louis Pasteur, the man who proved the existence of microbes, and of which HIV is simply one, is reported to have said, in reference to his lifelong rivalry with Claude Bernard, 'Bernard was right. Microbes are nothing, the soil is every thing'. His lesson applies today. The soil is the person upon whom the virus wreaks its havoc. We must focus on the whole person: the physical, emotional and spiritual. There are still quite a few gaps yet to be filled.

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Managing a Therapeutic Community 'K' Division - A Case Study

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In 1987 a joint submission from the Health Department of Victoria and the Office of Corrections was made for a drug education and prevention project for prisoners. This project was approved and funds were made available from the National Campaign Against Drug Abuse and from State health resources on a dollar-for-dollar basis. As a result, one program commenced in 'G' Division for males at the Metropolitan Reception Prison and another at Fairlea for women.

In early 1987 the Metropolitan Reception Prison received its second HIV seropositive prisoners (two prisoners). Due to industrial issues involving prison officers the prisoners were moved from 'D' Division to the hospital in Pentridge Prison. Over the next six months the numbers of HIV seropositive prisoners increased from two to a total of six. As the numbers grew an increasing burden was placed on hospital services which were not designed to house prisoners on a long-term basis. In addition, hospital beds were being occupied by persons whose needs were not being meet under a hospital regime. At this stage, the Corrections Health Board intervened and, as a result, facilities within the recently refurbished 'K' Division were made available for persons identified as being HIV seropositive.

This decision coincided with the relocation of the drug treatment programs to 'K' Division, in order to allow the redevelopment of 'G' Division into an acute psychological unit and the resources from the male unit to be shared with the female unit. Therefore, resources became available for the delivery of a drug program, to provide a service for persons identified as being HIV seropositive, and to increase the number of positions available for males and females within the drug treatment program.

In March 1988 'K' Division started to accept prisoners who were HIV seropositive. Initially, the unit opened with seven prisoners, six of whom were HIV seropositive. To address industrial issues negotiations with the unions took place for the unit to open with volunteer staff. An education program was made available to the staff and support provided to address their concerns. Since then, two other programs have been developed in 'K' Division to meet other prisoners needs. These are a small high protection/security unit and a programmed unit for offenders with intellectual disabilities.

Description Of Programs

Up to approximately 100 prisoners can participate in the various programs offered in 'K' Division. 'K' Division is dedicated to the delivery of programs across all its five Units. A brief description of each Unit follows:

Unit Two

Unit Two is a high security/protection unit with facilities to house a maximum of nine prisoners, for extended periods of time. Its goals are:

- the containment of high security risk prisoners and the safety of prisoners in need of high protection;
- to provide activities, interests and pursuits for prisoners that engage their interest and assist them in coping with long periods of confinement. Employment, education and recreational activities are examples;
- to provide an environment which promotes an harmonious and relaxed level of interaction between prisoners and prisoners and prisoners and staff; and
- to prepare prisoners for release or transfer to another division.

Unit Three

This Unit can accommodate up to twenty-four women. However, eighteen is considered its operating maximum. These prisoners are classified to the program for a period of four months. The objectives of the program are to enable women to understand their own drug use, develop self-esteem and confidence, equip them with more productive methods of coping, and enhance life-skills. The Alcohol and Drug Programme (ADP) for women is also designed to enable them to address chemical dependency issues by:

- developing self-esteem and assurance;
- enhancing assertive behaviour;
- increasing their understanding of the abilities and skills they possess and can utilise to change their lives;
- assuming responsibility for leading a drug-free lifestyle;
- working on personal issues and planning for release; and
- encouraging them to participate in the running of the program.

The program aims to achieve these goals by offering women the opportunity to discuss and explore their experiences in a non-threatening atmosphere. In the process they are given an opportunity to gain insights into lifestyle and behaviour patterns associated with their chemical dependency.

The program is primarily targeted at women with drug and alcohol issues, but also accepts women who have other problems and are willing to address them in this environment.

Unit Four

This Unit can accommodate up to twenty-four male prisoners. However, its operating maximum is set at eighteen prisoners. Prior to admission to the program, participants must volunteer to participate, undergo a rigorous assessment, enter into a contract to participate fully in the program and display a high level of motivation.

The goals of this program are to create an atmosphere that is safe, secure, and supportive. This is achieved by group cohesiveness, positive group interaction and by encouraging the prisoners to:

- run the Unit as a community which reflects the values and standards of society;

- manage the personal areas of their lives or issues that relate to their drug use and offending;
- participate in the running of the program;
- support each other in the maintenance of a drug-free Unit;
- share equally with other prisoners;
- not engage in prisoner politics; and
- prepare for release.

The program is targeted at mainstream prisoners who have a history of chemical dependency, criminal offences, and institutional living. It is also important that prisoners are motivated to participate in the program and are willing to comply with its management style.

Unit Five

This Unit can accommodate up to twenty-four prisoners. Once again, eighteen is considered the operating maximum. The Unit houses two groups of prisoners: those identified as being HIV seropositive and a number of mainstream prisoners who wish to participate in a drug and alcohol program, but do not wish or are ineligible to participate in the Unit Four program.

The goals of this program are similar to the other Units, that is to create an atmosphere that is safe, secure and supportive through group cohesiveness and positive group interaction. Briefly the Unit goals are to:

- promote through education, counselling and vocational activities, a better understanding of the psychological, social and physical effects of the virus;
- support each other and share with each other;
- encourage prisoners to participate in the program;
- support each other in the maintenance of a drug-free program;
- monitor and accommodate the short-term and long-term needs of (HIV seropositive) prisoners;

- provide assistance and referral sources to the family and others who may know the (HIV seropositive) prisoners;
- provide a creditable drug and alcohol program for all prisoners in the Unit; and
- prepare prisoners for release or transfer to other prisons.

In general, while the two groups share a number of similar goals the ADP prisoners have a number of extra goals as well. These are generally the same as the program in Unit Four, in addition to being HIV aware. The staff in 'K' Division provide formal education to the prisoners but, more importantly, prisoners receive considerable information from other prisoners about the virus.

Any prisoner (convicted or unconvicted) identified as being HIV seropositive will be placed in Unit Five upon advice from the Medical Superintendent. However, the Medical Superintendent does have the discretion to place HIV seropositive prisoners in Pentridge Hospital for a period, following the identification of the virus, to allow the prisoner to address any medical or emotional issues that might arise prior to placement in 'K' Division.

Confidentiality is maintained in that the only staff informed of a prisoner's HIV status is the Officer-in-Charge of 'K' Division or the Program Coordinator via the Medical Superintendent. However, any prisoner domiciled in Unit Five and not part of the ADP is assumed by the staff to be HIV seropositive. The staff in 'K' Division do their utmost to maintain and keep the information confidential. If a direct inquiry is made regarding a prisoner's HIV status, the person is told that the information is confidential, and a suggestion is made that if they wish they can take up the issue with the prisoner concerned.

Medical services for seropositive prisoners are the same as for all of 'K' Division, that is, weekly access to doctors and a 24-hour emergency service.

Once a month a specialist from Fairfield Hospital, Dr Sutherland, attends the Unit. To date, no prisoner has required hospitalisation for long periods of time due to the progress of the virus. A prisoner needing hospitalisation would be accommodated in the Pentridge facility or if medically required, at Fairfield Hospital. Prisoners have access to zidovudine (AZT) under the same guidelines as the general public and, to date, three prisoners have been on the drug at different times in the Unit.

Within the Unit the two groups of prisoners have very good relations and the HIV seropositive prisoners mix with all other Units for sporting and other occasions. As mentioned earlier, the HIV prisoners have access to support staff and a number have participated in the ADP program.

Unit Six

During the early part of 1990 the Special Purpose Unit (SPU) was relocated to Unit Six in 'K' Division and, as part of the move, Community Services Victoria agreed to fund one full-time position in order to service the needs of intellectually disabled prisoners.

The goals of the program are to identify those prisoners within the mainstream prison population and to attempt to maximise their potential via:

- an individual management approach that identifies their needs, provides them with attainable goals and monitors their progress;
- the provision of suitable programs which emphasise vocational, educational, social, recreational, therapeutic and life skills acquisition; and
- a regime that is defined clearly and applied consistently.

This Unit has a regime and programs which are directed specially towards the following groups of prisoners:

- Intellectual Disability Services (IDS) registered offenders; and
- prisoners who are not IDS registered, but who present as having similar difficulties and needs.

The Unit's programs have been developed in cooperation with the Office of Intellectual Disability Services, and are designed to assist these prisoners to prepare for release, and where appropriate, to rejoin prison life. The work of all the staff is coordinated through individual case management files, which the officers update daily.

Prisoner / Staff Interaction

The stated orientation of 'K' Division is that of programs. These are designed to meet the needs of the prisoners, and the officers play a critical role in their delivery and management. All staff working in the Division are selected to work there and must demonstrate a considerable commitment to the various programs within the Division.

'K' Division's divisional goals are diverse but, uniformly, the following are the base standards:

- to maintain a safe, secure, clean, drug-free environment that safeguards both the physical and mental well-being of prisoners;
- to provide prisoners with a diverse range of activities, which encourage responsibility, self-reliance, industry and independence from drugs or alcohol;
- to maintain an effective system of security based on the proactive management of prisoners and their surroundings;
- to provide living conditions which, within limitations of a prison, reflect the demands and obligations of ordinary life;
- to, as far as possible, manage prisoners in such a way that they are encouraged to determine their own future and direction;
- to provide a disciplinary system which emphasises: the value of a mutually supportive and cooperative system; earned reward rather than punishment; and consistent and persistent application of the rules; and
- to provide services, facilities and/or programs that attend the specific needs of individuals or groups of prisoner in 'K' Division.

Each unit has its own particular needs but fits into the overall goals of the Division.

Overview Of Unit Five

To date, 'K' Division has housed forty-six HIV seropositive prisoners of which two have returned to the system once and two have returned three times. It currently has eight HIV seropositive prisoners. As can be seen from the figures, the numbers have been relatively low. However, this should not be seen as responsible for the lack of incidents involving seropositive prisoners, as the Unit has domiciled prisoners who pose management problems without major incidents to date. Success, in this regard is achieved primarily by the utilisation of two strategies, Firstly, the introduction of a unit management regime. Secondly, the introduction of a reverse integration policy for seropositive prisoners.

The concept of a unit management regime in 'K' Division has meant the development of a unified approach to the management of issues and problems within the Unit and solutions which are practicable to that particular locale. In practice, this means that the community within the Unit acts for and takes responsibility for what occurs within the Unit.

This creates a community ethos within the unit, between the prisoners, and between the prisoners and staff. It tends to break down the traditional 'us and them' attitude amongst the unit members and towards the staff. Normal security or custody issues associated with the prison are not ignored, and there still are a number of traditional duties for the staff. However, via meetings amongst the various groups realistic goals and objectives can be set which create a mutually conducive environment for all concerned. An example may give some insight how mutual goal setting between staff and prisoners can be effective in problem-solving. Drugs within the prison are a constant and common source of problems - not only in terms of security but also in terms of the potential risk to officers of needlestick injury during searches. This issue was addressed in the early days of Unit Five. Prisoners and staff suggested a number of methods to reduce potential dangers. First, all prisoners in the Unit undergo regular urine testing for drugs. Second, all prisoners assume the responsibility of creating and enforcing a drug-free environment. As a result, not only are the traditional methods of drug detection utilised but also the prisoners take responsibility for keeping the Unit drug-free.

What is different in the regime is that there is a shift away from prison officers simply policing a rule. Instead, the community together has set a norm of behaviour which creates a powerful influence for any new person coming into the Unit, to conform to the Unit rules. The Unit takes responsibility for informing new prisoners of the advantages of keeping the unit drug-free and the sanctions imposed for breaches of the rules. However, there is more emphasis on rewards for positive behaviour than penalties.

Within 'K' Division there has been a shift in roles for most of the staff involved as well as for the prisoners, and an emphasis on mutually looking for solutions to problems. Moreover, there has been a change in role for civilian staff. They tend to perceive themselves now as consultants for uniform staff in the facilitating of the management of prisoners and the delivery of programs in conjunction with uniform staff and prisoners.

The other achievement of the program has been the integration of the Unit. What is meant here is the policy of reverse integration whereby HIV seropositive and seronegative prisoners are accommodated in the same Unit.

This has had an effect in both normalising the Unit and providing a venue for peer education. Also, as time has progressed, the Division as a whole has mixed regularly for various sporting and other activities. This has facilitated the crossover of knowledge between the various units about HIV, and the development of a peer education system. HIV seropositive prisoners have benefited because they have some control over how other prisoners perceive them, and they can tackle and breakdown some of the stigma associated with the virus. These benefits have had a flow-on effect, in that as prisoners move out of the Division and on to other locations the knowledge they have gained about the virus is transferred throughout the prison system.

Transfer of knowledge has not been limited to prisoners, because as staff move from one unit to another or on to new postings, the skills and knowledge they have developed in dealing with people and about the virus are incorporated into their work practices

throughout the prison system. Because they also act as peer educators for their fellow staff members, a more commonsense approach to HIV is slowly developing throughout the system. Therefore, the Unit is having a valuable catalytic effect in terms of education and work practices, as well as providing a relatively normal environment for HIV seropositive prisoners.

This is not to say that this method of management is a panacea or is perfect. What it does offer is a dynamic system which is constantly evolving as new people become involved. This has played a major role in making the Unit a safe and secure environment for staff and prisoners because it is constantly feeding back and setting new goals for itself as key people move through it.

In managing the Unit or others in the Division, it is the use of staff together with prisoners to set realistic and achievable goals which is critical in the development of an environment that meets the needs of a number of people both within the system and outside it.

Management Issues - A Prison Officers Union Perspective

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On 17 April 1990 I began a three month secondment to the NSW Prison AIDS Project and so began a new chapter in the history of the NSW Prison Officers Union, the POVB - (Prison Officers Vocational Branch). This secondment came about as a result of a four day strike at Berrima Gaol early in 1990 after the placement of a known HIV-infected inmate there rather than in the Malabar AIDS Unit within the Assessment Prison at Long Bay. At the time the POVB had a policy of segregation of HIV/AIDS inmates. As a condition of the settlement of the dispute the POVB sought an input into AIDS education and information programs for NSW prison officers.

The POVB Executive put forward a proposal that a person of their choice deliver the officer education program. The Union was of the opinion that a person from head office, travelling to the gaols to speak to officers about HIV/AIDS and related issues, would have little credibility with staff. It was also proposed that this person be seconded to the Prison AIDS Project for a period of three months. The proposal was agreed to by the Department of Corrective Services, the POVB and the Industrial Commission of NSW.

At this time I was a Union delegate at the Special Purpose Prison and the POVB Executive was aware that I had had seventeen years experience in maximum security institutions, including ten years with the Irish Prison Service. In 1984, a forty cell segregation unit for HIV/AIDS inmates was set up in Mountjoy Prison, Dublin the gaol to which I was then attached. Up until November 1987, when I returned to Australia, I worked a great deal with the inmates housed in this unit. As I had a sound knowledge of the issues and credibility with staff, the Union offered me this role and I willingly accepted.

[1] The views expressed in this article are those of the author and the POVB and do not necessarily reflect the policies of the NSW Department of Corrective Services and the NSW Public Service Association.

My brief from the POVB State Executive, following the introduction of integration of HIV/AIDS inmates into the mainstream prison population, was to put together and implement a safety and education package for NSW prison officers. My objectives were to provide officers with accurate and up-to-date information on HIV/AIDS, to increase their awareness of the virus to a level where myths and unnecessary fears would be reduced, to familiarise officers with infection control guidelines and to instil in them the need for safer work practices.

From an officer's perspective I then set about researching what I felt I would like to see available in the gaols to make the workplace safer in relation to the HIV virus. I visited Professor David Sutherland at the Royal Newcastle Hospital AIDS Unit and he demonstrated for me the infection control guidelines in use in the hospital.

I then put together a safety kit for officers. The kit consisted of an alcohol-based handwash, occlusive (waterproof) dressings, Sharps containers, sachets of powdered bleach, and hand-held mirrors. Some of these items were so cheap and easily obtained that I am amazed it took until 1990 to have them incorporated into the Department's occupational health and safety policy and procedures. The Prison AIDS Project is now investigating a new infection control pouch for officers which will include an eye wash, a mouth wash, a bleach solution, a disposable resuscitation mask, dressings and alcohol swabs.

I then visited every institution in the State and introduced and explained the safety kit to prison officers. I was accompanied on these trips by a consultant doctor who outlined the medical aspects of the AIDS virus to the officers. This proved to be a difficult time. Many officers felt that, because I was coming from head office, I was promoting integration. I explained that, like them, I was a serving prison officer, that when my secondment was finished I would be returning to gaol duties and that I was an elected Union delegate and working on their behalf. I felt that we were making an impact when, towards the end of my three month secondment, the dreaded 'mosquito' question stopped getting asked.

Some of the fears that officers related were: suffering a needlestick injury whilst carrying out cell searches, being assaulted with an infected syringe, and being taken hostage. NSW prison officers also expressed concerns about not knowing the identities of HIV/AIDS inmates. Many feel that knowing the identity of HIV/AIDS inmates would add to their safety in blood spill situations. Gaols, by their nature, can be very violent places. It is not uncommon for blood to be spilt and it is not unusual for an officer to get covered with an inmate's blood as the result of an assault, when assisting an inmate after self-mutilation, or as the result of an industrial accident.

While recognising that the incubation or window period of the AIDS virus presents difficulties in identifying inmates with the virus and also the legal position regarding confidentiality, the POVB has an obligation to its members to continue to negotiate this issue on their behalf.

The POVB is also of the opinion that in the event of an officer being assaulted, where it is likely that blood or body fluids have been exchanged, that the officer concerned should know the HIV/AIDS status of the inmate. Again, due to the present legal restrictions of confidentiality, the POVB recognises that this will be an ongoing industrial issue.

There have been a number of officer exposures to blood over the last twelve months. One officer related the trauma he had gone through whilst awaiting the results of his HIV screening test. During the window period he was even reluctant to kiss or cuddle his children. It must have been a harrowing period for him.

I heard many stories like this one on my travels around the gaols. They emphasise the real need prison officers have for an education program designed to meet their needs and delivered by someone who can identify with the problems they face on a daily basis as part of their normal duties.

Just six days after my secondment had ended and I had returned to gaol duty an unfortunate, but in my view inevitable, incident occurred. It is alleged that a young officer, only newly recruited to the service, was attacked and stabbed with a blood filled syringe. As a result of this incident, and its effects on the morale of staff, my secondment to the Prison AIDS Project was extended for a further three months.

This was a difficult time, emotions were running high, and the AIDS problem once again became a major industrial issue for the POVB. Relations between the Union and the Department of Corrective Services were strained.

When I discovered that the young officer who was allegedly assaulted had returned a positive test to the HIV virus I was totally shattered. The feeling in the office that day was one of numbness and disbelief. I had a tremendous battle with myself. What could I possibly say to officers around the State?

After some soul-searching I realised that now more than ever staff needed education on HIV/AIDS, hepatitis B and related issues. I deliberately directed my talks towards safer work practices, the need for infection control, and the development of occupational health and safety cabinets in all work locations. Some of the gaols took a responsible attitude and installed the cabinets straight away. In other institutions I have had a constant battle with that other deadly virus that is festering in our prisons - Complacency/Apathy.

There are a number of strains to this not so fragile virus which I am led to believe was first isolated by scientists around the time of Adam and Eve. Since then it has spread to all corners of the globe and it has almost reached epidemic proportions in the NSW Department of Corrective Services. I am hopeful that a cure can be found for the Complacency/Apathy virus, but it is likely that a cure for HIV/AIDS will be discovered first.

The question of segregation versus integration invariably raises its head during meetings with prison officers. While not advocating one or the other, I am in a position to talk about the problems which were experienced with segregation in Ireland. The Separation Unit in Ireland was set up after a prisoner had died in custody and an autopsy showed that he had died from an AIDS-related illness. As there was a lot of needle sharing in the prison, a large number of prisoners subsequently requested HIV tests. Based on my experience there, I estimate that 10 per cent of the prisoners in Mountjoy Prison, Dublin were HIV positive. Because of the seropositivity rate, the Department of Justice opted for segregation of HIV-infected inmates.

The same problems which were being experienced in the mainstream prison population - riots, self-mutilation, assaults on officers and barricaded cells - were experienced in this Unit. Housing a large number of HIV/AIDS prisoners together gave those inmates a powerful weapon to use against staff, namely their HIV-infected blood.

I have long been of the opinion that segregation of HIV/AIDS inmates in NSW gaols will take place, not because officers or the Department want it, but because the prisoners want it, either because HIV/AIDS prisoners do not feel secure or because the other prisoners do not feel happy with integration. It is a complex issue and not one that can be solved to everyone's satisfaction.

In a recent statewide vote on this issue amongst prison officers, the result was evenly divided. I believe that this was as a direct result of the HIV/AIDS education program for officers and that officers are coming to terms with the AIDS virus. The possibility of a direct assault on an officer with a blood filled syringe is one that will always be there, whether HIV/AIDS inmates are segregated or not. So is the problem of getting killed with an iron bar or a length of wood.

Every time officers enter a gaol they do not know whether or not they will walk out again at the end of the shift. Prisons are unpredictable places, calmness may exist one minute and in the next, unbelievable scenes of violence and destruction erupt.

This has been witnessed in the very recent past in NSW gaols after the policy to reduce prisoners' property was introduced. Whilst officers agree that there is too much property in prison cells, they do not agree that confiscation of property will make it easier to find drugs and syringes.

Measures must be taken to stop drugs and syringes from entering the gaols and to punish prisoners effectively who are caught with illegal substances. After seventeen years as a prison officer I still cannot fathom how a person can be arrested, tried, convicted and sent to gaol for something done in the community and yet, when the same crime is committed within an institution, it seems to be treated with much less severity. Perhaps one day prison administrators will tackle this issue and then perhaps attacks on officers with syringes can be reduced, and the spread of HIV/AIDS in prisons minimised.

The subject of trauma counselling needs to be mentioned. All jobs carry some degree of stress and prison officers can find themselves in a traumatic state for any number of reasons. A team of specialist trauma counsellors has been contracted by the NSW Department of Corrective Services to debrief officers who have suffered a traumatic experience. Identified areas where this service could be used are, hostage or siege situations, discovering a suicide or murder victim, discovering a grievously injured body, needlestick injuries and exposure to blood or other body fluids.

Whilst access to a trauma counselling service has been one of the positive steps taken to assist prison officers to cope with the AIDS virus and related issues in the prisons, it is not being fully utilised. The problem in the past has been that superintendents would offer the officer concerned trauma counselling but, if the officer refused, no further action was taken. What should happen is that the trauma counsellors are notified by superintendents of any incident falling within the criteria for counselling. The Trauma Unit should then automatically make contact with the officer.

It is in the Department's interest to minimise industrial disruption in the gaols, to ensure that staff do not become infected with the AIDS virus and to ensure that all staff receive adequate training and information on HIV/AIDS and related issues. Employers and unions have a responsibility to implement adequate infection control guidelines and accident prevention procedures, and employees have a duty to comply with these guidelines and procedures. An education program for prison officers must be an integral component of the implementation of these guidelines and procedures.

I want now to touch on the controversial subject of compulsory HIV testing for NSW prisoners. The POVB viewpoint is that compulsory HIV testing as proposed for NSW prisons is purely a political move. As it is only proposed to test on entry and exit from gaols, the Union believes that it will not give a true picture of the prevalence of the AIDS virus in NSW prisons.

Before concluding, there are two exciting developments which should be mentioned. The first is a 'Lifestyles Program'. This program provides an opportunity for self-disclosed HIV/AIDS inmates to learn practical skills to cope with the virus in prison and, on release, in the community. It also offers a more interesting and involved role to the officers working on the program. A trial is proposed and I am very optimistic about its success. The POVB also supports the program in principle. The other development is the production of a video designed specifically for prison officers.

Finally, I want to acknowledge the enormous support, assistance and guidance given to me by the Manager and the Regional Coordinators of the NSW Prison AIDS Project.

Rights, Duties, HIV/AIDS and Corrections

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In formulating policy on HIV/AIDS in prisons, concepts of rights and duties arise as considerations in a number of contexts. Relevant duties which have at least a minimal basis in law include:

- duty of care for the health and well-being of prisoners;
- duty to comply with human rights obligations and non-discrimination requirements; and
- duty to provide a safe system of work for employees.

The interpretation of these duties by prison administrators and consideration of these duties by legislators in framing new laws and regulations are significant to decisions regarding HIV testing programs, segregation and isolation practices, and the provision of health and welfare services for prisoners.

These should not be viewed as necessarily conflicting duties. Nor should it be assumed that to recognise prisoners' rights is at odds with the duty to minimise the HIV epidemic in the community at large. It is not a question of balancing prisoners' rights against the public health imperative of HIV prevention, but rather of recognising that the achievement of individual behaviour change necessary for HIV prevention requires recognition of individual prisoners' rights.

Practice and policy in relation to HIV/AIDS in Australian prisons over the last six years has demonstrated a lack of appreciation of the public health implications of failing to guarantee prisoners' rights. Simply put, failure to assess the impact of testing and segregation programs adequately, failure to acknowledge the duty to comply with human rights obligations, and failure to take seriously the occupational health and safety issues result directly in an increase in the spread of the HIV/AIDS epidemic.

Duty of Care to Prisoners

This duty is the one which, to date, has figured most prominently in discussions of the relevance of legal liability to policy development on HIV/AIDS. It is stated as a rationale for testing of prisoners upon entry and at regular intervals in the National HIV/AIDS Strategy. The National Strategy document explains that 'this duty includes taking precautions to prevent transmission of HIV by rape or consenting sexual activity, or needle sharing with infected prisoners, or protecting infected prisoners from assault by other prisoners or prison staff' (Commonwealth of Australia 1989, p. 50).

The legal basis of this duty is twofold. Firstly, prisoners retain some common law rights. I suspect that the precise position differs between each jurisdiction (for example, *Felons (Civil Proceedings) Act 1981* (NSW), *Treasons and Felonies Act 1981* (NT)). It is a well established principle of tort law that correctional authorities owe a duty of care to persons under their care or control, and that breach of this duty gives rise to liability in negligence (*Ellis v. Home Office* [1953] 2 All ER 149 at 154; *D'Arcy v. Prison Commissioners* (1955) *The Times* 17 November; *Anderson v. Home Office* (1965) *The Times* 8 October; *Egerton v. Home Office* [1978] Crim LR 494; *Howard v. Jarvis* (1958) 98 CLR 177; *L v. Commonwealth* (1976) 10 ALR 269). The duty extends to the taking of reasonable precautions to prevent one prisoner harming another.

Thus, Western Australian prison authorities have been found to be liable in negligence for failing to prevent one prisoner assaulting another prisoner where the assailant had a history of mental instability and violent behaviour. In this case the prison authorities failed to isolate the prisoner from other inmates or deny him access to potential weapons (*Dixon v. the State of Western Australia* [1974] WAR 69). Similarly, Northern Territory authorities have been found liable for failing to prevent a sexual assault where a prisoner was placed in a cell with two other prisoners who were prone to violence (*L v. Commonwealth* (1976) 10 ALR 269).

Although the application of this principle of liability to the protection of prisoners from HIV is yet to be considered by an Australian court, it is highly likely that the common law duty of care does extend to protecting uninfected prisoners from HIV infection in foreseeable violent incidents, such as rape or needle assaults where the assailant has a history of violence. It is less likely that liability could arise under common law principles where a prisoner is infected as a result of consensual sexual or needle use activity. The common law recognises a defence of consent to the risk of the harm (*volenti non fit injuria*). The common law is unlikely to grant a remedy where the prisoner claims compensation for the results of an unlawful activity (sex or drug use) in which he or she voluntarily participated.

The second basis of the duty of care is prisons legislation. The various Acts and Regulations governing prisoners impose or imply certain minimal duties of care owed to prisoners. In NSW, s. 16(1) of the *Prisons Act 1952* provides that every prisoner must be supplied at public expense with such medical attendance, treatment and medicine as in the opinion of the medical officer is necessary for the preservation of the health of the prisoner, other prisoners and prison officers. Regulation 154 of the NSW Prisons (General) Regulations 1989 provides that a prisoner shall not be subjected to cruel, inhuman or degrading treatment or be subjected to any other punishment or treatment that may reasonably be expected to affect adversely the prisoner's physical or mental health. In Victoria, s. 47 of the *Corrections Act 1986* provides that prisoners have a right to 'reasonable medical care'. In the ACT, r. 13 of the Remand Centre Regulations provides that prison medical officers are under a duty to do such things as are necessary to safeguard the mental and physical health of detainees.

There are major limitations on the enforcement of duties of care arising from prisons legislation or under common law principles. There are very few cases in which prisoners have litigated on the basis of rights derived from prisons legislation in order to secure more favourable conditions. The courts are reluctant to interpret such duties as enforceable duties. Statements of duties found in prison legislation or regulations have been described in

one New South Wales case as 'mere directions' bearing on prison administration which do not give rise to a right of civil action (*Smith v. Commissioner of Corrective Services* [1978] 1 NSWLR 317 at 328 per Hutley J).

Further, prison legislation generally protects prison authorities from liability. For example, in New South Wales, s. 46 of the *Prison Acts 1952* has the effect that no action or claim for damages lies against prison authorities unless it is proved that the act was done maliciously and without reasonable or probable cause. The section will be extended when the legislation facilitating compulsory HIV testing commences operation (*Prisons (Medical Tests) Amendment Act 1990*) with the effect that liability in relation to the taking of blood tests and disclosure of results is to be limited. Under Queensland legislation, prison authorities are not liable for acts done bona fide and without negligence (*Corrective Services Administration Act 1988* (Qld) s. 62).

Added to these legal barriers to enforcement of rights are the obvious practical barriers. Prisoners access to legal services is notoriously inadequate. In the context of HIV/AIDS, prisoners affected by HIV/AIDS have obvious incentives not to involve themselves in court battles with prison administrators. Fear of victimisation and the need to avoid stress for health reasons are major considerations. Cases where prisoners do gain access to the courts are most exceptional. The conditions imposed on NSW prisoners after an incident in which it is alleged that a prison officer was infected with HIV after a syringe attack has given rise to such an exceptional case. The recent ban on personal property held by NSW prisoners and the locking up of prisoners who resisted the ban has led to Supreme Court proceedings to challenge the measures adopted by Department of Corrective Services (*Newcastle Herald* 8 Oct. 1990, p. 9). It will be instructive to learn whether these most draconian measures are given the sanction of the courts.

Although the duty of care derived from common law and statutory or regulatory provisions is not subject to frequent enforcement or court review, and although the content of the duty tends to be diluted in judicial interpretation, the duty is a concept to which administrators and legislators do turn when developing policy options. It is vital that the concept of a duty of care owed to prisoners is developed in order to give meaning to HIV/AIDS prevention and care strategies. A brief examination of NSW's experience in introducing compulsory HIV testing demonstrates this point.

The *Prisons (Medical Tests) Amendment Act 1990* was passed by the NSW Parliament in June 1990 to provide a legal basis for compulsory HIV testing of the NSW prison population. The Ministers for Corrective Services and Health both spoke in the parliamentary debates of the Government's duty to pass the legislation (NSW Legislative Assembly, Prisons (Medical Tests) Amendment Bill, Second Reading Speech, 10.5.90, 21.5.90). They acknowledged that prison administrators have a duty of care at common law and under statute to protect the health of prisoners. The Minister for Corrective Services argued that compulsory testing would assist prison authorities to carry out their duty of care to both the infected and the uninfected.

The Minister for Corrective Services sought the advice of the Crown Solicitor as to what the duty of care means legally in the context of HIV/AIDS. The Crown Solicitor advised that the duty extends to:

- detection of the incidence of HIV infection;
- prevention of the spread of HIV; and

- provision of appropriate medical treatment to prisoners with HIV (NSW Legislative Assembly, Prisons (Medical Tests) Amendment Bill 1990, Second Reading Speech, 10.5.90, p. 2996).)

The politicians were duty bound to act, or so the argument ran. No one would doubt that law-makers must do something about HIV/AIDS in prisons. It is the NSW experience to date, that politicians' words mask grave failings in deeds. By passing a law to test all prisoners for HIV, the Government was seen to be grasping the nettle, making the hard choices, 'not shirking responsibility' in the words of the Minister for Corrective Services (NSW Legislative Assembly Prisons (Medical Tests) Amendment Bill 1990, Second Reading Speed, 10.5.90, p. 2995).

It is a commonly held misconception that HIV testing is a public health measure. With no other measures in place, it is not. Testing alone achieves nothing. It just satisfies some that something is being done. It goes nowhere in addressing the real issues of prevention and care. When made compulsory and without measures which enable prisoners to prevent the spread of HIV (that is, distribution of condoms and needle cleaning solutions and access to drug use rehabilitation programs), it is likely to be a counterproductive measure. At the same time as the NSW Government passed legislation making it compulsory for the prison population to be tested, it reaffirmed its decision not to distribute condoms in prisons (*Sydney Morning Herald* 14 June 1990, p. 4). Without comprehensive education and counselling programs, testing may encourage those who test negative to continue with high-risk activities.

In NSW, there is much evidence that prison authorities are not taking their duty of care seriously. Although the practical and legal barriers to enforcement of the duty to which I have referred mean that they are not held strictly accountable for failure to meet an appropriate standard of care, the duty still remains. Given the indisputably high number of drug users in prisons and in the context of the crucial epidemiological role of the drug using population in the spread of HIV in the general community, public health considerations place an additional onus on prison authorities to develop meaningful preventive policies and practices.

In the USA, there has been a great deal of litigation surrounding the discharge by prison authorities of their duties in relation to HIV/AIDS care and prevention. Uninfected prisoners have sued the authorities for failing to test and segregate. In a recently reported case, *Cameron v. Metcuz* 705 F. Supp 454 (N.D. Ind 1989), an uninfected plaintiff prisoner sued prison authorities for failing to segregate a known infected prisoner with a violent history who had bitten the plaintiff. In that case, the court found that the authorities' failure to segregate a known infected prisoner with a violent history did not amount to gross negligence or reckless indifference to the prisoner who was bitten. Infected prisoners have challenged segregation policies as unconstitutional, discriminatory or contrary to statutory obligations of care. The failed challenge to Alabama's testing and segregation policies in the class action *Harris v. Thigpen* 727 F.Supp 1564 (M.D.Ala. 1990) is the most prominent recent case of this nature. The prospect of looming court challenges has encouraged United States legislators to consider seriously the impact of new prison procedures introduced to deal with HIV/AIDS.

In 1987 the Government of Oregon sought to establish how best to discharge its duty of care. Central to its concerns was the impact of compulsory testing programs on HIV prevention. A study was conducted by the State Department of Corrections (Andrus et al. 1989). Nine hundred and seventy-seven prisoners entering the prison system were offered voluntary confidential HIV testing and counselling. Two-thirds of the prisoners accepted this offer. Those declining the offer were asked whether they would consider anonymous testing. Twenty-seven per cent of prisoners who had declined voluntary testing stated that they would have considered anonymous testing, had it been available. Those who declined voluntary testing were tested in any event at a later date. Blood specimens which had been drawn from all prisoners for the detection of syphilis were tested for HIV in a blinded

fashion. Of the total 977 prisoners, twelve were HIV antibody positive. Six of the twelve were from the group which had agreed to voluntary testing. Six were not. Fifty-six per cent of those who declined testing were considered to be high-risk for HIV due to their status as hepatitis B core antibody positive, IV drug users, and/or gay. The study found, however, that of the prisoners considered to be at risk of HIV by these criteria, only one in fifty-three was infected.

'The problem then', the study found, 'is not that there are a lot of infected inmates that need to be identified. Rather, there are a lot of at-risk, as yet, unidentified inmates that need to be convinced to change their behaviour (Andrus et al. 1989, p. 841).

The study concluded that, given that there was no evidence that mandatory testing has an affect on behaviour change, but that there is mounting evidence that voluntary testing and counselling does change behaviour, and given that two-thirds of at risk prisoners had availed themselves of voluntary testing, a voluntary testing program was the preferred policy option. The study was careful to confine its findings to the local context. In particular, low prevalence of HIV (about 1.2 per cent) in the prison population was considered significant. 'When most persons at risk are not yet infected, voluntary HIV prevention programs that emphasise counselling may be more effective than mandatory programs that emphasise testing' (Andrus et al. 1989, p. 842). The Government of Oregon acted on this study. Funding was provided for a comprehensive voluntary testing and counselling program. The legislature decided against compulsory testing.

More recently, a similar study which evaluated the rate of voluntary testing as against admitted HIV risk status and HIV seroprevalence assessed through blinded surveys, was conducted by the Wisconsin Department of Health and Social Services (Wisconsin Department of Health and Social Services 1989). This study found that the rate of acceptance of voluntary HIV testing by individuals at increased risk of HIV was greater than those denying high-risk behaviours, and that HIV antibody positive prisoners did not systematically defer from voluntary testing where counselling and education were provided. The study noted that some of the infected inmates who declined voluntary testing may have been tested prior to incarceration or in previous incarcerations. The study concluded that voluntary testing facilitates the acceptance of risk reduction counselling more effectively than mandatory testing because it enables the counsellor and the inmate to establish a relationship based upon consent. Voluntary counselling and testing were recommended for prison systems with low HIV prevalence prison populations.

The observations made in these United States studies apply to our own situation. HIV seroprevalence in Australian prisons is estimated to be at a similar level to that in Oregon and Wisconsin when those studies were conducted. Further, the level of at risk behaviour is estimated to be high in Australian prisons. The lesson then is that Australian policies must be aimed at behaviour change rather than at artificial attempts to confine the problem by identification and isolation of the infected. The NSW Crown Solicitor's advice that the duty of care of prison authorities extends to ascertainment of the incidence of HIV infection must be read in context with the other elements of the duty: prevention of spread and care for the infected. I submit that the only way in which these elements are reconcilable is through a voluntary testing program emphasising the crucial role of behavioural change.

Duty to Comply with Human Rights Obligations and Non-Discrimination Requirements

Over the last decade corrective service administrators have begun to acknowledge that international human rights obligations which bind Australia have a bearing on the duties of prison authorities (Birtles 1989). Standard Guidelines for Corrections in Australia have been agreed upon by corrective services Ministers in Australia and were published in 1989 (Conference of Correctional Adminstrators). They are based on international obligations contained in the UN Standard Minimum Rules for the Treatment of Prisoners drafted by the United Nations and endorsed by its Economic and Social Council in 1957 (UN Department of Public Information 1984).

Whilst not intended to have legal force, the Standard Guidelines are intended to 'provide a base for protecting human rights in Corrections in Australia'. The Guidelines state the following guiding principles:

> 1.2 Correctional programs are by the deprivation of liberty to varying degrees, a punishment in themselves. Therefore correctional programs must not, except as incidental to the maintenance of discipline or justifiable segregation, aggravate the suffering inherent in such a situation.
> 1.8 There must be no discrimination in any aspect of correctional programs on the grounds of ... physical or mental impairment ... except as it is necessary in properly meeting the needs of a disadvantaged individual or group.

Amongst the guidelines relevant to prisoner management are the following statements:

> 5.33 Prolonged solitary confinement, corporal punishment, punishment by placement in a dark cell, reduction of diet, sensory deprivation and all cruel, inhumane or degrading punishments must not be used.
> 5.70 Prisoners isolated for health reasons should be afforded all rights and privileges which are accorded to other prisoners so long as such rights and privileges do not jeopardise the health of others.

In addition to the existence of these non-legal guidelines, prison authorities must develop an awareness of human rights obligations as a result of the introduction of human rights and equal opportunity legislation in Australia at State and federal level over the last fifteen years.

Legislation currently in force in NSW, Western Australia, Victoria and South Australia makes it unlawful to discriminate on the grounds of physical impairment in the provision of a service. In South Australia and NSW it is also unlawful to discriminate on the grounds of homosexuality (*Equal Opportunity Act 1984* (SA), *Equal Opportunity Act 1984* (WA), *Equal Opportunity Act 1984* (Vic), *Anti-Discrimination Act 1977* (NSW)). Complaints in relation to HIV/AIDS are received by the agencies which administer this legislation. The legislation binds public authorities. I am not familiar with the use of the legislation in jurisdictions outside NSW, but I am aware that it has been used to review discriminatory treatment of prisoners by corrective service employees in NSW and South Australia (Mead 1990).

The Commonwealth's Human Rights and Equal Opportunity Commission is empowered to inquire into acts or practices which are inconsistent with, or contrary to, human rights recognised by human rights instruments to which Australia is a party. Special procedural provisions are made in the legislation for the taking of complaints from prisoners (*Human Rights and Equal Opportunity Commission Act 1986* (Cwlth), s. 20(6)). The Commission is currently considering a complaint lodged by a NSW prisoner regarding conditions of confinement subsequent to the crackdown on prison property (*Sydney Morning Herald* 10 Sept. 1990, p. 5.). Although the Commission's powers to deal with complaints from individual prisoners are limited to federal prisoners, the Commission has a wider jurisdiction to conduct general inquiries where human rights abuses are suspected. There are many human rights obligations which are relevant to HIV/AIDS prevention and treatment in prisons. In particular, reference should be made to Article 7 of the International Covenant on Civil and Political Rights which provides that 'no one shall be subjected to cruel, inhuman or degrading treatment. In particular, no one shall be subjected without their free consent to medical or scientific experimentation'.

Many prisoners with HIV experience discrimination in the conditions of their confinement (Godwin & Lake 1990, p. 46; WA Legislative Assembly 1990, p. 56). There is much evidence that inadequate care is provided for the health and safety of prisoners with HIV/AIDS.

The West Australian Parliamentary Select Committee on HIV/AIDS has reported that the conditions for prisoners with HIV at Fremantle prison are 'inadequate and completely inappropriate'. Unwarranted procedures were found in the serving of food and the laundering of clothing. Books which are used by prisoners with HIV/AIDS are destroyed and not circulated. The Committee called for 'urgent revision' of the double punishment which occurs where men who test positive for HIV and who would normally be incarcerated in a minimum or medium security prison must be confined, often twenty hours a day, to a maximum security prison (WA Legislative Assembly 1990, p. 57). The Western Australian experience does not stand alone.

Prisoners have seldom been able to lodge complaints for human rights abuses or discriminatory treatment. There are many practical reasons why this is so. Access to legal services, is in any event, limited. The powers of the new anti-discrimination and human rights agencies in the prisons context are largely untested. Nevertheless, it is important in the context of HIV/AIDS, that significance is accorded to the existence of prison authorities' duties to comply with international human rights obligations.

This is particularly so given the importance of anti-discrimination measures in the context of HIV/AIDS prevention in the general community. There is an important public health dimension to the duty of non-discrimination. Just as in the general community discrimination alienates people at risk from voluntary education, treatment and counselling programs (the only programs known to have an impact an HIV/AIDS prevention), discrimination in the prison context distances both uninfected and infected prisoners from programs which may have an impact on behavioural change. An essential additional point is, of course, that most infected and uninfected prisoners enter the general community upon release. Governments have just as much responsibility, for the sake of HIV/AIDS prevention, to educate infected and at risk prison populations about behaviour change, testing and treatment options as they do other sectors of the community. Failure to prevent discrimination both inside and outside prisons indicates a failure by the authorities to recognise this responsibility.

Duty to Provide a Safe System of Work

Since the recent incident in which it is alleged that a prison officer was infected with HIV after a syringe attack in a NSW prison, attention has been focused on HIV/AIDS as an occupational safety issue. Occupational health and safety legislation in all Australian jurisdictions imposes a strict duty on all employers, including corrective services departments, to provide a safe workplace.

HIV/AIDS as an occupational issue has only been addressed in Australia in any detail in the health care context. Since 1986 Infection Control Guidelines have been made available by the Commonwealth Government to guide health care employers on appropriate measures to minimise the risk of HIV transmission in the workplace (AIDS Task Force 1986; Australian National Council on AIDS 1990). The concept of universal infection control procedures (treating all people as if they are infected) has been adopted from United States. In that country, the application of infection control procedures is now mandatory in many States, and health care providers face penalties for failure to implement them.

In the USA, the current infection control guidelines issued by the Centers for Disease Control extend not only to health care workers but also to corrective service personnel (Centers for Disease Control 1989). These guidelines have been approved and adopted by the American Correctional Association, the affiliated American Correctional Health Services Association and the US National Commission on Correctional Health Care. The guidelines provide the following rationale for the extension of the principle of general infection control to emergency and public safety workers (including law enforcement and correctional facilities):

> Use of general infection control measures . . . is important to protect both workers and individuals with whom they work from a variety of infectious agents, not just HIV and HBV (Hepatitis B). Because emergency and public safety workers work in environments that provide inherently unpredictable risks of exposures, general infection control procedures should be adapted to these work situations. Exposures are unpredictable, and protective measures may often be used in situations that do not appear to present risk. Emergency and public safety workers perform their duties in the community under extremely variable conditions; thus control measures that are simple and uniform across all situations have the greatest likelihood of worker compliance. Administrative procedures to ensure compliance can also be more readily developed than when procedures are complex and highly variable (Centers for Disease Control 1989, p. 9).

It is important to understand the logic behind universal or general infection control in addressing HIV/AIDS in the workplace. Treating all prisoners as potentially infectious obviates the need to identify those who are infected. Implementation of guidelines should be accompanied by education of staff as to the nature of risks associated with different medical conditions and situations. The use of general infection control procedures defeats the argument that there is a need to segregate infected prisoners for the safety of prison staff. Thus, the duty to provide a safe system of work can be reconciled with the duty of non-discrimination. It is the most appropriate response given the legal parameters. It is also the only response which provides for the general safety of all staff, not just those thought to be specially at risk. In particular, it avoids overreaction by staff when they do work with prisoners with HIV.

The Commonwealth should, along the United States model, extend the application of its published infection control guidelines to correctional facilities.

Other Legal Duties

There are a number of other legal duties which are relevant to the formulation of prisons policy on HIV/AIDS. They will be mentioned briefly to flag their potential importance.

A controversial area relates to the duty of prison medical authorities where a person is tested prior to, or upon exit from, the prison system. What is the legal duty to the ex-prisoner to follow up the test with a result, be it a negative or positive one, and to provide post-test counselling? It would seem reasonable, in respect of a matter so important as HIV diagnosis, that the legal responsibilities of prison authorities may continue in certain circumstances even where the person is no longer a prisoner. Moreover, it is at least arguable that liability may arise as a result of a breach of duty in this regard.

Further, what duty is there to notify third parties at risk of infection, for example, the wife of an infected prisoner? The dilemma may arise where a prisoner is allowed visits from or visits to a sexual partner. There is no clear answer to these questions. Analogous situations have been considered in the non-prison context, particularly in relation to balancing the duty of a medical practitioner to keep patient information confidential with the possible duty of care to third parties at risk (Neave 1987). Authorities in these areas suggest that, except in cases where there is a clear and imminent risk to a third party, the duty is to maintain confidentiality rather than to warn third parties.

Significant developments have occurred in recent years in relation to legal rights to confidentiality and privacy. The sensitivity of HIV/AIDS related information is such that it is a likely candidate for legal protection. Prison authorities should be aware that breach of confidence is now a recognised action by which people may claim compensation or other remedies.

Conclusion

The duty of care for prisoners' health, the duty to comply with human rights and non-discrimination obligations, and the duty to provide a safe system of work each will have a slightly different legal appearance in each Australian jurisdiction. Each State and Territory must assess how best to reconcile these duties with local conditions.

I have sought to offer some directions as to priority concerns in formulating local strategies. Given the experience of voluntary educational programs in achieving behaviour change, voluntary testing programs combined with comprehensive education and counselling, availability of condoms and needle cleaning equipment, and access to drug rehabilitation programs would best fulfil the duty to prevent the spread of HIV/AIDS. Given the discrimination experienced by people in some segregated HIV/AIDS prison units, a policy of general integration rather than segregation would best fulfil the duty to provide non-discriminatory services. In the area of occupational safety, a policy of universal infection control procedures would best fulfil the duty to all prison staff.

Consideration of rights and duties should not be an exercise in merely avoiding the threat of court proceedings. In practice, prisoners seldom are able to enforce what legal rights they have. But this is not to say that the duties which correlate to these rights should not be taken seriously by authorities. Further, given the immensity of the impact of HIV/AIDS on the whole community, the duties of prison authorities must be interpreted in the context of a general HIV/AIDS prevention strategy which emphasises the voluntary compliance of affected communities with those strategies.

There is a clear case for urgent reform of the law as it relates to prisoners' rights to ensure meaningful HIV/AIDS prevention and care strategies for both the prison and general populations. Rights to health care and access to condoms and needle cleansing agents should be enshrined in legislation as enforceable rights. Human rights and anti-discrimination legislation should be reviewed to ensure that incarcerated populations have equal access to anti-discrimination remedies and equal rights to freedom from discrimination as the general population. For corrective services employees, the right to a safe workplace should be given meaning through the promulgation of universal infection control guidelines. Every decision made in respect of the administration of prisons must be assessed in terms of its eventual impact on society as a whole.

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Prisoners' Rights: Treatment, Testing, Accommodation and Privacy of Documents

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Many people may ask why prisoners should have any rights at all, or may say that they already have too many rights. The idea of prisoners' rights is in conflict with policies which give administrative discretion and convenience overriding importance in prison administration. Cooperation was a waning concept in NSW prisons before the alleged assault on a prison officer at Long Bay Gaol on 22 July 1990 and the subsequent policy of removal of prisoners' property. Proposals to introduce mandatory linked HIV testing without adequate support and counselling staff being available, in breach of international standards, is another aspect of such a policy.

In the middle ground are cases and reports of inquiries which stress that while persons who are prisoners have lost their right to liberty, they keep residual civil rights. Such comments may be found in the reports of the inquiries into NSW (1978), Victorian (1973) and South Australian (1981) prisons. They may also be found in judgments of British (*R v. Board of Visitors of Hull Prison: ex parte St. Germain* (1979) 2 WLR 42) and US (*Coffin v. Reichart* 143 F. 2d 443 (6th Cir. 1944)) courts. Unfortunately, prisoners' attempts to define these residual rights through litigation relying on either the English and US Bill of Rights have been largely unsuccessful.

Prisoners' rights were a late-developing chapter in the evolution of human rights philosophy. The expression of such concepts is to be found in twentieth century human rights documents rather than the common law.

The early documents setting out rights and liberties dealt mainly with the issue of rights at the point of entry into custody, including:

> No free man shall be arrested or imprisoned or disseissed (have property taken) or outlawed or exiled or in any way victimised . . . except by the lawful judgment of his peers or by the law of the land.
> (Magna Carta, 1215 (England), para. 39.)

> [E]xcessive bail ought not to be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.
> (Bill of Rights, 1689 (England))

> No man may be accused, arrested or detained except in the cases determined by Law, and following the procedure that it has prescribed . . .
> The Law must prescribe only the punishments that are strictly and evidently necessary; and no one may be punished except by virtue of a Law drawn up and promulgated before the offence is committed, and legally applied.
> (Declaration of the Rights of Man, 1789 (France), Articles 7 & 8.)
> Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.
> (Bill of Rights, 1791 (US Constitutional Amendments), Article 8.)

It is only in later human rights documents that concepts of the right of access to proper care and medical treatment for all citizens were developed, and prisoners included because 'everyone is entitled' to the rights and freedoms and to 'equal protection of the law'. These statements include:

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment . . .Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care . . .
> (Universal Declaration of Human Rights, 1948 (United Nations), Articles 5 & 25.)

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person . . .

> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour or reputation.
> (International Covenant on Civil and Political Rights (came into force 1976, first introduced 1966). Articles 7, 10(1) and 17.)

> The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

> The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:

> (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases;

> (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.
> (International Covenant of Economic, Social and Cultural Rights (UN), Article 12.)

Public opinion about prisoners' rights has often been negative as shown, for example, in the following summary of a 1976 McNair Anderson opinion poll:

Table 1

Conditions in Australian Gaols

	Too severe on prisoner %	Too lenient on prisoner %	About what they should be %	Don't know %
NSW	15	29	40	16
Vic.	11	41	33	15
Qld	4	42	35	19
SA	8	53	25	14
WA	8	44	30	18
Tas.	2	52	27	19
TOTAL:	**11**	**38**	**35**	**16**

* Source: Australian Law Reform Commission 1980, p. 144.

One lamentable aspect of the public attitude towards prisoners has been well expressed by the late Victorian Supreme Court Judge Sir John Barry:

> the prescription that the criminal should receive a dose of his own medicine has always possessed a dreadful attractiveness . . .
>
> The public image of prison as a place of degradation where it is right and proper that inmates should be repressed and debased is still strong. In the public mind . . . a prison is a place where people who have done wicked things are kept apart and held in subjection, so that they will not contaminate law-abiding citizens (Barry 1969, p. 74, 78).

The AIDS epidemic presents the same challenges to prison administrators as it does to other government agencies - protecting privacy, providing proper care for sufferers, preventing the spread of the disease and obtaining sufficient funds to carry out all these new as well as old commitments. There are international standards which guide the way generally and for prisons in particular, such as those of the World Health Organization and the UN Standard Minimum Rules for the Treatment of Prisoners. None is legally enforceable. The Australian States should pass legislation only permitting HIV testing with consent and protecting of the privacy of HIV test results.

The Lack of Enforceable Rights for Prisoners

Rights do not exist without enforceable remedies. What, if any, enforceable rights exist in international or domestic law for Australian prisoners with HIV/AIDS?

International Standards

Rights relating to prisoners are included in the UN International Covenant on Civil and Political Rights (ICCPR). Unfortunately these rights may only be invoked by prisoners convicted of federal offences such as drug smuggling and social security fraud. This is because the *Human Rights and Equal Opportunity Commission Act 1986* (Cwlth) can and does only oblige the Commonwealth Government to observe human rights standards in areas of Commonwealth powers. At 1 July 1989 there were 516 federal prisoners in custody out of a national prison population of 12 429, or 4 per cent of the total prison population. They serve their sentences in State gaols by virtue of s. 120 of the Australian Constitution.

A complaint from a federal prisoner may be investigated by the Human Rights and Equal Opportunity Commission. However, there is no legislation creating jurisdictions, offences and penalties for breaches of prisoners' rights.

An individual prisoner cannot complain to the United Nations about an alleged breach of right. This is because Australia has not yet ratified the 'Optional Protocol' of the ICCPR by which Australia could permit its citizens to complain to the UN after they had exhausted domestic remedies.

Further, the rights in the ICCPR are accompanied by qualifying phrases which permit the derogation of rights if they are 'prescribed by law' (Article 18) or 'imposed in conformity with the law' (Article 21). On the face of it, it would be a complete defence to such a complaint if the rights had been taken away by Parliament. The State Parliaments, in particular, have extraordinarily wide constitutional powers to legislate, for example, for 'peace, welfare and good government' even where such legislation seriously impinges upon access to the courts (*Building Construction Employees & Builders Labourers Federation of NSW v. Minister for Industrial Relations* (1986) 7 NSWLR 372).

UN Standard Minimum Rules

The UN Standard Minimum Rules for the Treatment of Prisoners provide standards of custody and medical care, with special rules for 'unconvicted prisoners'. The Rules are not an international convention and so do not create legal obligations in Australia. Nor do the Australian adaptions of the Rules published by the Australian Institute of Criminology in 1984 and 1989 have any force of law (Bailey 1990, p. 307).

Prisons Acts and Regulations

Prisons Acts and Regulations are not expressed in terms which give enforceable rights to prisoners. The High Court has held that prison regulations do not confer rights on prisoners (*Flynn v. R* (1949) 79 CLR 1). This interpretation was adopted partly for policy reasons:

> for if statutes dealing with this subject matter were construed as intending to confer fixed legal rights upon prisoners it would result in applications to the courts by prisoners for legal remedies addressed either to the Crown or the gaolers in whose custody they remain. (Flynn v. R (1949) 79 CLR 1 per Dixon J at 8).

Not only are rights not conferred, prison regulations actually take away rights enjoyed by other citizens including:

- the right to refuse treatment; and
- the right to refuse to give a body sample (including blood, breath and urine samples).

It appears that the only enforceable statutory right is that of federal prisoners to communicate with the outside world (s. 20(6), *Human Rights and Equal Opportunity*

Commission Act 1986 (Cwlth)). That section provides that a person in custody is 'entitled' upon making a request to the custodians to be provided with facilities (paper, pen and envelope) for making a written complaint to the Ombudsman and to have that complaint sent to the Ombudsman.

World Health Organization Guidelines

The World Health Organization set out guidelines for the prevention and control of AIDS in prisons in November 1987. The recommendations included voluntary testing, confidentiality of results and availability of counselling. They are not enforceable.

Right to Treatment

The introduction of mandatory linked HIV testing in prisons should place, one would think, an onus on prison administrators to provide proper medical and other care for prisoners identified as being HIV positive. Does a prisoner, or any person, have a right to treatment?

The law is expressed in terms of doctors' duties rather than patients' rights. There is no common law duty on doctors in private practice to treat 'all comers', although a refusal to assess (and treat) by medical staff in the casualty department of a public hospital has been held to be a breach of the duty of care (*Barnett v. Chelsea & Kensington Hospital Management Committee* (1969) 1 QB 428). Failure to give treatment in an emergency may be in breach of ethical duties, however, and may lead to disciplinary action (e.g. s. 27(1)(h), *Medical Practitioners Act 1938* (NSW)).

The duties of members of the Prison Medical Service are set out in the Prisons (Administration) Regulations (NSW), rr. 10-14, 17, 19, including attendance at medical emergencies (r. 10(2)) and carrying out 'such medical examinations, investigations and treatment of each prisoner as may be reasonably necessary' (r. 11(2)).

There are various services and treatments available to persons with or at risk of HIV/AIDS, some of them very expensive as the cost estimates in the 1988 Commonwealth government discussion paper show (Australia. Department of Community Services and Health, pp.74-5):

- access to diagnostic procedures, including pre- and post-test counselling (estimated minimum cost $6 per person);
- access to doctors experienced in dealing with HIV/AIDS;
- access to AZT (estimated cost of $10 000 per person per year);
- access to nutritional supplements and dietary advice to counter the effects of a weakened immune system, severe weight loss and chronic diarrhoea;
- access to services that assist in the maintenance of the immune system, positive attitudes and good health, including counselling and relaxation classes;
- assistance in containing the spread of the disease by sexual contact (condoms) or intravenous drug use (clean needles and needle cleaning procedures); and

- if necessary, hospitalisation (estimated average cost $35 000 per person per year).

Clearly, many large gaol systems are concerned about the possible future costs of caring for a large number of identified HIV/AIDS prisoners. One solution is to not introduce mandatory linked HIV testing, and thereby limit the number of prisoners identified as needing treatment. Another is to test but minimise costs by limiting services such as expert medical care and counselling, support and housing services. For example, the NSW HIV testing program is reportedly going ahead without adequate counselling staff.

The level of medical services may also vary from gaol to gaol. In many NSW country gaols, including Goulburn, prisoners are treated by a local GP on contract and not by the Prison Medical Service.

At law, however, any enforceable right to treatment for HIV/AIDS must await the determination of what is an acceptable reasonable standard of care for people who are HIV positive. That has not yet been established (Hammett 1987, p. xxiv).

Further, US case law suggests that prisoners do not have any rights to demand a diagnostic test (*Estelle v. Gamble*, 429 US 97 (1976)). It is not clear whether prisoners have a right to be informed of the results of any tests they undergo.

The Right to Refuse Treatment and Testing

Legislation has also affected rights to refuse treatment or testing.

No right to refuse treatment

In civilian life, mandatory medical treatment is usually limited to the area of psychiatric treatment. In prison, it occurs in a number of States in connection with medical treatment. One example can be seen in the *Prisons Act 1952 (NSW)*, s. 16(2).

No right to refuse testing

Non-consensual testing of prisoners for HIV was not recommended by the Commonwealth Government's National HIV/AIDS Strategy published in August 1989. Only voluntary testing is recommended in World Health Organization guidelines.

Mandatory testing does, however, exist in various States, including Queensland, South Australia, Tasmania and the Northern Territory, with a quasi-voluntary scheme in Victoria (some prisoners say they did not know or were not told that they could refuse) and a voluntary scheme in Western Australia except for prisoners regarded as 'high-risk'. At the time of writing legislation has been passed in NSW but not yet commenced. The policies are contained in the following legislation:

- *Prisons (Medical Tests) Amendment Act 1990* (NSW) which amends the *Prisons Act 1952* (NSW), ss. 46 & 50; Prisons (General) Regulations, r.34A;
- *Prisons (Correctional Services) Act 1985* (NT), s.75;
- *Corrective Services Act 1988* (Qld), s. 50;
- Correctional Services Act Regulations 1985 (SA), r. 65(1);
- *Prisons Amendment Act 1987* (Tas..) which amends the *Prisons Act 1977* (Tas.), s. 17(3)-(6);
- *Corrections Act 1986* (Vic.), s. 29; and
- *Prisons Act 1981* (WA), s. 39(b).

Confidentiality of Documents and Information

Do prisoners have any right to privacy and confidentiality in relation to information held on their prison files, whether it be based on a general right to privacy of sensitive personal information or on a particular right to have medical information dealt with confidentially?

At present, the general right to documentary privacy under the *Privacy Act 1988* (Cwlth) is limited to documents held by Commonwealth government departments and agencies, and will shortly be extended to the private sector to regulate credit reference agencies. There is no data protection legislation in the States.

The traditional concept of medical confidentiality is qualified by legislation and the needs of many groups to have access to information. These qualifications include mandatory notification of citizens with HIV infection or AIDS as seen in:

- *Public Health Act 1902* (NSW), ss. 50F-L;
- *Health Act 1958* (Vic.), s. 130; and
- *Health Act 1937* (Qld), ss. 32, 32A.

Confidentiality is further undermined by provisions in prisons legislation permitting disclosure of AIDS test results. Table 2 is based on material in the report of Heilpern and Egger (1989, pp.73-74), updated with the 1990 amendments to the NSW Prisons (Administration) Regulations 1989.

As well, the informal spread of information in prisons concerning HIV status is well-known. Such information may be spread by word-of-mouth or as a result of legal, informal or unlawful access to various prison and police records, including:

- property cards at police stations;
- police criminal records (in NSW, the practice of recording alleged HIV/AIDS status on the criminal records computer was prohibited in a circular from Commissioner Avery dated 9 March 1989);
- warrants requiring someone to be taken into custody; and
- administrative, medical and disciplinary prison records. Some have the insignia 'K5' on their cover and a yellow sticker denoting a contagious disease.

The rationale for confidentiality of HIV/AIDS information is the same in gaols as it is in the community - unauthorised release may result in the person suffering discrimination.

Table 2

Disclosure of AIDS Information in Prisons

	Vic.	NSW	SA	Tas.	NT	Qld	WA	
Medical Superintendent	Y	Y	Y	Y	Y	Y	Y	
Medical officer of the prison	-	Y	-	-	-	-	-	
Department Head	-	Y	Y	Y	Y	Y	Y	
Deputy Department Head	-	Y	-	-	-	-	-	
Prison Superintendent	-	Y	Y	Y	Y	Y	Y	
Executive Director, Prison Operations	-	Y	-	-	-	-	-	
Manager, Prisoner Classifications	-	Y	-	-	-	-	-	
Chairman, Serious Offenders Review Board	-	Y	-	-	-	-	-	
Chairman, Offenders Review Board	-	Y	-	-	-	-	-	
All staff (need to know)	-	Y	-	Y	-	Y	Y	
All staff (prisoner has a communicable disease)		-	-	Y	-	-	-	-
All staff:		-	-	-	Y	-	-	
Health Department (communicable disease)	-	Y	-	-	-	Y	Y	
Health Department (at the discretion of prison medical staff)	-	-	Y	-	Y	-	-	
Relatives of prisoner (if eligible for home detention, day leave, etc)		-	-	Y	-	-	-	-
Any person whom the (a)Executive Director, Prisons Operations; or (b)Director of Prison Medical Service considers requires the information to provide for the welfare of the prisoner or the good management of the prison in which the prisoner is being held.	-	Y	-	-	-	-	-	

Accommodation: Segregation/Integration

Should prisoners identified as being HIV/AIDS positive have the right to choose between non-medical segregation and integration? At law, they are subject to the direction of the prison superintendent, with the court having no power to direct the kind of custody in which a person will be held although it may make recommendations.

The adverse effects on prisoners kept in segregation in AIDS units have been documented in the press (Stapleton 1989) and recognised by the courts as a factor in sentencing (*Bailey v. DPP* (1988) 62 ALJR 319; *R v. Bailey* (1988) 35 A Crim R 458; *R v. Smith* (1987) 44 SASR 587). They include depression, preclusion from gaol activities

(including sport and work) and restrictions on movement around the gaol and the gaol system. These conditions could clearly be alleviated if funding were made available.

Hardship conditions may apply just as much, however, if a prisoner is not segregated but his or her HIV/AIDS status is known to prison officers and prisoners. These hardships include the threat of assaults, and lack of adequate counselling and nutritional support in a decentralised prison system. In some gaol systems there is also discrimination through denial of access to work, participation in sport and other activities.

The third option is the regular prison protection units. These are very crowded, offer little guarantee that there will be no assaults by other prisoners on protection, and have all of the faults and none of the special counselling and other services that the AIDS units had.

In an ideal world HIV positive prisoners would be accepted by others, but that acceptance requires a degree of peer education, cooperation and the provision of single cell accommodation that, regrettably, is not available at present in NSW gaols at least. The deeply qualified and unenforceable nature of standards set out in prisons regulations (*R v. Flynn* (1949) 70 CLR 1) has already been mentioned including r. 1 of the NSW Prisons Regulations which recommends single cell accommodation.

Civil Prisoners: Public Health Legislation

Public health legislation in many Australian jurisdictions also provides for the taking into custody of persons having or suspected of having, HIV infection or AIDS. For example, the NSW *Public Health Act 1902,* as amended by the *Public Health (Proclaimed Diseases) Amendment Act 1989,* provides for the detention of a person alleged to be suffering from HIV infection or AIDS if he/she is endangering or likely to endanger the health of the public. This legislation commenced on 19 January 1990 and is popularly known as the 'Charlene Amendment' after a prostitute who was HIV positive and who was reckless enough to appear on television current affairs programs to talk about her work. The Act provides for a medical practitioner to issue a 28-day detention order which is reviewed by a magistrate after it is executed and which may be extended for six months by a Supreme Court judge. The place of detention is not specified, but if the detained person or any other person attempts to contravene the detention order they face criminal penalties of a maximum of six months imprisonment and/or a $5000 fine.

Other jurisdictions with comparable legislation include the Northern Territory (*Notifiable Diseases Act 1981,* s. 13), South Australia (*Public and Environmental Health Act 1987,* ss. 32, 33), Tasmania (*Public Health Act 1962,* s. 17) and Victoria (*Health (General Amendment) Act 1987* amending the *Health Act 1958,* s. 121).

Such legislation takes society back to the days of 'syphilis gaols'. The appeal procedures against such detention are unfair and the detention conditions unregulated. The statutory provisions should be repealed.

Remedies

Existing laws and practices do not adequately protect the privacy interests of citizens, including prisoners, in relation to HIV testing and the disclosure of test results. Many US jurisdictions do have such legislation. One example is the Californian Health and Safety Code ss. 199.20-23, passed in 1985. The position can be rectified in Australia by all States and Territories passing legislation which:

- repeals compulsory universal HIV testing of prisoners;
- requires that written consent be obtained before HIV testing is carried out, with a separate and detailed consent form which is not part of a list of consents to be ticked; and
- provides civil and criminal penalties for the release of test results except where there is signed authorisation by the test subject. The civil penalties should be liability to court costs and fines of between $1000 and $5000 for each

disclosure. The criminal penalties following conviction for a misdemeanour should be a maximum of twelve months imprisonment and/or a fine of $10 000. The test subject should be able to sue for damages.

Although there are some exceptions in criminal legislation which undermine the same confidentiality protection being extended to prisoners (California Penal Law, s. 7520, s. 7521(a), s. 7522) such exceptions should be extremely limited.

Such legislation would also constitute recognition that prisoners have the least rights of any group in Australian society and should have enforceable minimum standards of custody and treatment.

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Educational Strategies and Policy Development

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The topic of this paper is the role of education in policy development. This paper identifies the major educational stages in this process which have been significant in:

- responding to the AIDS issue;
- managing AIDS issues in prisons; and
- effecting lasting changes which include breaking down traditional departmental barriers.

NSW Prison AIDS Project

In 1985 the New South Wales Department of Corrective Services responded to the need for AIDS information by incorporating AIDS education into existing drug and alcohol programs for inmates. In 1987 a group of inmates from Bathurst Gaol developed a proposal for a more effective AIDS education program involving both prison staff and inmates. As a result, a pilot AIDS education program was conducted at Bathurst Gaol followed by the introduction of the New South Wales Department of Corrective Services Prison AIDS Project.

Initially, many staff and inmates did not see a need for AIDS education and most saw no reason or relevance for them receiving any information or education on AIDS. The most common feelings expressed by both groups were fear, hysteria and homophobia.

The prison community's response to AIDS was similar to that of the wider community. Many officers and inmates preferred to take the ostrich approach, keep their heads in the sand and hope that AIDS would disappear. Through media figures such as the Grim Reaper everyone received the message of fear and not the accurate information which was essential to alleviate the hysteria.

The Prison AIDS Project's main goal was to prevent the transmission of Human Immunodeficiency Virus (HIV) throughout New South Wales prisons and ensure prisoners infected with HIV had equal access to treatment and care as they would in the outside community. Rather than impose policies on the system, it was necessary to develop a

[1] The views expressed in this article are those of the author and do not necessarily reflect the policies of the NSW Department of Corrective Services.

proactive educational process which the system could own and which would become part of the system.

The two major objectives were to:

- develop a departmental infrastructure capable of managing the AIDS issue in all stages of development; and
- ensure inmates had the knowledge, skills, attitudes and the means to avoid HIV infection.

Phase One of the project began with securing funding and resources, and establishing a usable infrastructure which could survive prison policy and deal with AIDS issues. Delicate and sometimes difficult issues which involved a person's innermost values, attitudes and the subjects of drugs, death and prison policy were incorporated.

If the AIDS Project had tried to introduce an AIDS education program for inmates or officers at this early stage, it would have failed due to the lack of support from both groups. A need to know and understand had to be established. AIDS information sessions were held in each gaol for officers and inmates to provide accurate information and eliminate some of the myths, fallacies, fear and hysteria.

In an effort to raise the level of awareness amongst officers and inmates, an AIDS coordinator was employed to facilitate information sessions throughout the State's twenty-seven correctional centres. These sessions did not aim to change attitudes or behaviour and frequently resulted in displays of anger, representing fear, which were directed towards either the gay community or the Department of Corrective Services for not testing and not agreeing to disclose prisoners' HIV status. Despite the State's anti-discrimination laws most officers and inmates felt they needed, and had a right, to know who was infected with HIV.

At this stage, although departmental policy supported the AIDS education program, it was very apparent when it came to funding, how low a priority AIDS education was given. Initially, there was only sufficient funding for one AIDS coordinator, to educate 5500 inmates and 3000 custodial officers in twenty-seven geographically distinct and sometimes isolated centres.

As the level of AIDS awareness was still quite low during this phase there were no demands placed on the Department of Corrective Services to provide policies and procedures. This situation has indeed changed in three years! Medical specialists from the community were contracted to help during this initial phase, to boost the level of credibility of the AIDS information sessions. The AIDS Project also benefited from this additional support. This strategy was successful in breaking down traditional barriers within the Department, in that Departmental initiatives are not always welcomed or supported by either inmates or officers.

The AIDS Project has shown a commitment to adhering to and respecting both the overt and the covert prison rules and regulations. At times this has meant working within the time restraints of the institution, for example, being locked out of gaols after travelling for hours, due to a shortage of custodial officers within the institution.

The main achievement during the first phase of the project was the establishment of an infrastructure providing each institution with the opportunity to be responsible for AIDS education and have the capability of dealing with AIDS issues within the institution.

The underlying theme advocated by the AIDS Project was self-ownership and self-management of AIDS issues by both officers and inmates at each gaol. This theme was based on the premise that:

> [i]nformation given on its own does not change behaviour or attitudes. The prison system is made up of two self-sufficient, highly developed, hierarchies and hard to access groups - officers and prisoners. Both of these groups are traditionally antagonistic towards one another, administratively interwoven and driven by an unpredictable political agenda (Scagliotti 1990, p. 3).

For these reasons, the very idea of prison officers working with inmates towards the same goal was unprecedented and challenged many traditional barriers.

At this stage two more AIDS coordinators were employed, funded by the AIDS Bureau in the New South Wales Department of Health. The State was divided into northern, western and metropolitan regions and, over a six-month period, an AIDS Action Committee was set up in each New South Wales prison. A prison officer from each institution was appointed as AIDS Program Organiser to chair the committee and liaise between the prison and the AIDS coordinator. This voluntary position is the linchpin of the structure and requires a special type of officer who has a commitment to the AIDS issue and also credibility with other officers, prison management and the ability to relate to inmates. The inmates on the AIDS Action Committee volunteer for selection. They are chosen on their commitment, length of sentence and credibility with their peers. Wherever possible representatives from the Prison Medical Service, psychology, drug and alcohol, welfare, education services and, in some cases, the prison chaplain also act on these committees. This group forms the infrastructure which has proved successful in maintaining AIDS awareness and focusing on educational strategies in all New South Wales prisons. Despite the fact that New South Wales has a flowthrough of 15 000 prisoners per year these committees have remained active due to the strength of this infrastructure. In a twelve-month period more than thirty different educational strategies were developed by the AIDS Action Committees throughout the State. Some of these included, video productions, T-shirt design, songs, plays and the latest idea for World AIDS Day - the release of helium filled balloons from gaols across the State to signify people who have died from AIDS in Australia and to raise money for the Kids with AIDS Appeal.

The AIDS Action Committees gained support from the prison system as AIDS awareness increased due to the educational process and people within the prison community were willing to take responsibility for the problem. As a result, educational strategies have played a major role in policy development. Policy has developed in response to education and as peoples' awareness of AIDS education has increased, so has the system's need for policies to reinforce this process. Then lasting changes can be accomplished. One example of a change which has occurred, is the provision of Milton bleach tablets for use by inmates for general cleaning purposes.

Phase Two of the project has focused on building on the awareness phase with skills-based training for both officers and inmates. The AIDS Project moved into this phase during the middle of 1989 with the introduction of the Prisoners Peer Education Program and the Officers Seeding Course. The AIDS Project worked proactively, concentrating attention on the educational needs of the two target groups rather than reacting to political agendas such as the proposed introduction of compulsory HIV testing.

The idea for a Prisoner Peer Education Program came from a small group of inmates at Bathurst Gaol and was implemented following a successful trial. The Centre for Education and Information on Drugs and Alcohol (CEIDA) was contracted by the Department of Corrective Services to develop a package from the model which could be implemented across the State. Planning for the implementation of the Peer Education Program was meticulous so that the prison system would both accept and support it.

Each institution was given the responsibility of organising the program which was coordinated through the AIDS Action Committee and the AIDS coordinator. Once again, the underlying theme of self-ownership of the program and self-management of the process was highlighted. The AIDS Action Committee used its own criteria to select suitable participants to undertake the program.

Despite the demands this program placed upon prison management at times, such as superintendents agreeing to paid work release for inmates to attend the program, it has been very successful with forty programs completed throughout New South Wales institutions. Four hundred and eighty-nine inmates have participated over a twelve month period. The program has been adapted to cater for the needs of Aboriginal prisoners and those with developmental disabilities.

The program has been in high demand, However, had it been imposed on the prison system before there was a perceived need for it, it would have failed.

The benefits of the program are numerous. For example, counselling skills learned by inmates will be extremely useful following the introduction of compulsory HIV testing. These skills will help prisoners assist other prisoners with support and information.

Another major benefit of this program is the self-esteem inmates have gained from participation. The program uses adult learning methods and participants are rewarded on their contribution and completion of the four-day program rather than on academic merit. For many participants this course represents the only thing they have successfully completed in their lives. The self-esteem they gain is a prerequisite for behaviour change. An inmate who has no self-esteem will not care enough about him/herself to use safer sex practices or to use intravenous drugs safely.

A useful adjunct in AIDS education for prisoners is the 'Gaolwize' comic and kit developed by Streetwize Comics. Despite controversy surrounding some of its contents, it has received ministerial approval for distribution throughout all New South Wales prisons. Comics can be a useful educational tool when it is remembered that up to 40 per cent of inmates in New South Wales prisons have some degree of literacy problem (NSW Department of Corrective Services, 1990). 'Gaolwize' was also successful in reaching out to those who would be unreceptive to other more formal methods of education.

Management of HIV/AIDS issues for officers constituted the second target area in Phase Two. Increased HIV/AIDS awareness amongst officers changed attitudes from not wanting to know about AIDS to requests for information on 'how to handle the situation'. A course similar to the inmates' Peer Education Program, was designed to train selected officers throughout the State. This course has been in high demand and the Department has pledged its support and funds to enable officers to attend.

The Prison AIDS Project is presently entering Phase Three of the educational process - integration. '[t]he building into the Departmental structure of key training programs, policies and management strategies required to manage the AIDS issue in the long term' (Scagliotti 1990, p. 2). The Peer Education Program has entered this phase with CEIDA developing a Train the Trainer program targeted at training staff from each centre so the Peer Education Program is ongoing and is built into the system. The same process may be necessary for the officers' management program.

By integrating these programs the dangers of repetition, stagnation and compartmentalisation are avoided. The role of educational strategies in program development, therefore, must respond to the need for change.

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HIV Education Strategies within Correctional Services - The South Australian Experience

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The Acquired Immune Deficiency Syndrome (AIDS) was first reported in the United States of America in 1981. By December 1988, the number of reported infections had grown to 132 976 cases worldwide. To date the actual scope and magnitude of the Human Immunodeficiency Virus (HIV) is unknown. The only certainty is that globally it is continuing to spread and the numbers of HIV infections and HIV related illnesses including AIDS, will increase.

Australia unfortunately is not unaffected by the transmission of HIV infection and continues to follow patterns similar to those occurring in other Western countries, where most cases of reported HIV infection have occurred amongst men who have sex with other men, and in people who choose to inject substances. Heterosexual transmission in Western countries, unlike many underdeveloped countries, accounts for only a small percentage of cases of HIV infection. Current data suggests this trend is on the increase (Heilpern & Egger 1989).

It has been suggested that prisons provide an environment which can further the spread of HIV/AIDS, not only to those incarcerated, but also to the broader community. The containment of HIV in prisons is vital in reducing its transmission throughout the community. There have been both national and international efforts to deal with HIV/AIDS in prisons. This paper outlines the South Australian experience, examines the educational strategies developed in this State to raise awareness amongst inmates and the obstacles which have prevented such strategies from being successful.

Overview

AIDS first became an issue for correctional services in South Australia in early 1983; soon after the first case of HIV infection was identified in Australia. Concerns were raised by the correctional officers' union which expressed fears for the safety and possible health risks to its members and uninfected prisoners.

In response to these fears, correctional services attempted to gather information, data and advice for officers on the then, limited knowledge available on HIV infection. Particular emphasis was placed on hygiene practices and procedures which were aimed at reducing the probability of occupational transmission. There was little emphasis on the social and

behavioural situations of either inmates or officers or the probability of transmission through these modes.

The fear, mystery and lack of knowledge about HIV, contributed to officers' genuine concerns, especially given hysterical messages conveyed through the media at the time. The Department of Correctional Services responded to these concerns by consulting with the South Australian Health Commission's Communicable Diseases Control Unit, and over the following twelve months presentations were made, discussion groups convened and information pamphlets distributed to all staff members. Whilst fear continued and issues still needed to be addressed, this was in effect the start of a correctional services' HIV education program.

In June 1985, through a voluntary testing program, the first South Australian prisoner with HIV antibodies was detected, bringing to a head many of the underlying fears previously discussed.

Officers responded to this with a series of industrial stoppages. They demanded more information, protection and the isolation of prisoners who were found to have HIV antibodies. The Minister of Correctional Services, Mr Frank Blevins, intervened and announced the establishment of a working party which would be responsible for developing infection control guidelines, examining the issues at hand and making appropriate recommendations.

In the meantime, HIV positive prisoners were isolated from fellow prisoners and received virtually no other contact. The infamous correctional officer 'space suits' were introduced to protect officers from any perceived infection. Fortunately these regimes did not last and, as officers began to receive more accurate messages about HIV infection, a calmer, more rational approach was developed. Following the recommendations handed down by the working party, known as the 'Cameron Committee', more appropriate procedures for dealing with HIV positive prisoners were implemented.

Inmates who were HIV positive were integrated back into the mainstream of the prison and provided with single cell accommodation, with a Departmental commitment to provide single cell accommodation for all inmates through the long term restructuring of its gaols. By 1990 this had been achieved in all institutions except for a very small number of cells.

The Department also developed a management regime through its Departmental Instructions to deal with prisoners identified as having a communicable disease (not necessarily HIV infection). These Departmental Instructions cover all aspects of managing prisoners who have a communicable disease, ranging from the use of gloves when searching a cell, through to a commitment to provide education and information to all staff and inmates, on all areas of communicable diseases ranging from infection control to lifestyle issues.

Despite this, fear and concern continued to prevail, not only amongst staff, but also amongst other inmates. Following attempts to integrate HIV positive prisoners into the mainstream population, there were a number of sit-ins with inmates refusing to allow seropositive prisoners to mix with them. The Department responded with discussions and negotiations on an issue by issue basis.

In addition to practical and physical responses, such as the provision of disinfectants and gloves, an AIDS Education Officer was seconded from the South Australian Health Commission for a six-month period to assist in the development of an education program which would address the management of HIV infection in the correctional setting.

During this period the AIDS Education Officer facilitated the development of booklets, posters and other publicity materials, aimed at raising awareness of HIV issues amongst correctional officers. These materials were used in conjunction with lectures and videotape presentations shown to staff and new trainees. Nearly all initiatives and strategies aimed to reduce anxiety levels amongst staff concerning HIV transmission. This was seen as crucial before education amongst inmates could begin.

Following the completion of the secondment, the AIDS Education Officer returned to the Health Commission and there was a six-month delay before a new Education Officer was appointed. Due to the delays in the appointment of this new officer, many of the

initiatives previously undertaken ceased to exist. In essence this meant the new Education Officer was required to start from the beginning again.

At this time, the media in South Australia had once again managed to raise fears and anxieties through a new wave of hysteria in their reporting. This necessitated further targeting of staff with education and dealing with potential industrial problems which were developing because of perceived risks.

A training package was developed and incorporated into the new officers' induction programs and into in-service training. Because of the nature of correctional institutions, it was difficult to reach all officers, and much of the information dissemination had to occur through individual discussions and informal talks with staff at their work sites and during lunch breaks. Whilst this system was not able to reach all staff, it did provide officers with the opportunity to discuss issues of concern in detail, and on a more personal level.

Throughout this process, information on HIV infection for prisoners was disseminated via formal presentations and lectures, or informal talks to inmates at their request. Without formalised programs, however, many prisoners missed out on this information or did not have the opportunity to internalise information appropriate for their individual needs or situation.

With the appointment of the Health Project Officer the education program was expanded to deal with communicable diseases and sexually transmitted diseases more generally. Its main thrust was on hepatitis B and HIV in gaols, largely because of the similarities in transmission patterns, recognising that by this time the issue of HIV/AIDS had been laboured for so long that many people had begun to 'switch off' when they heard about it.

Education Needs

It has long been recognised, in the absence of any cure for HIV infection, that education and awareness remain the only effective weapons in attempting to prevent the spread of the virus. Research appears to indicate that whilst there is some basic knowledge about HIV infection amongst prisoners, there has been no substantial reduction in risk behaviours, particularly amongst intravenous drug users.

Stories told by inmates include intravenous drug users being unwilling to share their syringe with people who have HIV infection, but willing to use the syringe of an HIV positive person thinking they are not at risk. Tales are also told of users cleaning syringes in hot water unaware that this causes blood to coagulate providing little, if any, protection against the virus (Behrens-Peters 1990).

Education delivered in lecture format to inmates does not meet their needs. To be effective, the content and style of delivery needs to be modified. Education programs on HIV infection need to be tailored to the attitudes, beliefs and practices of the target group and, where possible, involve inmates in the development and presentation of the education programs.

In research conducted into the knowledge of HIV amongst prisoners and prison officers, most prisoners and officers responded accurately 'to statements about HIV and its transmission but 13 per cent and 16 per cent respectively thought it was possible to be infected with HIV by sharing drinking cups' (Gaughwin et al. 1990, p. 61).

The majority of prisoners and officers were of the opinion that information about HIV has not reduced risk behaviours, particularly the use of intravenous drugs.

> Sixty four per cent of prisoners and 46 per cent of prison officers disagreed that prisoners are not worried about risks of contracting HIV in prison while 68 per cent of prisoners and 51 per cent of prison officers thought that prisoners did not know enough about HIV to protect themselves from it (Gaughwin et al. 1990, pp. 61-2).

Experiential Learning Model

The experiential learning method known also as student-centred, self-directed or adult learning has been used to develop HIV education programs for prisoners in correctional institutions in South Australia.

This educational theory is based on the principle that people learn most effectively when:

- they are involved in deciding what and how they will learn, and are allowed to take responsibility for their learning;
- learning is perceived to be relevant to their needs;
- learning is grounded in practical experience with time allowed for reflection and analysis;
- all learners are respected for the existing knowledge, skills and experience they bring to the task;
- relationships are valued and support is provided; and
- the community is used as a resource for learning.

For learning to occur and to be effective, participants need to be willing to participate and their ability to provide input and contribute to the development of a program is fundamental to the success or failure of a session.

Consideration needs to be given to individual personalities and what they identify their needs to be in relation to HIV infection. Often the incentive for their participation needs to be acknowledged. In essence, when working with prisoners, the question 'What's in it for me?' is often important, especially when many inmates perceive that they already know all they need to know about HIV, or think it does not affect them. In the course of running a program, many inmates reveal that they were not as well-versed about HIV infection as they had assumed they were, but the initial problem of encouraging inmates to participate is a basic problem.

Many community-based programs have been developed with specific target groups in mind. Many prisoners do not identify with these groups or they simply are not available in many prisons. For example, many inmates do not identify with the gay community. Therefore, community-based programs targeting gay and bisexual men do not reach them.

Prisoners themselves are not a homogenous group. There are many subgroups, each with differing needs in the prison population. Often the only thing these groups have in common is that they are incarcerated. Groups may include gay men, people who choose to inject, child molesters, Aboriginals, women, people from non-English speaking backgrounds, or developmentally delayed people.

In developing HIV education programs in the correctional setting, the correctional system itself can be a major issue. Gaols are made up of two diametrically opposed, highly developed and hard-to-access groups: the officers and the prisoners. These two groups are quite different, yet are administratively interwoven and driven by a range of unpredictable political agendas (Scagliotti 1990, p. 3).

Before working with inmates on the establishment of HIV education programs, the entire prison system needs to be addressed to establish a climate and infrastructure in which both officers and prisoners are administratively and personally willing to participate in the educational process.

To achieve this goal the various institutions need firstly to develop a recognition for, and a commitment to, HIV education for inmates and for staff. Due to staffing shortages and a preoccupation with security issues, this goal often receives little priority in the day-to-day management of institutions. Therefore before beginning work with inmates, discussion and negotiation needs to occur at all levels of individual institutions, commencing with the manager through to officers who work on the floor with the inmates on a day-to-day basis.

Discussion involves outlining the role of education in HIV infection, the process of education and how these objectives are to be achieved from a corrections viewpoint and also from a public health perspective. If the educator is new or unknown to the officers this process can be lengthy and often time-consuming, generally because many officers are cautious about upsetting prison routines and creating precedents. However, this process should be viewed as fundamental to the success of implementing such programs. Indirectly, it also serves as part of the education process for staff, through raising general awareness and support for what is happening within the institution and the broader community, therefore creating a climate in which the fostering of HIV education amongst prisoners can be successful.

As experiential learning relies heavily on individual support and commitment to the program, the support of the officers is often useful in helping identify key inmates who are influential in the informal but powerful prisoner hierarchy. Such inmates are crucial participants in any program, if it is to receive the overall support of other prisoners. Often, inmates do not wish to be identified as being involved in a HIV education program unless it is seen to be supported by other prisoners. They fear being labelled HIV positive or gay.

After identifying key inmates within the target group, the process of linking educational strategies with the specific needs of the group can begin. Through consultation and discussion with a range of prisoners in a unit or area, a program of specific needs and issues relevant for that group can be developed and implemented accordingly.

Many inmates would prefer information about HIV infection to be placed in a broader context. Others have a preference for a particular type of presenter depending on the composition of the group. Such presenters might be a gay man, an Aboriginal, a woman, an ex-inmate or an IV drug user.

As a result, HIV issues have been presented in sexuality workshops, women-only groups, sports medicine and AIDS, first aid courses and HIV infection, or Aboriginals and AIDS groups. Others prefer information on HIV discussed in conjunction with drug use and abuse or sexually transmitted diseases, thus removing the purely AIDS flavour to any presentation.

Within South Australian institutions, many inmates report interest and enthusiasm for HIV education programs, but often express concern and frustration at the lack of resource material such as pamphlets, or the absence of bleach or condoms to provide protection in prison.

In South Australia, both sex and drug use are expressly prohibited in prisons, and consequently neither bleach nor condoms are made available to inmates. There are also severe restrictions on the type of information material considered appropriate. Material which explicitly shows safe practices such as needle cleaning, and condom use is not allowed in prison.

Having accessed inmates and negotiated a commitment for a specific program, a proposed program is drawn up. Its contents and format are negotiated with inmates and institutional staff. Community groups such as the AIDS Council, STD clinics or community health centres often assist in the co-presentation of a session.

Outside groups are used largely as a linking exercise which recognises that prisons are not insular communities, but rather fluid groups of individuals who interact regularly with the rest of the community. This is often useful in assisting inmates to develop resource contacts with other agencies when released from gaol. Other programs have used inmates to assist in the presentation of a program, drawing on their experiences of gaol life or IV drug use to establish credibility with other inmates.

For example, Port Augusta Gaol has a high proportion of non-urban Aboriginal inmates, so an HIV education program was developed with this consideration in mind. Initially this was through an introduction to an elder from an Aboriginal drug and alcohol worker. Following negotiations and discussions with the elder and several Aboriginal inmates, it was proposed that a workshop on HIV and Aboriginal communities be run in conjunction with the local Pika Wrya Aboriginal Community Health Centre. This program

proved so successful that of thirty-two Aboriginal inmates at Port Augusta at the time, twenty-nine of those attended.

Likewise, in discussing the development of a program in the women's section of Northfield Prison Complex the education program was developed by the women. It comprised thirteen sessions, and examined a range of women's health issues, including pregnancy, sexually transmitted diseases, AIDS, drug use and abuse, lifestyles and relationships. The program was presented by a doctor and community health nurse from the Adelaide Women's Community Health Centre, and was very successful.

This method of education enables the inmates to own the program and, therefore, increases the chance of success and continued attendance. It also provides a critical link to the rest of the community through the presenters, as well as complementing additional services offered by corrections. This is an important factor when it is recognised that the majority of inmates serve sentences of less than twelve months and are often back in the community after having served only short periods 'inside'.

To date, the educational experience with South Australian prisoners is only in the first phase of a much broader program. Having established an environment in which conducting HIV education programs is seen as a norm within institutions, phase two will aim to develop a prisoner peer educational model, educating inmates to be educators to other prisoners.

The implementation of this next phase should not be seen as a deviation from using the experiential learning approach to teaching. Rather, it uses this model to build further on accomplishments already achieved. In establishing a peer education program amongst inmates, consultation on the involvement of inmates will be an important element in the process.

The needs of officers should not be overlooked in this educational process. An officer education program needs to be developed (*see* Appendix 1). Educational programs for officers and inmates need to be implemented in parallel and drawn together.

Human Immunodeficiency Virus is recognised as one of the greatest public health issues to confront the world this century. Its role in prisons is no exception. Although inmates and officers are often seen as being on opposite sides of the fence, HIV is an issue that affects them equally and needs to be dealt with as a complete package.

The South Australian correctional services' experience does not purport to have all the solutions to the problems. The policy of integration and the management of HIV in prisons has been complemented with a series of educational strategies which will continue to develop, thus leading to a safer environment for those who live and work in prisons, and at the same time, having positive benefits for the whole community.

Appendix 1

Communicable Diseases Education Program
Implementation Structure
Issue: Communicable Diseases

Problem: Lack of Knowledge, Awareness of Procedures, Fear, Hysteria and High-Risk Behaviours

Stage One - Education and Development

Aim: To develop a recognition and commitment to ongoing Communicable Diseases Education programs for all staff and inmates, whilst ensuring issues of policy and procedures are addressed and dealt with.

Officers	Policies and Procedures	Prisoners
Staff workshops through recruit training program, institutional workshops and sessions, community corrections staff and CSO supervisors.	AIDS Strategy Review	Workshops at all institutions for inmates including the use of outside agencies, plays and co-facilitation.
Study of Education Strategies employed in New South Wales.	Staff AIDS Education Strategy	Study of New South Wales Prison AIDS Project
Establishment of a Staff AIDS Education Strategy.		Development of Prison Peer Education Training Package.

Stage Two - Education and Training Implementation

Aim: To build on Stage One and implement strategies identified in Stage One.

Formalised workshops for Managers, Chief Correctional Officers, New Recruits, Custodial Staff, Programs/ Social Work, Correctional Industry Officers Community Corrections staff.

AIDS Strategy tabled and presented to Minister for endorsement.

Implementation Prisoner Peer Education Program.

Negotiate with agency to conduct program.

Pilot program in an institution

Evaluate pilot.

Implement Peer Education Program in all institutions.

Ongoing support for Peer Educators.

Such Workshops will involve information sessions and skills based workshops.

Development of new policies and procedures.

Coming together of Prisoner Education, Officer Education and policy through the formation of Institutional AIDS/ Health Committees.

Each institution will assume responsibility for the Education and Management of Communicable Diseases in their gaol via these committees which will consist of inmate and staff representatives.

Stage Three - Program Maintenance

Aim: To maintain Communicable Diseases Education Program, reviewing and modifying the program where appropriate at an institutional level.

To maintain and assist ongoing education services to staff at an institutional level.

Identify areas of policy which require further development.

To support Prison Peer Educators in their programs and identified education strategies.

To support and strengthen local AIDS/Health Committees and Occupational Health and Safety Committees to redress local issues.

It is anticipated these AIDS/Health Committees may develop local initiatives through their Prison Peer Educators and such activities may include Quiz nights, T-shirt printing, possible poster competitions just to mention a few.

Outcomes should result in the containment of Communicable Diseases infections, a greater awareness and concern for issues around Communicable Diseases and more caring and assistance for those who are infected.

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Prison AIDS Project: Prison Officer Education

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Prison officer AIDS training within the New South Wales prison system has experienced many difficulties and changes in the past three years. The main source of problems has been the anxieties and fears of the prison officers themselves, having to face the complex issue of managing HIV positive inmates within the prison system. Many of these anxieties appear to have originated from ignorance and misinterpretation of facts, combined with media publicity concerning AIDS transmission in the workplace. This paper will describe the education programs which have been implemented over the past two years by the Prisons AIDS Project to help officers come to terms with the everyday problems concerned with managing their working life and dealing with AIDS related issues simultaneously.

Background

As early as March 1987 attempts were made to introduce officers to some form of AIDS education. The group targeted initially was divisional heads, superintendents and other senior officers in the New South Wales Department of Corrective Services. Information sessions and seminars were held on a regular basis. Speakers included Dr Frank McLeod from the Prison Medical Service, Professor Ron Penny, Ms Ita Buttrose who was at the time, head of the AIDS Task Force, Ms Louisa Scagliotti, AIDS Project Manager, and Dr David Sutherland, head of the AIDS Unit at Royal Newcastle Hospital. The purpose of these seminars was to inform senior officers of the known facts, so that they would then develop management strategies to promote AIDS policies and conduct AIDS education within their own institutions. From this initiative, inmate committees were introduced with a custodial officer appointed as AIDS coordinator in each gaol.

In 1987 I became involved with the inmate committee at the Training Centre at Long Bay Gaol. As a ten-year custodial officer, I accepted the role of coordinator in that institution. This involved organising seminars and AIDS information sessions for inmates and also supplying appropriate AIDS literature to staff.

In April 1988 I was seconded to the Prison AIDS Project as a coordinator. My responsibility was to provide AIDS education for prison officers within two target groups. These were:

- current prison officers; and

- newly recruited officers undergoing prison officer training.

Information Sessions

During the period between April 1988 and September 1989 I organised forty-two information sessions across the State. These sessions were usually conducted by experts such as Dr Peter Bruce from Sydney Hospital and Professor David Sutherland from Royal Newcastle Hospital. However, it became apparent after a period of twelve months that there were a number of difficulties with the information sessions for officers.

Firstly, I was always at the mercy of the gaol superintendents for time allocated. This time was usually in the early part of the morning before the unlock of the gaol. On many occasions there was not sufficient time to address the complex issues raised by officers and certainly not enough time to dispel any of the officers' fears or apprehensions concerning the management of HIV positive inmates in the normal gaol routine.

Another difficulty was that superintendents would not agree to make these sessions compulsory. Officers only attended if they desired, even though sessions were held in departmental time, and they were paid to attend. Hence, information did not reach all officers and had minimal impact in alleviating fears, and changing prison officer attitudes with regards to AIDS. In addition, the Department made very little funding available for prison officer education.

There was also a difficulty in addressing occupational health and safety issues and encouraging officers to adopt 'safe work' practices. Officers were issued with 'AIDS Pouches' containing : one pair of rubber gloves, a bottle of Milton bleach and some swabs for initial precautionary measures. However, most used these pouches to carry their cigarettes and joked about the contents of the pouch.

In addition, the Prison Officers Union and the Prison Officer Vocational Branch (POVB) were promoting a policy of segregation at this time. Inmates found to be antibody positive were housed in the AIDS Unit within the Assessment Prison at Long Bay. Officers working in this area of the gaol were volunteers. This meant the majority of officers had no involvement in the everyday management of identified HIV positive inmates.

Many officers did not believe AIDS education was a priority and felt the department should protect them against any risks of transmission. They also refused to recognise that 'high-risk' sexual behaviour in their private lives should be a concern. Many officers believed that only homosexuals or intravenous drug users were at risk. These opinions were difficult to change especially given community attitudes and media reporting.

Evaluative studies carried out by the Research Division in the Department of Corrective Services indicated that although officers had gained some knowledge of AIDS, attitudes had not changed. Officers were still demanding segregation and had not adopted any occupational health and safety strategies to avoid 'high-risk' contaminations (Conolly 1990).

Primary Training

AIDS training for new recruits was introduced in April 1988 at the Training School of Long Bay Gaol. A training package was designed by myself, in an attempt to meet the needs of officers entering the Department (Adamson 1988a). All officers received general AIDS information and were instructed in 'safe work' practices, under the Occupational Health and Safety Guidelines (Adamson 1988b). This program was researched and evaluated over a two-year period (Conolly 1990). The results of the evaluation showed that:

- the use of a custodial officer to conduct training had a positive impact;
- the contents of the package were comprehensive and relevant to prison officers and the presentation had credibility with the officers;
- delivery in a classroom away from the intrusive distractions and interruptions of the normal working day was a major advantage in training prison officers.

A follow-up questionnaire distributed by the Research Division showed that officers who had received more structured education felt more secure in the workplace and were prepared to use the occupational health and safety procedures they had been taught. In addition, others who were working in the Assessment Prison at Long Bay had volunteered to work in the AIDS unit with HIV positive inmates.

However, over a longer period of time it became evident that junior officers experienced peer group pressure from their senior counterparts especially when they began wearing rubber gloves during cell searches and blood spill situations. A common retort was that 'officers who wore rubber gloves in blood spills were sissies and should not be in the job'. It was very difficult at this time to obtain a directive from the Department to require officers to practise appropriate occupational health and safety measures in the workplace.

The POVB was also insistent on a segregation policy and left no room for negotiation. This situation was further aggravated by local industrial disputes with officers demanding segregation each time an HIV positive inmate was admitted. When these disputes were heard in the Industrial Court, officers claimed they lacked HIV/AIDS education and that the Department of Corrective Services had not addressed their needs. They stated that the information sessions were not enough and they needed more indepth training.

Following these industrial disputes, the manager of the Prison AIDS Project, Ms Louisa Scagliotti, procured funding for the Officers Seeding Program from the New South Wales Health Department (later called the AIDS Management Course). The main aim of the Seeding Program is to provide officers with expertise, skills and knowledge of AIDS and occupational health and safety procedures so they can then act as role models within their gaols, for other officers. These officers would also be recognised by other officers as appropriate resource personnel when problems arose. All officers are thereby provided with a support mechanism to ensure 'safe work' practices are observed. The Department, in conjunction with the Prison AIDS Project, put forward an occupational health and safety policy for officers which carried definite instructions relating to HIV/AIDS and hepatitis B prevention. From February 1988 vaccinations were made available to all officers against hepatitis B.

The Minister for Corrective Services Mr Michael Yabsley has also given instructions for a compulsory testing scheme for New South Wales prisons in the near future and for all HIV positive inmates to be integrated into the system. Officers are feeling very threatened about this situation. Many of their fears and the myths concerning HIV/AIDS have to be addressed in order for this policy to be carried out effectively.

AIDS Management Course

Officers Seeding Program

In February 1990 sufficient funding was approved to provide training for thirty officers and a course coordinator. I was seconded to the Corrective Services Academy to design and implement the course (Adamson 1990).

Implementation

A Needs Analysis was carried out in five of the major gaols in the metropolitan area namely the Remand Prison, Assessment Prison, Reception Prison, Training Centre and Mulawa Training and Detention Centre for women. Officers in these gaols manage some of the most troublesome prisoners in New South Wales. In addition, the unit for HIV positive inmates is part of the Assessment Prison.

The results of the analysis showed that officers had some knowledge about AIDS but still believed AIDS was a disease of intravenous drug users and homosexuals. They believed that segregation of HIV-infected inmates would solve most of their problems. These officers appeared to have very little understanding of the testing process and even less

about the window period. They claimed if the Department of Corrective Services retained a policy of segregation for infected inmates, officers could then volunteer to work with them and mainstream officers and inmates would then be safe. The most vocal officers, were those with at least five years experience in prison and of middle management rank.

It was these officers, who were applying pressure to those newly recruited officers who tried to put occupational health and safety procedures into practice. However, during a group work session it was these officers who claimed to be apprehensive when handling the following situations:

- blood spills;
- needle stab injuries;
- suicides;
- Cardio Pulmonary Resuscitation (mouth to mouth resuscitation);
- self mutilators;
- violent inmates;
- assaults;
- bites;
- open wounds; and
- exposure to body fluids.

It became evident officers had not been reporting these incidents in an appropriate manner or seeking proper medical attention. None of the officers involved in heavy blood spills or needle stab injuries had sought testing or any form of counselling. Many admitted after such incidents that their greatest fear was contracting HIV. They maintained it was the Department of Corrective Services' responsibility to protect them from infection rather than themselves taking responsibility for their own private and working lives. The AIDS Management Course was implemented in order to break down barriers and alter behaviours in the workplace.

Course criteria

The criteria for the course was determined by the Needs Analysis. If the course was to be successful then it had to target officers who had some credibility within the gaol and who also had a good rapport with other officers.

The criteria targeted officers who:

- held the rank of Senior Prison Officer;
- held the rank of First Class and had more than two years experience in wing management;
- had a commitment to training junior officers about occupational health and safety in the workplace;
- displayed a commitment to working with HIV positive inmates; and
- displayed a commitment to AIDS issues within their respective gaols.

Fifteen officers were to take part in each course with a total of thirty officers participating. It was decided to target the metropolitan gaols and select six officers from each gaol thus establishing a 'critical mass' and a support mechanism to cut through the effect of peer group pressure. Officers applying to do the course were to do so on a voluntary basis with the final selection being determined by the course coordinator. This was to ensure officers were not forced to participate.

Behavioural objectives

The course objectives were clearly defined, and all areas of the Needs Analysis taken into consideration. It was of the utmost importance that the course cover all aspects of AIDS and occupational health and safety issues. For officers to become proficient in managing HIV inmates they had to be taught skills that would create for them a sense of competence and confidence when faced with complex situations. Prison Officers' training in the past has followed the philosophy of 'act first and think later'. It now had to be changed to 'think first and act later'.

Evaluation strategy

It was necessary to set up an evaluation procedure for the course, to ascertain if the training objectives had been achieved and if any learning had indeed taken place. To assess the learning level of the participants, the evaluation was carried out in the following manner.

Phase one involved a pre-test (AIDS questionnaire no. 1) covering HIV/AIDS and hepatitis B transmission and epidemiology. This was administered prior to the course and revealed a lack of knowledge about AIDS epidemiology, the window period and testing procedures.

Phase two assessed knowledge of occupational health and safety (AIDS questionnaire no 2) The questionnaire related to occupational health and safety and covered all areas concerned officers had outlined in the Needs Analysis. The questionnaire was administered directly after the sessions on occupational health and safety. Participants scored 100 per cent accuracy.

Phase three was a post-test (AIDS questionnaire no. 1). It was administered on the last day of the course and showed an improvement in participants' knowledge. Participants scored 98 per cent accuracy.

Reaction evaluation

A re-evaluation questionnaire was given to all participants at the end of the course. Responses were discussed with the participants. The participants indicated that the content of the course was relevant to their working environment, that the course was well-prepared and was easily understood. They felt it was an advantage to have a custodial officer design training packages and be a member of the Academy staff. They felt only one of their own could understand the problems they face on a day-to-day basis.

Performance level

The follow-up questionnaire and interviews are still in train. However, it is anticipated that the evaluation should be completed and documented by the end of 1990 and published at the beginning of 1991.

Data available from the major New South Wales gaols is showing some promising results. Officers appear to be more aware of AIDS issues and are taking responsibility not only for themselves, but for all gaol personnel in providing occupational health and safety information and equipment. This has occurred mainly in metropolitan gaols where gaol management has addressed the importance of providing appropriate equipment under recent occupational health and safety legalisation.

Gaol management

Addressing AIDS education within the prison system has always been a major problem and one that has been ignored until crises have arisen (Scagliotti 1990). Superintendents only recognised the need for AIDS education when faced with industrial unrest in response to the reception of an HIV positive inmate or where some form of blood spill or assault had taken place and disrupted normal gaol routine.

A major cause of concern during the development of the AIDS Management Course was the possible lack of enthusiasm by superintendents in releasing officers to participate in the course. I addressed this problem by visiting the gaols that had personnel involved in the training, and presenting an overview of the contents of the training package to senior management at each institution. This was only possible for gaols within the Sydney area owing to the commitments of training. Superintendents who were not addressed in this manner, but had been informed in writing, did have some reservations about releasing officers. On many occasions they merely paid 'lip service' to the project and, in the long-term, did not encourage staff to participate.

The AIDS coordinators from the Prison AIDS Project attempted at great lengths to liaise with the management at the gaols they visited, but they had difficulties convincing them to release officers. When it became evident that a certain amount of apathy was being displayed, it became necessary to spell out management's responsibilities to officers under the Department's occupational health and safety policy. This stated that superintendents had to provide a safe environment for staff in the performance of their duties.

Funding

Departmental funding was allotted to the Prison AIDS Project so gaols could be provided with an overtime allowance to replace the officers participating in the course. Even though funding has been available since May 1990 superintendents are still reluctant to release officers, because the guidelines set down by the department for gaols to re-coup overtime expenses are somewhat ambiguous and there is pressure on superintendents to minimise their use of overtime funds. One of the strategies I have used to overcome this problem has been to approach superintendents on an individual basis, giving my assurance the overtime funds would be forthcoming.

Impact of isolation

Many gaols are strategically placed in country areas, not easily accessible to the Academy. Visiting these institutions is time-consuming and unrealistic if training schedules are to be met. As the course developed, many such problems have arisen, with officers in outlying areas disadvantaged because of their geographical position.

Grafton Gaol has been one of the hardest gaols to target. Officers at the Gaol have been refused access to the AIDS Management Course even though numerous applications have been received from officers wishing to participate. The problem arose because officers needed to be absent from the gaol over a five-day period which, in the current financial climate is an unrealistic requirement. After much deliberation, it has been decided Grafton Gaol should be targeted as a special project, incorporating officers from the Glen Innes Afforestation Camp, with the idea of taking the training to them. This has been scheduled for early November 1990.

The Custodial Officer as Trainer

The research conducted by Conolly (1990) expressed the view that a custodial officer would be more effective in the role of trainer and give the course more credibility

than a person from outside the Department of Corrective Services. This view was also held by personnel within the Department. However it is necessary to consider the full implications of such a statement. A custodial officer will only be effective in this role if he or she:

- has a good working knowledge of prison environment;
- has some credibility with staff;
- is able to establish good rapport with custodial managers;

- is able to liaise with custodial managers and convince them the course can provide their staff with the expertise and skills necessary to manage the complexities of the AIDS issue; and

- is able to convince staff the training they will receive will be beneficial to their working and private lives.

The Corrective Services Academy

The Corrective Services Academy was considered to be the most appropriate place to design and implement the AIDS Management Course. As course coordinator I was seconded to that establishment in February 1990 and came under the direction of Mr Ian Loudon the Assistant Principal of the Academy and head of the Staff Development Section.

Previously the Academy was only involved in AIDS education of officers during the primary training segments for new recruits. These were conducted approximately every six weeks for one and a half hours. The courses developed before this time did not have an AIDS component as many of the instructors did not see a need for this form of training. Most were of the opinion that AIDS education was not a priority. However, this opinion has changed dramatically over the past six months. AIDS training segments are now incorporated in all relevant courses involving custodial and departmental personnel. In addition, facilities and expertise at the Academy enable the design and production of training packages of a high standard. The AIDS Management Course which places a strong emphasis on objectives and evaluation was designed there.

Conclusion

Prison AIDS Project personnel have played a major role in helping to advertise the AIDS Management Course and encouraging staff to participate. They should be commended for their efforts. The project has also recognised that it is not only important that custodial staff receive AIDS information and education, but that training is directed at the source of the problem and staff are trained in the skills necessary to manage the complex issues relating to AIDS in prison. The AIDS Management Course is the first of many to be developed. When dealing with such a complex issue as AIDS it is important to continue to explore other ways to maintain the momentum amongst custodial staff.

The introduction of compulsory testing into New South Wales prisons in the near future, I believe will present some problems. In order to combat these problems the Prison AIDS Project will be introducing a 'Life Skills' program. The aim of this program is to provide a 'time out' period for prisoners who are having difficulties in coming to terms with their antibody status. The custodial staff who elect to work in this area will need to be specially trained to manage such a delicate problem. This training will be the next challenge facing the Prison AIDS Project. It will also be a new concept in AIDS education for custodial staff.

Education about AIDS issues in prisons cannot only be seen as a way to provide information for custodial staff but must address the more difficult task of providing officers with skills to manage all the complexities associated with AIDS. The New South Wales Department of Corrective Services is beginning to recognise that AIDS in prisons is an important issue and one that must be addressed with strategies which enable staff to perform their duties with the utmost confidence.

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Perceptions of AIDS in Prisons: Relevance in Developing Educational Strategies

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In addressing the prevention of the spread of the HIV virus in prisons, we have seen a rush to develop and implement prevention measures. Much attention has centred on such controversial issues as: compulsory or voluntary blood testing; isolation versus integration of HIV infected inmates into the prison mainstream, provision of condoms and disposable needles, and effective educational measures for specific groups within the prison.

Unfortunately, this rush to develop and implement preventive measures has resulted in a degree of polarisation which has hindered progress towards implementation of effective prevention measures. A thorough analysis of the perceptions and positions of the two main groups affected by AIDS in prison, prisoners and prison officers, has been missing from much of the debate. These perceptions, rather than an imposition of conceptual frameworks from outside, provide a critical basis when formulating guidelines and strategies for the effective implementation of AIDS prevention measures, and AIDS educational programs in prisons.

Various committees and reports have recognised that immediate, major and appropriate educational strategies must be designed and implemented for prison staff and prisoners as a major means of preventing the possible spread of the virus in prison (NACAIDS report 1987; Hammett 1989).

Most AIDS studies in the general population focus on the individual's level of knowledge, attitudes and beliefs about AIDS and AIDS prevention measures (Dawson 1988; Clark et al. 1989). It seems that most studies in prisons both in Australia and overseas follow this same model (Gaughwin et al. 1990). Some studies in prisons have concentrated on estimating risk behaviours (Miner & Gorta 1986; Conolly & Potter 1990), presenting policy and practice in prisons (Harding 1987) or evaluating AIDS prevention programs (Conolly & Potter 1990). These types of research are obviously valuable. However, we believed it was important to investigate the perceptions of relevant groups prior to developing a comprehensive AIDS prevention strategy.

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[1] The views expressed in this paper are those of the author and do not necessarily reflect views or policies of the Department of Corrective Services.

This article presents findings from a study of prisoners, prison officers and staff within metropolitan prisons in an Australian capital city. The study explored not only individual knowledge and perceptions, but also investigated perceptions of others' perceptions - for example, what prison officers perceive prisoners think about a particular issue.

This paper presents several examples of the need to:

- consider other people's perceptions; and
- seek reasons why people perceive issues in specific ways.

These examples reflect a broad view of 'education'. Education relates to determining appropriate methods to inform prisoners, officers and staff about AIDS and AIDS prevention measures. However, we must also recognise the role and value of 'education', for all segments, individuals and groups who influence and determine policy and practice in prisons.

There are a number of controversial areas in which effective policy must develop if there is to be a strong commitment to prevent the spread of AIDS in prisons. Too often sensitive policy decisions are made as a result of people's unrealistic fears, or by groups with vested interests.

There is a need for all concerned to be aware of people's knowledge level and their concerns or anxieties in respect to AIDS, when developing strategies and policies.

The Research Process

Prisoners, prison officers and staff at each of the city's seven metropolitan prisons voluntarily participated in this study. A total of 201 prisoners, 210 prison officers and fifty staff were interviewed. Administrative staff and the Prison Officer's Union supported the research concept and saw the potential benefits in understanding the perceptions of each group in the strategy development process.

Personal interviews were conducted with individuals by trained market research interviewers. Interviewers external to the Department of Corrective Services were used to ensure that objectivity and confidentiality were explained and maintained. An Aboriginal interviewer was employed to conduct the majority of interviews amongst male Aboriginal prisoners. The interviews were conducted using a semi-structured questionnaire which was developed after discussions with all relevant groups within the prison community and with AIDS experts in Perth. The interviews took an average of 35 minutes with prisoners and 45 minutes with prison officers and staff.

Some Research Findings

Is AIDS a salient issue?

Prior to developing any 'educational' strategy it is important to understand how salient the issue is amongst the target groups, and what knowledge, attitudes and beliefs they currently possess.

The study found the AIDS issue was more salient amongst staff and officers than amongst prisoners: 64 per cent of staff and 53 per cent of officers claimed that their group 'talked about AIDS' 'a lot' or 'to some extent', compared with 24 per cent of prisoners.

Has sufficient information been disseminated?

Officers' and staffs' views of the amount of AIDS information given to officers were the same: around 52 per cent said 'the right amount'.

Officers' main reasons for believing insufficient material had been provided were:

- a desire for updated or follow-up information;
- a need for job-related information;
- insufficient depth of some information;
- a concern that they are not given the 'full picture' on AIDS.

The main reasons given by staff were:

- information is lacking
- information had insufficient depth
- inappropriate presentation methods were used.

These reasons highlighted content, medium and dissemination factors when considering the development of further educational strategies for officers.

Do people want more AIDS information?

Not surprisingly, the majority of prisoners and officers claimed they would like more information on AIDS (66 per cent and 79 per cent respectively). Whilst this question almost 'begged' a positive response, it is noteworthy that more officers than prisoners said they would like additional AIDS information. This is consistent with other findings in the survey on prisoners' receptivity towards information and education generally.

People's perceived knowledge level of AIDS

The media have publicised AIDS quite extensively in the past five to six years. Within the last four years the Department of Corrective Services has conducted some AIDS awareness programs mostly amongst officers and staff, but also amongst prisoners.

In comparing the results of individuals' perceptions of their own knowledge about AIDS and their perceptions of others' knowledge level, some interesting results were found:

- all individuals consider they are more knowledgeable than they perceive other groups to be, and compared to members of their own group;
- officers consider themselves and their group to be more knowledgeable than prisoners;
- staff think officers are more knowledgeable than prisoners; and
- staff consider themselves as individuals, to be more knowledgeable than either officers or prisoners.

The implications of these findings for strategy development are that whilst officers and staff consider prisoners to be less knowledgeable than themselves personally, they may not realise that prisoners consider themselves knowledgeable.

A number of prisoners have been exposed to AIDS educational material and the majority of those prisoners consider the information provided to be 'useful'. However, some exposed and some non-exposed prisoners do not consider educational material to be 'useful' because: they know it all already, or they say they are not concerned about AIDS. Therefore, material must be considered relevant by individuals and presented in an interesting manner.

Are people afraid of catching AIDS in prison?

Beliefs about and attitudes towards AIDS are formed as a result of the content of information, and manner in which it is received. These in turn directly affect a person's anxiety level associated with AIDS. It was considered important to gain some idea of how people felt about AIDS emotionally, as a person's emotions are likely to influence their opinions about their own or other's behaviours, and/or lead them to adopt certain behaviours.

A person's perceived likelihood of catching the AIDS virus could develop from either a logical base, for example, 'if I indulge in these behaviours I may be exposed to the AIDS virus' or it could develop from an irrational base fuelled by lack of knowledge or strong emotions or, from a combination of these.

Prisoners and officers were asked how afraid they personally were, of catching AIDS in prison and how afraid they considered their group and the other groups to be. The findings suggest:

- prisoners and officers consider themselves individually less afraid than their group generally;
- prisoners' views of officers are consistent with officers' own views;
- officers' view prisoners as less afraid than prisoners see themselves;
- staff see officers as more afraid than they see prisoners to be. Staff views are consistent with how officers see their group, and are similar to how prisoners view their group.

The implication for strategy development is:

- more officers overall are afraid, than are prisoners;
- prisoners are more afraid of catching AIDS than officers and staff believe.

For example, one quarter of prisoners claimed they were personally 'very afraid' of contracting AIDS in prison. Educationalists need to be aware that prisoners have perhaps been underestimated not only in their knowledge, but also in how afraid they are of catching AIDS. We need to be cautious not to conceive stereotypes of prisoners, as being unconcerned with their own health or future.

Table 1

Perceptions of One's Own AIDS Knowledge Level Compared to Other People's Knowledge Level

		% Prisoners View...(201)	
Knowledge Level...	Themselves	Other Prisoners	Officers
Good knowledge	18.5	3.0	24.4
Some knowledge	52.5	49.8	36.3
Not much knowledge	19.5	28.9	12.9
No knowledge	9.0	4.0	3.5
Don't Know	0.5	14.3	22.9
TOTAL:	100.0	100.0	100.0

		% Officers View...(210)	
Knowledge Level...	Themselves	Other Officers	Prisoners
Good knowledge	17.6	12.0	4.8
Some knowledge	65.3	65.1	48.1
Not much knowledge	17.1	12.8	32.9
No knowledge	-	0.5	2.8
Don't Know	-	9.6	11.4
TOTAL:	100.0	100.0	100.0

		% Staff View...(50)	
Knowledge Level...	Themselves	Prisoners	Officers
Good knowledge	36.0	6.0	2.0
Some knowledge	58.0	33.0	52.0
Not much knowledge	6.0	57.0	34.0
Don't Know	-	4.0	12.0
TOTAL:	100.0	100.0	100.0

Table 2

Fear of Catching AIDS in Prison - Self versus Own Group

	% Prisoners (201)		% Officers (210)		% Staff (50)
Afraid of Catching AIDS in Prison?...	Self	Other Prisoners	Self	Other Officers	Staff Generally
Very afraid	26.4	21.4	10.5	14.4	6.0
Fairly afraid	9.0	18.9	27.1	40.2	10.0
A little afraid	10.4	15.9	18.6	25.9	30.0
Sub Total	**45.8**	**56.2**	**56.2**	**80.4**	**46.0**
Not very afraid	9.0	13.9	20.5	11.0	24.0
Not at all afraid	44.3	13.4	23.3	3.3	22.0
Not sure	1.0	16.4	-	5.3	8.0
TOTAL	100.0	100.0	100.0	100.0	100.0

Table 3

Perception of Fear Amongst Other Group

	% Prisoners Views	% Officers Views		% Staff Views
Views Afraid of Catching AIDS in Prison?...	Of Officers	Of Prisoners	Of Prisoners	Of Officers
Very afraid	24.4	5.7	4.1	32.0
Fairly afraid	20.4	15.2	26.5	30.0
A little afraid	9.5	19.0	20.4	16.0
Sub Total	**54.3**	**39.9**	**51.0**	**78.0**
Not very afraid	8.5	17.1	24.5	8.0
Not at all afraid	7.0	13.8	14.3	2.0
Not sure	30.2	29.2	10.2	12.0
TOTAL	100.0	100.0	100.0	100.0

Analysis of the relationship between level of fear and likelihood of contracting AIDS in prison showed results in the expected direction. That is, the more likely respondents were to consider it likely they could contract AIDS in prison, the more likely they were to be afraid.

Perceptions of Various Informational Media

Prisoners

Table 4 below shows that prisoners, officers and staff held relatively similar views on what would be 'a good way' of educating prisoners about AIDS, although some differences between the groups emerged for the following:

- prisoners rated small discussion groups with external experts virtually equal with documentary videos, whereas more officers and staff thought videos better;
- prisoners and officers were more inclined to consider pamphlets to be better than posters, however the reverse was the case for staff;
- prisoners were far less likely than officers or staff to consider comics to be 'a good way'. It appears some prisoners consider the use of comics for a topic such as AIDS to be somewhat demeaning, although across all groups comments were made that they could be effective for illiterate people.

These results indicate we should be careful not to stereotype prisoners and thereby reduce the effectiveness of educational programs by using media which they may view as inappropriate. We need to avoid directing information towards the 'lowest common denominator' and be aware that such a process may be seen by prisoners as insulting, as it would be to people in the general community.

Table 4

Proportion of Prisoners, Officers and Staff Who Consider Various Informational Media to be 'A Good Way' of Educating Prisoners

Informational Media	% Prisoners	% Officers	% Staff
Small discussion group with external expert	79	71	72
Documentary videos	78	78	78
Films or movies	70	74	60
Small discussion group with external doctor	63	63	52
Pamphlets	48	49	32
Comics	36	55	64
Posters	33	33	46
Small discussion group with a prisoner who knows about AIDS	28	32	30
Small discussion group with departmental doctor	27	30	28
Small discussion group with an officer who knows about AIDS	16	7	20

Officers

Staff and officers' views are relatively similar with respect to the two highest rated educational strategies for officers, although officers rated films or movies higher than did staff.

More staff than officers considered posters and discussions led by a prison officer better than did officers themselves. Although both groups rated comics last, more staff than officers were inclined to think comics are 'a good way'.

Table 5

Proportion of Officers and Staff Who Consider Various Informational Media to be 'A Good Way' of Educating Officers

Informational Media	% Officers	% Staff
Small discussion group with external expert	82	80
Documentary videos	79	78
Films or movies	70	58
Small discussion group with external doctor	65	60
Pamphlets	46	40
Small discussion group with departmental doctor	36	32
Posters	24	42
Small discussion group with an officer who knows about AIDS	20	34
Comics	11	22

Comment

People generally are aware that AIDS information exists within the system. As publicity about AIDS continues, maintaining it in people's consciousness, provision of further AIDS information to prisoners, officers and staff needs to be carefully thought out rather than simply supplied. It is essential in further information dissemination that the style of presentation and content of material generate interest amongst target groups and take into account the varying fear levels at which people are operating.

Testing Prisoners

With regard to testing prisoners on arrival in prison and retesting, prisoners' and officers' views are similar to each others but different to staff views. Officers are more likely than are staff to consider that prisoners should be compulsorily tested and retested. The exception is with retesting high-risk prisoners, where prisoners' and staff views are similar to each others but different from officers' views.

Table 6

Prisoners, Officers and Staff Views on Testing Prisoners

	% Prisoners	% Officers	% Staff
Compulsory Testing on Arrival			
Yes - for High-Risk Groups	94.5	98.1	86.0
Yes - for All Prisoners	84.6	84.8	54.0
Retesting From Time to Time			
Yes - for High-Risk Groups	81.1	97.1	84.0
Yes - for All Prisoners	56.3	55.7	32.0

Similarly the main reasons why some members of all groups felt prisoners should be tested on arrival in prison were:

- so the individual feels safer and is aware;
- there is the risk of spreading HIV; and
- the 'unknown' factor.

Differences emerged with the following reasons:

- officers will feel safer and are more aware - far more officers than staff (22 per cent versus 7 per cent), and no prisoners gave this reason;
- prisoners and officers will feel safe and are more aware - more officers than staff or prisoners gave this reason (15 per cent versus 4 per cent);
- discrimination is avoided if testing is compulsory - this reason was given by more staff than the other two groups (15 per cent versus 5 per cent of prisoners and 3 per cent of officers).

These results challenge the stereotype of prisoner resistance to compulsory testing. Rather than being resistant, prisoners are overwhelmingly in favour of compulsory testing - for their own protection.

Testing Officers

Officers were more likely than were staff to agree that all officers should be AIDS tested (53 per cent versus 22 per cent).

The main reason given by officers, and to a much greater extent than was given by staff, was 'for the officer's own protection or reassurance' (45 per cent versus staff 18 per cent). Officers also considered it appropriate to 'reassure other people' such as the Department of Corrective Services, the officer's family and fellow workmates.

The main reason given by staff, and to a greater extent than given by officers, was 'to stop the spread of AIDS' (36 per cent versus 18 per cent).

Segregating Prisoners

Once again, prisoners' and officers' views about separating prisoners with either the HIV virus or full AIDS, were congruent and somewhat different to staff views.

Table 7

Prisoners, Officers and Staff Beliefs About Whether Prisoners Infected with the AIDS Virus Should Be Segregated from Other Prisoners

	% Prisoners	% Officers	% Staff
HIV-infected			
Move them away	68.6	73.7	42.0
All of them to stay with other prisoners	20.4	12.4	38.0
Full AIDS			
Move them away	94.0	96.2	84.0
Allow them to stay with other prisoners	2.5	1.4	6.0

Similar reasons obtained across all groups were:

- because they can still transmit the virus;
- they need medical attention (in the case of full AIDS);
- it would be in their own interest: 'to protect them against victimisation'; 'for their own dignity'.

All groups commented that HIV-infected prisoners and full AIDS prisoners should not be located together: 'for psychological reasons for the HIV positive people. They'd really feel bad to see 'people with full-blown AIDS'.

Differing reasons included:

- prisoners more than officers or staff claimed 'Prisoners wouldn't want them around', 'because they don't want to catch the virus', and with regard to inmates with full AIDS because 'they don't want to be around a dying person';
- prisoners and staff were far more likely than officers to consider prisoners with full AIDS should be segregated but not isolated.

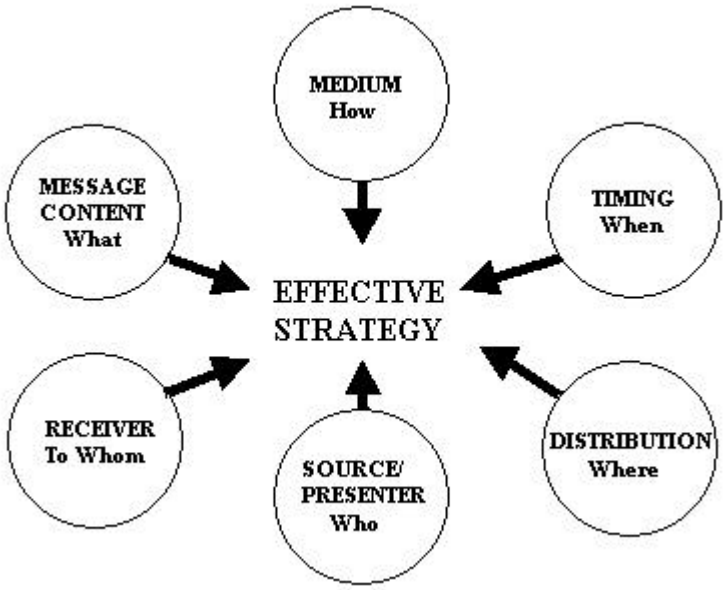
Knowledge of the reasons why people hold certain attitudes or beliefs is important when educating people as to appropriate strategies for preventing and managing HIV in prison.

Several recommendations made from this study highlighted the relevance of education in achieving appropriate separation policies. These were:

- a case-by-case approach be adopted for HIV-infected persons as it is already practised for other 'vulnerable' prisoners, but that this occur after an enhanced, systematic, ongoing educational process has commenced to better inform people and hence allay their fears;
- it is important, if a segregation policy is to be abolished, that educational procedures should precede the change of practice since 'only by achieving an appropriate degree of acceptance of the presence within their midst of HIV-infected individuals will prisoners and officers allow a segregation policy to be dismantled' (Dwyer 1989, p. 608).

Final Comment

It is essential that a coordinated and comprehensive educational program be developed for all the major stakeholders with regard to AIDS in prisons. For any educational strategy to be effective, the following elements must be appropriately blended together:



In developing educational strategies and policies for AIDS prevention and management issues, it is essential to incorporate the views of all affected groups on each of the above elements of an effective strategy. AIDS is a life-threatening disease. Reactions to it are emotionally charged because the main modes of transmission offend many people's moral standards. It is important, therefore, that decisions should be based on carefully researched and rational grounds and not on expediency or public emotion.

As Norton (1989, p. 620) states, 'Many countries, including Australia, still have the golden opportunity to create effective and innovative AIDS education and prevention programmes'.

To assist in developing such programs, overseas statistics are available, various practices have been tried overseas and some policies changed as a result of these trials. Studies are being conducted within Australia. This survey reports on knowledge, attitudes and likely behaviours with regard to AIDS on the part of three key groups within Western Australian metropolitan prisons.

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HIV Minimisation Strategies for Queensland Correctional Centres

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In autumn of 1989 a submission was made by the Prisoner & Family Support Association (Queensland), a non-government federation, to the Queensland Department of Health to fund an AIDS education and research program within correctional centres throughout the State. A grant of $29 500 was subsequently made available. Mr Errol Evans was appointed the Project Co-ordinator in August of 1989 by the funded Association with a brief to develop an education and preventive strategy for the containment of HIV infection among Queensland prisoners and to investigate the strengths and deficiencies of existing HIV management practices in the Queensland correctional system. Project STIR (an acronym for Sexually Transmitted Intravenous Risks) was supported by the Queensland Corrective Services Commission. The outcome of this investigation, the STIR Report, was adopted by the Executive Committee of the Association on 8 March, 1990 and submitted to the Ministers for Health and Justice and Corrective Services as well as the Queensland Corrective Services Commission on 12 March, 1990.

The primary aim of the Project was the prevention of HIV infection among prisoners, ex-prisoners, their families and remandees appearing before the courts. The expectation of the community to maintain public health and to be protected from infection coalesced with the expectation of prisoners for access to adequate health care and information on infection from risk behaviours, and formed the fundamental and complementary tenets of the Project. Among the objectives established in the realisation of this Project were:

- that all members of the target group have accurate knowledge about AIDS and its transmission; and
- that those in the target group will adopt safe behaviours.

Program strategies included:

- research into risk behaviours in the target population, current knowledge levels about HIV infection and appropriate educational interventions;

- the development and provision of information based upon the research outcomes; and

- the establishment of behaviour change programs and support.

By early 1990 a two-day inmate peer education and support workshop had been conducted in all Queensland prisons over a six-month period, involving over 150 prisoners, trained as peer educators, and a number of prison staff.

The recommendations of the STIR Report were based upon the feedback and insights into prison culture and risk practices drawn from these workshops. The contents of the Report suggest in part the existence of preconditions for a dramatic increase in HIV infection among inmates in the Queensland correctional system. These preconditions included the significant and increasing frequency of drug dependent behaviour, acknowledged levels of IV drug use and male-to-male/female-to-female situational sexual activity in Queensland prisons, and the fact that significant numbers of HIV antibody positive persons existed within the broader community. It is further suggested from the Report that the prevalence of HIV risk behaviours associated with imprisonment such as situational sex encounters, intravenous drug use and needle sharing will exacerbate infection potential, particularly in the absence of the preventative devices and practices that exist within the broader and `open' community.

Prisons historically have been closed institutions. In Australia they have evolved as places of quasi-militaristic containment and control. People within them have been obliged to be compliant to the rigours of this model and have been constrained by various formal rules, rituals and regulations. In a response to the limitations fostered by such a model, a strong sense of solidarity or camaraderie has developed within the prisoner class. This is particularly evident from the prisoner code and culture that operates within Australian prisons. The informal, yet enforceable, machinations of this code have developed a dynamic of their own. Prisons have become sub-communities as a result of this code with reference points for conduct that are at variance to those which prevail in the broader community.

There are compelling reasons to place Australian prisons under the microscope in these circumstances, particularly with respect to HIV infection. This matter was recognised in the National HIV/AIDS Strategy White Paper published in 1989 which acknowledged the potential for HIV infection in prisons and reported a lack of `information available on the extent of HIV infection in Australian prisons' (1989, p. 51). More significantly, the White Paper also indicated a need for `. . . more information . . . on the nature and level of risk activities within prisons' (p. 51).

The mandatory testing of prisoners in Queensland prisons has, to date, revealed only a small number of people being HIV positive. These prisoners have been administratively segregated from the mainstream prisoner population with the view that such segregation would `contain' and reduce the potential for further infection in the prison environment. In the absence of any serious research into the dynamics of the prison culture, the efficacy of medical interventions and segregation of those identified as HIV positive must be brought into question. There is a real danger if the primary indicator of HIV infection within prisons is taken as being the numerical level of HIV positive persons. Neither the specific community of a prison nor the broader community should be complacent about the seemingly small rate of infection currently evident within the system. The geometric growth implications of transmission of the virus together with the cultural imperative of the prisoner code that appears to legitimise risk behaviours within prisons should be sufficient to justify constant review and evaluation.

These matters are structurally and culturally determined. Factors such as the history of intravenous drug use by prisoners, along with needle and syringe sharing, and issues within the prison drug subculture coupled with the range of sexual transactions, either consensual, coercive or forced, which are apparently legitimised within the prison culture demand further investigation. Whilst mandatory testing will assist in a determination of who is HIV positive within the system, the matter of addressing the level of risk practices and the impact that such practices will have both within the Queensland prison system, and in the wider community remains unexplored.

Furthermore there appears to be a degree of conservatism that militates against the issues being adequately raised on the agenda. The matter of confronting institutional risk behaviours may simply be too challenging for prison administrators and governments,

particularly in the absence of any proactive community concern for intervention. The status quo is maintained. Sooner or later, though, the Pandora's Box of the correctional industry will need to be opened.

In the past twelve months there have been some encouraging developments in the philosophy that directs Queensland prisons. Whilst not directly addressing the issues, proposed structural changes to prisons in the State will indirectly impact on the prevalence of risk behaviour. The logic and methodology of the quasi-military model has been rejected by the Queensland Corrective Services Commission and a model of participatory management involving prisoners has been foreshadowed. This will, in time, contribute to the erosion of the `traditional' prisoner culture, leading to a social normalisation of the environment of the prison. Already, at institutions such as Borallon Correctional Centre, there is a greater awareness developing among prisoners about HIV infection and risk behaviour in response.

The recommendations of the STIR Report are produced below. They were guided by material obtained in workshops attended by prisoners and prison officers, together with program reviews of HIV interventions in the correctional sphere in other jurisdictions. Explanatory material for each of the recommendations is contained in the STIR Report but three particular issues should be detailed here.

Sexual Activity

Corrective services authorities have a clear responsibility to modify sexual behaviours which pose not only a psychological and physical risk to the community but may also present a potential for the violent or coercive transfer of HIV to the public. Case management programs by specialist personnel are essential on both counts. Other control strategies which may be controversial, such as chemical interventions, should be investigated. Program streaming, segregation and individualised risk assessment and management are complementary practices.

Single cell accommodation and individual ablution facilities may lessen the opportunities for non-consensual risk practices. There are indications that culturally sensitive options such as dormitory accommodation may be preferable for some Aboriginal prisoners.

In respect of condom distribution, a different moral criteria appears to have been applied to prisoners than to the general community. However, public health considerations favour the adoption of condom availability and outweigh arguments that condoms may be used as missiles or weapons because of the consequences of HIV infection both to the prison population and the wider community.

Conjugal privilege may modify and diminish institutional sex in prisons. Conjugal privilege should be part of a graduated release or leave program where sexual activity can be recognised, planned, anticipated and managed safely through the provision of education, testing and condoms. It should occur in an environment which is geographically distinct from correctional facilities.

Intravenous Drug Use

IV drug and needle sharing occurs in prison but is difficult to quantify and may vary among populations and settings. Correctional administrators may argue that the provision of bleach and information about cleaning equipment undermine drug rehabilitation efforts or sanction an illegal activity. The counter principle of harm reduction argues that the grave consequences of the spread of HIV necessitate a range of practical options. Since IV drug use cannot be immediately curtailed harm reduction strategies must be employed.

Research

There is little Australian research on risk practices such as anal sex and IV drug use. Research is urgently needed. However, anecdotal evidence from staff and inmates suggest that significant amounts of high-risk practices occur in prison.

Reference

Australia Department of Community Services and Health 1989, *National HIV/AIDS Strategy*, AGPS, Canberra.

Appendix

The STIR Report: HIV Minimisation Strategies for Queensland Correctional Centres

Report Recommendations

The following recommendations are presented by issue as they relate to the minimisation of the spread of the HIV in Queensland Correctional Centres.

1. The Antibody Test and Screening

1.1 Mandatory testing should continue provided it is complemented by adequate information, pre and post test counselling, training and resources for both inmates and correctional staff.

1.2 Accepted testing guidelines should be strictly adhered to with particular reference to follow-up and pre-discharge tests.

1.3 Inmates should be promptly advised of their test results regardless of outcome.

1.4 Principles of confidentiality of medical information and the security of medical records should be strictly observed.

2. Segregation

2.1 Segregation should continue to be a useful option in containing HIV infection provided that inmates are not doubly penalised by their HIV positive status in terms of discrimination, or unnecessary isolation from programs and social activities.

2.2 The policy and practice of providing single cell accommodation and individual ablution facilities should be continued.

3. Counselling

3.1 Counselling is an important corollary to mandatory testing and inmates should be given access to HIV pre and post test counselling. Counselling should be provided by training program staff or by contract personnel.

4. Education

4.1 Preventative education should be made available to both staff and inmates by regular and ongoing programs. Peer education should be researched, supported and resourced.

4.2 Infection Control Guidelines should be adopted, practised and performance monitored.

4.3 Information and equipment should be readily accessible.

5. Ethnic and Other Groupings

5.1 Specialist programs for groupings such as aboriginal and islander inmates; women; sexually distinct inmates, such as transsexuals; ethnic or culturally different prisoners; and disabled inmates are recommended.

6. Sexual Activity

6.1 Sexual predators should be segregated from vulnerable inmates and surveillance heightened.

6.2 Condoms should be freely made available in Correctional Centres and prior to leave and release. Condoms should be distributed by Correctional Officers, by health service personnel or by community agencies such as the Prisoner & Family Support Association (Queensland).

6.3 Conjugal privileges should be integrated into graduated release programs (where compatible with the rehabilitative and re-integrative goal of the case management plan).

7. Intravenous Drug Use

7.1 Bleach and information regarding decontamination of equipment should be made immediately accessible to inmates.

7.2 HIV preventative interventions should be integrated into existing alcohol and drug programs.

8. Tattooing

8.1 Decontamination of equipment and access to professional tattooists should be seen as options which could be linked to individualised case management plans.

9. Violence and Accidents

9.1 Violence should be minimised through sound managerial and corrective practices which include surveillance and segregation.

9.2 Accidents should be minimised through close supervision, the provision of safety and protective equipment, and workplace training to industry standards.

10. Correctional Officer Education

10.1 Equipment such as resuscitation masks and gloves should be used and correct search procedures adopted.

11. Medical Services

11.1 Medical Services for inmates as they relate to HIV should be of the same importance and quality as those provided in the community.

12. Research

12.1 Research which can give reliable indications of the prevalence and incidence of risk practices should be commenced immediately.

13. Financial and Administrative Support

13.1 HIV programs should receive adequate resources, funding and support from the Commission commensurate with national and state HIV control measures.

14. Infection Control Issues

The following standards should be adopted :

14.1 - barrier precautions (such as gloves) should be used in all situations involving blood or body fluids.

14.2 - lesions and dermatitis should be covered and contact with blood and other substances should be avoided.

14.3 - needle stick and sharp object injuries should be avoided through the use of torches, mirrors, gloves in search procedures.

14.4 - routine hygiene procedures such as regular hand washing with soap and water should be adopted (particularly if there is possible contact).

14.5 - blood and body substance spills should be cleaned with a chlorine based bleach (where possible by the individual concerned).

14.6 - disposable items soiled with potentially infectious materials should be treated as infectious.

14.7 - infectious linen should be stored and transported in leak proof bags.

14.8 - situations where potentially infectious material could enter the eye (e.g. blood spattering) should be avoided and the area should be immediately bathed

Behind Bars: HIV Risk-Taking Behaviour of Sydney Male Drug Injectors While in Prison

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It is now almost ten years since the clinical phenomenon of AIDS was first recognised. In that time, the causal agent, Human Immunodeficiency Virus (HIV), has been identified and enormous progress has been made in defining both the nature of the epidemic and the responses required for prevention of cases and management of persons infected.

In Western Europe, the epidemic of AIDS cases began in homosexual/bisexual men. In the last few years, the pattern of presenting cases has changed so that now, in Europe as a whole, AIDS cases associated with drug injecting are more common than any other risk category. A similar development has occurred in the north-east of the United States. In the last few years, epidemics of HIV infection in drug injectors have been reported in Poland in Eastern Europe, Thailand, Myanmar (formerly Burma), China and India in Asia, and Brazil and Argentina in South America. Almost 80 per cent of 177 drug injectors attending a treatment centre in Yangon (formerly Rangoon) in 1990 were infected. A range of preventive strategies has been developed to reduce the spread of HIV in injecting drug users (IDUs). Considerable progress in implementing many of these strategies has been achieved in a number of countries. Australia's record in HIV prevention among IDUs (with the notable exception of incarcerated IDUs) is very impressive by international standards.

It has recently been estimated that 40-50 per cent of male and female IDUs in contact with treatment services or research projects may spend considerable periods of their lives in prisons. It is important, therefore, to find out whether confinement in prison changes the risk of HIV infection for IDUs. This paper reports preliminary results of a continuing study of drug injectors in several cities throughout Australia. The study has been supported by a Commonwealth AIDS Research Grant.

The research commenced with a pilot study in 1988. In 1989 respondents were recruited in Brisbane, Armidale and Tamworth, Sydney, Canberra, Melbourne, and Perth. This paper will be confined to an analysis of results from the Sydney respondents.

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Methods

A detailed description of the method employed in this study has been submitted for publication and will not be repeated here. In summary, respondents were attracted by a variety of inexpensive forms of local advertising. Respondents were paid $20 for an anonymous interview lasting about one hour. Interviews were conducted in private by one of a panel of trained and supervised research interviewers who had extensive personal or professional experience in the area. Measures were taken to ensure that subjects were not interviewed on more than one occasion. Interviews took place in Surry Hills, an inner-city suburb of Sydney.

The interview questionnaire contained a core component completed by all respondents and a series of modules. The 'prison' module took approximately ten minutes to complete. At the conclusion of the interview, respondents were asked to provide a drop of blood taken from a finger tip by a small lancet and absorbed on to a strip of blotting paper which was forwarded to the national HIV reference laboratory at Fairfield Hospital for HIV antibody testing.

One thousand two hundred and forty-five injecting drug users were interviewed of whom 908 were males. This paper concerns male respondents since there is an increased risk of HIV transmission within prison both by male sexual activity as well as sharing injection equipment. Four hundred and three males (44.4 per cent) admitted to having previously been in prison. Of these, 209 (23.0 per cent of all respondents) had spent more than one month in prison and completed the prison module.

Results

The duration of imprisonment ranged from one to 122 months with a mean of 16.1 months. Slightly more than one-third (37.4 per cent) had spent less than one year in prison. The demographic characteristics of the respondents who had been in prison were generally similar to those who had not been in prison. The mean age of respondents was 26.9 years. The male drug injectors who had been in prison and were the subjects of this study in general had received less formal education and were more likely to be unemployed than the drug injectors who had not been in prison.

Respondents had been released from prison for a little over two years on average at the time of interview and thus the mean time of prison experience was 1987.

Drug use in prison

One hundred and fifty-five of the 209 respondents (74.2 per cent) reported having injected drugs at least once while in prison with heroin being the major drug reported (77.4 per cent of injectors) followed by amphetamines (31 per cent). Seventy-eight per cent of the subjects who reported injecting heroin while in prison, did so on five or less occasions per week. By comparing the answers to many questions, it is likely that the frequency of injection is usually much less than once a week. The distribution of frequency of injections per week was similar for all of the substances injected. It is interesting to note that 10 per cent of the respondents who injected heroin in prison reported injecting on sixteen or more occasions per week.

Reported sharing of injection equipment in prison

Of the 155 subjects who admitted to injecting in prison, only 100 (66.5 per cent) provided data on the frequency of sharing of injection equipment in prison with 75 (75 per cent) reporting sharing. Twenty-two per cent of respondents indicated that they always went first when sharing. However, 89 per cent indicated that on every occasion they cleaned shared needles and syringes before injecting. The cleaning methods included alcohol (10 per cent), boiling water (7 per cent), hot water (19 per cent), bleach (26 per cent), tap water (36 per cent), and miscellaneous methods (6 per cent). Alcohol, boiling water and bleach are likely to have killed HIV. The other methods are doubtful. Forty-seven per cent of the sample described access to bleach as 'quite hard' to 'impossible'.

In response to a question regarding whether they had ever accepted needles and syringes from known HIV positive drug injectors in prison, two out of forty-eight admitted that they had done so, 78 per cent denied having done so, while 19 per cent indicated that they never shared. Of the eight HIV-infected respondents, seven had injected in prison, and six reported sharing injection equipment. Their HIV status while in prison was not determined.

The respondents were then asked how frequently they shared injection equipment in the first few weeks after leaving prison. Twenty-seven per cent reported that they shared injection equipment in that period 'everytime' to 'occasionally'. A further 15 per cent said that they shared but 'not often' while 58 per cent indicated that they never shared in the few weeks after leaving prison.

Reported sexual behaviour in prison

Thirteen per cent of respondents reported having had sex with a man while in prison. Five per cent reported having been anally raped while in prison. Forty per cent of the sexually active men, reported that they had had anal intercourse while in prison. Of these men 50 per cent said they were always the insertive partner, 29 per cent the receptive partner and the remaining 21 per cent engaged in both practices. Only one subject reported that insertive anal intercourse had always been performed using condoms while three respondents indicated that receptive anal intercourse always occurred using condoms. Eighty-three per cent of 157 subjects reported that condoms were 'quite hard', 'difficult' or 'impossible' to obtain while in prison whereas 18 per cent indicated that they were 'easy' or 'not hard' to obtain. Four per cent of the respondents admitted to having had anal sex with a known HIV carrier.

One hundred and seventy-five respondents gave information on their sexual practices outside prison; 3 per cent reported only having sex with other men outside prison, 4 per cent mostly with other men while an additional 5 per cent sometimes had sex with other men outside prisons. Overall, 12 per cent of the respondents reported having sex with other men outside prison 'always' to 'sometimes'.

The respondents were also asked about the information they received about AIDS while in prison. Forty-three per cent of respondents said that they had not received any AIDS information while in prison. However, of those who had received information in prison, 59 per cent considered that this information was either 'good' or 'very good'.

Thirty per cent of the sample reported having received drug treatment in prison which included: methadone maintenance, methadone withdrawal, detoxification, counselling and 'other'. Methadone maintenance was the most common form of treatment received with 37 per cent of those who reported receiving treatment having participated in a programme while in prison. Of the 137 respondents who had not received any treatment, 51 (37 per cent) had wanted to receive treatment for their drug problems while in prison.

Further analyses of the data indicate some significant differences between those who injected in prison and those who did not. Respondents who did not inject in prison had, on

average, been released more recently (19 months) compared to those who had injected in prison (28 months). This raises the hopeful possibility that risk taking behaviour in prison may be declining. Respondents who had injected in prison had: on average started drug injecting earlier (17.1 years) than those who had not injected in prison (18.8 years); had a larger number of sharing partners on average (3.9) outside prison than those who had not injected in prison (0.6); and had also accepted used injection equipment more often (28 per cent) while outside prison than respondents who had never injected in prison (15.5 per cent).

Comparisons of respondents who had spent less than a year in prison with those who had spent more than a year showed no differences in the frequency of injecting the four major drugs, sharing, cleaning, obtaining bleach, accepting equipment from prisoners known to be infected, having sex with another male prisoner or anal intercourse.

Discussion

The respondents in this study had on average been injecting for ten years with more than 10 per cent of this time spent behind bars. If conditions in prisons are such that the spread of HIV among incarcerated IDUs is facilitated, the excellent work on prevention of spread outside prisons could in time be overcome.

Taken overall, the results of this study suggest that a disturbingly high level of HIV risk behaviour occurs in prisons. These data also raise the possibility that the level of high-risk behaviour may be declining and this possibility should be investigated by further study. The frequency of drug injection in prison is less than would be expected of a heavily dependent group of drug users outside prison. But injection equipment is frequently shared, inadequately cleaned, and probably shared with a larger number of partners in prison. It is likely that the risk per injection is higher inside than outside prison. Anal intercourse probably occurs less frequently inside prison than outside and men who practise homosexual behaviour inside prison also do so outside prison. But the relative unavailability of condoms inside prison suggests that there is a higher proportion of unprotected sexual activity in prisons than outside. Furthermore, the prevalence of anal rape in prisons is disturbingly high but we do not have comparable data on the prevalence of anal rape outside prison.

Before these conclusions can be further considered some qualifications are necessary. Firstly, only 209 of the 403 male drug injectors who had been in prison answered the prison module. Secondly, the subjects in this study were interviewed in 1989 and had been out of prison on average for a little over two years. Therefore, the prison experience which respondents described was predominantly between 1985 and 1987. This may have introduced a recall bias. Thirdly, the reliability and validity of this data is unknown and not easily tested. However, the reliability and validity of data in other studies of IDUs is surprisingly high. Furthermore, it may be that conditions in prisons have changed since these respondents were in prison.

It should be emphasised that this report describes preliminary analysis and interpretation of the data. Statistical analysis and conclusions will be presented elsewhere.

A small proportion of former prisoners reported that they had injected sixteen or more times per week. This suggests that some prisoners seem to have a far greater access to drugs in prison than the majority of drug injectors. Unfortunately, some of the questions did not allow for data on very low frequencies of activity to be collected. The number of episodes of drug injecting in prison is far less frequent in prison than outside. Between one in four and one in five IDUs who inject in prison, will never share in prison. The possibility that this proportion would be even higher today should be investigated in further research. It is encouraging that such a high proportion of drug injectors attempted to clean their injection equipment in prison two to four years ago. This suggests high levels of awareness about AIDS among prisoners in 1985 to 1987 despite the relative scarcity of AIDS education in prisons, and despite the unavailability of adequate cleaning materials. The fact that such a high proportion tried to clean their injecting equipment despite the scarcity of sterilising agents suggests that IDUs are anxious to reduce the hazards of drug injecting while in prison.

The respondents who participated in the riskiest activities in prison generally participated in these same activities to an ever greater extent outside prison. This study was conducted at a time when HIV seroprevalence was probably lower than it is today. If the activities reported in this study have not changed, but the level of HIV seroprevalence has increased, the alarming possibility arises that prisons could well become 'incubators' for HIV transmission. Although there is some evidence that the aggregate number of episodes of risk taking may be less within than outside prison, each risk taking episode is likely to be more hazardous in prison than outside prison.

The data from this study presents a dilemma to policy makers. One possible response is to attempt to further decrease the number of episodes of drug injecting and anal intercourse in prison. This carries the risk that the proportion of episodes of high-risk injecting or sexual activity could increase. For example, trying to reduce the availability of injection equipment may inadvertently increase the likelihood of sharing. Attempting to decrease any male to male sexual activity may result in an increase in quick, probably unprotected penetrative intercourse to minimise detection. A second approach is to recognise that there are major difficulties in further reducing or eliminating drug injecting or anal intercourse in prisons but possibly fewer in attempting to decrease the rate of sharing and unprotected sexual intercourse. Although there may be advantages and disadvantages in both approaches, and risks in both approaches, the ultimate approach adopted should reflect a commitment to public health first and foremost. What is required from a public health standpoint is to reduce the proportion of prisoners who participate in unsafe injecting or sexual behaviour, to reduce the number of episodes per participating prisoner, and to reduce the degree of risk per episode of high-risk behaviour. That is, the risk is a product of the proportion of prisoners engaging in high-risk activity multiplied by the frequency of high-risk behaviour and the hazardousness of each high-risk episode. As an added concern, there is a risk that zealous efforts to reduce or eliminate drug injecting or sexual behaviour in prisons may increase the risk of a prison riot with the possibility of injury, loss of life, damage, and immense suffering.

The results of this study provide little direction for resolving these dilemmas but do provide some indications where far greater activity could be rewarded. Although it may have been acceptable in 1986 to 1988 that 45 per cent of respondents had not received AIDS information in prison, this should be unacceptable in 1990. It is also unacceptable that many of those who had wanted to receive treatment for drug-related problems had not received such treatment while in prison.

The provision of condoms in prisons would seem to offer several advantages. Firstly, it offers a real possibility of decreasing HIV transmission in prisons. Secondly, it offers the possibility that with a less intolerant attitude towards consensual anal intercourse in prisons, a safer outlet for libido might be established and the apparently high incidence of anal rape decreased.

From a public health viewpoint, it is difficult to understand how bleach could not be readily provided in prisons when data indicates the prevalence of drug injecting and needle-sharing is substantial. We hope that data obtained from prisoners being released from New South Wales gaols this year would be different, indicating a lower risk to public health. Finally, the most disturbing results of this study suggest that a considerable proportion of IDUs in prison will still obtain illicit drugs and injection equipment in prison. Some will not be deterred by risks of HIV infection and continue to inject drugs in prison with little concern for the welfare of others or themselves. Far greater thought must be given to the range of possible strategies to reduce HIV transmission in prisons including the ready availability of bleach and condoms and the possibility that a strict one-for-one needle and syringe exchange system could be allowed to operate even if only on a carefully studied pilot trial basis.

The results of this study are preliminary. More work is needed to fill in important details. However, the data in this study indicate that drugs were available in New South Wales prisons in the late 1980s. They were being injected. Substantial sharing occurred with limited opportunity for obtaining sterile equipment or decontaminating used equipment even

though almost nine in every ten respondents showed an encouraging readiness to try to protect themselves and others. This study suggests that many prisoners are risking more than a sentence when they go to prison with implications following their release for their friends and lovers. In time, this will have implications for the broader community as well.

Methadone, Prisons and AIDS

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This paper does not pretend to be an academic dissertation on the intricacies of a methadone program, nor is it intended to be a definitive statement of what should or should not obtain in a methadone program. It certainly does not presume to be a model for other jurisdictions, as it addresses particular problems found in New South Wales, related to the specifics of the prison population there.

It is thus a narrative account of the development of a large and complicated program in New South Wales prisons, leaving out some of the politics, all of the personalities and most of the mistakes.

The Drug

Methadone is a synthetic opioid, that is, a manufactured drug which mimics in its properties drugs obtained naturally from the opium poppy, such as heroin and morphine.

Methadone was produced by German chemists about the time of World War II for use by the troops in the field. For this purpose, it had the advantages of being a strong analgesic, effective when taken by mouth and also having a relatively long duration of effect.

Methadone is a strongly addictive drug, and if withdrawn suddenly, causes more severe withdrawal symptoms than heroin. It is said by some that the withdrawal effects of stopping methadone do not occur in the first three to four days, but this is not in keeping with experience in gaols. Our clients complain of discomfort as soon as they realise that their next dose may be late or not arrive at all. Of course, it could be argued that this is more psychological than physical.

The use of methadone in the treatment of heroin addicts followed on from the work of Dole and Nyswander (1965) in the USA. These researchers, in the late 1960s/early 1970s, published what, in retrospect, were overly optimistic assessments of the benefits of methadone to the addict.

There are two main concepts central to methadone treatment, and which attract addicts to the various programs:

- the desired effects of heroin - the so-called 'rush' or 'flash' plus the following 'high' or sense of euphoria and well-being - are negated by methadone treatment. Addicts say that the cost of getting enough heroin to 'get over' the blocking effect of methadone is not worth the effort; and

- the dreaded feeling of 'hanging out' or 'narcotic hunger' is made tolerable by methadone. The chemical aspect of this phenomenon is controlled, but not the

> social/psychological drive which, arguably, was the initiating factor in the development of the addictive personality. In essence, methadone makes it easier for the addict to say 'no' to heroin.

The actual cost of the drug itself is born by the Commonwealth while other costs are either directly funded by the State, or indirectly by the Commonwealth through the National Campaign Against Drug Abuse.

In New South Wales, methadone can only be prescribed for known addicts by approved prescribers who, in addition, must apply for specific approval on behalf of each 'new' addict they wish to commence on treatment.

Since few, if any, of our clients are chemically addicted to heroin when commencing gaol methadone, their tolerance is low and doses and rates of increase must be slow. The usual regime is to commence on 20 mg daily as one oral dose, and increase 5 mg every third day till 60 mg is reached. After four weeks on this dose, if the inmate believes that he/she needs more, a blood test determines the level of methadone remaining just prior to the next dose. If the level is below a certain cut-off point, the dose is increased.

The usual dose range for the prison program is between 60 and 80 mg daily. While there are people on higher doses, this is usually due to increased tolerance determined by the blood levels as above, or due to the prescribing pattern of the person's outside doctor.

There are certain conditions where the metabolism of methadone is increased. Thyrotoxicosis (an overactive thyroid gland) is one and although not common amongst prisoners, has occurred. Also, certain types of medication, for example anti-epileptic treatment, can lead to a more rapid turnover of methadone. Both these situations require a dose increase to maintain the client at a comfortable level .

There are many myths surrounding methadone, for example:

People on methadone have a higher pain threshold because of its powerful analgesic properties

The analgesic effect of all narcotics diminishes with continued use producing a need for increasingly higher doses in order to maintain the desired effect. This is best seen in some terminally ill patients who display an increasing tolerance to the effects of narcotics.

The importance of this is that methadone recipients require analgesia additional to their methadone, for example, when undergoing surgery or after major trauma. Some junior and inexperienced doctors have been known to restrict the necessary medication because the patient was on methadone.

People go on methadone to get 'stoned'

The sedative effect of methadone generally wears off as the addict becomes stabilised on the drug. Dose regardless, a stable methadone client can drive a truck or heavy machinery, perform other complex physical and intellectual functions and, indeed, has a reaction time on testing at least as good as non-addicted persons.

A person on methadone can be identified because they are 'high' or look intoxicated

As already stated, a person stabilised on a dose of methadone looks, sounds and acts normal. Any stable methadone client who appears 'stoned' has been dabbling with something else.

Unwanted Side Effects

Taking methadone requires a certain degree of commitment. The taste is vile, even in the syrup form presently used. Many people cannot tolerate it at all, and vomit immediately after dosing.

Nausea and vomiting, however, are also due to a central as opposed to local effect, as is loss of appetite. Some recipients lose considerable weight, while others, paradoxically, gain weight. Severe constipation is universal and, of course, not amenable in New South Wales to the usual advice concerning fresh fruit in the diet due to local policies.

There is a varying degree of sedation on commencement of treatment which always comes as a surprise to our clients who wrongly presume they will have retained some of their old narcotic tolerance.

The biggest danger in the use of methadone is of overdosing leading to respiratory arrest and death. The risk is increased remarkably by the use of other forms of sedatives, particularly the benzodiazepine group (see below).

By itself, in the non-addicted person, methadone is a strong respiratory depressant, and can be fatal. Due to its long action, reversing this depressant effect takes quite a long time, the actual length of which is dose-dependent. Some three years ago, a number of female prisoners broke into the medical clinic at Mulawa Prison and locked themselves in the drug room, having forcibly taken the keys away from one of the nurses. They then proceeded to distribute 200 mL bottles of methadone to their colleagues through the pill window. These bottles contain 1 000 mg of methadone. The usual dose range is between 40 and 160 mg. By the end of the day, six women had had respiratory arrests, all in different security areas of the gaol. While no one died, mainly due to the quick and effective responses of staff, officers and inmates, some were still going in and out of respiratory arrest in the nearby referral hospital twenty-four hours later, in spite of treatment.

Methadone in Overseas Gaols

As far as can be determined, there is precious little in the way of overseas experience on which to rely for assistance in managing a gaol-based methadone program. Needless to say, those who are anti-methadone have no hesitation in using this fact to question the present policy in New South Wales.

While not having had the benefit of seeing first-hand, the systems of other countries, I am led to believe by reading and discussion with others that the systems are simply not comparable. Custodial practices and policies overseas do not seem to equate with those in New South Wales. Cell sharing, the amount of time spent in common areas with other inmates, contact visits, lack of invasive body search techniques and the sheer number of people passing through the gaols all preclude a successful program to control the entry into, and sharing of drugs, in gaols.

A Brief History of Methadone and Gaols in New South Wales

Methadone slowly insinuated itself into gaols, developing as 'the best game in town' to prevent needle sharing in the prison setting. Up to the time that its possible advantage was realised, methadone was rather a nuisance. Added paperwork along with the incessant manoeuvring of prisoners to get either on the program or have their dose increased was an absolute disincentive to its expansion.

Initially, my predecessor, Dr John Ward, obtained approval for a limited program to examine the effects of the program on recidivism. Before that aspect got under way, however, he moved out, and I moved in, soon to be followed by the rapidly increasing recognition of the AIDS epidemic.

However, 'the system' was not enthusiastic about methadone being prescribed in gaols. The AIDS threat in gaols through needle sharing had not yet been recognised as a potential source of spread of the infection into the general community. All that was approved was an

expanded version of Dr Ward's idea, for pre-release (three-months-to-go) prisoners. This was too limited to be effective in reducing recidivism, and created tension as prisoners queued up for the limited number of places on the program.

Spurred along by AIDS, overseas opinions and the difficulty of keeping New South Wales prisons drug-free, the program was eventually funded by the Commonwealth, through the New South Wales Directorate of the Drug Offensive (DODO).

Corrective services staff were responsible for the assessment and counselling of methadone clients, while Prison Medical Service (PMS) personnel prescribed and dispensed the drug. This separation of functions, along with difficulties about finances, caused trouble.

Crossed organisational charts do not work. The system that was used initially revolved around the Department of Corrective Services being funded by DODO, and then reimbursing PMS for its 'costs'. Corrective services and PMS never did come to agree on what was a fair and just division of the cake. Eventually, after increasing problems, both financial and philosophical, the earlier arrangement was disbanded and the present system introduced on 1 July 1990. Now, PMS is directly funded by DODO to run the program independently of corrective services.

The Community Methadone Program in New South Wales

Methadone came into use in New South Wales in the late 1960s, and was initially very limited in its availability. There was a great deal of competition for the limited number of methadone places on the even fewer programs. Originally, it was given in orange juice, in an abortive attempt to hide the vile taste. Later, a syrup was used, but the taste is still most unpleasant; often those commencing on the program experience nausea and vomiting after ingestion.

There were relatively few places in the total program until about five years ago, when, due largely to the AIDS epidemic, there was a change in attitude towards methadone. By Government policy, an increase in accessibility through an increase in available positions, occurred. There was also a decision to expand the role played by private prescribers. The net effect is that now there are approximately 5000 persons on methadone in the State. Approximately 400 of these are in full-time custody at any one time.

Treatment Models

Methadone is one of a range of treatment options in the management of narcotic drug addiction

This idea was the basis of the early methadone programs. There are still some who adhere strongly to the model, to the exclusion of all others and thus have difficulty in adapting to the increasingly popular 'harm reduction' school of thought. This line of thinking tends to discount the effect of AIDS.

Those who subscribe strictly to this view have in the past, tended to make entry to a methadone program very selective and difficult. They often run their programs in what is seen by some to be an overly paternalistic and authoritarian manner. It was common practice, for example, to exclude poly-drug abusers from these programs.

Difficult entry into a methadone program, by dint of strict and inflexible assessment criteria gives program personnel a high level of personal power over the powerless addict. This in itself is a handicap to effective intervention for persons already lacking in self-esteem.

Methadone is a treatment for drug addiction and a cure is the accepted end point of treatment

There is a tendency for those who see methadone as a 'treatment' to expect, by implication a 'cure'. This can make it difficult working with a client population with such a high failure rate, and can lead to what others see as inappropriate dismissals from the program.

Similarly, it has been shown that the length of methadone treatment is best determined by the addict rather than the therapist. There is a significantly higher failure rate amongst those who are taken off, as opposed to take themselves off, treatment.

Methadone is part of a no-frills harm (AIDS) reduction program

This treatment model is at one end of the philosophical spectrum. Entry is relatively easy and the eligibility criteria more flexible. Basically, this type of program is available to any addict who uses intravenous narcotics and who wishes to join the program. Those who use heroin as only their second choice drug would not automatically be excluded. The development of 'no-frills' programs was largely precipitated by the AIDS epidemic, adopting the philosophy of reducing the need for needle sharing by the use of methadone.

These programs are of the 'dose and go' type with minimal restrictions, and counselling available only on request by the client. The length of treatment is open-ended so long as the client is exposed to significant risk of harm, wishes to continue and is shown to be benefiting from continued treatment. By reducing the risk of harm to the patient, there is a reduced risk to the community as a whole. This style of approach seems to be more common in private sector programs.

Methadone is a drug treatment option with an anti-AIDS additional benefit

This is probably the model with the widest acceptance by those in the field. There is still ease of access to the program, but staff/client interaction is encouraged, and there is greater availability of counselling. There is usually a stricter regime applied when compared to the 'no frills' school, but not anywhere near that which was the norm in the past.

In New South Wales, at present, our program more closely approaches the 'no frills' model. We are aiming to improve this, and expect to do so in the foreseeable future. Lack of suitable funding and appropriate staff have been the impediment, but this is now being resolved. However, it is important to state clearly that in New South Wales prisons, methadone programs are supported mainly as an anti-AIDS strategy.

The Impact of AIDS

Five years ago, methadone was only an organisational irritant to the Prison Medical Service, requiring additional paper work and extra nursing input. About that time, AIDS raised its head, and testing for the related antibody became available. The situation is now remarkably changed, with methadone being the 'tail that wags the PMS dog.'

This unfortunate situation has arisen not only because of AIDS, but also because of controls and limitations placed on the program by security requirements demanded by others. Some of this is also based on intransigent ignorance about methadone, its pharmacology and its purpose and place in the overall anti-AIDS armamentarium. On the other hand, some of it is based on the reality of prisons and prisoner behaviour.

The main reason PMS promotes methadone in New South Wales is as an AIDS prevention strategy whereby it is hoped that needle sharing will be limited. However, it is acknowledged that for some individuals, methadone is a major help in overcoming addictive behaviour. My own view is that it is more effective in attaining this goal in the over thirty age group and less so in younger recipients. Having said that, I would add that if needle sharing in New South Wales goals was not a problem, then support for methadone would be markedly reduced. It is very time consuming and expensive in terms of staffing and administration.

The Practicalities of a Methadone Program in a Gaol Setting

In general terms, dispensing methadone involves the following for each inmate on the program:

- A prisoner applies to go on the program.
- He/she is assessed for suitability according to criteria laid down in both national and State guidelines. These are slightly modified for use in prisons. The assessment usually is done by specific people paid out of methadone funding, or by one of the authorised prescribers (medical officers) associated with the PMS The prisoner is asked to sign a methadone contract which, among other things, involves obligations to refrain from using illicit drugs and from abusing staff as well as submitting to urine testing as and when required by staff. The contract also makes it clear that the inmate may be involuntarily withdrawn from treatment for repeated breaches of the contract.
- An authorised prescriber interviews the applicant prisoner and, if in agreement with the recommendation of the assessor, completes and signs the 'Application to Prescribe Methadone' form and writes up the Treatment Sheet.
- The application form is faxed to the Health Department for approval prior to treatment actually commencing. Approval is usually obtained within twenty-four hours, and treatment commences.
- The prisoner attends at a given time and is 'patted down' by a prison officer for hidden containers etc. A registered nurse, meanwhile, draws up the appropriate dose of methadone, checks it with a colleague and makes the necessary entries in the drug register. The inmate produces his/her ID and the dose is then handed to him/her in a standard sized plastic container. The container is then filled with water, to make diversion by retention in the mouth or regurgitation more difficult, and taken in front of the nursing staff.
- At least once a week, a supervised urine specimen is collected from the inmate, temperature-tested electronically to ensure that it is a specimen freshly passed, and sent off for drug screening. The results are confidential and not available to the Department of Corrective Services.
- The prisoner then joins the others already dosed and waits under custodial supervision for fifteen minutes in a holding yard before being permitted to return to normal discipline. This procedure again is designed to reduce diversion.
- Any inmate can request an increase in dose, but must have a methadone blood level test performed before any alteration is possible. This enables some degree of objectivity to be introduced into the vexed question of dosage level. Similarly, any inmate can request to come off methadone at a rate dictated by the recipient to best address their needs and comfort.

The Benefits

There is anecdotal and research based evidence that methadone in New South Wales prisons has a beneficial effect on intravenous drug use by inmates. While the best indication is found in the small number of so-called 'dirty urines' found to be contaminated with non-prescribed drugs, it is not suggested that all the urine specimens tested come from the person who supplies them. There is here, as in other areas in prisons, a never-ending game whereby the inmate attempts to beat the system, and the system attempts to stay one step behind.

The largest problem is the concomitant use of drugs from the benzodiazepine group. Serepax, rohypnol, valium and mogadon are examples. This group of drugs has an additive effect on methadone and can lead to intoxication or, worse, unconsciousness, respiratory arrest and death.

A quandary arises when a person is avoiding intravenous drugs, but continually putting their health at risk by potentially overdosing on a combination of methadone and one of the benzodiazepine group. The primary, that is, anti-AIDS goal has been met, but at what potential cost?

As a rule of thumb, and in the absence of a major breach, such as threatened assault on staff or drug-induced unconsciousness through overdosage on a combination of drugs, inmates are involuntarily taken off the program if they accumulate three breaches against the agreement over a three-month period. If this occurs, they are detoxified comfortably, and may apply to re-join the program after three months 'in the wilderness'.

Another welcome outcome of methadone treatment derives from its use in heroin-addicted, pregnant women. Methadone, alters the lifestyle of the pregnant woman by eliminating the need to 'hassle' for drugs, at least during her pregnancy, and has a significant beneficial effect on the outcome of the pregnancy. There is a reduction in premature labour and stillbirths and, by stabilising the activities of the mother, the bonding between the woman and her child is enhanced.

The Costs

In money terms, the methadone prison program cost the New South Wales Government approximately $560 000 in 1989-90. Because of the difficulties in moving inmates through clinics and performing all the bureaucratic and security steps required, it is estimated that for each dose of methadone administered to an inmate, there are ten minutes of staff time required. By calculating this out, and allowing for holidays etc, it works out that 14.5 full-time equivalents of nursing staff are needed. Without including on-costs, the cost is approximately $500 000. When this figure is added to clerical and prescriber costs a figure of $560 000 is easily attained.

There are also opportunity costs involved in that the time taken up by methadone limits that available for other nursing and medical duties. This, in fact, has been a problem for some of the nursing staff who see the methadone program as an increasing distraction from caring for the majority of prisoners. The methadone program in a busy gaol will dose fifty prisoners daily, and effectively block the clinic to other inmates for up to two hours. There is also a cost in terms of the additional prison officers required for the security aspects of the program. This leads to problems for corrective services who see the need for the program as marginal at best, but the costs as real and significant. Here, health and custodial priorities come yet again into conflict.

The Opponents

There has never been a great deal of support from corrective services for the methadone program in gaols. Many prison officers only see it as 'another drug' or 'a crutch' and do not, or will not, regard it as a public health program. Certainly, there have been some notable exceptions, where senior corrective services officers have seen and acknowledged the benefits for some individuals who no longer have to 'hassle' for drugs in gaol. However, the majority of corrective services staff would rather not have anything to do with methadone.

Admittedly, as already noted, the methadone program causes a great deal of trouble, relative to the number of prisoners presently on it. While this is due in part to prisoners diverting the drug either because of 'standovers' or for re-sale, it is in part due to security measures imposed through or by the Department of Corrective Services itself. Of course, there are the usual practices required by the Health Department relating to restricted drugs, which also take up more time in a gaol than elsewhere and these all compound the problems for prison administrators.

The Proponents

In the health field, the attitude is very different. The methadone program is supported by most if not all of the luminaries in the AIDS field, although it was slower to gain the acceptance of drug and alcohol experts. I believe this was because it was harder for the latter to let go of the view that methadone was a form of therapy for drug addiction per se, and accept a position where the emphasis was altered to making the anti-AIDS thrust the dominant motivating factor, especially in gaols.

Other AIDS-related Strategies

Methadone is not the only program aimed at reducing the spread of HIV. Other initiatives are:

Milton tablets

With the necessary political approval, Milton tablets, a form of concentrated bleach, are distributed in gaols for disinfection of syringes. While this was not welcomed into prisons, it is there, and it is working. Most inmates who either cannot get onto, or elect not to try, the methadone program, are aware of, and have access through prison clinics to, Milton tablets. Of course, as part of the game, those on the program have discovered that by introducing Milton into their urine by urinating over their fingers with traces of the tablet under their fingernails, they will totally destroy the ability of the test to determine the presence of any illicit substance.

Condoms

Condoms remain a vexed issue. There are industrial and 'moral' impediments to their introduction. Some $47 000 worth of condoms previously held by the Prison Medical Service have long since been distributed through community health clinics to sexually active people attending those service centres. It would have been a shame to see them all perish while negotiations continued about their distribution.

Compulsory testing

Compulsory testing for HIV status is soon to commence in New South Wales. It will be applied to all those being received into prisons, and to those being discharged, as long as more than three months have elapsed since their last test. Others may also be directed to be tested at the discretion of senior prison officers.

While there are arguments both for and against this government decision generally, I believe that most medical practitioners working in the area are in favour of testing. For the first time, there will be an objective measure of what is actually going on. It may not be the perfect instrument, but it is the best to hand. As a result, it is hoped that rational planning and funding decisions will be made as, with the passage of time, a clearer picture is obtained of what until now has been at best, only educated conjecture.

Also of interest is the strong feeling that the majority of prisoners do not have real objections to compulsory testing. With the absolute absence of physical compulsion, the general opinion is that cooperation will be the norm.

Education

While held by authorities to be the mainstay of all anti-AIDS strategies, in the prison setting it is difficult to feel enthusiastic about the success of education programs as they effect the behaviour of inmates, or the attitudes of prison officers.

The recent sad event in New South Wales where it is alleged that a prison officer was assaulted with a needle and seroconverted did little to advance things. The 'what if' syndrome is alive and well in New South Wales amongst prison officers. The argument is that, although no-one has contracted the virus through being, spat on, for example, 'you can't prove that it couldn't occur'.

As for the intravenous drug users amongst prisoners, they still share needles, but admit to concerns about becoming HIV positive. How real these concerns are in altering their behaviour is dubious. As a group they remain impulsive and retain the 'it won't happen to me' philosophy that kills so many young people on the road.

Certainly, the theoretical knowledge base of both officers and inmates has been expanded, largely by the educational efforts of the Department of Corrective Services. It is a moot point how this knowledge translates into altered attitudes when incidents such as minor assaults and spitting, occur.

Conclusion

Other speakers, no doubt, will address American and European statistics of the AIDS epidemic in gaols. Information about deaths, the number of antibody positive persons being received into gaols and the prevalence of HIV positive status amongst inmates and the population generally are all relevant, available and disturbingly high.

Australia, on the other hand, has some limited right to optimism in its approach to AIDS. The earlier gloomy predictions about the rate of spread amongst intravenous drug users is well over the actual rate being measured, and to some extent, this must have an effect on the rate of HIV spread to the heterosexual community.

Our knowledge of HIV prevalence within the New South Wales prison community will be significantly advanced with the introduction of compulsory HIV testing later this year. Thus, for the first time, there will be the beginnings of a measurement system which will give an overview not only of HIV prevalence, but also over time, the rate of seroconversion in prison. It is in this area that methadone, if as effective as hoped and thought, will come into its own.

If methadone as a treatment modality cannot be shown to be effective in reducing the expected seroconversion rate amongst prisoners, then its very use in gaols must be questioned. There will be statistical difficulties in assessing the success or otherwise of the program. Until they are identified and addressed, the program must continue.

Reference

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Juveniles and HIV/AIDS Policy Development and Practice in Victoria

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This paper is about juvenile corrections and more specifically, Youth Training Centres (YTCs). It is aimed primarily at those working in the juvenile area, though many of the issues raised will be of interest and relevance to those in other correctional settings.

The paper will outline the response of one organisation, Community Services Victoria (CSV), to the issues HIV presents. Rather than focusing on a single area such as testing or education, it is the totality of Victoria's approach with which this paper is concerned. We will trace the HIV policy development process, examine issues which we have found particularly difficult to deal with, discuss initiatives that are in place in YTCs at present and look at what needs to happen next.

This paper is based on the premise that the juvenile corrections system has features that make it different from adult corrections, both in a general sense and in terms of responding to HIV. In Victoria, some of these features are as follows:

- Regulation 248 of the Community Welfare Services Regulations 1985, provides that:

> All officers and employees who have responsibility for the care, management or supervision of trainees in a remand centre or youth training centre shall, consistent with community safety, regard the welfare of trainees as the first and paramount consideration and any provision made for their physical, intellectual, emotional or social development shall be such as good parents would make for their child.

This Regulation adds a clear 'care' imperative to youth corrections. It distinguishes the adult and juvenile systems most clearly.

- Staff in YTCs are given the same pre-service training as staff caring for children and youth in the protective services stream of the Department of Community Services. They are educated and encouraged to deal with client issues from a welfare perspective that places emphasis on client rights.
- Youth corrections are administered by the Department for Community Services, not the adult correctional authority. These arrangements are found in most States. Administration within a community service framework is likely to reinforce the 'care' and 'rights' orientation of responses to HIV.
- At some time in their sentence, most youth trainees are entitled to regular weekend leave. This ongoing contact between trainees and the community has implications for youth corrections policies and practice regarding HIV testing, education and the provision of harm minimisation equipment.

These are just some of the features that indicate the need to consider HIV issues in YTCs separately from HIV issues in prisons.

The broader social value in promoting discussion and activity around HIV in youth corrections is clear. Although adolescents show a relatively low incidence of AIDS, the sharp rise in incidence among people in their twenties indicates that HIV is frequently contracted in the teenage years. Since many trainees practise behaviours that place them at risk of contracting HIV, their presence in an institution affords an excellent opportunity for YTCs to educate young people who may be otherwise hard to reach. The aim that youth trainees will use information to protect themselves and to spread the message to peers when they leave the institution, underlies every HIV initiative within YTCs.

On one level, CSV is at a very early stage in dealing with HIV. As yet, we have not had a youth trainee who is known to be HIV positive. This may simply be a product of our voluntary testing policy. On another level however, CSV has developed HIV education and prevention programs and has planned for the care of clients with HIV.

Discussion with program staff from youth corrections services around Australia indicates a great variation in the nature and amount of activity that has occurred in relation to HIV. Some States and Territories have developed detailed responses while others are just beginning to address the issues in a planned way. By presenting a total picture of CSV's response so far, it is hoped that other services will be able to focus on the issues that are relevant to them.

CSV has responsibility for an extremely wide range of human service programs. These include juvenile corrections, child protection, pre-schools, child care centres, home care services, supported accommodation, adoption and a wide range of services for people with an intellectual, physical or sensory disability.

CSV provides some of these services directly and partly resources the provision of others in the non-government sector. It directly employs some 8000 staff.

It became clear at a very early stage that HIV/AIDS would raise significant issues for CSV as a human service organisation and as a large employer. CSV began responding in a planned way to these issues in 1986. Early initiatives, however, came from individual program areas and lacked coordination across the Department. Recognising the potential for duplication of effort, or worse, the pursuit of inconsistent approaches, the CSV executive elected to appoint a Policy Officer to coordinate the development of a broad-based policy.

Policy Development Process

Work on the HIV/AIDS policy began in July 1989 and was completed in February 1990. A Departmental Reference Group was formed, comprising seventeen senior management representatives from the range of CSV programs outlined above. This group drafted a series of principles that underlined the broad Departmental HIV/AIDS policy. The Reference Group identified major areas to be addressed and formed working groups to develop detailed policy covering:

- personnel practices and HIV/AIDS;
- infection control for blood borne viruses;
- staff education and training;
- client education and counselling;
- client access to condoms, needles, syringes and bleach;
- client HIV antibody testing and informed consent;
- client privacy and confidentiality;
- case management and treatment of HIV infected clients.

Working groups brought their policy statements back to the Reference Group for discussion, coordination and consultation with executive-level managers and relevant unions. The policy package was finally endorsed by the Minister for Community Services and a broad-based distribution and marketing strategy put in place.

This policy development process worked well for CSV. Firstly, it resulted in a comprehensive document within a reasonably tight time-frame. Because of the wide representation of the Reference Group, the policy was well-tuned to the range of issues that arise in CSV's many program areas. The number of participants involved meant that many parts of the organisation knew the policy was developing and had some investment in its content and application. Most importantly, as we have approached implementation issues in the months since, the Reference Group members have continued to 'own' the issues, acting as change agents and role-models within their respective programs.

CSV HIV/AIDS Policy Principles and Youth Training Centres

> That HIV related policies and programs be developed in the wider context of communicable diseases and human relations programs.

Adoption of this principle requires CSV to provide youth trainees with education regarding health, sexuality, communicable diseases, self-esteem, assertiveness and communication to ensure trainees have the skill and knowledge base to apply safe behaviour messages.

It requires CSV to train youth officers in similar areas so that they can properly resource clients. Recognising that not all staff will be comfortable or effective in this role, CSV is required to ensure that specialist, often external services are available to YTCs.

> That the development and implementation of appropriate education programs concerning HIV and communicable diseases be incorporated in any future CSV policies and programs

Adoption of this principle requires CSV to entrench messages about HIV prevention and care of infected people in the range of programs to which youth officers and youth trainees are exposed, and in the policies and guidelines covering YTC management. For staff, this includes incorporating infection control and HIV content into pre-service training in the post-secondary sector, and normal induction and in-service training programs in CSV. It means placing HIV in the broader context of CSV's occupational health and safety responsibilities as an employer. For trainees, the principle requires educational programs and materials to address HIV issues and day-to-day interactions with staff to reinforce safe behaviour messages.

> That policies and programs developed for communicable diseases maximise the rights of all individuals to:
> - self-determination
> - the least restrictive living environment
> - access to appropriate protection against infection.

While sentencing reduces a young person's right to self-determination and the least restrictive living environment, this principle ensures that CSV's policy response to HIV does not in itself, further minimise these rights. It is a reminder that the sentence is the punishment and that CSV's broad duty of care requires an empowering approach to all health and personal development issues.

The principle of maximising the individual's right to access protection against infection, that is, condoms, needles, syringes and bleach, is worth special consideration in the youth correctional setting.

CSV sought detailed legal advice regarding the balance between its duty of care to protect trainees from infection and its obligation to work within Victorian laws covering the drug usage and sexual activities of minors. The essence of the advice received was that if counselling were provided to young people about the danger involved in sexual activity and drug use and if illegal sexual activity and drug use were actively discouraged, the provision of harm minimisation equipment to youth trainees by CSV would be considered part of the discharge of its duty of care.

Within this legal framework the ethical, political and practical implications of providing trainees with condoms, needles, syringes and bleach were considered. Given the critical stage many trainees are at in terms of their personal development and identity formation and the potential for exploitative activities in enforced group living situations, sexual activity between trainees is prohibited. As an illegal activity, intravenous drug use is also prohibited. Within the broader context of weekend leave however, it is clear that some trainees use intravenous drugs and practise sex in ways that may place them at risk.

CSV has decided not to provide condoms explicitly for use within YTCs. However, condoms and educational material are made available to trainees within an overall educative framework and procedures for distributing condoms at times of weekend leave are being piloted. CSV will not provide needles and syringes to trainees at any point. However, educational material including information on the location of needle exchange centres is provided prior to weekend leave. Needles and syringes have remained banned items within YTCs while condoms brought into the section by a trainee, as part of his or her personal property, are allowed.

> That no routine HIV antibody testing or screening be conducted and that testing only be conducted
>
> - with the informed consent of the individual
> - where recognised pre- and post-test counselling is provided.

This principle acknowledges the dilemmas associated with the decision to be tested for HIV and locates decision-making responsibility at the individual level. Its adoption requires CSV to ensure that specialist counselling is provided to assist trainees to sort through the issues and to ensure that the test is available with pre- and post-test counselling to any trainee who requests it.

CSV is very clear that youth trainees should not be tested to allay workers' concerns about their own risks of infection. Youth officers are trained in infection control procedures and urged to treat every client as potentially infectious. This approach promotes the health and safety of staff more thoroughly than a simple testing procedure in that it protects them from a range of blood borne viruses including hepatitis B and from HIV that may not be detected in an initial client screening process.

> That HIV related policies for clients and staff uphold the principles of confidentiality.

Because CSV policy and practice encourage the same treatment of trainees regardless of their HIV status, staff and management do not automatically need to know if a client is HIV positive to protect themselves or to offer optimum care. There are, of course, situations where youth officers will need to know a trainee's HIV status. This is important where it has implications for the care of an infected person or where the behaviour of an infected person is placing other trainees or staff at significant risk.

In cases such as these, information about a trainee's HIV status will be given to the smallest number of staff possible. The trainee concerned will be told in advance who will be notified.

> That HIV related policies for clients and staff reflect the principle of non-discrimination.

Adoption of this principle within a YTC means that staff and clients who are HIV positive or who are presumed to be HIV positive will not be automatically excluded from any regular activity or duty within the institution. Where an HIV infected trainee is placed at risk or places others at risk through specific behaviours, intensive counselling and education will precede any move to restrict the activities of that person. CSV does not support routine isolation or segregation of trainees with HIV infection.

HIV/AIDS Unit

Translation of these policy principles into practice is of course, the ultimate challenge. To work towards this end, an HIV/AIDS Unit has been established within CSV. It has four staff members, including a doctor, a social worker and a teacher. The Unit is time-limited. It works closely with the program direction areas of CSV to develop and promote on-going:

- staff education and training;
- client education and counselling; and
- infection control practices.

The HIV/AIDS Unit works in close cooperation with the Youth Support Program Direction Branch of CSV to ensure that the HIV/AIDS policies are implemented in YTCs.

Before looking at current initiatives in this regard, a brief introduction will be given to the Victorian YTC system.

Victorian Youth Training System

The YTC system in Victoria deals with male and female young offenders and young people on protective orders between the ages of ten and twenty-one. There are four YTCs, one for females and three for males.

Winlaton is a female institution and it holds fifteen to twenty-one year old offenders and those on protective orders. Turana holds mainly fourteen to seventeen year old young male offenders and a few young men on protective orders. It is the remand centre for the Children's Court and holds seventeen to twenty-one year old convicted offenders before they are classified to one of the two country adult YTCs.

These two adult centres, at Langi Kal Kal and Malmsbury are part of Victoria's unique dual track approach to imprisonment of the seventeen to twenty-one years age group. The Victorian courts have the sentencing options of adult prisons or YTCs when they wish to incarcerate convicted offenders.

The Problem for Juveniles

A quote from Professor Brent Waters' (1988 p. 9) final report from the Youth Working Party of the Australian National Council on AIDS, gives an insight into the place of young people, in the overall picture of HIV/AIDS in our community:

> Many Australian teenagers engage in unsafe sexual activities. At least a third of boys and quarter of girls in the final years of high school have had intercourse. Many teenagers do not protect themselves against pregnancy or sexually transmittable diseases. As many as 5 per cent of teenagers may be homosexual. About 4000 Australian teenagers run away from home each year and many of them become involved in drug use, prostitution and drug trafficking. While intravenous drug use is uncommon amongst Australian teenagers, the rate of HIV infection among those who use IV drugs has increased rapidly in the last eighteen months. Moreover, it has been suggested that teenagers are more likely than older IV users to share needles.
>
> Teenagers who use IV drugs, or are gay or bisexual, or are homeless, or are involved in prostitution, should all be considered target groups for special efforts that will help them develop safer sexual and drug use behaviours.

The 1989 YTC census gives a picture of a typical young offender. The offender is most likely male. He has offended under the influence of, or to obtain, drugs or alcohol. He is unemployed and probably homeless at least some of the time. In 75 per cent of cases, he comes from a family where death, separation, divorce and/or remarriage has occurred. It is most likely that he did not successfully complete Year 9 and in many cases, not even Year 8. Many of the young people we see have lived as what the media call 'Street Kids', amongst whom crimes such as prostitution and drug taking, are a way and sometimes even a necessity, of life (Youth Support Branch 1989).

System Dilemmas

Having established the fact that the Victorian young offender population falls into the high-risk group, we then need to consider some of the other issues which make the youth training system in Victoria, a difficult place in which to implement educational strategies to promote and support behaviour changes, aimed at stopping transmission of HIV/AIDS.

Some of the dilemmas associated with confidentiality, testing, issuing of condoms and bleach, and the temporary leave program have already been mentioned.

Young offenders are not merely locked up for the period of their sentence, they are reintegrated into the community and into their families, through a graded release system. Weekend leave, special leave and work release are all part of this system.

Temporary leave is a strength of the system, but it presents special problems in terms of risk-taking behaviour. Young people are released for weekends after eight weeks in the institution and then each four weeks after that time. This places these young people in an extremely high-risk situation because after enforced abstinence, they tend to have a 'binge' mentality. Binge drinking amongst underage drinkers is a well-documented phenomenon, and is often extended into drug taking and sexual behaviour by the young offenders. CSV has some supervision in place, but a balance must be established between this and allowing the young people enough freedom to maintain and, when necessary, rebuild their relationships with their families and the community. The chances of high-risk behaviour in areas such as needle sharing and unsafe sex are especially high during these periods.

CSV's education strategy takes this and other factors into account. Health education in the institutions has been plagued by problems which affect all aspects of institutional life. Many different players can have inputs into the health education of young people in institutions. Some of these include youth officers, education staff, nurses, doctors, chaplains and volunteer agencies. To provide a common approach is a difficult and at times, impossible task.

It is in the area of preventative education that CSV, through its HIV/AIDS policy and through its work in institutions on health and personal development, plays a role in the 'New Public Health' approach to dealing with issues such as HIV/AIDS. A key part of the policy for our juvenile institutions is in the client HIV/AIDS education and counselling area. CSV has an education and advocacy role for its clients and the policy reinforces this role and gives the institutions the mandate to operate in these two areas.

The New Public Health Approach - Advocacy and Education

The Ottawa Charter developed through the World Health Organization suggests new approaches to old problems. This is today referred to as the 'New Public Health'. It gives communities and people responsibility for health. This is a basic shift in focus on health thinking, so that health education becomes a 'bottom up' rather than a 'top down' approach. CSV has a responsibility to the community to be part of the process and it must become an advocate for its clients.

It must also help the young people in its care to develop their own advocacy skills, which they need both in the institution and even more so, on their release. CSV is not solely responsible for all the education of its clients, but is responsible for that which they receive in its institutions and in part, for what happens when they leave. CSV must advocate on its clients' behalf with other government departments, so that these services are available to them on their release. Education as a preventative measure is one of these services which must be available to all young people and in particular to the high risk groups into which many of our clients fall.

Youth Support Branch is at present fulfilling its advocacy role through the work it is doing with other departments such as Health Department Victoria (HDV) and the Ministry of Education (MOE).

With HDV, CSV is building community links so that young people leaving institutions, have real access to community health services. This is being augmented through joint HDV/CSV processes and in particular, the proposed formation of the Young Offenders Health Board. This Board is modelled on the Corrections Health Board which operates between HDV and the Office of Corrections and which has worked successfully to improve health services for adult prisoners. The Young Offenders Health Board has, as one of its proposed terms of reference, to develop systems for young offenders to link them to community-based health resources.

In the education sphere, CSV has worked with the MOE to give young offenders much more access to mainstream education, both during and after their stay in our institutions. This is a broad field and health education is one part of the overall picture.

The 'New Public Health' tells us that almost everything in our lives affects our health and there are direct links between things such as educational level, employment, housing and people's health status. CSV's advocacy role extends into all of these areas because the work it can do with and for young offenders to improve their overall situation, can have a direct effect on risk-taking behaviour. It is often not the health authorities who solve health problems. Action by the police and the justice system has reduced death rates on the roads and in developing countries, the provision of clean water does much more to reduce illness and infection than truckloads of penicillin.

As well as our advocacy role for young offenders, we have taken a role in preventative education. Education in its many forms is, of course, the basis of the world strategy against HIV/AIDS and correctional institutions are a part of this whole process. The institution cannot control the problem but as a subset of the broader community, it can have some effect in terms of preventative education.

Current Initiatives

Many people are now working together to try to provide a more common approach to health and all other issues in the institutions. I will outline some of the more promising co-ordinated responses which currently exist or will be implemented in the near future.

In 1989, Turana School, in consultation with its local School Support Centre, developed a comprehensive personal development program for its students. This program provides education for young offenders on a broad range of health issues including HIV/AIDS. The program is designed to be delivered to all young people going through Turana School. It also forms the basis of education around the Condom Issue Program, currently operating at Turana for trainees going on weekend leave.

The Health Access Program (HAP) has been a joint HDV/CSV initiative, which has run for the last three years. However, while it will not operate in its present form in the future, it is worth mentioning the excellent work which the HAP has done with both trainees and staff on health issues, as this work forms the basis of valuable, current and future programs.

The HAP has operated with five workers statewide in the youth health area with a particular focus on young offenders. One highly successful YTC program providing HIV/AIDS education for young offenders has been held at Langi Kal Kal with the new intake trainees each week. The Health Access worker has run a three hour session with the trainees on a broad range of health issues including HIV/AIDS, STDs and drug and alcohol use. An integral part of this process has been the adoption of a 'train the trainer' model where youth officers have sat in on each session with a view to eventually running these sessions themselves.

The Health Access team has also been working on a 'Release Kit' of information for trainees. Some health issues covered in the kits include community health links, a general health information and needle exchange program and condom distribution points. Although the HAP program is shortly to finish, this development will be picked up by Youth Support Branch. The kit will be part of an overall pre-release program for trainees.

Youth Support Branch is currently initiating a new approach to health education within the YTCs, based on the idea of having a small interdisciplinary team of people within the institution who have responsibility for health issues, promotion and education. The Institutional Health Team will use the skills of the existing staff in consultation with doctors, outside experts and professionals. The institutional nurses will be taking a greater health promotional role as part of these teams, as we see the nurses as a valuable resource which has been under-utilised in the past. The teams will also include two youth officers and a senior youth officer, who have received their basic health training course. The teacher in the institutional school who has health responsibility will be included and finally two trainees will be included in meetings and activities of the teams.

Members of these teams will be given all available health related training and in the HIV/AIDS area this will be provided through the CSV HIV/AIDS Unit. This training will be across the range of CSV HIV/AIDS policies and will again be based on the 'train the trainer' model so that the information will be passed onto other staff by the Health Team members.

Health Team members will deliver HIV/AIDS information sessions to trainees within a personal development program, based on the Turana model mentioned previously. Youth Support Branch places a high priority on the provision of information to both staff and trainees as there are many common myths to be explored and that is part of the overall strategy of education in all health areas in YTCs.

The staff training which is such a vital part of the process is aimed not only at the Health Team members. The HIV/AIDS Unit has implemented a thorough Infection Control Training Program. At this stage 85 per cent of first line supervisors in our institutions and all senior managers have been trained in infection control procedures. These supervisors are now training their staff and this process is being closely monitored by the HIV/AIDS Unit. The Unit is also working with TAFE to have HIV/AIDS training included in pre-service training for Youth Officers. CSV's Staff Development Branch is including the training in all induction courses run internally. Finally, the Unit provides an in-house consulting service and training in response to case- specific queries.

The final educational approach I wish to mention, is a pilot project going at Winlaton at the moment. The project is a Peer Education Program being coordinated through Winlaton YTC, CSV's HIV/AIDS Unit and Youth Support Branch. The success of peer education amongst homosexual males and prostitutes cannot be questioned and this educative approach is one which is already used for many purposes at Winlaton. The project will be seen as a pilot for other YTCs and it is particularly attractive as it reaches not only institutionalised young people, but also their community networks as well, when they are released.

Conclusion

I wish to draw some conclusions and make some observations about our approach. We are very much at the beginning of a continuum of education in not only the specific HIV/AIDS area, but right across the health spectrum. CSV's response is part of a total 'New Public Health' response and must be seen as such. It is not the final solution, merely part of it.

We must ensure that the initiatives I have outlined become firmly entrenched in the institutional culture. They must become institutionalised. At the same time, we must be flexible. We must respond to the changes in thinking, knowledge and strategies which will, without doubt, occur in the HIV/AIDS area in the years to come.

Health and health education are the 'flavour of the month' at the moment, not only in institutions, but throughout the community. CSV has the responsibility along with other government departments to see that it remains on the agenda and that programs are resourced at a level which will allow this to happen. It is sometimes difficult to imagine that YTCs could be healthy places but they must be both healthy and health promoting. Youth

Support Branch and the institutions are at the moment developing institutional health plans which are aimed at making the institutional environment as healthy as it can be, given that in the end, it is a detention centre and that depression and stress are a part of a detainee's life. Issues such as nutrition, physical exercise, stress reduction, anger management, cleanliness and personal space all affect the general health of trainees. If we can work in these areas, then we can have an effect on young people's health and hopefully reduce their risk-taking behaviour. This, together with education, is our approach.

Let us conclude then by going back to my profile of an institutionalised young person. All of these issues - drug-taking, alcohol abuse, employment, accommodation, family life, community life and education - can be tackled in part by the institutional program. However, the whole community must play a role. Government Departments such as Health, Education, Police, the Department of Employment, Education and Training, Labour, Social Security and many others must all be active because the 'New Public Health', whether it be in HIV/AIDS education or anything else on the health agenda, is the whole community's responsibility.

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Women Prisoners and HIV/AIDS

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This paper addresses women prisoners' issues in regard to HIV infection. It is descriptive because the nature of the prison environment and the illegality of risk behaviours such as drug use mean that it is difficult to collect quantitative data.

Operating within prisons in NSW are Prisoners' AIDS Committees, whose function is to impart knowledge of HIV/AIDS prevention to other prisoners. Methods used include group sessions, pamphlets, posters, running HIV/AIDS knowledge-based competitions, plays, video script writing, and musical compositions. All are means of attracting the attention of fellow prisoners to the dangers of HIV transmission in prison.

My role as education officer is to facilitate the committees' work with up-to-date information. This takes many forms such as allowing openly HIV positive people from the outside community to talk about issues, using videos and medical literature, using professional script writers to develop educational resources, and organising poster competitions. Liaising with prison staff and superintendents about committee activities keeps communication channels open.

It is from Prisoners' AIDS Committees within two women's prisons, one maximum and one medium security, that material for this paper has been received. It is important to note the significant differences between these two security classifications in considering the effectiveness of prisoner AIDS peer education. Also important to note is that the women's AIDS committees' views are based on anecdotal evidence: observation, their own surveys of fellow prisoners and personal knowledge. Having said that, it should be remembered that many committee members are from drug-taking backgrounds and are very aware of drug taking in prison. In my view, their input on drug-sharing activities is fairly accurate.

Sexual Activity

Woman-to-woman sex risks are a common concern among women prisoners. Women prisoners want to know the risk of HIV transmission in lesbian sexual activities, which, in my view, are widespread in women's prisons. Although officially stated as 'low risk' this does not mean 'no risk'. Not enough research has been done to clarify what risks there are.

Speaking of the situation in gaol, one prisoner said:

> In what I see and hear, I regret to say I don't think anyone takes care when having woman-to-woman sex - perhaps a handful - but most don't bother. Most don't think they can contract the virus from a woman, others who are aware that infection is a possibility still don't bother to take care. What needs to be done . . . is to have literature available all the time, have one-to-one talks, weekly group talks, and have access to 'dental dams'.

Dental dams are now available to lesbian women, as a woman-to-woman safe sex aid. They are latex sheets which are used by dentists to cover the mouth while working on one tooth. During oral sex, the dam stops contact with vaginal fluids where HIV may be concentrated. Presently, there is no access to dental dams in prison. If they were introduced, there would be a need for positive education strategies to encourage women to use them. Many women feel uncomfortable with them and regard them as an obstacle to sexual pleasure.

It is important to note that many women are in prison for drug-related offences, that women have sex with other women in prison, and share needles, in and out of prison. They are, therefore, potential carriers of the AIDS virus. The possibility of HIV being transmitted during woman-to-woman sex cannot be ruled out at the present time. There is very little literature on safe lesbian sex and at present the Prisoners' AIDS Committees can only advise people not to have sex during menstruation.

Women prisoners may also be at risk because their husbands, de facto husbands or boyfriends may have spent time in prison. While in prison these men may have been exposed to the AIDS virus through intravenous drug use, consensual sex or rape.

As an AIDS educator in male prisons also, I understand from their AIDS committees that male-to-male sex does take place and is seen often as a 'sexual act' not necessarily with the 'stigma' so often attached to 'homosexual sex'. Male-to-male rape also occurs and is often hidden by the victim because of feelings of shame, guilt, hurt and denial. Female partners would not necessarily be told of any of these experiences by either established or future partners. In addition, a survey conducted by one Prisoners' AIDS Committee in a women's prison revealed that women did not believe that their partners would engage in consensual sex while in prison, or rape another prisoner. The women prisoners believed that their risks of contacting HIV are minimal if their partner is not an intravenous drug user.

An essential issue in discussing HIV/AIDS with women prisoners, whether their future partners be ex-prisoners or not, is to empower women to negotiate safer sex practices. Assertiveness in getting resistant, defensive partners to use condoms is often a difficulty for women.

These are all issues which are important to include in women's HIV/AIDS education programs in prisons particularly considering the average stay of female prisoners in prison is about three months (Walker, 1989).

Needle Sharing

By far the greatest HIV transmission risk in women's prisons is needle sharing. A participant of one Prisoners' AIDS Committee in a maximum security prison said:

> [Wanting] the drug is compounded by 'secrecy of everything' and this often means that sterilising goes out the window. Women are depressed, they have little self-esteem and feel worthless. They often come from 'crisis' situations and intense peer pressure especially for younger women, means responsibility is lost, as are the educational messages. Only a handful bother to go through the two times water, two times bleach, two times water method and usually the same fit (needle) is used throughout; so God knows!

In contrast to the view expressed above, the medium security Prisoners' AIDS Committee states:

> Women take more responsibility for themselves probably because they have more time, and are in a more relaxed environment. Also people take time to talk to them and help them with their problems, they see other women acting in a more mature way and doing time more easily. It makes them see advantages they can get out of a medium security prison thus the educational messages are easier to get through.

In summary, needle sharing goes on regardless of the reality of AIDS. The prisoners' peer educators seem to suggest education can only be effective if issues of low self-esteem, boredom, peer pressure and drug addiction are also addressed. They suggest, too, that the type of prison - maximum or medium security may have a bearing on the effectiveness of HIV/AIDS education.

Support Groups

At present, in the women's prisons in which I work, there is a significant number of openly HIV positive women. Some 'openly positive' prisoners have been stigmatised by some officers and other prisoners for revealing their HIV status. This is making it difficult for Prisoners' AIDS Committees to make contact with HIV positive women in prison, in a supportive role.

There is a need for HIV positive support groups to be set up without 'stigma' within the system. Problems are ensuring confidentiality, being able to raise the confidence of HIV positive women to 'come out' and developing an effective surrounding support structure.

The importance of women's HIV prisoner support groups is to assist with access to the latest medical information and treatment, emotional support, and support to practise safe activities while in prison and to carry them out upon release. They can also advise gaol superintendents about HIV positive prisoners' needs. This will be a great challenge in all prisons in the 1990s.

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Management of HIV in Community Based Corrections

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The Office of Corrections in Victoria administers the State's prison system and a range of community-based programs for offenders and ex-prisoners. These programs aim to:

- facilitate the smooth reintegration of prisoners into the community;
- develop and reinforce pro-social norms;
- aid the development of independent living skills; and
- redirect offenders towards socially acceptable and useful forms of behaviour.

At the same time offenders are supervised to minimise their risk to the community, and to ensure that the conditions of their orders are met. Failure to comply with the terms of an order will result in the offender being proceeded against, and this may lead to his or her incarceration.

Currently there are three types of orders which are managed by Community Based Corrections. There are two post-custodial programs, pre-release and parole. An offender who has not been to prison will fall under the jurisdiction of the Office of Corrections only if placed on a Community Based Order as the result of his or her court appearance. Each of these orders include a combination of supervision, unpaid community work and self-development conditions. Persons suffering from drug, alcohol, psychological or medical problems will be conditioned to seek appropriate assessment and treatment.

No offender will be placed on a Community Based Order unless that person has been assessed by a Community Corrections Officer and the court is satisfied that he or she is a suitable person for the program, and that facilities are available for the order to be implemented.

The objective of Community Based Corrections is contained in a document entitled 'Corrections and The Way Ahead - Corporate Direction 1990-95'. It states:

> The objective of Community Based Corrections is to provide, develop and promote integrated, cost-effective, community-based correctional services which, whilst having regard to community interests and expectations, expand the proper use of alternatives to imprisonment and without unwarranted intrusion, ensure effective supervision and facilitate an offenders personal development.

Community Based Corrections acknowledges the need for corrections to be involved in community and social policy development:

- to share its knowledge of offending behaviour with the community; and
- to advocate on behalf of the offending population for equity of access to community services in order to develop the opportunities for offenders to be rehabilitated.

Community Based Corrections should also intervene in offender's personal lives where some effective outcome is achievable and where the intervention can effect a change in offending behaviour. Clearly then, Community Based Corrections has a role to play in assisting disadvantaged groups obtain access to the resources they need in order to lead fulfilling lives.

An HIV Policy for Community Based Corrections

With the increasing incidence of HIV infection within the community, a policy was developed and adopted in 1989 which addresses the management of infected persons within Community Based Corrections. Because of the frequent link between intravenous drug use and offending behaviour, Community Corrections staff have access to a large number of individuals who engage in high-risk behaviours. Its role can therefore emphasise preventative and safe behaviours as well as aiming to assist offenders who have already contracted HIV. This policy is as relevant to all communicable diseases as it is to HIV. However, because of the hysteria which has sometimes surrounded HIV infection, an AIDS manual was incorporated into the policy which assists staff to understand the related issues, how they impact upon case management practices, and the community resources which can be accessed for the benefit of HIV-infected persons.

The policy examines the following areas:

- education and training;
- management of offenders;
- confidentiality;
- supervision and counselling;
- community organisations;
- infection control.

Education and training

The provision of accurate and up-to-date information to offenders and staff is of prime importance in reducing the spread of HIV and other communicable diseases, and ensuring a sensible attitude towards them.

By and large, offenders will have had less exposure to accurate educational material and information about the transmission of communicable diseases than the community in general. There is therefore an onus on Community Corrections staff to ensure that programs available within Community Based Corrections include a session or sessions on communicable diseases, their transmission and their prevention.

Each of the State's ten regions have an officer on staff who has completed an extensive AIDS training course, and who is available to other Community Based Corrections staff for consultation and training.

Management of offenders

Offenders who are known to have a communicable disease will be considered on the basis of their individual needs in accordance with a case plan, as would any other offender. They can be treated no differently to offenders who suffer from any other significant medical problem. Offenders with HIV infection will not be categorised or isolated in terms of their

supervision, or in terms of any program they are required to undertake. There is, however, an emphasis on developing and maintaining their links with the specialist services which exist within the general community specifically for people with HIV/AIDS.

Confidentiality

The offender's right to confidentiality is to be respected by both staff and management in relation to all medical conditions, including communicable diseases. The issue of safety must be balanced against the issues of privacy and protection of persons who are, or are considered to be, infected with HIV or any other communicable disease. However, as the actual risk of transmission is so slight, the perceived risk of contracting HIV from an offender must not be used as a pretext for discriminatory treatment.

Community Based Corrections staff are required to prepare reports for courts and for the Adult Parole Board, and it does need to be acknowledged that information regarding health can be relevant to proper consideration of a case. However, the proposed inclusion of information relating to an infectious disease must be discussed with the treating doctor, with the consent of the offender.

Offenders with a communicable disease who require a lengthy period of hospitalisation may have the program components of their order suspended or, with the consent of the judiciary, varied or deleted. Alternative means of supervising the offender, such as by way of regular contact with the treating doctor, are considered. However, simple knowledge that an offender has HIV are not grounds for suspending, varying or deleting any program requirement.

Supervision and counselling

The role of the Community Corrections Officer is to link offenders who are affected by a communicable disease to appropriate resources, and to provide basic information concerning the disease. It may be appropriate for Community Based Corrections staff, in conjunction with the health care service doctor, to assist in the counselling of the offender, or to refer him or her to an appropriate agency. Community Corrections Officers can assist the offender to communicate with health care staff and advocate on their behalf if necessary. Safe behaviours should also be promoted. It must be stressed, however, that in the end offenders must accept responsibility for their own behaviour, including protecting themselves from infection, and obtaining professional counselling or treatment if infection is suspected or confirmed.

Community organisations

This section is specifically relevant to those agencies for whom offenders undertake unpaid community work in accordance with the conditions of their orders. These agencies are asked to treat any incident which results in the spillage of blood with routine infection control techniques. Agencies are advised to include in their first aid kits, disposable gloves, resuscitation masks, bleach and any other items which will reduce the possibility of disease transmission. It is emphasised that such a strategy is purely a preventative measure, which will protect agency staff in the unlikely event of HIV-infected blood being spilt at their premises.

Where it is known that an offender has HIV, care needs to be taken in organising an appropriate worksite so as to minimise the risk of an accident or mishap occurring whilst the offender is undertaking a community work program.

Infection control

This section outlines the steps to be taken in the event of blood spillage. All blood spills are to be treated as if infectious. The equipment required is to be packaged together and included in the first aid kits located at each Community Corrections Centre. This self-contained package is labelled 'Blood Spills Kit', and will also include a laminated copy of the instructions for its use.

The AIDS Manual

The AIDS Manual is incorporated into the Communicable Diseases Policy. This manual is divided into eight sections:

- What is AIDS?;
- How is it transmitted?;
- How is it prevented?;
- Testing;
- Symptoms and signs of HIV infection;
- Information and resources;
- Implications for Community Based Corrections staff; and
- Implications for offenders.

The Manual will be subject to review and updating as new information about the disease comes to light. The section which addresses work implications for staff examines strategies for incorporating safe sex and safe using counselling, into the supervision of offenders. It recommends making bleach sachets available at Community Based Corrections locations, and this in fact now occurs on a state-wide basis. This section also looks at cultural and religious differences, and how they may impact upon discussion of such issues within the context of offender supervision. Finally, the section requires the reallocation of cases where the Community Corrections Officer identifies the need for safe behaviours counselling, but feels unable or uncomfortable about doing this.

The final section of the Manual discusses the social, medical, emotional and financial implications of HIV infection for the affected person. It is intended to highlight to the Community Corrections Officer the areas of difficulty which the offender is likely to encounter, facilitating a discussion of these issues in supervision, and thus a swift and appropriate response as problems arise and are identified.

Incidence of HIV Infection in Community Based Corrections

It is difficult to identify accurately the number of persons who are HIV positive and being supervised by Community Based Corrections in Victoria. A survey of regions conducted in October 1990 revealed no more than eighteen known HIV-infected persons within a total client population of 5600. This compares with forty-nine known HIV-infected prisoners being held within the State's institutions at the same time, out of a total prison population of 2300.

There are several reasons for the difficulty in obtaining accurate data within Community Based Corrections. First, offenders are only known to be HIV positive if they are prepared to volunteer that information. There is no way of knowing how many choose to keep their condition secret for fear of discrimination or other repercussions, although with time a skilled Community Corrections Officer can succeed in encouraging the offender to discuss his or her predicament. Second, it is realistic to assume that there are many people with HIV/AIDS within the community who have not been tested, and therefore are not themselves aware of their illness. Testing is available within Victoria's prisons to all persons entering the system. It is not compulsory, yet attracts a 98 per cent compliance rate. No such testing is offered to Community Based Corrections clients, nor could it be made available given the absence of medical staff and facilities. However, as a matter of policy, safe behaviours counselling is incorporated into offender supervision, and persons identified as being in the high-risk category will be encouraged to seek testing through an appropriate body.

Ongoing Strategies

Community Based Corrections in Victoria maintains an ongoing commitment to addressing the needs of disadvantaged groups. In the area of HIV infection, there are a number of avenues through which policy formulation and information gathering and updating can occur.

The Corrections Health Board is an initiative of the Corrections Health Service which investigates and makes recommendations on a range of health related issues as they affect prisoners, offenders and correctional staff. The Communicable Diseases Committee is a sub-committee of the Corrections Health Board, and is comprised of representatives from Community Based Corrections, prisons, the Victorian Public Service Association, and the Corrections Health Service. There are currently two medical practitioners who serve on the committee, representing prisons and the Health Department respectively. The Corrections Health Service employs an AIDS educator to work within the corrections system, and she also has membership of the Communicable Diseases Committee.

To date much of the Committee's work has focused on prisoner reception and management. However it has also developed an education program for all corrections staff which deals with HIV, infection control and prevention. The availability of bleach to prisoners and offenders owes its existence to the Communicable Diseases Committee. It is also the Committee's job to facilitate the dissemination of new information about the virus through to correctional staff. This will occur in conjunction with senior management and the AIDS educator. The Communicable Diseases Policy had to be approved by the Communicable Diseases Committee and the Corrections Health Board before being adopted by Community Based Corrections.

It is evident that both the Committee and the Board fulfil an extremely useful role in terms of HIV management in both prisons and Community Based Corrections, and do so in a most pro-active fashion.

At a higher level, every government department in Victoria, eighteen in total, is represented on an Inter-Departmental Committee on AIDS. To date, this Committee has completed two major tasks; the Victorian Government response to the National HIV/AIDS Strategy, and a position paper concerning the needs of staff who are HIV positive. The

Inter-Departmental Committee has much broader terms of reference than to focus specifically on the needs of the HIV-infected offender. However, with the Office of Corrections' Executive Director, Sue Wynne-Hughes, as departmental representative on the committee, there will be enormous opportunity for input and discussion on related issues.

There is also considerable interaction between senior management and non-government organisations which work in the interests of prisoners and offenders. Of particular relevance is the Victorian Association for the Care and Rehabilitation of Offenders (VACRO), which has produced the AIDS Community Resource Kit, a package promoting safe behaviours which is handed to every person being released from a Victorian prison. Such an initiative highlights the important role which community groups have to play in preventing the spread of HIV, even within the context of a structured government operation.

Problems for Community Based Corrections Staff

It would be naive to suggest that Community Based Corrections has found the answers to all the questions that have been raised in relation to this sensitive and misunderstood disease. Information and education can go a long way towards helping staff to better comprehend and manage offenders who are infected. It cannot, however, remove the pre-existing bias nor discomfort brought about by discussing the virus and safe behaviours with offenders, particularly where safe sex is concerned. Hopefully, this will not be too much of a problem, provided that staff are prepared to acknowledge their feelings, and agree to request that their supervisor allocate or reallocate HIV offenders to staff who feel more comfortable in dealing with these issues.

A far bigger problem, one with which I am very familiar as a country-based manager, is the difficulty in obtaining access to specialist services for HIV-infected persons who do not live within the metropolitan area. Community Based Corrections staff must by definition be generalist workers. It is often impractical for them to take on specialist skills and functions, and whilst there is opportunity for counselling and support to be offered to the client group, the need to link the offender into long-term HIV-specific community supports is paramount. Currently, however, offenders who reside in the country regions of Victoria have no option but to travel to Melbourne if they wish to avail themselves of the specialist services which exist.

Travelling from country centres to a capital city on a regular basis is demanding at the best of times. However, to a person with HIV whose health is deteriorating, it is near impossible and possibly destructive. A telephone counselling service such as Direct Line has an important role to play, but it is no substitute for face-to-face contact. The retraining of existing health care staff is of limited value within the context of shrinking resources.

The fact that HIV-infected persons continue to be a small minority group within the community makes it difficult to justify the establishment of permanent specialist facilities in country areas. It is also quite proper that a large part of the health budget be directed towards prevention in this case. Failure to properly educate persons who engage in high-risk activities could have catastrophic results. However, there is a need for a specialist outreach service to be established and promoted in country areas so that those who are now infected and isolated, geographically as well as socially, can be offered as decent an existence as their disease will allow them.

Conclusion

The Office of Corrections in Victoria has a high level of commitment towards the sensitive management of both prisoners and offenders on community based programs who are affected by HIV. The policy which is in force is progressive and realistic. The mechanisms

which are in place to ensure that staff and offenders are provided with up-to-date, accurate information about the virus, should ensure that we are able to provide our HIV client group with the best possible advice and guidance concerning the treatment of this disease.

There is no justification for treating offenders who are suspected of having contracted HIV differently to any other group of offenders. Ongoing education and training of staff will continue to form the cornerstone of the response to communicable diseases within Community Based Corrections. The spread of the AIDS virus is within our control.

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Aboriginals, HIV/AIDS and Prisons

Stanley Nangala
Chairperson
Communicable Diseases Advisory Committee
Aboriginal & Torres Strait Islander Commission
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Aboriginal or Torres Strait Islander people who are prisoners are not at risk of HIV/AIDS infection just because they are Aboriginal or Torres Strait Islanders. Some Aboriginal people may be in a high-risk category because of their behaviour, but no more so than other people who behave in a like manner. Simply being an Aboriginal or Torres Strait Islander does not place a person at risk of contracting the AIDS virus.

Education and Prevention

Aboriginal or Torres Strait Islander people who are prisoners, and in fact all people who are prisoners, require ongoing information about HIV/AIDS prevention and access to education and the means of protection.

The issue of Aboriginal prisoners and HIV/AIDS has received little attention despite the level of racist treatment they receive in prisons. However, there is now a need to provide resources to address the specific issues of AIDS and Aboriginal and Torres Strait Islander prisoners in a more open and concerted manner. This is especially so given fears expressed about AIDS by Aboriginal and Torres Strait Islander people, by prisoner officers and by prisoners.

AIDS education and prevention should be addressed in a comprehensive package for all Aboriginal prisoners. In addition, the health status of Aboriginal people must be taken into account. The generally lower health status of Aboriginals may mean that the onset of AIDS after exposure to HIV will be more rapid than in the general prison population. Education and prevention programs must also address use of intravenous drugs and other substances, because some Aboriginal prisoners have said they are tempted to use heroin or other substances when really depressed or bored in prison.

HIV Screening/Testing For Aboriginal and Torres Strait Islander Prisoners

This issue is a major concern that Aboriginal prisoners have expressed to a number of Aboriginal health services. Aboriginal prisoners do not agree with compulsory HIV testing. There are serious ramifications that have to be considered such as:

- the close-knit Aboriginal community within the prison system;
- traditional Aboriginal cultural values;
- lack of confidentiality in some prison systems; and
- ostracism of Aboriginal inmates who are HIV positive by their fellow inmates.

There is a great need within the prison system for pre- and post-counselling, and support mechanisms which are regarded as culturally acceptable and appropriate by Aboriginal prisoners. In addition, trained Aboriginal health workers must be employed to provide counselling and support.

There is some fear expressed by Aboriginal prisoners that AIDS could be another weapon against Aboriginal people in the prison system. It is not necessary to be an Aboriginal or Torres Strait Islander to know that discrimination is rife in prisons. The fear that Aboriginal prisoners have expressed is that HIV seropositivity together with their Aboriginality would subject them to increased discrimination.

Media Issues

Aboriginal people, whether in prison or not, strongly resent irresponsible and sensationalised media reporting of stories relating to Aboriginal people, AIDS and sexually transmitted diseases (STDs). What is asked for is that the media consult with Aboriginal people and report issues accurately rather than misrepresent them.

Royal Commission Into Aboriginal Deaths In Custody

There have been many deaths in custody of Aboriginal people. The Royal Commission into Aboriginal Deaths in Custody is inquiring into nearly a hundred deaths. While it has not completed its inquiries it is quite clear that:

- the high number of Aboriginal deaths is largely related to over-representation of Aboriginals in prison - ten times the national average; and
- the vast majority of deaths are health-related, primarily to alcoholism.

In its interim report the Royal Commission made fifty-six recommendations concerning the need to review sentencing practices, treatment of drunkenness, conditions and procedures at police lockups, training of police and prison officers, medical issues and post-death investigations.

These recommendations are primarily matters for the States to implement. They are providing some impetus for improved police and prison practices and the adoption of sentencing practices which keep Aboriginals out of prison. There is clearly a long way to go.

Gaols are high-risk environments for the transmission of the AIDS virus. Measures which keep Aboriginals out of prison as well as procedural reforms within the prison systems are vital to avoid increased exposure of Aboriginals to AIDS risks.

Aboriginal Visitors Scheme

In February 1988, the Western Australian Cabinet approved the implementation of major recommendations of the Vincent Interim Inquiry into Aboriginal Deaths in Custody (1988).

One of the recommendations approved was for the establishment of an Aboriginal Visitors Scheme (AVS) to appoint people who would visit Aboriginal detainees in police lockups and prisons. It was also envisaged that these visitors would provide support to Aboriginal prisoners and observe and report on conditions in places of detention.

The AVS has been effective as one means of reducing the incidence of self-harm and deaths in custody. Visitors appointed under the AVS are Aboriginals who have the confidence of their local community and who are expected to be able to make informed and objective judgments, and to report appropriately. They are afforded a status which facilitates the performance of their functions and receive payment in recognition of their duties. Aboriginal Visitors are appointed to participate in the Scheme on a rostered basis in areas with a significant Aboriginal population. The roster provides for regular attendance at prisons and police lockups, as well as crisis visits. A number of other States have similar programs.

Consideration should be given to establishing similar schemes specifically relating to HIV/AIDS. Alternatively, the existing Aboriginal Visitors Schemes could be adapted to address the issue of HIV/AIDS and Aboriginal and Torres Strait Islander prisoners.

Conclusion

In conclusion, HIV/AIDS is a major issue for the Aboriginal community in general and in particular, for Aboriginal people in prison.

Many people argue that any person in prison is likely to be at an increased risk of HIV infection. As is well-known, Aboriginal people are over-represented in prison. It is not uncommon for an Aboriginal person to have spent time in gaol, albeit only brief periods for minor offences. Once in prison an Aboriginal person has reduced access to protection from HIV infection because he or she is less likely to be able to effectively use the health education, counselling and information services that are generally available.

In the unhappy event that an Aboriginal person becomes infected with HIV, the risk that this infection poses to his or her health may be increased because of the chronic health problems that are so common in Aboriginal communities.

The challenges are quite clear:

- finding socially acceptable alternatives to imprisonment for Aboriginal people in particular in relation to minor offences;
- improving the access Aboriginal people have to health information and education services once in prison;
- providing educational material which is culturally relevant particularly in terms of language and general presentation;
- improving prisoners' access to the means by which they might protect themselves from HIV/AIDS and other STDs - for example, clean needles and condoms;
- keeping testing confidential and voluntary, and improving pre- and post-test counselling facilities;
- ensuring that Aboriginal or Torres Strait Islander people from appropriate health services are used as health educators within prisons to deliver programs to Aboriginal and Torres Strait Islander prisoners; and
- ensuring that State and Territory Governments and prison administrators consult and liaise with Aboriginal community-based health specialists, so that culturally appropriate approaches to dealing with AIDS are implemented.

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