HIV POLICIES AND PRACTICES IN PRISONS*

By Hans Heilpern
Chair
Commercial Tribunal of New South Wales

and Sandra Egger
Faculty of Law
University of New South Wales

INTRODUCTION

The transmission of HIV infection in prisons should be viewed as a high priority for both prisons policy and public health policy. The problem of seroconversion within the prisons is not just a problem for prison administrators and staff: it has the potential to cause an epidemic of HIV infection in the community at large. The majority of prisoners are sexually active young heterosexual males serving short custodial sentences for relatively minor offences. Upon release they resume or establish relationships with wives and girlfriends thus creating a potential vehicle for both perinatal and heterosexual transmission outside the recognised high risk groups.

Whilst the seriousness of the problem is increasingly recognised by those in a position to determine and influence policy, the recognition has not been backed by the implementation of effective policies and appropriate budgetary allocations. Prisons policy continues to be the Cinderella of the Australian AIDS strategy.

In the present paper we first address the particular risk factors present in the prisons which, of necessity, determine the appropriate policies. The next section of the paper is concerned with the development of effective HIV policies followed by a brief review of the position in Australian prisons. The final section is concerned with our failure to deal effectively with the problem of HIV transmission in the prisons, a failure made more marked by the progressive and effective AIDS policies implemented amongst other high risk groups in the community: injecting drug users and the gay community.

RISK FACTORS IN PRISONS

There is widespread agreement that the key HIV risk factors present in prisons are injecting drug use and unprotected anal intercourse. The other risk factors which require attention are fights within the prison (including the possibility of assault with a contaminated needle and syringe) and tattooing with non-sterile equipment. It is not the purpose of the present paper to exhaustively review the Australian and international literature on the

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prevalence of high risk activities in prisons. There are many comprehensive reviews available for those interested in a more detailed examination of this issue.[1]

Injecting Drug Use

It is generally accepted that injecting drug users represent the major risk group for HIV infection in prisons in all countries except Africa. The factors which are considered to determine the rate of seropositivity amongst prisoners are:

- The proportion of prisoners who were injecting drug users prior to imprisonment
- The extent to which injecting drug use occurs within the prison system; and
- The extent of seropositivity among the injecting drug users in the community.

In Australia all these pre-conditions are present.

All available research suggests that there are significant numbers of injecting drug users in Australian prisons. Estimates of the number of prisoners in New South Wales prisons having a history of prior injecting drug use range from 32 per cent to 66 per cent.[2]

Research also suggests that a certain amount of injecting drug occurs within the prison. Estimates of injecting drug use in Australian prisons, as in any other prison in the world, are at best guesses. As far as Australia is concerned all commentators agree that it occurs and that needle sharing is almost always associated with injecting drug use in prisons because of the lack of availability of syringes. It has been estimated that some needles at Long Bay prison complex in Sydney are used 30-40 times per day.[3]

There are a significant number of seropositive injecting drug users in the Australian community.[4]

Sexual activity in prisons

While empirical evidence on sexual activity in prisons is scarce, it is generally believed that consensual homosexual intercourse between male inmates occurs frequently and also that there is a significant amount of sexual assault.[5] It is also a widely held belief that much of the homosexual intercourse in prisons occurs between males who are heterosexual in the outside world and that the homosexual activity is restricted to the

1 See for example Heilpern, H and Egger, S, *AIDS in Australian Prisons — Issues and Policy Options* (1989) Dept of Community Services and Health, Canberra, and *HIV/AIDS in Australian Prisons* (1991), Australian Institute of Criminology, Canberra; Harding, T, Manghi, R, and Sanchez, G, "HIV/AIDS in Prisons: A survey covering 54 prison systems" (1990), in *Report to the WHO Programme on AIDS*, Geneva; Hammett, T M, *AIDS in Correctional Facilities: Issues and Options* (1988), 3rd Ed. The broad conclusions only are presented in the present paper.

2 Gorta, A, *Estimates of Prior Drug Use by Prisoners in NSW Gaols* (1988), Unpublished Report, NSW Dept of Corrective Services.

3 Dwyer, J M, "Diminishing the Spread of AIDS in Australian Gaols" (1988), in *The Australian Bicentennial International Congress on Correctional Services*, Sydney.

4 Wodak, A D, Shaw, J M, Gaughwin, M D, Ross, M, Miller, M and Gold, J, 1990, "Behind Bars: HIV Risktaking Behaviour of Sydney Male Drug Injectors While in Prison" (1990), paper presented at a conference entitled "HIV/AIDS in Prisons" held by the Australian Institute of Criminology on 19–21 November 1990 in Melbourne.

5 Douglas, R M, Gaughwin, R L, Davies, L M et al, "Risk of Transmission of the HIV Virus in the Prison Setting" (1989), 150 *Med J Aust*, 722.

period of incarceration. Rape and sexual assault in prisons is held to be widely prevalent and unreported with the trauma involved in violent rape likely to increase the risk of HIV transmission. Quasi-consensual sexual activity, for example sex in exchange for protection of favours, is also reported to be common in many prison systems.

While little is known about sexual activity in male prisons even less is known about sexual activity in women's prisons. While HIV transmission through female to female sexual acts is possible there are few documented cases.

Other risk behaviour in prisons

There are other risk factors which have the potential to transfer HIV infection amongst prisoners. Both tattooing with non-sterile equipment and fights occur regularly in prisons and both are potential if not actual modes of transmission.

The potential for significant HIV transmission within the prisons is thus present particularly in New South Wales where the prevalence of HIV infection and injections drug use in the general community is higher than in the other States. Occasionally it is argued that whilst the potential may be present there is no evidence that seroconversion is actually occurring within prisons, and thus prisons should not be a high priority on the national AIDS agenda. This argument is rather like a blindfolded man in a forest denying the presence of trees. Appropriately designed longitudinal epidemiological research is simply not being conducted to enable the examination of seroconversion. The so-called compulsory mass screening in many Australian prison systems is not able to examine the problem of seroconversion. Firstly, although most programs purport to test all prisoners received, analysis of the data suggests that only 60 to 80 per cent of receptions are being tested. Secondly, only the Queensland program tests existing long-term prisoners, an essential procedure if the gaol is the scientific monitoring of seroconversion. It is dangerous and short-sighted to discount the problem of seroconversion in the prisons given the present state of knowledge.

HIV POLICIES IN THE PRISON

There are a number of policies and programs which are widely regarded as being crucial to effective HIV prevention in the prison. The following sections review these policies and present the situation in Australian prisons.[6]

High Risk Sexual Activity

There are several policy initiatives which may reduce the sexual transmission of HIV infection in the prison setting.

- The provision of single cell accommodation with individual showering facilities;
- The provision of conjugal visits in circumstances which enable prisoners and their sexual partners to have full privacy and sexual intimacy;
- Appropriate education programs; and

6 For a more detailed review of this material see Wodak et al, above n4.

- The distribution of condoms.

No Australian state permits the issue of condoms or provides conjugal visits. In South Australia and Victoria private visits are permitted at a few selected institutions. In many States there is a reluctance to deal with sexual activity in educational materials. In South Australia and Western Australia, for example, information on safer sex practices is provided only as part of a prisoner's pre-release program. The only positive steps which are taken in most States and Territories to minimise homosexual activity is the provision of single cell accommodation and increased supervision at such perceived high risk locations as communal showers. The availability of such accommodation varies considerably from State to State.

Access to condoms has often been vigorously opposed by prison officers and politicians. The arguments for opposing the distribution of condoms include:

- to participate in distribution would condone illegal sexual activity;
- condoms can be used as weapons;
- condoms can be used to smuggle goods.

No evidence has been collected to support these latter two assertions. The failure to provide condoms prevents prisoners from taking responsibility for safe sexual behaviour and therefore undermines the accepted strategies for minimising the transmission of the virus.

Condoms are available to prisoners in 21 prison systems (from 13 countries) which includes 16 European systems.[7] Five US systems currently make condoms available to inmates.[8] No prison system implementing a program of condom distribution has abandoned these programs or reported any of the problems predicted by opponents of the measure.

Injecting Drug Use

The policies and programmes which may reduce the transmission of HIV infection through the sharing of injecting equipment include:

- minimising the availability of drugs;
- providing education on techniques for cleaning injecting equipment;
- ensuring that effective cleaning material is available; and
- providing needle exchange programs.

Whilst there is little hard data on the extent of injecting drug use in prisons, most observers would agree that the efforts of government and prison authorities to eliminate drugs from prisons have been unsuccessful.

7 Harding et al 1990, above n1.

8 Hammett, T M and Moini, S, "HIV/AIDS in US Prisons and Gaols: Epidemiology Policy and Programs" (1990), paper presented at a conference entitled "HIV/AIDS in Prisons", held by the Australian Institute of Criminology, November 19–21, Melbourne.

Most States use mandatory urine testing to detect and deter drug use in prisons with a variety of penalties imposed on prisoners found to have used prohibited drugs. The provision of information on techniques for cleaning injecting equipment also varies from State to State with two States providing face to face presentations, two providing pamphlets only and three providing no information prior to release.

Bleach/disinfectant is available for other purposes in most prisons but no cleaning material is specifically provided for the cleaning of needles and syringes. Clean needles are not available in any prison system in Australia or elsewhere. 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 drug dependent prisoners in some states (for example, New South Wales and South Australia).

Education

Education represents the cornerstone of efforts to prevent the transmission of HIV infection in prisons. All States and Territories of Australia provide some information and education on AIDS and HIV infection.[9] Similarly, the provision of information appears to be widespread in the United States[10] and in the 54 countries recently surveyed.[11] While the widespread acceptance of the importance of education is welcome, without systematic evaluation of educational programmes their full value cannot be assessed.

Counselling

It is widely recognised that appropriate 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.

In all Australian states some counselling is provided before an antibody test is given to a prisoner but 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. While all States provide post-test counselling for seropositive prisoners, only South Australia and Western Australia provide support or information for seronegative prisoners, that is, those who are not infected with the virus. This is a major deficiency as post-test counselling after a negative result provides a vital opportunity for dealing with high risk behaviour and communicating information on the prevention strategies.

Confidentiality

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

9 Heilpern and Egger, above n1.
10 Hammett, above n1.
11 Harding et al, above n1.

A variety of practices are adopted in prisons throughout Australia which range from information only being given to the medical superintendent to information being given to all operational staff who might have direct contact with the infected prisoner. While the desire of custodial officers to know the identity of seropositive prisoners may be understandable, it can be argued that the knowledge may in fact be dangerous to the prison officer as well as detrimental to the prisoner. Custodial officers may be lulled into a false sense of security by believing they know the identity of all prisoners with the HIV virus. Any prevention strategy does not take account of the difficulty of maintaining confidentiality in the prison system is unlikely to receive co-operation or trust from the prisoners.

Accommodation

In South Australia, Tasmania and New South Wales there are policies which integrate seropositive prisoners into the general prison population. In other States and the Northern Territory prisoners are segregated with or without other selected groups such as prisoners with a history of injecting drug use.

The segregation of HIV positive prisoners cannot be complete because of the window period: the latent period between infection and the detection of antibodies on a prisoner. Whereas prisoners are usually housed in accommodation appropriate to their security classification, segregation based on HIV infected prisoners provided they are not sexual predators. Sexual predators should be isolated whether or not they are infected.

The Antibody Test

One of the most striking features of HIV policy in Australian prisons is the centrality of, and the faith placed (or rather misplaced) in the antibody test. In the majority of Australian prison systems, the antibody test assumes first priority over all other policies. It is often proudly portrayed as evidence that governments are "doing something about the AIDS problem in prisons," and enables avoidance of the difficult questions associated with the essential issues: sexual activity and the availability of condoms, injecting drug use and the availability of clean injecting equipment.

It must be recognised that testing is not an end in itself. The 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 result is put. One of the key arguments by the proponents of mass screening is that it enables the epidemic to be monitored. However, mass compulsory screening is no substitute for proper epidemiological research. As indicated previously, all States and Territories purporting to conduct mass compulsory screening in fact exclude relatively large numbers of prisoners. Short stay prisoners are almost always excluded. Better information on prevalence can be obtained by blind epidemiological studies. The needs of scientists trying to understand, predict and contain the epidemic are not those of the prison administrator faced with the day to day management problems of the prison.

The antibody test is an important tool in HIV prevention but it does not reduce the need for the implementation of effective prevention policies.

Table 1: Number of HIV Positive Prisoners in Australian Prisons on 9 November 1990

	Number	Prison Population† for June 1990
Northern Territory	0	405
Western Australia	1	1,807
South Australia	11	930
Victoria	8	2,312
New South Wales	16	5,321
Queensland	2	2,205
Tasmania	1	226
	39	**13,319**

† Source: Australian Institute of Criminology, *Prison Trends*, No 169, June 1990.

AIDS and HIV Prevalence in Australian prisons

On 9 November, 1990 there were 39 known HIV positive prisoners in Australian prisons (Table 1) and one known prisoner with AIDS.[12] It must be emphasised however that:

- information on AIDS and HIV prevalence and incidence in Australian prisons is not systematically collected, counted or analysed;
- mass testing programs operated only in South Australia, Queensland, Northern Territory and Tasmania at that time and the universality of even those programs is questionable;
- very few tests were carried out in New South Wales, the State with the largest number of prisoners and the largest number of persons infected with the HIV virus. Mass compulsory screening has now been introduced in New South Wales.

Seroprevalence (the proportion of HIV positive prisoners as a fraction of the number of prisoners tested) could not be estimated in most States due to the limited data available.

In Europe, Professor Tim Harding has extrapolated from the existing data and estimated that in European countries more than 10 per cent of prisoners are seropositive.[13] In the USA, recent research found that HIV seroprevalence rates among inmates ranged from less than 1 per cent to 17 per cent. While methodological problems prevent any firm conclusions as to the overall US rate (the value of which would be limited in any case), the findings from a blind epidemiology study among incoming New York state prisoners in late 1987 and early 1988 found a seroprevalence rate of 17 per cent. A similar study a year later found an even higher rate among female entrants to New York state prison.[14]

12 Egger, S and Heilpern, H, "HIV/AIDS and Australian Prisons", in Norberry, J et al (eds) *HIV/AIDS and Prisons: Proceedings of a Conference held 19–21 November 1990* (1991), Australian Institute of Criminology, at 65–83.

13 Harding, T W "AIDS in Prisons" (1987), 2 *Lancet* at 1260–4.

POPULAR MISCONCEPTIONS ABOUT AIDS PREVENTION IN THE PRISONS

There is a widespread belief that the solution to the problem of HIV transmission in prisons is a simple one: identify and isolate. Such a simple solution is so widely advocated that we find it necessary to often point out the deficiencies in the solution.

The proposed policy is to test all prisoners for HIV antibodies upon admission and stream them according to the result. HIV positive prisoners should be placed in one, segregated part of the prison and special services developed to deal with their needs. Life in the HIV negative part of the prison may then go on as normal.

Unfortunately, the "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:

- the antibody test itself is unreliable as there is a time lag between infection and the appearance of detectable antibodies which means that certain infected individuals will not be identified (the 'window' period). This means that despite the best attempts to screen and segregate there will be a certain number of 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.

THE FAILURE OF AIDS PREVENTION IN AUSTRALIAN PRISONS

In the six or so years my co-author and I have been involved in research in this area we have seen many changes. Dedicated people working all over Australia have struggled to have the problem recognised and intelligent policies introduced despite prejudice, political opposition, lack of funds and controversy. Within the scientific community the problem has gained some recognition and last year the Australian Institute of Criminology organised a highly successful national conference on the topic. There are now professors of medicine and other respected scholars prepared to openly stress the seriousness of the problem and attempting to lobby for the introduction of effective, but often unpopular policies. A national data base is being established by the National HIV Centre.

A national AIDS in prison clearing house has been established with a view to increasing co-operation and the exchange of information between the fiercely independent States and Territories in our federation. In New South Wales, the changes have been no less striking. Within the Department of Corrective Services the work of the AIDS educators, policy advisers and researchers has been invaluable. Within the Prison Medical Service a commitment to HIV prevention has resulted in the maintenance of some progressive programs. New South Wales is one of the few prison systems in the world with a methadone program. Bleach was re-introduced quietly into the NSW prisons by the Prison Medical Service after its public and highly irresponsible banning by the former minister, Michael Yabsley. The change in the attitude of the prison officers is also to be commended. My co-author and I regularly find ourselves in the somewhat unusual position of offering full support for the views of the Prison Officers Union.

Despite the promising changes it is difficult to avoid the conclusion that HIV prevention in prisons remains an unattained goal in Australia. No prison system has tackled the problems of condom availability and programs providing clean injecting equipment are nonexistent. Where measures are taken to allow access to bleach, they are shrouded in secrecy and coexist with harsh punitive measures should a prisoner be found possessing (which includes cleaning) injecting equipment. Compulsory anti-body testing is provided as the primary anti-AIDS tool despite its dubious value. Education programs wax and wane with budgetary fluctuations and single cell accommodation is an unattainable goal in many prisons. In New South Wales the explosion in the prison population has resulted in three or four prisoners sharing cells designed for one or two. Prison medical services remain underfunded and unable to exert much influence on effective policy formulation.

In the wider community the problem is regarded with apathy and is largely neglected. Vital research in this area is not being conducted. Indeed it is highly unlikely that the present authors will continue to conduct research in this field because of the lack of availability of funds. HIV prevention in the prisons is simply not viewed as a priority area.

Before progress can be made it is necessary to investigate the pre-conditions which have created this situation. It is our view that problem of HIV prevention in the prisons is inextricably linked with the politics of law and order and that an intelligent and effective approach must confront the ramifications of the law and order debate.

Effective HIV prevention is impossible in a political climate where crime, crime prevention and prisons policies are regarded by politicians of all persuasions as the raw material for election slogans, to be manipulated in a cynical fashion for electoral gain. Punitive approaches to crime and prisons are perceived to be a popular way to deal with rising crime rates and are thus endorsed despite all the evidence demonstrating the failure of the rhetoric of law and order to deal with the causes of crime. Measures which both increase the size of the prison population and worsen conditions inside the prisons are justified in the crudest of terms. New South Wales in recent years provides a good case study in this regard. The so-called truth in sentencing legislation (which is no more or less truthful than any other sentencing policy) has resulted in great increase in the prison population and a serious decline in prison conditions. There has been, of course, no discernible impact on the crime rate. The failure to introduce effective HIV policies is an

integral part of the failure to deal seriously with crime, crime prevention and the inadequacies in the criminal justice system.

In general, the "AIDS community" in Australia has failed to come to terms with this relationship. Firstly, prisoners are not in a position to lobby effectively for their share of the HIV prevention and treatment budget. They may be contrasted with the gay lobby, the most successful high risk group in community in terms of both funds allocated to HIV programs and (to give them full credit) in terms of the success of their prevention programs. The gay community has proved to be an articulate, sophisticated and powerful lobby group which governments ignore at their peril. In contrast, prisoners needs can be ignored and justified by the politics of law and order.

Secondly, the army of professionals involved in the struggle against AIDS have been largely blinded to the relationship between criminal justice policies in general and the introduction of HIV prevention policies in the prisons. We have frequently heard well meaning medical researchers proclaim the importance of separating HIV policies from the unpopular issue of prison reform.

It is difficult to see how a debate on single cell accommodation, for example, can be conducted with no reference to the explosion in prison numbers and the serious overcrowding evident in New South Wales prisons. It is difficult to see how a debate on appropriate policies for injecting drug use in the prisons can be conducted without reference to the availability of drug diversion programmes as a sentencing option. There are may other such examples. AIDS education which stresses individual responsibility is at odds with every other aspect of prison life and must be viewed in the context of the failure to introduce small scale unit management. HIV prevention programs need to be informed by a knowledge of criminal justice policies and a readiness to address the broader issue of prison reform.