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CONFERENCE ON HIV/AIDS AND PRISONS

WHO GLOBAL COMMISSION, AIDS RECOMMENDATIONS AND PRISONS IN AUSTRALIA

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A LEGITIMATE CONCERN

My special concern to address the issues of the human immunodeficiency virus (HIV) and acquired immuno 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.[1] 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.[2] So the advent of AIDS in prison necessarily concerns me as a judge.

My second concern arises from my membership of the Global Commission on AIDS at the World Health Organisation. 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 world-wide 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 ten percent 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 unrealized. 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 of the prisoners recently testified to the United States Commission that recidivism amongst HIV positive prisoners runs as high as ninety or ninety-five percent because the deprivations and neglect of homelessness and poverty can then be replaced by security and treatment within the prison walls.[3]

The Global Commission on AIDS is one unit in the Global Programme on AIDS of WHO. Within that programme 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.[4] 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 the 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".[5] The Minister, at the time of the second 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."[6]

Unfortunately, eight weeks later an antibody test performed on the prison officer jabbed in the buttock produced a positive reading. Following the shock of this news the New South Wales Minister, Mr Michael 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 attack on the prison officer

has led to calls for the segregation of prisoners with HIV/AIDS[7] and editorials demanding that "gaol officers need AIDS protection".[8] 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.[9] 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 suggest 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.[10] 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.[11] 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 8 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 $4,000 per person per year. Obviously in poorer countries - such as some of those represented in the meeting in Seoul - 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.[12] 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.[13]

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 prisons: 2 of 137 inmates incarcerated for 9 years in Merryland, USA, tested HIV positive as did 6 inmates incarcerated for between 4.6 and 7 years in New York."*[14]

Further statistical data on the presentation of HIV in prisons is collected in a paper on the topic of Hans Heilpern and Sandra Egger.[14] 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% were sero positive. Other high figures were reported from France: 13% (testing of 500 consecutive entries); Italy 16.8% (screening of 30,392 prisoners in 1986); Switzerland 11%. And the Netherlands 11% (screening of a sample of prisoners in Amsterdam). The low figure returned by the United Kingdom (0.1%) 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 to other studies, an estimate was put forward that the overall prevalence of sero positivity in European prisons was in excess of 10%.[16] Amongst IV drug users in prisons the level of sero positivity was much higher. In one study of IV drug user prisoners in Fresnes in France, it was found that 61% were sero positive. More recent research in France paints a still grimmer picture of the French prisons surveyed. Twelve percent of prisoners admitted in 1987 admitted to drug dependence; an estimated 50% of IV drug user prisoners were deemed HIV positive. The overall HIV sero positive rate in French prisons was estimated to be 6% - 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 sero prevalence. In one Spanish prison, for example, it almost doubled in one year from 24% in 1986 to 46% in 1987.

Similar patterns emerge from studies in the United States. Two national prison project surveys in 1985 and 1987 showed a 293% 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%. At October 1987, there had been a cumulative total of 1964 AIDS cases amongst prison inmates in the United States. Five percent of the inmates with AIDS were women. The correctional administrators attributed approximately 66% 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.[17] 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:

1. The responsibility of prison administrations to minimise HIV transmission in prisons; and
2. Prisoners' rights of access to educational programmes, 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 programmes.

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 practises 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 programmes. 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 boldy 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.[18] 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".[19]

In the other States, at least until recently, voluntary testing programmes 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%) is reported.[20] In Western Australia, a voluntary testing programme 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%). 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, eg industry, education, 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 unreliabity of the available statistics are:

1. The numbers of false negatives/positives in jurisdictions where tests are not repeated;

2. Prisoners in the "window period" where tests are not repeated;

3. Self-selection and exclusion in jurisdictions where tests are voluntary; and

4. 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:

(a) High levels of drug using persons who -

(i) are imprisoned for drug related offences, or

(ii) gain access to injected drugs in prisons; and

(b) 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 prison in Sydney, about 60% of inmates used intravenous drugs once or twice a week.[21] 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%) 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 programmes, 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% of prisoners engaged in sexual activity at least one time whilst in prison.[22] A 1989 study of a sample of prisoners in the South Australian prison system reported that about 42% of prisoners engaged in risk behaviour at least once whilst incarcerated. Thirty-seven percent were estimated to use drugs intravenously. Twelve percent were reported as having engaged in unprotected anal intercourse.[23] 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:

1. 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;
2. To provide facilities for antibody testing on a voluntary basis whenever a prisoner reasonably wishes to undergo the test;
3. To 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;
4. Attention to tattooing by unsterile tattooing equipment 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;

5. Facilities for treatment, as with AZT, therapy and therapeutic counselling should be available 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

6. For the purpose of tracing the problem and constantly reviewing policies in relation to it 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 on the South Australian prisons, reveal relatively high levels of accurate knowledge about HIV and its modes of transmission within prisons.[24] 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.[25] 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 it 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.[26] 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 whist 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/AIDS. But they clearly reduce the risk very substantially. They would not be likely to be used in violent sexual acts, eg 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:[27]

> *"[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."*

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.[28] 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, 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 discrete 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 programmes both within prison and afterwards.[29] Again, I agree with the Sydney Morning Herald[30] leader:

> *"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. As I have said before [31], it is unfortunate that Australian politicians and prison administrators have not adhered to them. Not enough has been done to spread and repeat the educational messages to the constantly changing prison population. Political gestures, such as mandatory testing, have been taken 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 of 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 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.

FOOTNOTES

* 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 of New South Wales. Personal views only.

1. See eg R v Perez-Vargas (1987) 8 NSWLR 559, 565.
2. R v Michael Smith (87) 27 A Crim R 315.
3. Letter to the author by Dr June Osborn, 20 August 1990, 2.
4. World Health Organisation, Consulation on Prevention and Control of AIDS in Prisons, 6-18 November 1987, WHO, Geneva.
5. M Yabsley, New South Wales Minister for Corrective Services, quoted The Age, 7 July 1990, 16.
6. Ibid.
7. "Segregate the AIDS Carriers", Australian, 8 September 1990, 12.
8. Melbourne Herald, 7 September 1990, 10; see also Sunday Telegraph, 2 September 1990, 30.
9. Sunday Telegraph, 2 September 1990, 2.
10. See K Mutton and I Gust, "Acquired Immune Deficiency Syndrome" (1983) 2 Medical Journal of Australia 540.
11. A M Brandt, "AIDS in Historical Perspective: Four Lessons from the History of Sexually Transmitted

Diseases" 78 American Journal of Public Health #4, 367 (1988).

12. H Strang, "AIDS in Prisons" (1990) 4 National AIDS Bulletin #6, 42.

13. Ibid.

14. J Wolk, A Wodak, A Mortlet et al, "HIV-Related Risk-Taking Behaviour Knowledge and Sero Status of Intravenous Drug Users in Sydney" (1990) 152 Medical Journal of Australia, 453.

15. H Heilpern and S Egger, AIDS in Australian Prisons - Issues and Policy Options, March 1989, Report commissioned by the Federal Department of Community Services and Health, Canberra, 21.

16. Ibid, 23.

17. World Health Organization, note 4 above.

18. Heilpern and Egger, 29.

19. Id, 30.

20. Loc cit.

21. J Norberry and D Chappell, "AIDS and Prisons" in Australian Institute of Criminology, Trends and Issues No 21, Canberra, 1989. See Strang (above) 42.

22. P L Nakki and T R Kane, "Intimate Sexual Aggression: Some Evolving Propositions, Empirical Findings and Mitigating Counterforces" in Gender Issues, Sex Offences and Criminal Justice, The Hayworth Press Inc, Washington DC, 1984. See Strang 42.

23. R M Douglas, R L Gaughwin, L M Davies et al, "Risk of Transmission of the Human Immunodeficiency Virus in the Prison Setting" (1989) 150 Medical Journal of Australia

722.

24. M D Gaughwin et al, "Preventing Human Immunodeficiency Virus (HIV) Infection Amongst Prisoners: Prisoners' and Prison Officers' Knowledge of HIV and their Attitudes to Options for Prevention in (1990) 14 Community Health Studies 61.

25. Ibid, 63.

26. Sydney Morning Herald 14 June 1990, 3.

27. Ibid, 30.

28. See eg Australian Parliament, Parliamentary Joint Committee on the National Crime Authority, Rethinking Drug Policy, Canberra, 1989; A Wodak, "Heroin Legalisation, Totem and Taboo Revised" in Modern Medicine of Australia, May 1990, 76; J Kaplan, "Taking Drugs Seriously" in 92 The Public Interest, 32 (1988).

29. See Strang (above). See also report of the Victorian Ombudsman (Mr N Geschke) reported The Age, 20 July 1990, 16.

30. See Sydney Morning Herald 14 June 1990.

31. See The South Australian Justice Administration Foundation, 1990 Annual Oration, "AIDS Strategies and Australian Prisons", forthcoming. This essay is an adapted and updated version of that oration.