



Research Publication

Lifestyles Unit - Evaluation Study

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Foreword

This research study provides a thorough evaluation of the Lifestyles Unit (LSU). This Unit located in the Special Care Centre at the Long Bay Correctional Complex, has provided a voluntary live-in program for inmates who are HIV antibody positive and now includes placements for Hepatitis C (HCV) positive inmates.

The New South Wales Department of Corrective Services is committed to the provision of programs and services for inmates which will help them to successfully reintegrate into society upon release.

The LSU program is designed to promote the maintenance of the health and well-being of HIV and HCV positive inmates whilst in the correctional system and in the community upon release. It also promotes their successful integration into the mainstream correctional centre population and minimises their involvement in the transmission of HIV and HCV.

The release of this report reflects the need for continuous evaluation and improvement of health related services for inmates. During the period in which this evaluation study took place and since then a number of the recommendations made in the report have been implemented or are in the process of being implemented. The action being taken on each of the recommendations is summarised in Appendix E.

The Lifestyles Unit Program demonstrates the Department's ongoing commitment to providing one of the most comprehensive, effective and innovative responses to HIV and related diseases in the correctional environment.

LEO KELIHER,
Commissioner.
NSW Department of Corrective Services.

June 1997.

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PREFACE

The Lifestyles Unit (LSU), located in the Special Care Centre at the Long Bay Correctional Complex, accommodates up to eight inmates who are HIV antibody positive and who have volunteered to take part in the sixteen week program offered by the unit. The LSU opened in November 1992 and offers a program which aims to help inmates learn about, and make informed decisions about, the lifestyle choices they make in respect to their illness, both within and once they leave the NSW correctional system. As such the program is unique, both within Australia and throughout the rest of the world. This report is the result of an evaluation of the LSU and makes recommendations for its future direction and development.

The project was funded by the NSW Department of Corrective Services (DCS) through funds made available from budgets of the HIV & Health Promotion (HHPU), and Research and Statistics, units.

I would like to acknowledge the assistance of Gino Vumbaca from the HHPU; Margaret Bowery, Maria Kevin and Simon Eyland from the Research and Statistics Unit of the DCS; Janine McGlynn, Governor, Special Care Centre; Hannah Musgrave, Officer in Charge, LSU; Amanda Christensen, Public Health Unit of the Corrections Health Service and last but not least of all, the contributions made by inmates, staff and sessional specialist staff without which this evaluation would not have been possible.

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EXECUTIVE SUMMARY

The Lifestyles Unit (LSU) was opened to inmates in November 1992 as a voluntary unit for HIV positive inmates in the NSW correctional system. The unit is located in the Special Care Correctional Centre at Long Bay, and accommodates up to eight inmates who have applied and been accepted to take part in the 16 week program offered by the unit. At the end of January 1996, forty nine inmates, both sentenced and unsentenced, had taken part in the LSU program.

At the end of the LSU's first year of operation, it was decided it would be appropriate to evaluate the unit's operation. The evaluation was to include the following components:

1. review of key stakeholders;
2. brief history of the LSU;
3. literature search and review;
4. follow-up interviews with ex-residents;
5. identifying the limitations on the program structure, and;
6. to develop recommendations and options for the program.

This study is the result of this evaluation. It has shown the establishment of the Lifestyles Unit and program has been an important step in meeting the needs of inmates who are HIV positive in the NSW correctional system.

As such the LSU has met what can be considered as the primary aim that was set for the Unit when it was established in 1992 - the maintenance of the health and well-being of HIV positive inmates whilst in the NSW correctional system. The establishment and operation of the Unit has resulted in the following primary outcomes - enabling HIV positive inmates to:

- learn about HIV and living with HIV, and coming to terms with being HIV positive;
- reduce their stress and anxieties by allowing them time out from the mainstream in a safe environment;
- access to better and closer medical services;
- supportive peer environment;
- make informed decisions relating to lifestyle

choices, and;

- access to external groups, agencies and individuals.

This evaluation has highlighted various operational and environmental factors which have impacted on the Unit successfully meeting all of its aims and objectives. These factors can be best addressed if we look at the findings in relation to the three questions outlined below.

i) What's wrong with the LSU? -

- limited space available in the unit;
- sharing of facilities and yard with the Crisis Support Unit;
- insufficient briefing and training of staff;
- staff not properly consulted regarding operational issues;
- insufficient time allocated for staff to participate in program;
- inmates of lower classifications must forgo most, if not all, of the privileges available to them if they attend the LSU;
- insufficient information on the unit for HIV positive inmates to be able to make informed decisions on whether to participate;
- unit and program not really suitable for HIV positive inmates who are women;
- not enough information provided to, or education undertaken with inmates in the mainstream about the issues surrounding being HIV positive, and;
- program has had problems maintaining consistency and quality standards.

ii) What stops inmates participating in the unit? -

- lack of information on the unit;
- concerns with confidentiality (sharing yard and facilities with CSU, being identified by being in the unit and having to go back into the mainstream);
- not interested, or want to keep to themselves, and;
- loss of/reduction in privileges.

iii) What about the integration of inmates with acute HCV infection into the LSU? -

- groups have different needs and agendas;
- cause problems with respect to maintaining confidentiality;
- number of inmates who are HCV positive in correctional system;
- LSU not large enough, they each need their own unit;
- increased risk of cross infection;
- program not set-up or suitable for both groups;
- crowding out effect on HIV positive inmates, both directly by greater numbers of HCV positive inmates and indirectly by serving as a disincentive for those HIV positive inmate considering attending the unit, and;
- greater demands on staff and training.

The points outlined above provide the answer the four key questions, and one implied objective, that were to be addressed by this evaluation. As such they raise the inevitable question of what should be done with the LSU program and Unit.

While most of the recommendations made in this report are relatively straight forward, there are six key areas which, if addressed, would ensure the continued viability and existence of the LSU program, thus enabling the unit to continue providing important services to HIV positive inmates in the NSW correctional system. These key areas are -

1. **appointment of a program co-ordinator** - who could address recommendations relating to the program quality, structure and content, as well as provide training to staff (Recommendation 42);
2. **improving procedures and protocols relating to confidentiality of HIV status** - (Recommendations 19, 27 and 28);
3. **make the unit larger with its own yard and visits areas, separating it from the CSU** - to overcome confidentiality and operational problems associated with having a shared yard and facilities

(Recommendation 20, 22 and 23);

4. **inmates are able to remain in the unit for their sentence** - enabling them to maintain their confidentiality (by not having to return to or being in the mainstream) and assist in maintain group cohesion and harmony while assisting in maintaining a high occupancy rate for the unit (Recommendation 4, 22 and 34);
5. **improve staff training and briefing and provide more information to inmates** (Recommendations 2, 5, 30, 33 and 40), and;
6. **proposal to incorporate inmates with acute HCV infection into the LSU be discontinued** (Recommendation 25).

RECOMMENDATIONS

This evaluation resulted in forty two recommendations being made for the continued operation of the LSU. Each recommendation contains two types of page references, the first providing the detail of the page where the recommendation was first made in the report, while the second (and following page numbers) relate to pages of the report which provide additional information to further support the recommendation.

Recommendation 1. A formal review be undertaken of the specific services and needs of HIV positive women within the NSW correctional system, and that appropriate strategies, policies and procedures are developed, and implemented, that address these requirements. p 9 - 25, 50.

Recommendation 2. The LSU program philosophy be included in all information, training and briefing provided to staff, inmates, sessional specialists and other people involved with the LSU. In order to ensure this philosophy is not lost in the operation of the unit and program. p 10 - 28, 34, 34, 34, 36, 36, 37, 46.

Recommendation 3. A decision be made on the timeframe, if any, the unit and program is to operate under. At present the inconsistency in the length of time inmates are able to spend in the unit creates serious problems for the operation, consistency, quality and continuity of the program structure. p 17 - 18, 48, 50, 52.

Recommendation 4. Inmates have the option, with due consideration given to disciplinary, security, space and operational requirements, to remain in the LSU for their entire sentence if they so desire. p 17 - 19, 20, 25, 26, 52.

Recommendation 5. All inmates, prior to entering the LSU program, be fully briefed about the unit so they are able to make an informed decision about participating in the program. p 17 - 20, 24, 25, 25, 26, 30, 39, 39.

Recommendation 6. The program offered to inmates be regularly reviewed, updated and changed as required. p 18 - 26, 28, 39, 41, 48, 48, 50, 52.

Recommendation 7. Inmates be individually assessed for their need to participate in all aspects of the conflict resolution and psychology sessions run as part of the program. p 18.

Recommendation 8. Increase the involvement and participation of outside agencies (such as ACON) in the program and sessions run. p 18 - 30, 48, 52.

Recommendation 9. Consideration be given to structuring the program so there is a set of compulsory core sessions, with other sessions being optional once an inmate has attended at least one session to see what it has to offer them. Furthermore that the type and level of inmate participation in the program be clearly established. p 18 - 26, 28, 30, 39, 48, 48, 50, 52.

Recommendation 10. Specific sessions are developed and run in the program on how to handle life outside of the correctional system (setting goals, budgeting, resources available, choosing doctors etc.) to assist inmates when they are released. p 18 - 50, 52.

Recommendation 11. A greater proportion of the program be dedicated to how to manage and live with HIV, and maintaining/improving health and fitness. p 18 - 52.

Recommendation 12. All attempts be made to provide inmates at the LSU full access to the services and programs offered by the Education Unit, along with any other programs and services, that are available to inmates held in the mainstream inmate population. p 18 - 37, 39.

Recommendation 13. Consideration be given to the establishment of a session or program where inmates partners, friends or family can attend the unit to get some information on HIV and discuss issues with inmates and a group facilitator.
p 18 - 32.

Recommendation 14. An information and referral package be developed as an ongoing resource for (or by) the inmates to pass on to partners, friends or family who need advice, help or information on HIV and who to contact to get it. In addition, that this resource be offered, as a matter of course, to all HIV positive inmates in the correctional system.
p 19.

Recommendation 15. A specific module or session/program be developed for inmates which addresses in a practical way how inmates can deal with issues and situations relating discussing HIV, and their status, that arise with their families, partners and friends. p 19.

Recommendation 16. Minimum standards and measures, relating to the quality and structure of the program and sessions offered be developed which include appropriate built-in quality assurance mechanisms in order to maintain a consistency and high quality program. p 19 - 30, 48, 50, 52.

Recommendation 17. Where possible, flexibility be incorporated into the program to meet the individual interests and case management requirements of inmates. p 19 - 26, 28, 30, 39, 48, 48, 50, 52.

Recommendation 18. Services or rights identified by inmates which are not currently utilised in the program, but which are available to them in the community, be considered for inclusion in the program. p 19 - 30, 50, 52.

Recommendation 19. Procedures relating to how the LSU and it's inmates are identified to all persons should be reviewed; and new procedures be adopted which do not result in an inmates health status being implied or disclosed. p 19 - 21, 24, 25, 25, 26, 29, 39, 39, 48, 52.

Recommendation 20. The LSU be provided with its own recreational/outdoor area which inmates do not have to share with the CSU. In order that (i) confidentiality is improved, (ii) unit is not forced to run under the requirements of a self harm maximum security centre.
p 19 - 20, 21, 24, 25, 25, 26, 28, 29, 36, 37, 39, 39, 41, 46, 48, 52.

Recommendation 21. Inmates who attend the LSU are entitled to, and have access to, all privileges due to them under their classification and their participation in the program or unit should not revoke any of these privileges. p 20 - 20, 28, 39, 52.

Recommendation 22. In line with earlier recommendations, (should inmates be allowed to apply to spend the rest of their sentence in the LSU) the unit be expanded to a suitable size and layout to house up to sixteen inmates; thereby allowing a larger program to operate with a greater range of options and sessions available for inmates, and overcoming many of the problems caused by the current units layout and operation. p 20 - 25, 28, 36, 37, 41, 46, 52.

Recommendation 23. An adequate and suitable visit area be established for HIV positive inmates so they are able to discuss personal issues with visitors in private, and consideration be given to the introduction of a special access scheme whereby inmate's visitors can apply to visit them on days other than official visiting days. p 20 - 37, 46.

Recommendation 24. A critical review of the current points system used in the unit be conducted to ensure it is used and applied equitably and without discrimination/bias.
p 20 - 30.

Recommendation 25. Strongly recommended that, after giving due consideration to the information contained in this evaluation, that the proposal, and move, to integrate inmates with acute Hepatitis C infection into the LSU be discontinued. In addition, that serious consideration be given to the establishment of a separate unit and program in the SCC, which caters to the needs of the relatively large numbers of inmates with Hepatitis C infection in the NSW correctional system, and that this program is operated with the same philosophical ideology as that used in the LSU. p 21 - 30, 41, 49.

Recommendation 26. A comprehensive review be undertaken on the type, level and quality of services and treatment that is provided to all HIV positive inmates in the NSW correctional system by the CHS in order to see if it meets the minimum standards set by the WHO guidelines [WHO, 1993]. p 21 - 28, 37, 48, 48.

Recommendation 27. Procedures, policies and protocols relating to maintaining inmates HIV - or other medical - status confidential (including their operation in practice) be re-inforced in all correctional centres and at all levels to ensure inmates medical confidentiality is not breached in line with legislative requirements (Prison Regulations, Public Health Act, Anti-discrimination Act and WHO guidelines). p 21 - 24, 25, 25, 26, 29, 39, 48.

Recommendation 28. Breaches of confidentiality by staff and inmates be treated as breaches of discipline and should be rigorously enforced, in addition the requirements for maintaining confidentiality (and the penalties for its subsequent breach) should be provided to all current and future staff and inmates. p 21 - 24, 25, 25, 26, 29, 39, 48.

Recommendation 29. LSU program develop specific modules to address the issue of the high level of recidivism amongst HIV positive inmates (with a view to reducing these levels) in line with its objectives to provide skills for inmates to successfully integrate into the community upon their release. p 22 - 23, 52.

Recommendation 30. The promotion of the LSU, and non-discriminatory attitudes towards HIV and those affected by it, to the mainstream inmate population be included (or continued) in all relevant inmate programs and services. Furthermore, other activities and programs (such as awareness raising days) are designed and implemented to further promote these issues. p 30 - 28, 30, 37, 46.

Recommendation 31. Consideration be given to allow HIV positive inmates to visit the LSU (for example for one or two days), before they are admitted to the program so they can see what the unit is like. p 26 - 39, 52.

Recommendation 32. All components developed for the LSU program be retained, in some form, to meet the needs of inmates, and ensure program integrity. p 26 - 27, 30, 48, 50, 52.

Recommendation 33. All staff who work (or will work) in the unit are provided with appropriate and on-going training and briefing so they have sufficient knowledge and understanding of HIV and related issues. Furthermore, this training should not only cover the physiological and practical issues, but psychosocial/attitudinal issues as well. p 28 - 30, 34, 34, 34, 36, 36, 46.

Recommendation 34. The feasibility of allowing other HIV positive inmates at the Long Bay Correctional Complex to participate in the program without having to be residents be fully investigated and implemented if at all feasible. p 30 - 52.

Recommendation 35. All HIV positive inmates have access to food and meals that are suitable to their particular dietary and nutritional needs and requirements; and if possible they be given the option to prepare their own meals. p 30 - 48.

Recommendation 36. Where possible, staff are consulted on a regular basis (for example, every one or two months, or as required) on the operational procedures and strategies used at the LSU. p 37 - 41.

Recommendation 37. For as long as the LSU shares facilities and staff with the CSU every effort should be made to enhance and maintain a good working relationship between the staff and management of the two units. Including where necessary staff meetings, workshops or forums to discuss and resolve any disputes or problems that arise or exist. p 37.

Recommendation 38. The role, type and level of participation of staff in the LSU program be determined, and appropriate guidelines be established which outline this involvement. p 38 - 41, 48, 52.

Recommendation 39. The guidelines relating to the management of dangerous or problem inmates be clearly defined and/or enforced. Furthermore that the unit is not used as a dumping ground for inmates with HIV (or any other illness) that no-one else wants in their centre/unit/area because they are difficult (or perceived to be difficult) to manage. p 41 - 52.

Recommendation 40. All sessional specialist staff should receive appropriate briefing prior to working in the LSU and the correctional system. It is suggested that as part of this briefing an appropriate resource be developed which contains important information they need to know about working in the correctional system and at the LSU (including practical issues such as signing in and out of centres, universal infection control and security requirements etc.), and that this resource is regularly reviewed and updated. p 45.

Recommendation 41. A suitable forum be held once or twice a year for sessional specialists who work at the LSU in order for them to conduct workshops, network, discuss issues, review the program and meet. p 47.

Recommendation 42. A position for an appropriately qualified Program Co-ordinator (non-custodial) be established and filled whose role would be to run, develop and maintain the operation of the LSU program. This requirement is further supported through Recommendations 1, 2, 6, 7, 8, 9, 10,11, 13 - 18, 22, 29, 32, 33, 34, 36, 38, 40 & 41 of this report. p 47 - 48, 48, 50, 52.

INTRODUCTION

Following the discovery in 1981 of the first cases of infection with the Human Immunodeficiency Virus (HIV) in the USA, we have seen the emergence of a world wide pandemic of the virus, affecting millions of people.

Throughout the Australian community, the preventative education and health strategies implemented have to date been very effective in containing the spread of HIV. In fact, many of these strategies have been used as examples and role models for initiatives and programs overseas.

One area where this has happened, is that relating to the strategies adopted in the NSW correctional system. These strategies have served as a model for, not only the seven jurisdictions in Australia, but also for many others throughout the world. The primary strategies adopted in NSW include:

- establishment of the Prison AIDS Project (now called the HIV & Health Promotion Unit) to develop, co-ordinate, monitor, review and implement most strategies relating to HIV in the correctional system;
- development and implementation of comprehensive staff and inmate peer education programs;
- the establishment of a methadone program for inmates;
- availability of bleach, and other appropriate cleaning and disinfectant materials to all inmates and staff;
- policies relating to the confidentiality and other requirements of people with HIV;
- development and implementation (in a joint collaboration with the Prison & Commissioned Officers' Vocational Branches of the Public Service Association) of appropriate Occupational Health and Safety standards, equipment, programs and training for all staff and centres;
- a three month trial of the introduction of condoms and water based lubricants to all

inmates (though this has been recently approved by government through legislation, and is scheduled to take place early in 1996);

- the provision of exit kits for distribution to inmates upon any release, which contain information on lower risk HIV strategies; and condoms and water based lubricant;
- the establishment of a voluntary unit for HIV positive inmates to learn about to deal and adjust to their HIV status.

It is the last item listed above which is the subject of this report.

In 1985 a compulsory segregation unit was established to house HIV positive inmates at the Long Bay Correctional Complex. In 1989, following changes in policy and legislation, and after a review of the units legitimacy, effectiveness, and operation, the unit was disbanded and the compulsory segregation policy was replaced by an integration (of HIV positive inmates) policy.

A committee was established early in 1991 to review the options available, and make recommendations on, the management of HIV positive inmates. It was decided that a program and unit which offered information on lifestyle and health issues would be the best strategy to adopt and that this could be of benefit to both inmates and staff.

A planning committee was then established with the objective to design a comprehensive, short term voluntary program which would help HIV positive inmates become self reliant and responsible with the desired outcomes of (i) for inmates, the maintenance of health; (ii) for management, the reduction of the impact of the HIV epidemic in the correctional system; (iii) for the community, the responsible preparation of HIV positive inmates for release, and; (iv) for the epidemic, the reduction of virus transmission in the inmate population.

The result of the planning committee's work was the development of a program and unit called Health and Lifestyles Program that it was hoped would achieved the desired outcomes which had been set.

This unit was officially opened in late September 1992 and the first inmates were accepted into the program early in December of the same year. The unit was called the Lifestyles Unit, and is located in the Special Care Centre as part of the Long Bay Correctional Complex in Sydney.

Following the first year of the unit's operation it was decided (by all those involved in the unit - staff, management and inmates) that it would be valuable to have the unit and program evaluated in order to ascertain if it was meeting the goals that had been set for it.

Funding was obtained for the evaluation in mid-1994, but the study was delayed primarily because of a proposal to introduce inmates with acute Hepatitis C infection into the unit. It was felt once the proposal had been finalised and distributed for consideration/discussion that peoples' feelings towards the proposal would need to be accounted for in the evaluation - as if they were in support of the proposal it would impact on the future direction the unit should take.

Therefore the study commenced in March 1995 and was undertaken throughout the remainder of that year.

The aim of the study was to (i) conduct a review of the management of HIV positive inmates and, (ii) document an evaluation of the Lifestyles Unit and Program.

This report is the result of that study.

OVERVIEW OF THE MANAGEMENT OF HIV POSITIVE INMATES

BACKGROUND

In 1981 the Centre for Disease Control (CDC) located in Atlanta, Georgia, in the United States of America noted the appearance of a pattern of unusual serious illnesses amongst people living in San Francisco, New York and Los Angeles. Those first identified as being affected (in the USA at least) were primarily young male homosexuals. It was for this reason that the illness was initially called GRIDS (Gay Related Immune Deficiency Syndrome). It soon became clear this name was inappropriate, as many other cases started to emerge (such as those in haemophiliacs and drug users) that made it clear that this illness was not just gay related. Consequently the illness was given the name, AIDS - Acquired Immuno-Deficiency Syndrome. In 1983 French researchers discovered the agent that caused these illnesses. It turned out to be a virus, and they called the virus HIV - the Human Immunodeficiency Virus (HIV).

The discovery of the HIV and how it is transmitted has had major ramifications throughout the world. In particular it raises many challenges for public health, social and correctional system service providers.

One of the most significant challenges for correctional system management was what action should be taken regarding people who were sentenced to imprisonment in the correctional system and who were known to be, or found to be HIV antibody positive. A further complication arises when one considers the variety of circumstances under which people can find themselves in the correctional system. Circumstances which include being held on remand, awaiting trial or sentencing, and those who have been sentenced to imprisonment or detention.

Throughout the world many different approaches have been taken in the management of HIV positive inmates. As part of this evaluation a comprehensive literature review was carried out; and information requests were made regarding the treatment and management of HIV positive inmates from approximately thirty five countries. In addition relevant papers from the last two

international AIDS conferences held in Berlin and Yokohama were also requested - see Appendix A. Responses were received from eighteen of the countries contacted and relevant policies from nine countries have been included in Appendix A - for comparison and information. In addition, a summary table of management practices adopted in different countries is also contained in Appendix A.

The most commonly cited guidelines, principles, or targets, used for the management of HIV positive inmates by many jurisdictions are based on those produced by the World Health Organisation (WHO) Global Programme on AIDS - "*WHO Guidelines on HIV Infection and AIDS in Prisons*" [WHO, 1993]. A summary of the key components of these guidelines for the treatment and management of HIV and HIV positive inmates within a correctional system environment are briefly outlined below. Please note that this list is a summary and does not cover all the issues addressed by the guidelines. It only represents those that fall within the scope of this evaluation.

A. General Principles

- *All prisoners have the right to receive health care, including preventative measures equivalent to that available in the community without discrimination.*
- *Specific policies for the care of HIV positive prisoners should be defined and developed in collaboration with health authorities, prison administration, relevant community representatives.*
- *The need of prisoners should be taken into account in the planning of national AIDS programs, community and primary health care services, and the allocation of resources.*
- *The active involvement of non-governmental organisations, the involvement of prisoners, and the non-discriminatory and humane care of HIV positive prisoners and of prisoners with AIDS are prerequisites for achieving a credible strategy for preventing HIV transmission.*

B. HIV Testing in Prisons

- *Compulsory testing for HIV is unethical and ineffective and should be prohibited.*
- *Voluntary testing requiring informed*

consent should be available with appropriate pre and post test counselling.

- All test results should ensure medical confidentiality and be communicated by appropriate health personnel.

C. Management of HIV positive prisoners

- The segregation, isolation and restriction on occupational activities, sports and recreation of HIV positive inmates is not considered appropriate or relevant.
- Decisions on isolation for health conditions should be taken by medical staff only; in accordance with public health standards and regulations.
- Prisoners' rights should not be restricted further than is absolutely necessary on medical grounds in accordance with public health standards and regulations.
- HIV positive prisoners should have equal access to workshops and to work in kitchens, farms and other work areas, and to all programs available to the general prison population.
- Protective isolation where required for prisoners with immunodepression related to AIDS should only be carried out with a prisoner's informed consent.
- Disciplinary measures, such as solitary confinement, including perpetrators of aggressive, or predatory sexual, acts, or those who threaten such acts, should be decided upon without reference to HIV status.
- Efforts should be made to encourage among prisoners and staff supportive attitudes towards those affected by HIV in order to prevent discrimination and to combat fear and prejudice about HIV positive people.

D Confidentiality in relation to HIV/AIDS

- Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel. Health personnel may provide prison managers or judicial authorities with information that will assist in the treatment and care of the patient, if the prisoner consents.
- Information regarding HIV status may only be disclosed to prison managers if the health personnel consider, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of prisoners and staff applying to disclosure the same principles as those generally applied in the community.
- Principles and procedures relating to voluntary

partner notification in the community should be followed for prisoners.

- Routine communication of HIV status of prisoners to prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.

E. Care and support of HIV positive prisoners

- HIV positive prisoners should receive appropriate medical and psychosocial treatment equivalent to that given to other members of the community.
- Medical follow-up and counselling for asymptomatic HIV positive prisoners should be available and accessible during detention.
- Prisoners should have access to information on treatment options and the same right to refuse treatment as exists in the community.
- Treatment for HIV, and the prophylaxis and treatment of related illnesses, should be provided by prison medical services, applying the same clinical and accessibility criteria as in the community.
- Prisoners should have the same access as people living in the community to clinical trials and treatments for all HIV/AIDS related illnesses and may not be the subjects of medical research unless they freely provide informed consent to it and it is expected to produce a direct and significant benefit to their health.
- The decision to hospitalise a prisoner with AIDS or other HIV related illness must be made on medical grounds by health personnel. Access to adequately equipped specialist services, on the same level available to the community, must be assured.
- Prison medical services should collaborate with community health services to ensure medical and psychological follow-up of HIV positive prisoners after their release if they so consent. Prisoners should be encouraged to use these services.

G. Women prisoners

- Women prisoners, including those who are HIV positive, should receive information and services specifically designed for their needs.
- Women should be able to care for their young children while in prison regardless of their HIV status.

It should be further noted here, that the WHO guidelines identified above were used as one of the primary assessment criteria when

undertaking this evaluation, as such they were seen as providing guidance and minimum standards of care for HIV positive inmates while at the LSU and in the NSW correctional system generally.

In Australia, each of the six states and two territories have their own correctional system, and each state's response to HIV has been different. Unfortunately, as noted by the 1992 National Evaluation Steering Committee's report on Australia's National HIV/AIDS Strategy [NESC, 1992] all jurisdictions, except NSW, have fairly poor records with respect to their adoption of progressive policies, programs and practices in relation to HIV and other Blood Borne Communicable Diseases (BBCD's). With most jurisdictions disregarding many of the WHO guidelines outlined above.

In all jurisdictions, except NSW, they:

1. continue with compulsory testing of inmates (note: this is notional in Victoria as under the state's "voluntary" testing policy they have a compliancy rate of 99%);
2. have relatively little HIV education of staff and inmates addressing not only the biomedical and transmission aspects of HIV but also the attitudinal, psychosocial aspects of HIV; with this primarily resulting from the under resourcing of these services;
3. separate inmates known or found to be HIV positive in either (i) segregation units/areas - justified in some cases as a method to facilitate supportive management, or (ii) in mandatory single cell accommodation (for NSW see discussion below).
4. retain confidentiality guidelines, policies and practices that are difficult to maintain and implement given the nature of their management of HIV positive inmates;
5. show considerable variation in the level and type of participation HIV positive inmates are allowed to undertake while imprisoned, in particular with respect to special support programs, work release and normal prison programs and activities.

The strategies, policies and management practices adopted in the NSW correctional system have not always been ideal. Over the years of the HIV epidemic, and assisted greatly by the efforts of the Prison AIDS Project and others, they have evolved to be one the most progressive in the world, with most (at least in theory/policy) of the WHO

guidelines identified above being adopted or addressed. Many of these policies and management practices are contained in the "HIV/AIDS Policies, Procedures and Management Guidelines" [PAP 1994 (revised edition due early 1996)]. The notable exceptions to these guidelines are outlined following with explanation.

G. Women prisoners

- *Women prisoners, including those who are HIV positive, should receive information and services specifically designed for their needs.*

Appropriate information and services regarding HIV are provided to all women in custody in NSW. Given the relatively small number of HIV positive women who have been, or are, in the NSW correctional system there are no set policies relating to the provision of services specifically designed for their needs (other than for their medical requirements and treatment). In general the specific needs of each inmate are catered for as part of the individual case management process adopted in NSW. It should be noted that on one occasion an HIV positive female inmate voluntarily participated in the LSU program with relatively little disruption to the unit. However since then, as far as can be ascertained, all the women who have been approached about applying to participate in the LSU program have declined this option. Therefore, the review of the somewhat complicated mechanisms and screening processes used for the acceptance of women into the program have not been examined as part of this evaluation.

- *Women should be able to care for their young (under school age) children while in prison regardless of their HIV status.*

At present there is no provision in NSW for women to care for their young children while in the correctional system. Currently this policy is under review and it is expected that some women inmates will be able to care for their young children while in custody by the end of 1996.

With regard to the segregation of inmates in the NSW correctional system, the general policy provides for HIV positive inmates to be housed in single cell accommodation. Any HIV positive inmate can make an application to share a cell with any other inmate who must also give their informed consent to the arrangement (see PAP, December 1994, Appendix 17 - "Association of

HIV Positive Inmates" for further details). Thus, in practice any HIV positive inmate can share a cell with any other inmate in their wing or unit.

In relation to the WHO guidelines pertaining to "*Confidentiality in relation to HIV/AIDS*". With one exception these guidelines are followed in the NSW correctional system. All information relating to inmate's current health status and medical treatment is maintained confidentially on their individual medical file. However there is a policy in place (see PAP December 1994 - Appendix 17) which requires that a list of the names and locations of all HIV positive inmates within the NSW correctional system be sent at the end of each month to the Commissioner. This list is kept under strict locked security and the only time other members of senior staff (and only if they are expressly listed on the policy statement) are notified of an inmate's HIV positive status is if they make a formal, justified request; or as required. In addition, correctional centre governors and the four regional commanders, are the only other staff members who are notified regarding inmates HIV status, but they are only notified of those inmates who are within their centre or region of responsibility.

As far as the clinical management of HIV positive inmates is concerned, in all Australian correctional jurisdictions the clinical cover of HIV positive inmates is undertaken by each prison medical service. This care is supplemented with visits from (external and internal) medical, counselling and support services as required. With specialist treatment in relevant public hospital units where medically necessary. As raised in the report of the 1992 National Evaluation Steering Committee on Australia's National HIV/AIDS Strategy [NESC, 1992] there is "*considerable debate about the quality of treatment services for HIV positive prisoners, the availability of support from outside individuals or agencies and the adequacy of pre-release planning, with no evidence or information available on disease progression among offenders in correctional facilities in comparison to people in care in the general community*".

As such, given this is an evaluation of a particular unit and not the clinical care of HIV positive inmates, this evaluation only briefly touches on the level and quality of clinical care provided to HIV positive inmates in the NSW correctional system

by the (NSW) Corrections Health Service (CHS).

MANAGEMENT OF HIV POSITIVE INMATES IN NSW

Initially in NSW, there was neither coercive HIV antibody testing nor segregation. The policy requiring segregation of prisoners known or suspected of being HIV positive was introduced in 1985, and a special unit called the Malabar Assessment Unit was established in the Long Bay Correctional Complex. This unit was grossly inadequate in resources, and was the subject of a number of complaints under the Anti-Discrimination Act. It severely restricted the inmates' access to facilities normally available to inmate in the correctional system.

It was also known (regardless of its official name as the Malabar Assessment Unit) as the AIDS Unit or Death Row, prisoners' mail was routinely labelled AIDS, and visitors informed that the prisoner they wished to see was in the "AIDS Unit". This was the way in which some family members and friends learned that the person they were going to visit was HIV positive.

Various attempts were made to rectify the problems of the unit, and, with the increase in the number of identified HIV positive prisoners, the concept of a single, small, specialised unit became less practical.

In 1989, the Prison AIDS Project (PAP) assessed the purpose and activities of the MAU and found that, while the physical accommodation and layout of the unit was adequate, both the staff and the inmates were dissatisfied and unhappy. Those involved felt that little was being achieved by placing HIV antibody positive inmates in a segregated unit.

Furthermore, there was increasing pressure from many sectors on the discriminatory nature and legality of a segregation unit and its violation of basic human rights.

PAP's investigation of the MAU found that despite a range of services being provided, the inmates felt nothing was being done for them and they had nothing to do except to think about their health status.

It was found that this, in effect, was a reflection of several factors:

- the lack of co-ordination of the services being provided;
- the inability of the inmates to work or be classified, and;
- the concentration of the case management process only on the medical aspects of their condition.

Overall, the 1989 assessment of the MAU concluded that the unit exemplified the feelings expressed by the inmates of being held in a 'leper' colony and provided no organised means of helping them cope with their condition either in the mainstream inmate population or the community.

On 5 November 1990 the NSW Department of Corrective Services (DCS) introduced a compulsory HIV testing policy for all new admissions into the NSW correctional system. At the same time it abandoned the segregation of all HIV positive inmates and adopted a policy of integration of HIV positive inmates into the mainstream inmate population. The MAU was still maintained "*as a training centre for HIV/AIDS inmates to acquire the skills not to transmit the disease, and to cope better*" (Collins 1989).

In response to these actions it was decided to form a committee to review the options available for the management of HIV positive inmates. With the advent of compulsory testing and the non-segregation policy the DCS felt it would be facing increased numbers of inmates who were identified as being HIV positive. It was felt that the potential for problems, assaults and aggression involving these inmates would be greatly increase.

Therefore, it was decided that a program which offered information on lifestyle and health issues would be one strategy that could be of benefit to both inmates and staff.

For staff: because they would be managing HIV antibody positive inmates who have a better understanding of their illness; and,

For inmates: because it would provide a constructive means of coming to terms with their status in a practical and down-to-earth way.

A planning committee consisting of all service providers and security staff of the MAU and staff

of the Prison AIDS Project, was established. The objective of the committee was to design a comprehensive, short term voluntary program which would help HIV positive inmates become self reliant and responsible; with the desired outcomes of:

- i. for inmates, the maintenance of health;
- ii. for management, the reduction of the impact of HIV in the correctional system;
- iii. the community, the responsible preparation of HIV positive inmates for release, and;
- iv. for the epidemic, the reduction of virus transmission in the inmate population.

It was agreed by the committee that if the new non-segregation policy was to succeed, most inmates who became aware of their HIV positive status would benefit from a short period of time away from the mainstream where they could have the opportunity to learn how to maintain their health and well being. It was also agreed that the following items would need to be addressed:

- the referral process - who did the referring and who was referred;
- assessment - case management;
- program philosophy;
- accommodation needs;
- which services would be the most cost effective and useful and what form they would take;
- staffing requirements and what special training they would need, and;
- follow up - how inmates would be supported in their changed behaviour patterns once they return to the mainstream population.

It wasn't however until October 1991 that a final proposal for the unit/program had been developed for full consideration by management - see Appendix B. It was from this proposal that the name, aims and objectives of the Lifestyles Unit (LSU) emerged.

RECENT EPIDEMIOLOGICAL DATA

The following is an extract from the NSW Corrections Health Service (CHS), first Annual Report [1995], containing epidemiological information relating to the incidence and testing rates of Hepatitis B, Hepatitis C and HIV in the NSW correctional system. -

Hepatitis B, Hepatitis C and HIV

On December 24, 1994, the compulsory HIV Screening Program ceased and voluntary Blood Borne

Communicable Disease Screening was introduced. The screening program was expanded from HIV testing to include the provision of pre-test counselling, education on harm minimisation strategies in prison, individual risk assessment, post test counselling and follow up of "at risk" clients, and screening for Hepatitis B, Hepatitis C and Syphilis.

For the period 1 July to 31 December 1994, 5734 HIV tests were performed on entry and exit from prison under the compulsory HIV Screening Program. One inmate was diagnosed as being HIV positive and fifteen inmates returned to prison who were previously diagnosed or known to be HIV positive.

From 1 January to 30 June 1995, 3794 inmates were seen, assessed, provided with information and education on Blood Borne Communicable Diseases and Sexually Transmitted Diseases and of these 2170 inmates agreed to be tested under the voluntary testing program. Two inmates were diagnosed as being HIV positive and three inmates returned to prison who were previously diagnosed as being HIV positive.

The introduction of the voluntary Communicable Diseases Screening Program has seen a reduction in the number of serological tests performed. Strategies are being considered to improve the testing acceptance rate of 57% as it was not anticipated by CHS that the reduction would be as large.

The number of HIV positive inmates in custody over 1994/95 ranged from 18 to 27 with an average of 22 persons. These inmates have daily access to clinic staff and monthly access to special immunology services for the assessment, monitoring and review of their health and HIV status.

The Public Health Unit of CHS conducted a Hepatitis Research Project in conjunction with the Eastern Sydney Area Health Service Public Health Unit. The outcome of this study has provided Corrections Health Service with a predictive prevalence rate of Hepatitis B and C infection on reception to prison. The study tested 408 inmates on reception to Long Bay Prison and found that:

- 31% were Hepatitis B core antibody positive, which means they have been previously infected with Hepatitis B;
- 37% were Hepatitis C antibody positive, however it cannot be said if this means they can spread Hepatitis C or not; and
- a further 3% were Hepatitis B surface antigen positive which means they are currently infectious.

The project is currently following up inmates enrolled in the survey to examine conversion rates from negative to positive during imprisonment.

Compulsory and Voluntary HIV Screening

	Number Tested		Positive Results
	Screened	Tested	Number %
Compulsory 93/94	12,032		55 0.46%
Compulsory July to December 94	5,734		16 0.28%
Voluntary January to June 95	3,794	2,170	5 0.23%

A Hepatitis Clinic to assess and treat the long term effects of Hepatitis B and C was established at Long Bay and is conducted by specialists from Prince Henry Hospital.

THE LIFESTYLES UNIT

This section of this report provides an overview of most aspects of the Lifestyles Unit (LSU) and as such raises many issues relating to its' evaluation. Rather than discussing these issues in detail here the majority of them - where currently relevant - are examined in later sections of the report.

The LSU is located in the Special Care Correctional Centre at the Long Bay Correctional Complex. The unit was opened to inmates in November 1992 and accommodates up to eight inmates who have voluntarily applied and been accepted to take part in the program provided in the Unit.

As at the end of December 1995, forty nine inmates, both sentenced and unsentenced, had been received into the LSU. Eighteen of these (36.7%) had been in the Unit on more than one separate occasion.

Since opening, the Unit has been occupied close to full capacity. This has been achieved by allowing inmates (when the demand for placement is low) to remain in the Unit for longer than the specified program period.

The LSU, to date, has had only one female inmate attend the unit. She had her own cell and had to be properly dressed in all common areas with no other inmates being allowed into her cell. The female inmate required closer supervision than her male inmates because of the shared yard with the Crisis Support Unit (CSU) inmates. There were, however, other female inmates in CSU, and the inmates in the CSU knew she was HIV positive which created some disincentive among them for sexual liaisons. Overall, the inclusion of a female inmate in the program (in this instance) caused few problems for the unit and those that it did were mainly attributable to personality conflicts. For more information on the needs of HIV positive women in the correctional system environment see the discussion contained in the previous chapter.

Recommendation 1. A formal review be undertaken of the specific services and needs of HIV positive women within the NSW correctional system, and that appropriate strategies, policies and procedures are developed, and implemented, that address these requirements. (see pages - 25 and 50)

AIMS OF THE LSU

- The maintenance of the health and well-being of HIV positive inmates whilst in the correctional system and in the community upon their release.
- The successful integration of those HIV positive inmates attending the program into the mainstream correctional centre population.
- The minimisation of HIV transmission in correctional centres and in the community upon the release of the inmates who have completed the program.
- Providing an opportunity for the rehabilitation of the HIV positive inmates completing the program.

The program should achieve these aims by addressing the complex physical, emotional and psychological needs of the HIV positive inmates.

OBJECTIVES OF THE LSU

- To create an environment for HIV positive inmates which will allow them to understand their status by providing:
 1. Individual assessment and medical care.
 2. Necessary counselling and emotional support.
- To facilitate the development of HIV positive inmates with the required knowledge, skills and attitudes to enable them to:
 3. maintain their well-being;
 4. utilise their practical coping skills;
 5. avoid placing others at risk of getting HIV;
 6. deal with being HIV positive in the correctional centre system, and;
 7. deal with being HIV positive when released back into the community.

STRATEGIES USED TO MEET AIMS AND OBJECTIVES

- To train LSU custodial staff in the effective care of HIV positive inmates.
- To provide in-service familiarisation to non-custodial practitioners/staff and consultants as required.
- To develop and deliver a twelve (now a sixteen) week program enabling inmates to achieve the aims and objectives of the unit. Including access to outside/community services, facilities and agencies available for HIV positive people.
- To monitor the progress of inmates after completion of the LSU program.

The proposal developed for the LSU program also contained a program philosophy (see below) which underlies the aims, objectives and strategies outlined above. It is important to note here, however, that this philosophy is central to the ideology behind the LSU and for the purposes of this evaluation was used to measure the success of the LSU in meeting its goals.

PHILOSOPHY OF THE LSU

The philosophical framework developed for the LSU utilises a holistic approach aimed at optimising the health and well being of inmates with a combination of therapeutic and educative strategies. These should be:

1. tailored to the needs of each individual inmate;
2. focused on the medical, physical, emotional and psychological areas of an inmates ability to cope;
3. aimed at building **self reliance and self responsibility**.

Overall, the environment should be one in which inmates would want to be in voluntarily. Where all staff (custodial and non-custodial) would play an active, positive role in the programs operation.

Recommendation 2. The LSU program philosophy be included in all information, training and briefing provided to staff, inmates, sessional specialists and other people involved with the LSU. In order to ensure this philosophy is not lost in the operation of the unit and program. (see pages - 28, 34, 36, 37 and 46)

ESTABLISHMENT OF THE LSU

After the proposal for the LSU had been approved it was decided that the unit would be established as part of the Special Care Centre (SCC).

In 1991, an inmate attacked an officer at the Long Bay Correctional Complex (LBCC), with a blood filled syringe which resulted in the officer becoming HIV positive. This incident contributed to the development of many phobias (relating to HIV) and a great deal of fear, resentment and mistrust among many staff within the correctional system and in particular among those located at the LBCC. Thus the decision to locate (what was seen by many at the time), a haven for HIV positive inmates within the SCC was met with much resistance, fear, hostility, obstruction and resentment by many of the staff at the LBCC. These factors were manifested in various different ways, especially in the first three months of the units operation, and included actions such as delaying access to the unit.

The Crisis Support Unit (CSU) which had been operating in the SCC for 6-7 months before the LSU was opened, was a larger unit that had experienced problems in getting a suitable program operational.

Initially, there was a level of resentment and hostility by some of the staff working in the CSU towards the LSU. This was justified by the belief that that the LSU inmates had "everything" compared to those in the CSU, where inmates, due to management requirements (being a self harm prevention unit), had "nothing" and were under constant supervision.

To add to all these factors, as far as can be discovered, there were no briefing, consultative or educational sessions or workshops held with any staff in the CSU, SCC or LBCC; on the integration of the LSU into the complex.

During the first (inmate free) month of the LSU's operation the Officer In Charge (OIC) offered to conduct training for staff in the CSU which, at the time, was declined by the staff of the CSU. Additionally, after its' opening the OIC LSU tried to establish (with somewhat limited success) a co-operative operational environment by organising joint sporting activities with CSU staff and inmates.

Therefore, it can be surmised from the above that the LSU was not established in the most ideal of circumstances and little was done to address any of the factors that contributed to this situation. In hindsight it would have been prudent to at least address some of these factors prior to the establishment and operation of the LSU, thereby minimising the level of hostility and resentment generated by its' establishment and the associated problems this caused .

The LSU officially opened in September 1992 with the first month of operation being used to train staff of the LSU and organise the Unit and program. The first intake of inmates occurred on 12 November 1992.

STAFFING

As mentioned above, the LSU opened to staff one month before any inmates were admitted to allow for the settling in and training of staff. A formal program for the initial training of staff had been developed as part of the implementation proposal for the unit. This training consisted of:

- one week with staff from PAP, during which time all officers were educated on HIV transmission, stages of infection, treatment etc. In addition to this, staff visited agencies such as the AIDS Council of NSW, Matraya Day Centre for HIV positive people, Corrections Health Service and the HIV ward at St Vincent's Hospital. Officers also discussed potential problems, burnout, pressure from inmates to supply condoms and needles, occupational exposure etc.
- after this first week of training the officers were then provided with two weeks of procedural training by the Therapeutic Manager of the SCC; which was followed by a week of in house peer education amongst the staff.

Throughout their training staff were actively encouraged to participate in the program and management of inmates when working in the unit. The involvement of the staff, through case management, was considered crucial for the creation of an environment where inmates are able to either openly or privately discuss HIV, its effect on their life and their future.

No extra or formal training programs have been undertaken with any new staff to the unit since this initial training, and no formal follow-up education and training programs have been conducted with staff in the unit. As far as can be ascertained only limited and intermittent training was conducted with staff throughout the units operation.

Due to the size of the unit it is not viable to have staffing rosters made up solely of staff dedicated to the LSU. As such the LSU operates with five permanently based custodial staff, one senior prison officer (the Officer in Charge - OIC) and four other officers of lower rank.

The role of the OIC is primarily to be the case management supervisor. They are the only member of staff in the unit who has access to all the inmate files. One of the primary responsibilities of the OIC is to review case files daily and review them with inmates every month (or as appropriate); this function is vital as inmates case files need to be carefully monitored. The OIC is also responsible for managing any conflicts between inmates and staff or amongst inmates/staff. This is also an important role as it is relatively difficult to re-assign staff (or inmates) and doing so can be the potential cause of further conflicts in such a small unit.

A roster system, which ensures there are always two staff members in the unit, was established (see Table L1) in order to adhere to operational agreements on minimum staffing levels. A crossover time for staff on a change of shift also occurs under this system. The extra staff member required for this schedule is generally drawn from within the SCC.

Officers on A & D watches work a 28 day roster - with 19 days on and 9 days off during the period. Usually they work 5-7 days on followed by 2-3 days off depending on their use of their recreation, sick and flex leave entitlements.

Table L1. LSU Roster/Timetable

TIME	DAY		NIGHT	MON - FRI	SAT & SUN
7am	A		Start		Visits
8am			9pm		
9am	Watch		SCC	Morning	&
10am			Patrol		
11am	Two		Two	Program	Some
12pm			staff		
1pm	Staff	D	patrol	After-	Industry
2pm	Detach		SCC		
3pm		ed	CSU	noon	
4pm	Watch	Duties	& LSU	Program	
5pm	Two	One	Checked		
6pm			Every		
7pm	Staff	Staff	2 to 3		
8pm			Hours		

Notes: Two hour change over period between A and D watches is required for: training, case management, handover, interviews, getting food/buy ups, delivery of inmates to CHS (at call) and to catch up on case files. For the detached duties shift, OIC tries to get people from SCC who were interested in working in LSU by co-ordinating rosters.

Though no formal comparison was carried out as part of this evaluation, it is my opinion that the LSU has a relatively low level of staff absence. This is primarily attributed to four factors (i) the voluntary nature of the permanent positions at the unit, (ii) the working strategies officers are able to utilise, (iii) the flexibility and responsibilities they have in carrying out their duties, and (iv) the responsibility officers have as case managers for individual inmates.

Staff absence is mainly effected by two types of stress:

1. environmental stress - due to location within SCC & CSU, and;
2. "Intensive Case Management" stress - due to the nature of the unit, staff do not just record conversations/issues on case files, but work closely with inmates, including such things as: providing support in telling inmates' family/friends they have HIV/AIDS, or are gay, help with housing and support services etc.

The OIC aims to minimise the impact of the staff stress in the unit three main ways through (i) staff support; (ii) debriefing sessions, and; (iii) trying to get staff to work in the SCC for periods of up to three months in order to break ties with inmates while still enabling them to stay in touch with the LSU. Management practices of the SCC also help achieve this practice with the complementary staff rotation structure they have in place.

INMATE SELECTION

Inmates wishing to enter the unit must apply through the Governor of the correctional centre they are currently in or through a member of the Corrections Health Service Public Health Unit (this is to ensure only HIV positive inmates apply for entry). The completed application form is then sent to the LSU the Governor of the SCC and then onto the OIC at the LSU who arranges an assessment with the inmate. The LSU is able to house up to eight inmates at any one time.

Inmates are assessed individually by OIC LSU and another LSU officer (usually the one to be assigned to their case management) for their suitability. The OIC and the other officer that interview the inmate confer on their assessments, and if an inmate is deemed to be suitable they are invited to enter to the unit. It should be noted that the OIC gives the final advice on who is invited to the unit, but must explain their decision to both the inmate and the other interviewing officer (should they be in disagreement). A formal interview schedule has also recently been developed for the process.

Comprehensive assessment procedures were developed for the LSU - taking into account such issues as:

- the inmates feelings towards protection inmates;
- their behaviour;
- their attitude towards mixing with people with different sexual preferences;
- what they wanted to get out of the program;
- how long they have been HIV positive;
- their willingness to participate in the program;
- how they felt about having HIV, and;
- their compatibility with other inmates in the unit at that time.

The Unit is available for the following HIV positive inmates in the NSW correctional system:

- new receptions;
- inmates already in the system;
- inmates requiring respite or step down treatment and care as an alternative to hospitalisation;
- inmates due for release, and;
- inmates who have already undertaken the program who wish to apply for re-entry.

When the unit first opened the LSU had to rely solely on the Correction Health Service (CHS) for all referrals to the LSU. Many people in the CHS at the time felt they should have had control of the management of HIV antibody positive inmates and that the LSU should have been a program that was jointly run by them. Thus initially, CHS would only refer inmates who it thought should be in the unit. This problem was eventually overcome through liaison and negotiation with CHS.

Most of these initial problems relating to the referral of inmates resulted from policy/legislative requirements which restricted access to inmate's HIV positive results to CHS and (primarily) the Commissioner.

Representations for changes to these requirements resulted in the Manager of the Prison AIDS Project being added to the list of authorised officers who could (formally) request a copy of the list. This enabled the Manager to carry out independent follow-up recruitment and referral work if and when required. While waiting for this change to be adopted, the LSU had to rely on the HIV positive "inmate" network to pick up any inmates who had not been referred to, or advised about the unit, by CHS.

In addition, initial disagreements also occurred between CHS and LSU on the prioritising of inmates who should be at the LSU. CHS appeared to prefer to advocate for people who were difficult to be kept in the mainstream inmate population, whereas the mix and compatibility of inmates in the LSU were important to its successful operation. It has been suggested in some interviews that perhaps this resulted from different expectations of the services that the LSU was (or should have) been able to provide. Factors used in determining a balanced mix of inmates in the LSU were:

- their crime, sentence and classification;
- their history and attitudes - including injecting drug use history, and;

- their age, sexuality and health status.

Furthermore, there were three main groups each trying to influence the inmate mix in the Unit at the time. With each of these groups, their own perceptions on how the selection criteria should have been weighted - the LSU staff, the LSU inmates and the CHS, and each group was trying to see how much influence it could have over the inmate mix.

It is important to note however, to the credit of all those involved, that the initial problems between the CHS and LSU relating to the placement of inmates in the unit have been overcome, and the referral and assessment procedures now operate (for all practical intents) incident free.

OPERATION

When inmates are transferred to the LSU their case file is usually obtained from their previous correctional centre and then a separate file is created for them at the LSU. Only the case officer, case supervisor and governor have access to the LSU file. Relevant information only is placed on inmates "regular" case management file, for example, charges (behavioural), behaviour improvement, etc.

Confidentiality rights of inmates are maintained as high priority items in the unit's operation. Given the unique nature of the unit, there is much interest shown by other agencies, organisations and individuals to see how it operates. When these groups are invited to visit or tour the unit, inmates are consulted about the visits and always have the option to maintain their anonymity by staying in their (closed) cells.

The LSU and Prison AIDS Project (PAP) have an essential and close working relationship. At present PAP is the main link for LSU with outside agencies, and organises programs, visits, resource requirements and sessional specialists for the unit. In addition, PAP provides administrative support for the unit. The maintenance of a good working relationship between the two units is essential for optimum operation of the LSU program.

Conflicts between inmates are generally resolved by having a "community" meeting every morning to "clear the air" and raise issues, and usually every month there is a meeting with the Governor

of the SCC. Harmony in the unit has also been maintained through the establishment of an inmate committee. This forum is a place where inmates can discuss various aspects of the program and any issues or ideas they have relating to the program structure. The head of the committee is rotated to avoid power hierarchies developing.

Some initial problems were experienced in having to regularly explain to people that the Unit was a voluntary lifestyles program and was not an isolation or segregation unit for HIV positive inmates to spend their sentence.

The differing operational strategies for inmates in LSU and CSU cause a variety of problems, with a significant number of the CSU staff refusing to work in or with LSU unless security procedures were the same for both units. Thus, the LSU had to conform to the procedures designed for inmates considered at high risk of self harm. Often these procedures were/are more stringent than those used for maximum security inmates. For example, inmates are required to be individually supervised while shaving and once they have finished their razors are then confiscated by the supervising officer. Disagreement between CSU and LSU staff on the level and type of personal property allowed in LSU inmates cells also occurs.

When it first opened inmates in the LSU complained that the SCC/CSU staff that were required to supervise the LSU on the night shifts deliberately disrupted their sleep by making noise and shining torches into their cells. Additional concerns were raised by LSU officers that the night staff may have also be attempting to obtain access to LSU inmates confidential case files. It should be noted that most of these problems have now been satisfactorily resolved once clearly defined duties had been established for night shift staff.

EVALUATION OF THE LSU

Late during the first year of the LSU's operation, in 1993, following discussions by many of the people involved with the unit, it was decided it would be necessary to evaluate the units operation. Equal funding for the evaluation was applied for (and secured) from the Department's research budget and that of the Prison AIDS Project. A briefing for the project was developed and it was scheduled to be undertaken between July 1994 and June 1995. However, when the evaluation was due to commence a number of factors arose which suggested it would be wise to delay the project by eight months. The three main factors contributing to this delay were (i) the change in the program length from 12 weeks to 16 weeks; (ii) the recently raised proposal to incorporate inmates with acute Hepatitis C infection into the unit, and; (iii) the availability of a suitable researcher to undertake the evaluation. Hence the project was rescheduled and took place between March 1995 to January 1996.

AIMS OF THE EVALUATION

The aims of this evaluation were to carry out a comprehensive review of the LSU, and to specifically address the following questions:

1. What are the inmates getting out of the program? Looking at pre-release inmates and long-term inmates - are their needs different and if so, how can these differing needs be met?
2. What are the barriers to access to the program, if any, and how can they be overcome (i.e., perceptions held/fostered among inmates, "policy" problems, etc.)?
3. Is the program suitable for women and can their needs be adequately catered for in the LSU?
4. What affect, if any, does an inmates classification have upon inmates volunteering for the program (i.e., minimum security inmates' not prepared to give up privileges etc.)?

Also to be included in the study:

1. Review of key stakeholders - inmates, staff, CHS etc.
2. Brief history of the LSU.
3. Literature search and review.

4. Follow-up interviews with ex-residents, both those within and, where possible, those who have left the correctional system.
5. Identify the limitations imposed on the provision of a more flexible program structure.
6. To develop recommendations and options for the program.

It is hoped that the results of this evaluation will enable decisions to be made in relation to refinements and changes to the program for HIV positive inmates in the LSU; including how to make the program more attuned to the needs of both the inmates and staff involved.

STRATEGIES ADOPTED TO UNDERTAKE THE EVALUATION

A number of different strategies were devised in order to meet the aims set for the evaluation. Detailed below is an overview of these strategies:

Aim 1. What are the inmates getting out of the program? Looking at pre-release inmates and long-term inmates - are their needs different and if so, how can these differing needs be met?

Strategies:

- ask inmates who have been involved in the program, both in the past and present, and;
- review the program structure and content.

Aim 2. What are the barriers to access to the program, if any, and how can they be overcome (i.e., perceptions held/fostered among inmates, "policy" problems, etc.)?

Strategies:

- ask all key stakeholders, and;
- review operational framework and program.

Aim 3. Is the program suitable for women and can their needs be adequately catered for in the LSU?

Strategies:

- review program, and;
- review the operational and logistical considerations associated with women taking part in the program.

Aim 4. What effect, if any, does an inmate's

classification have upon inmates volunteering for the program (i.e., minimum security inmates not prepared to give up privileges etc.)?

Strategies:

- review operational requirements, and;
- ask key stakeholders and review responses.

Review of key stakeholders - inmates, staff, CHS, etc.

Strategies:

- conduct voluntary interviews with all inmates undertaking the program during the evaluation period;
- conduct a voluntary survey of all HIV positive inmates in the correctional system who were not enrolled in the LSU program (at a given point in time);
- attempt to contact and survey inmates who had participated in the LSU program but who had been released from the correctional system;
- conduct on-going informal discussions with the Manager Prison AIDS Project;
- conduct a voluntary survey of all past and present custodial staff who have worked in the unit;
- interview the first Officer in Charge of the Unit, and;
- conduct a voluntary survey of all past and present sessional specialists who took part in the program since the unit began operating.

Brief history of the LSU

Strategies:

- review all PAP files on the unit, and;
- review information obtained from the review of key stakeholders

Literature search and review

Strategies:

- conduct an international literature review (including Australia) of materials available on the management of HIV positive inmates;
- contact overseas countries/jurisdictions with information requests, and;
- review conference proceedings from the last two International AIDS conferences (Berlin and Yokohama) and request relevant papers.

Follow-up interviews with ex-residents, both those within and, where possible, those who have left the correctional system.

Strategies:

- review information obtained from interviews with inmates who had been in the unit before;
- attempt to trace and contact ex-LSU inmates who had left the corrections system, and;
- review survey returns of inmates, not currently in LSU, but who had been in the unit previously.

Identify the limitations imposed on the provision of a more flexible program structure.

Strategies:

- review the operational requirements of the unit and program, and;
- review comments provided by key stakeholders.

To develop recommendations and options for the program.

Strategies:

- integral part of the evaluation processes.

Thus, the review of the key stakeholders, the program, and the Unit's operation will address the key requirements of this evaluation, and as such form the basis of the rest of this report.

It should be noted that only one of the strategies devised was not undertaken, that being contact with ex-inmates who had attended the LSU. This was primarily due to logistical problems associated with undertaking this task.

In addition, while it was not expressly stated in the original brief developed for the evaluation, an important implied objective, being one of the reasons why the study was delayed, was to review the feelings of the key stakeholders on the proposed integration of inmates with acute Hepatitis C infection into the LSU. To meet this additional implied objective, specific questions were asked of all the key stakeholders contacted on their feelings towards this issue. These results are presented and discussed as they arise in the relevant sections of this report.

LSU INMATE INTERVIEW RESULTS

Inmates who were residents of the LSU during the course of its evaluation were interviewed in two rounds.

In the first round, eight inmates were interviewed individually at the LSU between 22 July and 31 July 1995. This accounted for all but one inmate who had been in the program. The inmate who was not interviewed did not want to participate in this evaluation.

In the second round, a further three inmates were individually interviewed on December 19 at the end of the next cycle of the program. Of the remaining five inmates in the unit at the time, two did not want to participate in the evaluation, and the other three had been interviewed in the earlier round.

Presented below is a review of the results obtained from these two rounds of interviews. A detailed summary of the results is contained in Appendix C.

REVIEW OF LSU INMATE INTERVIEW RESULTS

Interviews provided overwhelming evidence that a "strict" twelve/sixteen week stay at the LSU to complete the program has (in reality) not been adhered to, with extended lengths of stay and return visits to the unit commonplace.

Recommendation 3. A decision be made on the timeframe, if any, the unit and program is to operate under. At present the inconsistency in the length of time inmates are able to spend in the unit creates serious problems for the operation, consistency, quality and continuity of the program structure. (see pages - 18, 48, 50 and 52)

Inmates who have been in the LSU generally prefer to spend as much of their sentence as possible in the unit. Important factors cited for this were:

- learn a lot about being HIV positive;
- better environment;
- enables them to maintain their confidentiality (by not having to be in or return to the mainstream);
- reduced stress and anxiety, and;
- access to better and closer medical services.

Recommendation 4. Inmates have the option, with due consideration given to disciplinary, security, space and operational requirements, to remain in the LSU for their entire sentence if they so desire. (see pages - 19, 20, 25, 26 and 52)

The two main reasons inmates came to the LSU were to (i) have time out from the mainstream, and (ii) learn about HIV and how to look after themselves. However, four of the eleven inmates interviewed reported they: knew little about, had apprehension about, or weren't told much about the unit, before they came in, and so did not know what to expect.

Recommendation 5. All inmates, prior to entering the LSU program, be fully briefed about the unit so they are able to make an informed decision about participating in the program. (see pages - 20, 24, 25, 26, 30 and 39)

Most inmates' expectations of the unit were met or exceeded when they attended the unit, though at least one inmate responded that:

- they didn't think the unit would be so small;
- they thought there would be more programs and things to do, and;
- they had not been provided with as much (bio) medical knowledge on HIV as they had expected.

When asked what they were getting out of the program inmates provided a range of responses, with the majority being in favour of what the program offered them. A summary of the key positive and negative aspects of their responses is detailed below:

Positive

- how to live and accept having HIV and how to help others;
- a chance to sort themselves out, their lives and relationships;
- access to outside medical advice, information and services;
- skills on how to deal with conflict and stress;
- other skills, such as writing, pottery, arts and crafts, and;
- a chance to share the experience of being HIV positive with others who are HIV positive.

Negative

- nothing in terms of knowledge, the program

quality seems to have deteriorated and doesn't get reviewed and updated.

Recommendation 6. The program offered to inmates be regularly reviewed, updated and changed as required. (see pages - 26, 28, 39, 41, 48, 50 and 52)

The parts of the program which inmates listed as of most benefit to them were:

- visits/sessions conducted by external agencies, services, individuals and groups;
- conflict resolution, psychology and stress management group;
- arts/crafts, industry and creative writing sessions;
- access to clinic and medical facilities/staff;
- fitness/health (status) awareness and maintenance session, and;
- being in the unit - staff, inmates and sessional specialists.

The parts of the program inmates listed as being of little, or no benefit to them were:

- conflict resolution and psychology sessions (as individuals felt they had already completed the sessions on offer or had little or no need for them);
- some of the operational rules imposed by the proximity to the CSU;
- massage sessions.

Recommendation 7. Inmates be individually assessed for their need to participate in all aspects of the conflict resolution and psychology sessions run as part of the program.

Recommendation 3.

When asked what parts of the program they would change to make it more beneficial to their needs; most of the issues raised by them warranted consideration and so have been listed as recommendations below.

Recommendation 8. Increase the involvement and participation of outside agencies - such as ACON - in the program and sessions run. (see pages - 30, 48 and 52)

Recommendation 9. Consideration be given to structuring the program so there is a set of compulsory core sessions, with other sessions being optional once an inmate has attended at least one session to see what it has to offer them. Furthermore that the type and level of inmate participation in the program be clearly established. (see pages -26, 28, 30, 39, 48, 50 and 52)

Recommendation 10. Specific sessions are developed and run in the program on how to handle life outside of the correctional system (setting goals, budgeting, resources available, choosing doctors etc.) to assist inmates when they are released. (see pages - 50 and 52)

Recommendation 11. A greater proportion of the program be dedicated to how to manage and live with HIV, and maintaining/improving health and fitness. (see page - 52)

Recommendation 12. All attempts be made to provide inmates at the LSU full access to the services and programs offered by the Education Unit, along with any other programs and services, that are available to inmates held in the mainstream inmate population. (see pages - 37 and 39)

Recommendation 13. Consideration be given to the establishment of a session or program where inmates partners, friends or family can attend the unit to get some information on HIV and discuss issues with inmates and a group facilitator. (see page - 32)

Recommendation 14. An information and referral package be developed as an ongoing resource for (or by) the inmates to pass on to partners, friends or family who need advice, help or information on HIV and who to contact to get it. In addition, that this resource be offered, as a matter of course, to all HIV positive inmates in the correctional system.

Recommendation 15. A specific module or session/program be developed for inmates which addresses in a practical way how inmates can deal with issues and situations relating discussing HIV, and their status, that arise with their families, partners and friends.

Recommendation 16. Minimum standards and measures, relating to the quality and structure of the program and sessions offered be developed which include appropriate built-in quality assurance mechanisms in order to maintain a consistency and high quality program. (see pages - 30, 48, 50 and 52)

Recommendation 17. Where possible, flexibility be incorporated into the program to meet the individual interests and case management requirements of inmates. (see pages - 26, 28, 30, 39, 48, 50 and 52)

Additional services that were not available to inmates, but were available to them outside the correctional system which they felt would be of benefit included:

- a specialist HIV counsellor;
- access to all treatment options and drug trials, in particularly alternative and natural therapies, treatments and practices;
- individual assessment by a qualified nutritionalist experienced in HIV;
- an easily accessible independent mechanism or body they can lodge complaints with about the medical and other treatment they receive;
- access to the Positive Speakers Bureau, and;
- full access to all information sources and products that are available in the community.

Recommendation 18. Services or rights identified by inmates which are not currently utilised in the program, but which are available to them in the community, be considered for inclusion in the program. (see pages - 30, 50 and 52)

When asked what things they thought stopped people coming to the LSU (i.e., barriers to access). The most commonly cited reasons were:

- location of the unit in the SCC sharing the yard with the CSU, which leads to a lack of (and breach) in confidentiality;
- don't want other people to know they're HIV positive;
- don't want to give up their classification privileges;
- don't want to be separated or moved away from their friends and family;
- worried about having to re-integrate back into the mainstream once they've attended the unit (and having to explain their absence), and;
- worried that their movement to the LSU will result in other inmates, family, partners or friends being inadvertently told their HIV status

(where it is not known) when they inquire about their location/whereabouts. For example when calling to inquire about inmates.

Recommendation 4.

Recommendation 19. Procedures relating to how the LSU and it's inmates are identified to all persons should be reviewed; and new procedures be adopted which do not result in an inmates health status being implied or disclosed. (see pages - 20, 21, 24, 25, 26, 28, 29, 36, 37, 39, 41, 46, 48 and 52)

Recommendation 20. The LSU be provided with its own recreational/outdoor area which inmates do not have to share with the CSU. In order that (i) confidentiality is improved, (ii) unit is not forced to run under the requirements of a self harm maximum security centre. (see pages - 20, 21, 24, 25, 26, 28, 29, 36, 37, 39, 41, 46, 48 and 52)

Recommendation 21. Inmates who attend the LSU are entitled to, and have access to, all privileges due to them under their classification and their participation in the program or unit should not revoke any of these privileges. (see pages - 20, 28, 39 and 52)

The most common suggestions put forward by the inmates interviewed on how to make it easier for people to attend the LSU were:

- provide more information to inmates on how the unit operates, what is and isn't expected and include comments from inmates who have been through the program;
- separate the LSU from the CSU to improve confidentiality and allow a relaxation of security measures;
- have a bigger unit so inmates have the option to spend the rest of their sentence in the unit;
- give people the privileges associated with their classification if they come to the unit;
- lock-in hours should be the same as in the SCC - 9:30pm;
- unit needs to be slightly bigger with more inmates - say up to about sixteen, to provide greater choice and options of things to do;
- outdoor area/yard is too small, unit needs it's own yard;
- visits section has to be share with CSU, so there is no privacy, in addition it is maintained in line with maximum security self-harm protocols so no vending machines etc are permitted and it's very unfriendly and small;
- points system needs to be reviewed and open to

scrutiny and appeal.

Recommendation 22. In line with earlier recommendations, (should inmates be allowed to apply to spend the rest of their sentence in the LSU) the unit be expanded to a suitable size and layout to house up to sixteen inmates; thereby allowing a larger program to operate with a greater range of options and sessions available for inmates, and overcoming many of the problems caused by the current units layout and operation. (see pages - 25, 28, 36, 37, 41, 46 and 52)

Recommendation 23. An adequate and suitable visit area be established for HIV positive inmates so they are able to discuss personal issues with visitors in private, and consideration be given to the introduction of a special access scheme whereby inmate's visitors can apply to visit them on days other than official visiting days. (see pages - 37 and 46)

Recommendation 24. A critical review of the current points system used in the unit be conducted to ensure it is used and applied equitably and without discrimination/bias. (see page - 30)

Recommendations 4, 5, 20 & 21

On the integration of inmates with acute Hepatitis C Virus (HCV) infection into the unit the overwhelming majority of inmates felt this was not a good idea because:

- unit is only small and HIV positive inmates need to be given priority and easy access to the unit;
- HIV and HCV are different illnesses with different requirements, stigmas and agendas;
- it would cause further problems with maintaining confidentiality in the unit;
- alienate HIV positive inmates and could prevent many participating in the unit;
- HCV positive inmates need their own unit and program as it would need to cover a wide range of different health issues and requirements as well as different problems and operational/security issues;
- potential for increased exposure risk for both groups, and;
- if only acutely ill HCV positive inmates are allowed into the program, they could well be quite ill and so may not be able to fully contribute and participate in the program thereby disrupting its integrity and harmony.

Recommendation 25. Strongly recommended that, after giving due consideration to the information contained in this evaluation, that the proposal, and move, to integrate inmates with acute Hepatitis C infection into the LSU be discontinued. In addition, that serious consideration be given to the establishment of a separate unit and program in the SCC, which caters to the needs of the relatively large numbers of inmates with Hepatitis C infection in the NSW correctional system, and that this program is operated with the same philosophical ideology as that used in the LSU. (see pages - 30, 41 and 49)

The next question asked inmates about their experience with the Corrections Health Service (CHS) and was included to see if there were any logistical or discriminatory issues faced by inmates through being in the LSU with respect to the CHS. As this is an evaluation of the LSU and not the services of the CHS no discussion will be entered into here on the level and quality of service provided (or perceived to be provided) to inmates by the CHS. Suffice to say, no major logistical or discriminatory issues were experienced by inmates through being in the LSU with respect to the CHS.

Recommendation 26. A comprehensive review be undertaken on the type, level and quality of services and treatment that is provided to all HIV positive inmates in the NSW correctional system by the CHS in order to see if it meets the minimum standards set by the WHO guidelines [WHO, 1993]. (see pages - 28, 37 and 48)

The inmates interviewed had in the most part all experienced breaches of confidentiality by being in the LSU and some while within the mainstream inmate population. The main factors raised which contributed to this were:

- sharing yard/facilities with CSU and SCC;
- by being identified as being in the unit - primarily on transfer to/from unit and with respect to phone calls;
- open access of other staff and visitors to the unit, with the "lock-in" policy not really providing much option.

Recommendation 27. Procedures, policies and protocols relating to maintaining inmates HIV - or other medical - status confidential (including their operation in practice) be re-inforced in all correctional centres and at all levels to ensure inmates medical confidentiality is not breached in line with legislative requirements - Prison Regulations, Public Health Act, Anti-discrimination Act and WHO guidelines. (see pages - 24, 25 26, 29, 39 and 48)

Recommendation 28. Breaches of confidentiality by staff and inmates be treated as breaches of discipline and should be rigorously enforced, in addition the requirements for maintaining confidentiality (and the penalties for its subsequent breach) should be provided to all current and future staff and inmates. (see pages - 24, 25, 26, 29, 39 and 48)

Recommendations 19 and 20

Ten of the eleven inmates interviewed had been first diagnosed as being HIV positive in 1989 or earlier. One being only diagnosed in February 1995.

All but two of the inmates had spent more than ten months (in total) in the correctional system since they were first diagnosed.

Eight of the inmates had been in the correctional system on more than one instance since they had been diagnosed.

Ten of them had an relatively good idea of when and how they got HIV, with most not being confirmed seropositive until some months after their suspected time of getting HIV.

Three inmates mentioned sex as being the sole means of infection, while another three mentioned this was due to sharing fits. The other five inmates contributed their getting HIV to more than one risk activity - 3 involving sex and sharing fits, and 2 involving blood spills.

Recommendation 29. LSU program develop specific modules to address the issue of the high level of recidivism amongst HIV positive inmates (with a view to reducing these levels) in line with its objectives to provide skills for inmates to successfully integrate into the community upon their release. (see pages - 23 and 52)

MAINSTREAM INMATE SURVEY RESULTS

In addition to interviewing the inmates who attended the LSU during the period in which the evaluation was carried out. It was decided that obtaining information from other HIV positive inmates on their understanding and perceptions of the LSU was an important objective.

This, however, presented a great number of methodological and logistical problems, as in line with legislative requirements and departmental policy, the names and location of HIV positive inmates held in custody could not be disclosed in order to maintain confidentiality.

To overcome this hurdle, a strategy was developed to attempt to obtain the information required (anonymously) from those HIV positive inmates held in the mainstream inmate population. This strategy essentially involved three stages:

1. the development of a suitable, short, easily completed survey which contained no questions that could be used to identify individuals;
2. co-ordination with Corrections Health Service (CHS) to discreetly distribute the survey to inmates in the mainstream asking for their assistance, and;
3. a method of determining the success rate of the strategy.

Given the number of movements in the NSW correctional system (approximately 20,000 in 1994/95 [DCS 1994/95]), and the demands conducting this survey would place on CHS clinic staff, it was only practical to conduct the survey once during the evaluation - that is at one point in time.

Figures obtained from the CHS showed that on 12 March 95 there were twenty inmates who were known to be HIV positive in the NSW correctional system, with the number as at 31 December 95 being twenty two. In addition, between these two dates there were:

- nine HIV positive inmates who remained in custody;
- sixteen new admissions of HIV positive inmates;
- thirteen HIV positive inmates who were released and did not return;
- four HIV positive inmates who were released and returned, and;

- two HIV positive inmates who were released and returned twice.

These results give us an HIV prevalence rate amongst inmates in full time custody (as at 30 June 95) of 313.3 per 100, 000; which compares to a HIV prevalence rate in the NSW population (as at 30 June 95) of 203.6 per 100,000 current population and for Australia of 107.0 per 100,000 current population. [NCHECR 1995]

Recommendation 29.

Thus, allowing for the eight inmates located at the LSU, there were somewhere between ten to twenty inmates who were known to be HIV positive held in custody in the mainstream inmate population (at any point in time) who needed to be contacted.

In order to contact them the following methodology was developed:

- a short easily completed survey was designed for distribution;
- CHS was approached seeking their co-operation in the distribution of surveys - which was duly forthcoming;
- CHS was contacted to provide the names of the centres which held HIV positive inmates and the number held in each centre on a given date (16 November 95);
- a letter was sent to each clinic at these centres explaining the project and their role in the projects completion;
- clinic staff were asked to discreetly contact inmates and give them a letter explaining the survey and requesting their participation;
- inmates were to be allowed to complete the survey while at the clinic, and seal it in a self-addressed reply envelope provided, so it could be returned via the internal mail system, and;
- inmates were advised they could be paid fifteen dollars for their participation in the survey, but that this was optional as it would require them to provide their details in order for the payment to be made.

See Appendix C for copies of the letters and survey distributed.

Table N1. summarises the success rate achieved using the methodology previously outlined. It

should be noted that the nineteen inmates contacted in the survey were from eight different correctional centres, with all but two centres being represented in the replies.

Table N1. Survey participation and success rates.

Region Located In	Number Contacted	Number Participated	Participation Rate - %
Long Bay Correctional Complex	11*	6	54.5%
Women's Correctional Centres	2	1	50.0%
Centres Outside of LBCC	6	3	50.0%

Notes: there were nineteen known HIV positive inmates as at 16 November 95 in custody. *Six inmates held in remand, only two of which participated in the survey.

Therefore the method developed not only received a relatively good response rate but also ensured inmates confidentiality was able to be maintained. All but one of the respondents took up the fifteen dollar payment offer for their participation in the survey. The responses received were then entered into the SPSS/PC computer based statistical package and analysed using multiple response analysis.

The information obtained from this analysis, and the implications it holds (if any) on the LSU are outlined in the remainder of this section of the report. It should be noted that because the sample size was very small, (n=10), percentages have been excluded from the analysis.

All of the ten inmates participating in the survey knew about the LSU before being asked to complete the questionnaire, with:

- eight of them having heard about it through the clinic;
- one through friends;
- four through other inmates, and;
- one through the Inmate Peer Education Program.

Nine of the ten respondents were men, with the other being a woman. Eight of the men had attended the LSU program, while one man and the women had not attended.

When asked what their main concerns were (or are) about going into the unit the inmates provided the responses outlined in Table N2.

Table N2. Main concerns about going into the LSU.

Response	No.
Have/had none	3
Don't know what to expect	6
Loss of privileges	-
Full of gays	3
Full of junkies	1
Loss of confidentiality	3
Moved away from mates inside	2
Thought it was a segro unit	3
Have to move to Long Bay	-
It's maximum security	-
<i>Sharing with crisis</i>	1
<i>Problems with how gays and straights mixed</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

Thus, where inmates had concerns they were centred around (i) a lack of information about the unit; (ii) confidentiality, and (iii) having to move away from their friends to participate in the program.

Recommendations 5, 19, 20, 27 and 28

Inmates were then asked if they intended to apply to go to the LSU, half of them ticked "Yes at some stage", three ticked "No, not interested", with one ticking each of "Yes, before I'm due for release" and "No, don't want to go there again". These results show that most of the inmates surveyed had a high regard for the unit evidenced by their desire to return.

When asked what they thought the LSU provides for inmates, none of them said they didn't know; with the majority of them ticking all options provided - as can be seen in Table N3.

Table N3. What LSU provides inmates.

Response	No.
Don't know	-
Time-out from mainstream	6
Place to learn about HIV	8
Place to come to terms with being HIV+	6
Place to learn about services and treatments for HIV+ people	7
<i>Place to live a healthier lifestyle</i>	1
<i>HIV peer support & education</i>	2
- = No inmates ticked this response	

Thus we can conclude that the inmates believed the LSU offers them the benefits it was originally designed to provide. This is an excellent result for the program and the unit.

When asked what was stopping them going to the LSU the inmates provided the responses listed in Table N4.

The major issues raised by inmates which they felt were stopping them from entering the unit were related to (i) confidentiality; (ii) size and location, and (iii) uncertainty as to whether women were allowed into the unit. Two inmates, who were partners, noted they had been restricted from going into the unit at the same time by management, and did not want to have to go into the unit alone. Investigation into their responses reveal that they had in fact been barred from being in the unit together; and this was because of problems that had arisen when they had been in the unit together on previous occasions.

Recommendations 1, 5, 19, 20, 22, 27 and 28.

Inmates were asked to identify the things they thought stopped other HIV positive inmates going to the LSU and they provided the results shown in Table N5.

Table N5. Barriers that stop other HIV positive inmates going to the LSU.

Repines	No.
Don't know about it	4
Loss of privileges	1
Fear about confidentiality	5
Shares yard with Crisis Support Unit	2
Think it's full of gays	4
Wouldn't want to have to go back into the mainstream afterwards	3
Its location at Long Bay	2
Want to keep to themselves	1
It's run as maximum security	3
Moved away from mates inside	1
Serving a long sentence	-
Not interested	3
Limited access to IDS staff	1
Limited access to IDS programs	2
Attitudes of guys in the mainstream	3
<i>It's up to the individual</i>	1
<i>Some guys told it's too homophobic</i>	1
<i>No access to day leave, Tech etc</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

These results showed that the inmates thought the main things that stopped other inmates participating in the LSU related to:

1. a lack of information about the unit;
2. confidentiality;
3. having to return to the mainstream;
4. because they weren't interested, and;
5. the attitudes of guys in the mainstream to HIV and people with it.

Recommendation 30. The promotion of the LSU, and non-discriminatory attitudes towards HIV and those affected by it, to the mainstream inmate population be included (or continued) in all relevant inmate programs and services. Furthermore, other activities and programs (such as awareness raising days) are designed and implemented to further promote these issues. (see pages - 28, 30, 37 and 46)

Recommendations 4, 5, 19, 20, 27 and 28.

When inmates were asked what they thought could be done so more HIV positive inmates participated in the program they ticked the responses as shown in Table N6.

Table N6. Actions that could be taken so more HIV positive inmates participate in the LSU program.

Response	No.
Improve confidentiality	6
Stop sharing yard with Crisis Support Unit	4
Provide the privileges appropriate to an inmates classification	7
I don't know/No Idea	1
Provide more information	2
Allow them to visit	4
Improve access to IDS staff	1
Improve access to IDS programs	2
Run different programs	5
Allow guys to spend the rest of their time in the unit if they behave	4
<i>Have visits like mainstream (Fri - Mon)</i>	1
<i>Allow access to works release program etc without status going on paperwork/records</i>	1
<i>Show them the video</i>	1
<i>If it's a 16 week program it should be run strictly that way, not one rule for some and not for others</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

The most frequently chosen responses here related to:

1. a lack of information about the unit;
2. location/sharing with CSU;
3. confidentiality;
4. the program;
5. having to return to the mainstream, and;
6. loss of privileges.

Recommendation 31. Consideration be given to allow HIV positive inmates to visit the LSU (for example for one or two days), before they are admitted to the program so they can see what the unit is like. (see pages - 39 and 52)

Recommendations 4, 5, 6, 9, 17, 19,
20, 27, and 28

More than half the inmates ticked all the options provided when asked what they thought the program should cover, except for the option relating to legal matters. This is shown in Table N7.

Table N7. What LSU program should cover.

Response	No.
Living with HIV	8
Current treatments/research	10
Services available to PLWHA	5
Stress management	7
Conflict resolution	6
Telling others your status	5
Alternative therapies	7
Industries	6
Arts/Crafts/Writing	5
Fitness & health maintenance	9
Interpreting test results	9
Dealing with HIV inside	6
Self esteem & responsibility	6
Dealing & living with others	6
Legal matters eg wills	3
Cooking, diet & nutrition	6
Access to HIV specialist staff	8
<i>Teaching people how to deal with difficult situations - like someone asking for their blood</i>	2
<i>Facing/dealing with death, loss & grief</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

This list was compiled from the items that are to always be part of the LSU program. It was included to see if there were any particular areas that inmates felt did not need to be covered by the program, and as the results clearly show all items listed - except for legal matters - were considered important components of the LSU program and so should be retained.

Recommendation 32. All components developed for the LSU program be retained, in some form, to meet the needs of inmates, and ensure program integrity. (see pages - 27, 30, 48, 50 and 52)

Next inmates were asked to indicate which sessions conducted in the program were of benefit to them; they provided the responses shown in Table N8.

Table N8. Sessions in program that were of benefit.

Response	No.
None of it	-
HIV treatments	4
Discussion/Psych groups	4
Arts & Crafts	3
Fitness classes/Relaxation	6
ACON groups	3
Nutrition/Cooking	7
Just being in the unit	6
Industry	4
<i>Good staff</i>	1
<i>Learning something new each day</i>	1
<i>Better food/diet</i>	1
<i>Haven't been there</i>	2
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

These results show that many of the inmates felt that most of the sessions conducted in the program were of benefit to them. With the most popular sessions being the Fitness/Relaxation (Health Awareness) and the Cooking/Nutrition sessions

Recommendation 32.

Inmates were then asked to identify those things they thought were wrong with the way the LSU was set up. The results of this are shown in Table N9.

Table N9. What's wrong with the way LSU set up.

Response	No.
Never been there	2
Lack of independence/autonomy	2
Limited space	9
Shared yard/facilities with CSU	6
Access to IDS staff for inmates	2
Way the program operates	3
Staffing levels are inadequate	1
Run in line with maximum security/ self harm regulations	6
Program fails to maintain a consistent quality and standard	2
Unit has lost sight of its aims	5
Poor level of support and services provided by CHS to inmates	2
Still perceived as a segregation unit	3

Inadequate staff training	4
Officer interaction with inmates	3
<i>Officers told inmates past behaviour record and so some try and ride the inmate</i>	1
<i>Favouritism in placement</i>	1
<i>Too many clinic visits, could be once a week or as required, not daily</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

Those factors most commonly acknowledged by the inmates as being what was wrong with the way the LSU was set up related to:

1. size and location;
2. the program operation;
3. restriction on privileges;
4. perceptions of other inmates, and;
5. staff training.

Recommendation 33. All staff who work (or will work) in the unit are provided with appropriate and on-going training and briefing so they have sufficient knowledge and understanding of HIV and related issues. Furthermore, this training should not only cover the physiological and practical issues, but psychosocial/attitudinal issues as well. (see pages - 30, 34, 36 and 46)

Recommendations 2, 6, 9, 17, 20, 21, 22 & 30

In order to see whether inmates were experiencing any major problems with their health, care and treatment, they were asked to rate the medical services they had received. The results obtained from this are contained in Table N10.

Table N10. Rate service of Health Care Providers.

Provider	Very Good	Good	Poor	Not Seen
Clinic nurses	3	3	4	-
Clinic doctors	3	3	4	-
Visiting/outside doctors	1	3	1	5
Immunologist	9	1	-	-
Specialists	-	5	1	4
PHU Nurses	7	3	-	-
CHS Dentists	-	3	2	5
Visiting Dentist	-	4	1	5
- = No inmates ticked this response				

Note: All respondents provided answers for this question (n=10).

From this we can see that overall the majority of inmates rated all of the medical services they had been provided while in the correctional system as good or very good. When asked to indicate what was wrong with the medical services they had been provided they gave the answers contained in Table N11.

The primary complaints related to:

- quality of services compared to those in the community;
- access to treatments, especially alternative treatments and therapies;
- no provisions for them to order/request their own blood test, and;
- staff not adequately trained in the area of HIV.

Table N11. What's wrong with the Health Care you receive inside as someone who's HIV positive.

Response	No.
Nothing, it's pretty good	3
Staff don't care	2
Worse quality than on outside	3
Can't access treatments	5
Inadequate health monitoring	2
Can't order your own blood tests	3
Hard to see the doctor	2
Can't access drug trials	5
Not interested in/can't access alternative treatments and therapies	5
Staff not trained enough with respect to HIV and it's treatment	5
<i>Depends on the centre your in</i>	1
<i>Can't access vitamin co-op in mainstream</i>	1
<i>Inadequate pain control dispensed</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

Recommendation 26.

Inmates were asked about any breaches in their confidentiality while they were in the correctional system. They provided the responses outlined in Table N12.

Table N12. Has confidentiality been breached while inside.

Response	No.
No	-
Yes, by custodial officers	9
Yes, by clinic staff	2
Yes, by drug & alcohol worker	-
Yes, by other inmates	4
Yes, by psychology staff	-
<i>Yes, by way selected to see doctors</i>	1
<i>Yes, because the movement sheet shows you've been in the LSU so all staff know</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category".

These responses indicate the biggest problems experienced with confidentiality related to custodial officers and inmates.

Recommendations 19, 20, 27 & 28.

The next two questions of the survey were included to see if inmates had different experiences/understandings related to their level of openness about their HIV status (Table N13), and how long they had known they were HIV positive (Table N14).

Table N13. Open about HIV status while inside.

Response	No.
No, only clinic knows	2
Yes, with my friends only	4
Yes, everyone knows	4
<i>Everyone knows because of the breach of confidentiality I experienced</i>	1
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10). Italics represent responses received in "Other - please specify category"

Table N14. Length of time known HIV positive.

Response	No.
Less than one year	1
Between one and five years	7
More than five years	2
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10).

As can be seen from these result most inmates were excepting of other knowing about their HIV status while inside the correctional system with only two stating that only the clinic knew their status. As for the length of time they had known their HIV status, all but one had known they were HIV positive for at least one year. As these results were so heavily biased no analysis was undertaken on any differences that openness about HIV status and length of time they had known they were HIV positive may have had.

The final topic the inmates were asked about in the survey was about the integration of inmates with acute Hepatitis C infection. Their responses to whether they thought the proposal was a good or bad idea are presented in Table N15.

Table N15. Thought about the integration of inmates with acute HCV infection into the LSU.

Response	No.
Good Idea	5
Bad Idea	3
Don't know	2
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10).

The inmates feelings on whether they thought the integration of inmates with acute Hepatitis C infection into the LSU would work are presented in Table N16.

Table N16. Integration of inmates with acute HCV infection would work.

Integration of HCV+ inmates work	No.
Yes	3
No	3
Maybe	2
Don't k know	2
- = No inmates ticked this response	

Note: All respondents provided answers for this question (n=10).

Interestingly the ten inmates surveyed were split on their thoughts about the integration proposal, with half indicating they thought it was a good idea and the other half thinking either it was a bad idea, or they didn't know if it was a good or bad idea. Keeping this in mind, if we look at the responses they ticked when asked if they thought it would

work, only three inmates said yes, with the remainder saying no (3), maybe (2) or they didn't know (2). Therefore there would appear to be a level of uncertainty amongst the inmates surveyed about the proposal. When looking at the comments they provided when asked what problems (if any) they thought could arise, their attitudes to the proposal become clearer. These comments can be summarised by the following (figures in brackets indicating the number who provided a comment of the same intent).

- afraid of catching illnesses off HCV+ inmates (x2);
- not enough room in the current unit (x2);
- help both groups learn about their illnesses and deal with their health status (x2);
- unit should be run by non-custodial staff with custodial staff for security (x2);
- don't know/no idea (x2), and;
- increase the drug use and problems in the LSU and so they need to set up a separate unit.

These replies show the inmates (overall) were not in favour of proceeding with the proposal. Thus, in line with these results it would seem unwise to continue with this proposal.

Recommendation 25.

The last question inmates were asked was an open ended question to see if they had anything else they wanted to raise about the LSU (and how it's run) that hadn't already been covered. At least one of them provided one of the following additional comments (figures in brackets indicating the number who provided a comment of the same intent):

1. learnt a lot from the unit/program;
2. helped me come to terms with my status;
3. the services it offers inmates benefits them greatly;
4. should be recommended to all HIV positive inmates;
5. officers often treat inmates like kids;
6. HIV positive women aren't catered for in the correctional system;
7. need more professional/medical input into the way the program/unit is run (x2);
8. not all of the officers treat you properly because they're homophobic or afraid of getting HIV;
9. need more activities/industries as there was lots of time spent doing nothing;
10. allow other HIV positive inmates at the Long Bay Correctional Complex to participate in the

-
-
- program without having to be residents;
11. heterosexuals should not be discriminated against, and;
 12. food/diet in the mainstream not appropriate to the needs of HIV positive people and there is no alternative available, at least at the LSU we could prepare our own food/meals.

Recommendation 34. The feasibility of allowing other HIV positive inmates at the Long Bay Correctional Complex to participate in the program without having to be residents be fully investigated and implemented if at all feasible. (see page - 52)

Recommendation 35. All HIV positive inmates have access to food and meals that are suitable to their particular dietary and nutritional needs and requirements; and if possible they be given the option to prepare their own meals. (see page - 48)

Recommendations 5, 8, 9, 16, 17, 18,
24, 30, 32 & 33.

Thus overall, we can see the results obtained from the survey of HIV positive inmates in the mainstream inmate population added further weight to many of the recommendations previously made, and resulted in the making of additional recommendations where new issues were raised.

CUSTODIAL STAFF SURVEY RESULTS

As part of the review of the key stakeholders required for this evaluation an easily completed voluntary survey was designed in order to obtain information from the staff that had been involved with the unit on their experiences and feelings - see Appendix D.

A list of all staff that had worked at the LSU, or the Crisis Support Unit (CSU) since the LSU had been in operation, was compiled from the duty roster held in the Special Care Centre (SCC). Seventy eight officers were on this initial list and a check was then made to see if they were still working in the Department and if so, where they were currently located. This check revealed that eleven officers had left the Department and so were unable to be surveyed. The remaining sixty seven officers on the list were all sent a survey pack.

As an incentive to return surveys three strategies were adopted. The first was the inclusion of a fully addressed envelope for them to return their survey via the internal mail system (no postage required). The second was an offer to enter them into a raffle draw for one hundred dollars if they completed their survey and returned it by the deadline. The third incentive was linked to the survey design itself and consisted of making the survey as short and easy to complete as possible. Therefore careful consideration went into the design, layout and content of the survey questionnaire. Most questions were answered by respondents ticking the appropriate box or boxes, and most of these included an "other - please specify" option for them to provide responses other than those provided. It was only the last page of the survey which contained more general open ended questions where they had the option to write their responses.

Thus, each survey pack contained (i) letter of introduction explaining the study and requesting their involvement, (ii) survey questionnaire, (iii) a slip for them to complete to be entered into an incentive raffle for their participation, (iv) a slip for them to complete to be added to the mailing list to receive a copy of this evaluation report (once completed), and (v) an addressed envelope to return their completed survey.

Of the sixty seven survey packs distributed, three were returned to sender and one addressee telephoned to say they would not be participating in the survey as they did not consider themselves appropriate (nor had they wanted) to work - at any time - in the LSU. This left sixty three possible respondents to the survey. Twenty nine of these possible respondents chose to

participate in the study which gives the custodial staff survey a relatively good overall response rate of 46.0%. It should be noted here that the incentive payment did not turn out to be the sole reason for respondents participation as only twenty four (82.8%) of them returned their survey within the two weeks grace period allowed for after the deadline. The remaining five (17.2%) returned their surveys after this period, with most noting their ineligibility for the raffle, but saying they still wanted to contribute to the study.

Of the sixty three possible respondents to the survey 21 of them (33.3%) no longer worked in the SCC, however they accounted for 14 of the 29 responses received (48.3%) - giving a response rate of 66.7% (14/21). The forty two staff who worked at the SCC made up the balance of these results, that is 66.6% of possible respondents (42/63) and 51.7% of actual responses (15/29) - giving a response rate of 35.7% (15/42). No analysis was conducted as part of this evaluation as to why these different response rates were obtained; so any reasons would be only be speculative and so have not been outlined. Furthermore, it is possible that these differences have no significance on the results obtained. However, when reading the information presented below, it would be prudent to keep in mind the different response rates obtained from these two groups.

The results from all of the surveys returned were then entered into the SPSS/PC computer based statistical package for multiple response analysis.

For all the responses outlined in this section of the report, unless otherwise indicated, the sample size is twenty nine (n=29) - the number of officers replying to the survey. In addition, most responses have been broken down according to three categories relating to the respondents identified working role in the unit. That is, if they worked as (i) Permanent staff - **Per.** (ii) On rotation within the SCC - **Rot.**, or (iii) Casual/Relief Staff only - **Cas.** It was felt these were the most appropriate breakdowns to use as they provide different perspective's on the unit relating to the level of involvement in the unit by staff.

Responses are reported by identifying where forty percent or more of the members of each of the three categories (who responded to the question), replied or ticked a response (or responses).

Table C1. Currently working at the LSU.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Yes	3	-	-
No	8	3	6
Sometimes	1	4	4
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29).

Table C1 shows us the number of staff who responded to the survey from each group and their current work status at the LSU.

From these results we can see most of the people who participated in the survey no longer, or only sometimes, work in the unit. This was to be expected given the low staff operating requirements of the unit. In addition, Table C2 shows the responses received to the question asking them the number of separate times they had worked at the unit.

Rather predictably, the answers with the greatest responses were:

- more than four times - for the permanent staff;
- casual/relief - for the casual staff, and;
- on rotation within the SCC - for the rotation

Table C2. Number of separate times worked at the LSU for more than one month.

Response n = 28 →	Per. 11	Rot. 7	Cas. 10
Three times		-	-
More than four times	✓	-	-
Casual / Relief	-	-	✓
On Rotation within SCC	-	✓	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Per. staff member did not complete this section (n=28). Only answers which received responses listed.

staff.

Also predictable were the responses received when they were asked in what capacity they had worked at the LSU, being:

- Permanent Staff - 12 (41.4%)
- On Rotation within SCC - 7 (24.1%)
- Casual Relief - 10 (34.5%)

The results provided to the question asking how much time (in total) they had worked in the LSU are presented in Table C3.

Table C3. Length of time (in total) worked at LSU.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
More than 1 year	✓	-	-
6 months to 1 year		-	-
3 months to 6 months			-
Less than 3 months ago			
Only a few times	-	✓	✓
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

Again these responses are consistent with what would be expected given the overall number and type of officers from each group responding to the survey. As are those provided when they were asked when they last worked at the LSU - Table C4.

Table C4. When Last worked at the LSU.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
More than 18 months ago	✓		
More than 1 year ago			
More than 6 months ago	-	-	
More than 3 months ago	-	✓	
Less than 3 months ago			✓
Currently working there		-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

What these results do tell us is that there was a good all round representation of the staff (and the different roles they played in the unit's operation), who participated in the survey. Thus providing feedback from all groups of staff members associated with the unit over the period of its' operation.

When asked how they got to work at the LSU the staff provided responses listed in Table C5.

Table C5. How got to work at the LSU.

Response n = 28 →	Per. 11	Rot. 7	Cas. 10
Volunteered	✓		
On rotation in SCC	-	✓	✓
Asked to		-	
Rostered	-	-	
<i>Volunteered/On rotation SCC</i>	-		-
<i>Relief</i>		-	-
<i>Applied</i>		-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

Table C6. Training Received Prior to working at the LSU.

Response n = 27 →	Per. 11	Rot. 6	Cas. 10
None		-	✓
Universal Infection Control	✓		
Biomedical Aspects of HIV			
Transmission of HIV	✓	✓	✓
Physiological Impact of HIV			
Working with HIV	✓		
Psycho/Social aspect of HIV	✓	-	-
Confidentiality Issues	✓		
Stress Management	✓		
Rehabilitation Strategies		-	
Sexuality Issues			
Injecting Drug Use Issues			
Grief & Bereavement		-	
<i>AIDS Training Program</i>	-	-	
<i>CSA - Primary Training</i>	-		
<i>LSU - Primary Training</i>		-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Perm. & 1 Rot. staff member did not complete this section (n=27). Italics represent responses received in "Other - please specify category"

In line with the staff recruitment practices that have been adopted for the unit the majority of permanent staff volunteered to work in the unit. While most of the rotation and casual staff worked at the unit through their employment at the SCC. Generally these people would either express an interest in working at the LSU, or be approached by the OIC

of the LSU to see if they were interested in undertaking some work in the unit.

A key issue to be canvassed with staff was what things they had been trained or briefed on prior to working in the LSU. Table C6 presents the results obtained from staff in relation to the training they received.

From these results we can see the only item that more than forty percent of the staff in each category was trained on prior to working in the LSU was the transmission of HIV. With the permanent staff indicating they had received greater overall levels of training than the staff members in the other two groups. The training they received however could only be described as adequate, as it covered only about half the items listed. In general the rotation staff received very little training prior to commencing duties in the unit, notable in their responses is that none of them indicated they had received training in the psych/social aspects of HIV, rehabilitation strategies, or grief and bereavement. Furthermore, less than forty percent of them received training on any of the other items listed (apart from transmission of HIV), a poor result. The level of training received by the casual staff prior to working in the LSU almost mirrored that of the rotation staff. The significant results in their responses being (i) over forty percent of them indicated they had not received any training at all, (ii) none of them had been trained on the psycho/social aspects of HIV, and (iii) less than forty percent of them received training on any of the items listed (apart from transmission of HIV). Again this is a poor result.

Recommendations 2 & 33.

The replies received from staff when they were asked about the items they had been briefed on prior to working in the LSU are outlined in Table C7.

Table C7. Briefing Received Prior to working at the LSU.

Response n = 22 →	Per. 9	Rot. 4	Cas. 9
None		-	✓
Universal Infection Control		-	
Biomedical Aspects of HIV			
Transmission of HIV			-
Physiological Impact of HIV	✓		
Working with HIV			
Psycho/Social aspect of HIV		✓	
Confidentiality Issues	✓	✓	
Stress Management			
Rehabilitation Strategies		✓	
Sexuality Issues	✓	✓	
Injecting Drug Use Issues	✓	✓	
Grief & Bereavement			
<i>Case Management</i>		-	-
<i>Security Duties</i>		-	-

✓ = 40% or more in group ticked this response
 - = No one in group ticked this response

Note: 3 Perm., 3 Rot. & 1 Cas. staff members did not complete this section (n=22). Italics represent responses received in "Other - please specify category"

These results are only marginally better than those received from the officers relating to the training they had received. What they show is that the briefing permanent staff received filled in some of the gaps (items) that had not been covered in their training, with forty percent or more of them indicating they received briefing on three of the six items not covered by their training. The rotation staff also appear to have been briefed on many of the items that they received no training on, with at least forty percent of them receiving briefing on five of the twelve items listed (only one of which they had been trained on). It is important to note from these results that none of the rotation staff indicated they had been briefed on Universal Infection Control procedures (with less than forty percent having received training in this area) indicating a serious omission in the education the rotation staff should have received prior to working in the unit. In addition less than forty percent of the casual staff were briefed on any of the twelve items listed; except that they had no briefings. So the only item at least forty percent of them appear to have received training on was the transmission of HIV. This is an inexcusable result, and not only indicates a gap in management practices but indicates a serious breach of Occupational Health and Safety requirements.

Recommendation 2 and 33.

The conclusions in relation to the training and briefing of staff are further supported when the results obtained from staff regarding the type of training they should received (a) prior to working in the LSU, and (b) as on-going training; which are presented in Table's C8 and C9.

Table C8. Training staff should receive prior to working at the LSU.

Response n = 26 →	Per. 11	Rot. 5	Cas. 10
No Extra Training Required	-	-	-
Universal Infection Control	✓	✓	✓
Biomedical Aspects of HIV	✓	✓	✓
Transmission of HIV	✓	✓	✓
Physiological Impact of HIV	✓	✓	✓
Working with HIV	✓	✓	✓
Psycho/Social aspects of HIV	✓	✓	✓
Confidentiality Issues	✓	✓	✓
Stress Management	✓	✓	✓
Rehabilitation Strategies	✓	✓	
Sexuality Issues	✓	✓	✓
Injecting Drug Use Issues	✓	✓	✓
Grief and Bereavement	✓	✓	✓
<i>Hepatitis B, C & BBCD's</i>	-		-
<i>Different Management Tech's</i>	-	-	
<i>Case Management</i>		-	-

✓ = 40% or more in group ticked this response
 - = No one in group ticked this response

Note: 1 Perm. & 2 Rot. staff members did not complete this section (n=26). Italics represent responses received in "Other - please specify category"

More than forty percent of staff in each group indicating that staff should receive prior training on all of the items listed. The rotation staff did not see training on rehabilitation issues as being so important to them.

The results received in relation to the on-going training staff should receive while working at the LSU, again almost mirror those they supplied when asked about the prior training they should have received. More than forty percent of respondents in each of the three groups ticked all of the items listed - the notable exception here being the rotation staff who felt that on-going training on sexuality issues was not so important for them (though they did think they should receive training on this issue).

Recommendations 2 & 33.

When asked to indicate the main concerns they had prior to working in the unit the custodial staff responding to the survey provided the responses listed in Table C10.

Table C10. Main concerns staff had prior to working at the LSU.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Had none	✓	✓	✓
Fear/personal safety	-		
Apprehension	-		
Little training on HIV		-	
Low knowledge of HIV	-	-	
Restricted my career options	-	-	-
Increased stress		-	-
<i>Loved it!</i>	-		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

As the results show, more than forty percent of each category of staff indicated they had no concerns prior to working in the unit. The only concerns receiving a mention from the permanent staff being they had little training on HIV and were worried about increased stress. For the rotation staff, some of them indicated they had apprehension and fear relating to their personal safety prior to working in the unit.

Some of the casual staff were concerned with the first four items listed.

Table C11. Concerns staff had now having worked at the LSU.

Response n = 28 →	Per. 12	Rot. 6	Cas. 10
None	✓	✓	✓
Fear/personal safety	-		-
Little training on HIV		-	
Low knowledge of HIV		-	
Restricted my career options	-	-	
Increased stress		-	-
<i>Entry of HCV+ Inmates</i>		-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Rot. staff member did not complete this section (n=28). Italics represent responses received in "Other - please specify category"

Staff were then asked what their concerns were now that they had worked in the unit, and their responses are outlined in Table C11.

As can be seen from these results, after having worked at the LSU, more than forty percent of the staff from all groups said they had no concerns about working there. In addition none of the permanent or casual staff ticked they had fear or concerns over their personal safety, with only a few of the rotation staff still expressing this concern (the only concern any of them expressed they still had). None of the permanent staff felt working in the unit would restrict their career options, but a few of them the casual staff still had concerns relating to the little ticked each of the other items listed. Some of amount of training they had received, and their low level of knowledge, on HIV; and that working in the unit may restrict their career options.

Recommendations 2 & 33.

Table C12. Adequately prepared/trained to work at the LSU.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Yes	✓	✓	✓
No			
<i>Yes, but further training never goes astray</i>	-	-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

The responses to the question asking staff if they felt they had been adequately/trained to work at the LSU are presented in Table C12.

Interestingly at least forty percent of staff in each group answered yes to this question. These responses would seem to suggest they perceived a difference between being adequately prepared/trained and being appropriately prepared/trained. All staff indicated they should have been trained or briefed on a number of significant issues relating to HIV in earlier questions both, prior to working at the LSU, and on an on-going basis.

Table C13. What's wrong with how the LSU is set up and operates.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Lack of autonomy	✓		-
Limited space	✓	✓	✓
Shared yard/facilities with CSU	✓	✓	✓
Access to IDS staff for inmates	✓		
Way the program operates			-
Staffing levels are inadequate		-	-
Run in line with maximum security/self harm regs/protocols			
Not enough briefing, update & info sessions run for staff	✓	✓	✓
Insufficient consultation with staff regarding operational strategies.	✓		
Poor working r/ship with CSU staff & management	✓		-
Difficult to instigate change			-
Being located in the SCC		-	
Inmates program. fails to maintain consistent quality & standard			
Unit lost sight of its aims		-	-
Poor level of support & services provided by CHS to inmates	✓		-
Inadequate support to help staff manage the stress. etc			-
Still perceived as a segro unit	✓		-
Inadequate staff training			
<i>Having to accept inmates who've done the program</i>		-	
<i>Made some inmates feel special</i>	-		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

The next question asked staff to indicate what they thought was wrong with the way the LSU is set up and operates. Their responses are listed in Table C13.

At least forty percent of staff in all three groups indicated what was wrong with the way the unit was set up related to (i) limited space; (ii) shared yard/facilities with the CSU, and; (iii) not enough

briefing, update and information sessions run for staff.

Recommendations 2, 20, 22 & 33.

More than forty percent of permanent staff also indicated they thought the following items were what was wrong with the way the LSU was set up and operates:

- lack of autonomy;
- access to IDS for inmates;
- insufficient consultation with staff regarding operational strategies;
- poor working relationship with CSU staff and management;
- poor level of support and services provided by CHS to inmates, and;
- still perceived as a segregation unit.

For the remainder of the items listed at least one member from the permanent staff group thought they contributed to what was wrong with how the LSU was set up and operates.

No other items, other than the three mentioned previously, were ticked by more than forty percent of the rotation staff. With none of them thinking there were problems related to:

- staffing levels;
- being located at SCC, and;
- unit having lost sight of its aims.

However, a few of them did tick the other items listed.

Similarly, for the casual staff, no other items (other than the three mentioned previously), were checked by more than forty percent of staff. With only a few of them thinking there were problems related to the following items:

- access to IDS staff for inmates;
- run in line with maximum security/self-harm regulations;
- insufficient consultation with staff;
- being located in SCC;
- program quality and standard, and;
- inadequate staff training.

Therefore, not surprisingly, the number of issues raised as causing problems with the operation of the LSU, was related to the level of involvement staff had with the unit. With the greatest number of problems identified by the permanent staff, followed by the rotation staff and then the casual

staff. While all group's comments are important, the observations of the permanent staff should be given the most weight as they had the highest involvement in the unit and it's operation.

Recommendation 36. Where possible, staff are consulted on a regular basis (for example, every one or two months, or as required) on the operational procedures and strategies used at the LSU. (see page - 41)

Recommendation 37. For as long as the LSU shares facilities and staff with the CSU every effort should be made to enhance and maintain a good working relationship between the staff and management of the two units. Including where necessary staff meetings, workshops or forums to discuss and resolve any disputes or problems that arise or exist.

Recommendations 2, 12, 20, 22, 23, 26 & 30.

Staff were then asked what proportion of the program they took part in, and the results are presented in Table C14.

Table C14. Proportion of program took part in.

Response n = 28 →	Per. 12	Rot. 6	Cas. 10
None of it	-		✓
Less than 35%	-	✓	✓
Between 35% & 70%	✓		
More than 70%	✓	-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Rot. staff member did not complete this section (n=28).

Again these results are in line with what would be expected given the combination of staff members responding to the survey. Permanent staff participated the most in the program with all of them participating in at least thirty five percent of it. The rotation staff participated less, with at least some of them participating in up to seventy percent of the program, and none of them not participating in any of the program. Finally, for the casual staff, at least forty percent of them did not participate in the program, and none of them participated in more than seventy percent of the program.

When staff were asked why they didn't participate more, at least forty percent of them in each group

indicated this was because they felt that was not enough time to do so. These results are presented in Table C15.

Table C15. Why didn't participate more in Program.

Response n = 27 →	Per. 10	Rot. 7	Cas. 10
Not enough time	✓	✓	✓
Not appropriate			-
Not relevant			-
Not interested	-	-	-
Not on duty			
Asked not to		-	-
Didn't feel I could join in			
<i>Regarding an OHS matter</i>	-	-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response			
Note: 2 Per. staff members did not complete this section (n=27). Italics represent responses received in "Other - please specify category"			

None of the respondents marked that they did not participate more in the program because they were not interested. Only a few of the permanent staff indicated they didn't join in because they had been asked not to, while no one in the other groups ticked this item. Some of the staff from each group also noted they didn't join in because they didn't feel they could join in. With the remainder of the responses spread fairly evenly over the table.

Recommendation 38. The role, type and level of participation of staff in the LSU program be determined, and appropriate guidelines be established which outline this involvement. (see pages - 41, 48 and 52)

Table C16 shows us the majority of the permanent staff felt they benefited from all parts of the program, the low responses for the other two groups are in line with the level of participation they had in the program. With at least forty percent of the rotation staff benefiting from the following groups:

- psychology;
- arts and crafts, and;
- nutrition/cooking.

While only some of the casual staff indicated they benefited from the sessions they had participated in.

Table C16. Parts of program benefited from.

Response n = 27 →	Per. 12	Rot. 7	Cas. 8
I didn't participate	-		
HIV treatments	✓		
Psychology groups	✓	✓	
Arts & Crafts	✓	✓	
Fitness classes	✓		
ACON groups	✓	-	-
Nutrition/Cooking	✓	✓	
<i>Relaxation/Stress M'ment</i>		-	-
<i>Role Play</i>		-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 2 Cas. staff members did not complete this section (n=27). Italics represent responses received in "Other - please specify category"

The responses received from the previous questions are further reinforced when we look at whether the officers would have liked to participate more in the program (Table C17). For this question at least forty percent of the staff responding from each group said yes, in addition none of the staff in any group said no because they didn't feel it was appropriate that they participate in the program.

Table C17. Would have liked to participate more in the program.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Yes	✓	✓	✓
No			
Don't feel it is appropriate that officers participate	-	-	-
Officers are not encouraged or welcome to participate			-
No & Not appropriate officers participate.		-	-
Yes & Officers not encouraged to participate.		-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

The next part of the survey asked the officers what they thought stopped inmates coming to the LSU - see Table C18.

Table C18. What stops inmates coming to the LSU.

Response n = 28 →	Per. 12	Rot. 7	Cas. 9
Loss of privileges		-	
Fear about confidentiality	✓		✓
It's location at Long Bay	✓		
Want to keep to themselves		✓	✓
Don't know about it			
Have misconceptions about it	✓		✓
Serving a long sentence	-		
Not interested	✓	✓	
Limited access to IDS staff		-	
Limited access to IDS programs			
<i>Small size</i>	-	✓	-
<i>Limited access to resources</i>	-		
<i>Homophobia</i>	-		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Cas. staff member did not complete this section (n=28). Italics represent responses received in "Other - please specify category"

These results show the officers raised many of the same issues as the inmates had when asked to nominate the things they felt stopped inmates from participating in the LSU. The main things they raised included:

- a lack of information about the unit;
- confidentiality;
- units location, and;
- because they (inmates) weren't interested in the unit and wanted to keep to themselves.

Recommendations 5, 19, 20, 27 & 28

When asked what they thought could be done to get more inmates to participate the officers provided the responses contained in Table C19.

These results are again very similar to those provide by the inmates, with the main suggestions selected that would improve the participation rate being:

- provide more information about the unit;
- stop sharing with CSU;
- improve confidentiality;
- run different programs;
- improved access to IDS staff;
- allow them to visit, and;
- provide privileges appropriate to inmates classification.

Recommendations 5, 6, 9, 12, 17, 19, 20, 21 & 31.

The next section of the survey asked staff about support services and facilities available for staff working at the LSU. The first question asked if they had ever used any of these services, and the responses received are detailed in Table C20.

Table C20. Ever used support services for staff.

Response n = 28 →	Per. 11	Rot. 7	Cas. 10
There aren't any	✓		-
No	✓	✓	✓
<i>Yes - psychologist</i>	-	-	
<i>Yes - PAP staff</i>		-	-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Per. staff member did not complete this section (n=28). Italics represent responses received in "Other - please specify category"

Virtually all of the staff surveyed indicated (i) they had not used any of the support services or facilities, or (ii) there weren't any available to them. This result is supported by the results obtained from the next question asked relating to how helpful they had found the support services - see Table C21.

Table C21. How helpful were staff support services.

Response n = 27 →	Per. 11	Rot. 7	Cas. 9
There aren't any	✓	-	-
Haven't used any	✓	✓	✓
Very helpful	-	-	
No help	-	-	-
<i>Some help</i>		-	-

Table C19. What can do to get more inmates to participate.

Response n = 28 →	Per. 12	Rot. 6	Cas. 10
Stop sharing with CSU	✓	✓	✓
Improve confidentiality	✓	-	✓
Privileges appropriate to classo	✓	✓	
Provide more information	✓		✓
Allow them to visit	✓		✓
Improve access to IDS staff	✓	-	
Improve access to IDS programs		-	
Run different programs			
<i>Improve CHS services</i>	-		-
<i>Have bigger unit</i>	-		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 1 Rot. staff member did not complete this section (n=28). Italics represent responses received in "Other - please specify category"

✓ = 40% or more in group ticked this response
- = No one in group ticked this response

Note: 1 Per. & 1 Cas. staff member did not complete this section (n=28). Italics represent responses received in "Other - please specify category"

Again most noted they had either not used, or that there weren't any staff services available. It should be noted that a couple of the casual staff had spoken to the staff psychologist(s) and found them to be very helpful. However for the most part staff were either unaware, reluctant to use or felt no need to use any of the staff support services and facilities available to them.

The last question in this part of the survey asked the staff what type of support services or facilities they thought should be available. Their responses are contained in Table C22.

Table C22. Staff support services that should be available for staff.

Response n = 26 →	Per. 10	Rot. 7	Cas. 9
Don't need any	-	-	-
Counsellor	✓		
Extra training	✓	✓	✓
<i>Debriefing from time to time</i>	-		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: 2 Per. & 1 Cas. staff members did not complete this section (n=26). Italics represent responses received in "Other - please specify category"

The main support practically all staff thought should be available to them was extra training, with a significant number of them also stating they felt access to a counsellor should be available to them. Furthermore, no staff in any of the groups thought they didn't need any support services, and a couple of the rotation staff felt a debriefing from time to time would be useful for them.

The final issue officers were asked to comment on in the survey related to what they thought about the integration of inmates with acute Hepatitis C infection into the LSU, and whether they thought this would work. Their responses are provided in Table's C23 and C24.

Table C23. Thought about integration of inmates with acute HCV infection.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Good Idea			✓
Bad Idea	✓	✓	✓
Don't Know			
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

Table C24. Would integration of inmates with acute HCV infection work.

Response n = 29 →	Per. 12	Rot. 7	Cas. 10
Yes			✓
No	✓	✓	✓
Maybe			
Don't Know			-
✓ = 40% or more in group ticked this response - = No one in group ticked this response			

Note: All respondents provided answers for this question (n=29). Italics represent responses received in "Other - please specify category"

Overall the results reveal that at least forty percent of the staff surveyed in each group felt the proposal was (i) a bad idea, and (ii) wouldn't work. Another significant result was that at least forty percent of casual staff thought it was a good idea and would work, making the casual staff fairly evenly divided on the proposal. Practically all the permanent and rotation staff thought it was a bad idea or didn't know; and thought either it wouldn't work, it may work or they didn't know. Therefore we can conclude there is little support for the proposal to integrate inmates with acute Hepatitis C infection into the LSU. This result is further reinforced when we look at the answers provided, by when they were asked to comment on any problems they thought would arise or this would probably cause. The most commonly raised issues and comments can be summarised by the following (figures in brackets indicating the number who provided a comment of the same intent):

- cause problems with confidentiality (x3);
- the number of inmates HCV positive inmates in the correctional system (x5);
- facilities not large enough to accommodate them (x4);
- increased risk of cross infection between the two groups (x8);
- program not set up or suitable for it (x6);
- greater demands on staff and training (x5);
- unit could be overrun/taken over by HCV positive inmates (x6), and;
- the groups have different needs and agendas.

Given these results it would seem unwise to continue with this proposal as part of the current LSU program.

Recommendation 25.

For the last question staff were asked an open ended question to see if they had anything else they wanted to raise about the LSU (and how it's run) that hadn't already been covered. At least two of them provided one of the following additional comments:

- great concept, unit, idea;
- officers should be encouraged to participate more;
- enjoyed working at the LSU;
- unit/program encourages a good inmate/staff relationship and interaction;
- there needs to be better guidelines relating to the management of dangerous/problem inmates;
- unit appears to be a good start towards achieving proper rehabilitation;
- unit is currently only really a time-out place that is not meeting its objectives, and;
- unit needs more space/own yard.

Recommendation 39. The guidelines relating to the management of dangerous or problem inmates be clearly defined and/or enforced. Furthermore that the unit is not used as a dumping ground for inmates with HIV (or any other illness) that no-one else wants in their centre/unit/area because they are difficult (or perceived to be difficult) to manage. (see page - 52)

Recommendations 6, 20, 22, 36, 38.

Therefore, we can conclude that surveying the officers who had worked in the unit was a valuable exercise in meeting the objectives set for the evaluation of the LSU. Not only did it provide information to support many of the previously made recommendations, but it also resulted in the raising of a number of important issues which resulted in further recommendations being made.

SESSIONAL SPECIALIST SURVEY RESULTS

In order to obtain information on the experiences, and perceptions of the sessional specialists who ran sessions in the LSU program, an easily completed voluntary survey was designed and distributed - see Appendix D. This process enabled the review of their feedback as a group of key stakeholders in the unit as required by the evaluation brief.

An initial list of sessional specialists that had worked at the LSU was compiled from the (often incomplete) unit's operational files that are held in the Prison AIDS Project. This search resulted in forty seven people being identified as having, at some stage or another, run at least one session at the LSU since it opened in November 1992. Contact tracing and investigation uncovered a forwarding address for all but one of these people. While five of them, who had run the massage sessions, had to be contacted c/- their employer. A total of forty six survey packs were distributed.

As an incentive to return surveys the same three strategies were adopted as were used for the custodial officer survey. That is, (a) the inclusion of fully addressed envelope for them to return their survey in via the internal mail system (no postage required); (b) offering to enter them into a raffle draw for fifty dollars if they completed their survey and returned it by the deadline, and; (c) making the survey as short and easy to complete as possible. Once again careful consideration went into the design, layout and content of the survey questionnaire. Most questions were answered by respondents ticking the appropriate box or boxes, and most of these included an "other - please specify" option for them to provide responses other than those provided. The last two pages of the survey contained more general open ended questions where they had the option to write their responses.

Thus, each survey pack contained (i) letter of introduction explaining the study and requesting their involvement, (ii) survey questionnaire, (iii) a slip for them to complete to be entered into an incentive raffle for their participation, (iv) a slip for them to complete to be added to the mailing list to receive a copy of this evaluation report (once completed), and (v) a stamped pre-addressed envelope to return their completed survey.

Of the forty six survey packs distributed, one was returned to sender and none of the five surveys sent to the massage specialists via their employer were returned. This led to the conclusion that either (a) none of these were forwarded or (b) they were forwarded and none of the specialists chose to participate. It was felt that explanation (a) provided the most likely answer, and so as not to distort the results, this group of five specialists were treated as being uncontactable. This left forty possible respondents to the survey. Twenty of these possible respondents chose to participate in the study which gives the sessional specialist survey a relatively good overall response rate of 50.0%. It should be noted here that the incentive payment did not turn out to be the sole reason for respondents participation as only fifteen (75.0%) of them returned their survey within the two weeks grace period allowed for after the deadline. The remaining five (25.0%) returned their surveys after this period, with most noting their ineligibility for the raffle, but saying they still wanted to contribute to the study.

The results from all of the surveys returned were then entered into the SPSS/PC computer based statistical package for multiple response analysis.

For all the responses outlined in this section of the report, unless otherwise indicated, the sample size is twenty (n=20) - the number replying to the survey. In addition, most responses have been broken down according to two categories relating to the respondents level of contact with the unit. That is, if they worked at least once a week, they were deemed as being regular workers (Reg.). While those not working this frequently - for example, once a month, or once every six months - were deemed as being casual workers (Cas.). Given the responses received, these were the most logical categories to use as they provided different perspectives on the unit which related to levels of contact.

Responses are reported by identifying where forty percent or more of the members of each of the two categories above (who responded to the question), replied or ticked a response (or responses).

The breakdown obtained from the survey results on the number of sessional workers who currently worked at the LSU is outlined in Table S1.

Table S1. Currently working at the LSU.

Response n = 20 →	Reg. 12	Cas. 8
Yes	5	4
No	7	4
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20).

Table S2 shows the responses received when these workers were asked when they had last worked at the LSU.

Table S2. When last worked at the LSU.

Response n = 20 →	Reg. 12	Cas. 8
Currently working there	✓	-
Less than 3 months ago		✓
Between 3 & 6 months ago	-	
Between 6 & 12 months ago	-	-
More than 12 months ago	✓	
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20).

While Table S3 shows the length of time they had been running sessions at the unit.

Table S3. Length of time worked at the LSU.

Response n = 20 →	Reg. 12	Cas. 8
Less than 3 months		
Between 3 & 6 months		
Between 6 & 12 months		-
More than 12 months	✓	✓
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20).

The results contained in Table's S1, S2 and S3, show us that those who replied to the survey represented a good cross-section of the people who ran (or run), sessions at the unit. There were about half in each category who were currently working in the unit and half who were not. Most of the regular workers were either currently working there (recent) or had worked there more than twelve months ago (past). While none of the casual workers were currently working in the unit, at least

forty percent of them had given sessions within the previous three months (recent) - with the remainder having worked there between three and six months, or greater than twelve months ago (past). In addition at least forty percent in each category had run sessions while working in the unit for more than twelve months. With the remainder of the results for each category spread fairly evenly between less than three to less than twelve months.

As with the officers, it was deemed important to find out the level and type of briefing the sessional workers had received prior to working in the LSU and the correctional system generally.

The responses given by the sessional workers when asked what briefing they had been given about working in the LSU before they started are contained in Table S4.

Table S4. Briefing received about working at the LSU before starting.

Response n = 20 →	Reg. 12	Cas. 8
None		-
Spoke to Manager PAP (Gino)	✓	✓
Received Information Pack		
Met with Manager PAP (Gino)		✓
Visited the Unit	✓	✓
Read the LSU pamphlet	✓	
Talked to staff	✓	
Talked to inmates	✓	
<i>Did trial session</i>		-
<i>By previous psychologist</i>		-
<i>Saw the LSU video</i>		-
<i>Initially was a volunteer with RC</i>		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20). Italics represent responses received in "Other - please specify category"

These result show that the regular workers received a more comprehensive briefing prior to working at the LSU than did the casual workers, with at least forty percent of them ticking the following items:

- spoke to manager PAP;
- visited the unit
- read the LSU pamphlet;
- talked to the staff, and;
- talked to the inmates.

Whereas for the casual workers at least forty

percent of them only ticked three of the items listed, these being:

- spoke to manager PAP;
- met with manager PAP, and;
- visited the unit.

In order to gauge the appropriateness of these briefing sessions sessional specialists were then asked to indicate what they been briefed about (Table S5), and what they should have been briefed

Table S5. Briefing received about working in the Correctional System etc.

Response n = 17 →	Reg. 9	Cas. 8
Aims & Objectives of LSU	✓	✓
Restrictions on LSU program		✓
Security Issues - Do's & Don'ts	✓	✓
Personal Safety Issues		
Universal Infection Control	✓	
Correctional System Culture		
Correctional System Procedures		✓
Correctional System Operations		
Inmates access to medical services		
Support mechanisms for inmates	✓	
Confidentiality Issues	✓	✓
How to deal with custodial staff		
Grievance Procedures		
Sexuality Issues		
Injecting Drug Use Issues		
Grief and Bereavement		
<i>Activities that might prove popular</i>		-
<i>Custodial assessments of inmates</i>		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: 3 Reg. sessional specialists did not complete this section (n=17). Italics represent responses received in "Other - please specify category"

about (Table S6) prior to working in the correctional system and LSU. The results in these tables clearly show us that there was a notable difference between what the members in both groups had been briefed on and what they felt they should have been briefed on.

Table S6. Briefing sessional specialist staff should receive about working in the Correctional System etc.

Responses n = 18 →	Reg. 12	Cas. 6
Aims & Objectives of LSU		
Restrictions on LSU program	✓	
Security Issues - Do's & Don'ts	✓	✓
Personal Safety Issues	✓	
Universal Infection Control	✓	-
Correctional System Culture	✓	✓
Correctional System Procedures	✓	✓
Correctional System Operations	✓	
Inmates access to medical services	✓	✓
Support mechanisms for inmates	✓	✓
Confidentiality Issues	✓	✓
How to deal with custodial staff	✓	✓
Grievance Procedures	✓	✓
Sexuality Issues	✓	
Injecting Drug Use Issues	✓	✓
Grief and Bereavement		
<i>Supervision client/group interactions</i>		-
<i>Activities that might prove popular</i>		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: 2 Cas. sessional specialists did not complete this section (n=18). Italics represent responses received in "Other - please specify category"

Recommendation 40. All sessional specialist staff should receive appropriate briefing prior to working in the LSU and the correctional system. It is suggested that as part of this briefing an appropriate resource be developed which contains important information they need to know about working in the correctional system and at the LSU (including practical issues such as signing in and out of centres, universal infection control and security requirements etc.), and that this resource is regularly reviewed and updated.

When asked to indicate the main concerns they had prior to working in the unit the sessional specialists provided the responses listed in Table S7.

Table S7. Main concerns held prior to working in the LSU.

Response n = 20 →	Reg. 12	Cas. 8
None	-	✓
Fear/personal safety		
Didn't really know what to expect	✓	
Apprehension		
Increased stress		
<i>Unclear what inmates expected</i>	-	
<i>Whole correctional system</i>	-	
<i>Getting HIV or other BBCCD's</i>	-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20). Italics represent responses received in "Other - please specify category"

Interestingly at least forty percent of the casual workers said they had no concerns prior to working in the unit, while the remainder of them had concerns relating to some of the other items listed. In contrast none of the regular workers said they had no concerns, with the majority saying their main concern related to not knowing what to expect, and the remainder responding to at least one of the remaining items listed in the table. While the results obtained from the regular staff can be explained by the replies received to the two questions relating to their briefings that have been covered above. The casual workers answers indicating a relative lack of concern by them is not so clear cut. The most likely explanations for this are (i) that casual staff were generally quarterly (three monthly) visitors, and; (ii) most were from organisations like ACON, NUAA etc who are more used to dealing with HIV positive people. Therefore casual workers were not so concerned about working in the unit (and correctional system) because of their relatively low exposure to it.

The sessional specialists were then asked what they thought was wrong with how the LSU is set up and operates, their responses are outlined in Table S8.

At least forty percent of workers in both groups ticked the item relating to the sharing of the yard and facilities with the CSU. This being the only item that at least forty percent of the casual workers selected. For the permanent workers however, at least forty percent of them selected the following additional items:

- limited space;

- not enough briefing, update and information sessions run for staff, and;
- LSU still perceived as a segregation unit.

Recommendations 2, 20, 22, 23, 30 & 33.

Table S8. Wrong with how the LSU is set up and operates.

Response n = 20 →	Reg. 12	Cas. 8
Lack of autonomy		
Limited space	✓	
Insufficient resourcing		
Shared yard/facilities with the CSU	✓	✓
Access to IDS staff for inmates	-	-
Way the program operates		-
Staffing levels are inadequate	-	-
Run in line with maximum security/self harm regulations & protocols	-	
Not enough briefing, update and information sessions run for staff	✓	
Insufficient consultation with staff regarding operational strategies.		
Difficult to instigate change		
Being located in the SCC		-
Inmates program. fails to maintain consistent quality & standard		-
Unit lost sight of its aims		-
Poor level of support & services provided by CHS to inmates		-
Still perceived as a segro unit	✓	
Inadequate staff training		-
<i>IDS staff supervision/support could be located in a better environment</i>		-
<i>Lack of privacy/space when running sessions</i>		
<i>More contact with PAP staff would help with my problems</i>		-
<i>Hard to access different/alternative treatments and dietary needs</i>	-	
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: All respondents provided answers for this question (n=20). Italics represent responses received in "Other - please specify category"

When they were asked to indicate the type of support services or facilities that should be available for them, as sessional specialist who work in the LSU, they provided the responses contained in Table S9.

Table S9. Support services or facilities that should be available for sessional specialists.

Responses n = 19 →	Reg. 11	Cas. 8
Don't need any	-	
Counsellor	✓	
Extra Training		
Workshops/networking sessions for sessional specialists to meet	✓	✓
Program Co-ordinator	✓	✓
Better resourcing		
<i>Training on biomedical aspects of HIV</i>		-
✓ = 40% or more in group ticked this response - = No one in group ticked this response		

Note: 1 Reg. sessional specialist did not complete this section (n=19). Italics represent responses received in "Other - please specify category"

At least forty percent of both groups indicated they thought the provision of (i) workshops or networking sessions for them to meet, and (ii) a program co-ordinator, would provide them with the type of support services they required. In addition, more than forty percent of the regular staff thought they should have access to a counsellor with whom they could talk over any issues that arose. None of the regular workers said they didn't need any support services, while some of the casual staff members ticked this response. Again the most plausible explanation for these, albeit relatively minor differences, would be the level of exposure the two groups have to both the LSU and the correctional system.

Recommendation 41. A suitable forum be held once or twice a year for sessional specialists who work at the LSU in order for them to conduct workshops, network, discuss issues, review the program and meet.

Recommendation 42. A position for an appropriately qualified Program Co-ordinator (non-custodial) be established and filled whose role would be to run, develop and maintain the operation of the LSU program. This requirement is further supported through Recommendations 1, 2, 6, 7, 8, 9, 10, 11, 13 - 18, 22, 29, 32, 33, 34, 36, 38, 40 & 41 of this report. (see pages - 48, 50 and 52)

The sessional specialists responding to the survey were then asked to detail which part or parts of the program they ran sessions for. For this question

sixteen of them (n=16) provided the following answers (figures in brackets indicating the number who provided the same answer):

- HIV treatments (x5);
- psychology, stress management and living skills (x6);
- arts and crafts (x4);
- fitness sessions (x1);
- AIDS Council of NSW groups (x2);
- Nutrition/Cooking (x2);
- massage sessions;
- HIV awareness/grief & loss (x2);
- conflict resolution/anger management;
- services of outside agencies (for example the Ankali project) (x3), and;
- Chaplain/counsellor.

These results show workers who were involved with all aspects of the program contributed to the survey. In addition they show that these workers often ran sessions which covered more than one area. While there is little doubt that the services offered by all of these services was excellent, it should be noted that there are no formal mechanisms in place to evaluate the quality of the services they provide, apart that is, from informal discussions with inmates and staff by the manager of PAP. Given most of these workers are professionals or specialists in their fields it would seem that this informal process of evaluation is all that is required. However consideration should be given to some guidelines on ensuring the quality and level of services they provide is adhered to and maintained. The hiring of a program co-ordinator would contribute significantly to this aim.

Recommendation 42.

The next question in the survey asked the sessional workers what comments they had on the program. A summary of their responses is outlined below, with figures in brackets indicating the number who provided a comment of the same intent:

- very good program and unit, that's important and important/innovative (x9);
- hard to provide inmates with some resources and certain (generally alternative/natural) medications and treatments (x2);
- program needs to get re-focussed and concentrate on its' aims and objectives and how these are achieved (x5);
- new sessional specialists should have peer support and backup from PAP and LSU staff and be properly briefed about the inmates (x2);
- it appears sometimes the inmates get sick of

- talking HIV/AIDS all the time (x2);
- program needs to be reviewed and updated (x4);
- good if staff were able to provide more input and participate more, and;
- industries shouldn't over-ride program participation and operation (x2).

Recommendations 6, 8, 9, 16, 17, 26, 38

Sessional specialists were then asked how successful the program is in helping inmates dealing with their HIV status (a) generally; (b) while inside prison, and (c) for their release into the community. A summary of the responses received from the seventeen workers who completed this section is outlined below (figures in brackets indicating the number who provided the same answer):

- (a) generally -
- quite successful, giving them a chance to explore their futures (x11);
 - reasonably successful (x6)
 - be better if they had a non-departmental employee to case manage them (x2);
 - it raises many personal issues for them to deal with and look at (x3);
 - program needs to meet the needs of each individual in the unit, providing one-on-one flexibility (x2), and;
 - arts, crafts and other programs are essential as they provide something else for inmates to do and think about, in addition they offer personal rewards and result in increased self esteem.

Recommendations 17, 32 & 42

- (b) while inside prison -
- access to specialists who they would otherwise have difficulty accessing (x3);
 - measurably successful (x8);
 - gives them a break from the mainstream and an opportunity to increase their awareness and knowledge, with access to peers (x10);
 - inmates staying in the program longer than sixteen weeks upset the program structure (x2);
 - they jeopardise their confidentiality going into the unit (x3), and;
 - have very limited access to alternative treatments and therapies, while the CHS is not interested or does not encourage their use (x2).

Recommendations 3, 19, 20, 26, 27, 28 & 35

- (c) for their release into the community -

- access to outside organisations, resources, contacts and support services (x11);
- reasonably successful (x10);
- good, but really also need a follow-up type program, such as a half way house, to help them on their release (x4);
- contacts made on the inside are often broken or lost upon release;
- good, but it's really up to the individual, and;
- need more practical components - back in ? - the program.

Recommendations 6, 9 & 17.

The final issue sessional workers were asked to comment on in the survey related to what they thought about the integration of inmates with acute Hepatitis C infection into the LSU, and whether they thought this would work. The responses received from the nineteen workers who answered these questions are provided in Table's S10 and S11.

Table S10. Thought about integration of inmates with acute HCV infection into the LSU.

Responses n = 19 →	Reg. 11	Cas. 8
Good Idea	3	2
Bad Idea	4	3
Don't know	4	3

Note: 1 Reg. sessional specialist did not complete this section (n=19). Italics represent responses received in "Other - please specify category"

Table S11. Would integration of inmates with acute HCV infection work.

Response n = 19 →	Reg. 11	Cas. 8
Yes	2	2
No	3	2
Maybe	5	3
Don't know	1	1

Note: 1 Reg. sessional specialist did not complete this section (n=19). Italics represent responses received in "Other - please specify category"

No one item (response) was ticked by at least forty percent of the workers in each group. Therefore the results have been presented showing the actual number of workers who ticked each answer.

Only five of the workers surveyed indicated they thought the proposal was a good idea, with seven saying they thought it was a bad idea and a further seven indicating they didn't know.

Similarly, only four of the sessional workers thought the proposal would work; with five indicating they thought it wouldn't work, eight indicating they thought it may work and two stating they didn't know.

These results are further clarified when we look at the answers provided by the workers when they were asked to comment on any problems they thought would arise or this would cause. The most commonly raised issues and comments can be summarised by the following (figures in brackets indicating the number who provided a comment of the same intent):

- groups have different issues, agendas and needs (x12);
- could cause the unit to lose sight of it's objectives (x7);
- raises the problems associated with the potential for cross infection (x7) - especially considering the HCV+ guys will have acute infection and so may be quite ill, thus it would seem inappropriate to put them in the same area as people with compromised immune systems (x2).

Therefore we can conclude there is not much support for the proposal to integrate inmates with acute Hepatitis C infection into the LSU by many of the sessional workers. In line with these results it would seem unwise to continue with this proposal.

Recommendation 25.

And finally, sessional workers were asked an open ended question to see if there was anything else they wanted to raise about the LSU (and how it's run) that hadn't already been covered. At least two of them provided one of the following additional comments (figures in brackets indicating the number who provided a comment of the same intent):

- need to look at program and content and tighten it up to focus on the aims and objectives, a program co-ordinator would be an excellent idea (x4);
- great program and I enjoy/enjoyed working there (x9) - though what about the women (x2);
- support from the custodial and PAP staff is very

good (x5), and;

- there are too many interruptions when running sessions which often disrupts the dynamic (x2).

It should be noted that a number of sessional specialists provided lengthy and useful replies to this final open ended question. Most of these however can be summarised by some or all of the points outlined above. One exception though was that a few thought it was important to mention that the interaction between the inmates at the LSU and CSU (because of the shared yards), was not always a bad or undesirable thing; and that often both groups of inmates benefited from the contact with each other.

Recommendations 1, 3, 6, 9, 10, 16,
17, 18, 32, & 42.

Therefore, we can conclude that surveying the sessional specialist workers who had run sessions as part of the LSU program was also a valuable exercise in meeting the objectives set for the evaluation of the LSU. Not only did they provide information to support many of the previously made recommendations, but the information they provided led to further issues which resulted in more recommendations being made.

OPERATIONAL SUMMARY

Essentially there are two categories of inmates allowed for in the LSU program. Firstly, those who are about to be released from custody - to provide details on access to the services available in the community and practical skills for living with HIV & AIDS upon release, and secondly, to help longer term inmates with being HIV positive within the correctional system environment. Consideration was given to the needs of both of these groups when the original program structure and outline was developed.

The review of the management of HIV positive inmates throughout the world outlined at the start of this report revealed that the program offered at the LSU is unique. As far as could be ascertained, all other known special units (be they voluntary or involuntary) for HIV positive inmates in other jurisdictions are modelled on the provision of primarily hospice type care facilities, rather than programs designed to assist people who are HIV positive in making (and having the skills, knowledge and understanding) lifestyle changes aimed at maximising both the quality and length of their lives.

It is important to note that the program was developed taking into account two main design considerations. The first was to allow for the inmate turnover and flow through the unit, and the second related to ensuring that the structure and program quality were able to be maintained.

This was because it was not practical or desirable to have a group of eight inmates come to the unit at the same time, do the program and leave the unit ready for the next batch. Instead it was determined it would be better to stagger the entry and exit of inmates from the unit in order to maintain group and program cohesion along with a sense of community. Thus inmates leave and enter the program usually in groups of two or three ensuring the continuity of the unit is maintained.

Appendix E contains the original outline developed for the twelve week program when it was opened to inmates in December 1992. This outline contains three sections (sections 8, 9 and 10) which addressed how the various components of the program had been developed and structured to meet the objectives set for the unit and the management of HIV positive inmates in relation to (i) health and wellbeing, (ii) prison management, and (iii) community management. Additionally, Appendix E contains details of a typical twelve week programs that was run at this time.

The program operated relatively successfully until mid 1993, with only a few (mainly operational and teething) problems causing concern. The only significant problem that arose with the program structure was that it provided for inmates to undertake the Prison HIV Peer Education Program (PPEP) by completing one session a week during eight of the twelve weeks in the program. The main problem caused by this was that many inmates did not get to complete the program and become qualified Peer Educators (an important objective of the unit) because of the inmate turnover and flow through the unit. In order to overcome this problem the program was reorganised so that the Peer Education Program was conducted in a one-off block during one week of the program. Additionally inmates felt it would be good to be able to have more sessions run on conflict resolution incorporated into the program.

At around the same time, mid 1993, a operational problem arose, which was that there were not enough eligible inmates in the correctional system (who had not already completed the program) who wanted to apply to come to the unit. This was partly contributable to two things. Firstly, the problems experienced relating to the referral of inmates to the unit by the Corrections Health Service (CHS), and secondly the relatively low numbers of inmates who were known to be HIV positive in the correctional system at the time.

Therefore, at the end of July 1993 the program structure was changed and the program was extended to sixteen weeks. This allowed for the incorporation of some industry sessions into the program to enable inmates to undertake other activities and earn some extra money.

The original program outline however, was not updated to allow for these changes, nor was a review carried out on the impact, if any, they would have on the integrity of the program.

This can be primarily attributed to the fact that the manager PAP was responsible for the on-going review and monitoring of the program and had to do this along with all his other duties.

Recommendation 42.

In addition, five further initiatives were undertaken and implemented in 1993 to help promote the unit among inmates and staff, and increase inmate

participation in the program. These were:

1. the production of a pamphlet on the LSU which provided a comprehensive overview of the unit and the program, for general distribution - to increase awareness of the program and its goals;
2. the distribution to all positive inmates in the correctional system (through the CHS) or a form letter from the manager of PAP telling them about the LSU and inviting them to apply to attend the unit;
3. the production of a booklet on the unit which contained life stories, quotes and comments from inmates in the unit; and photographs of the unit and the inmates while participating in the unit - which was targeted at HIV positive inmates who were considering applying to participate in the unit, but who were unsure what it would be like;
4. the production of a video on the unit which (in order to maintain the confidentiality of those inmates shown in it) had restricted access to other HIV positive inmates, and staff who would be involved with the unit, and;
5. a review of the problems that had been experienced with the referral of inmates by the CHS to the unit which resulted in increased understanding, agreement and co-operation between the LSU and CHS.

These five initiatives helped, with varying success, to considerably raise the profile of the unit (the video and pamphlet are still currently in use). The booklet, however, was only used for around six months as it was considered too hard to maintain the restricted access required. So, rather than risking breaching inmate confidentiality by unauthorised distribution, its use as a promotional tool was stopped. The distribution of the form letter to all HIV positive inmates through the CHS was only carried out once.

Even after all these initiatives had been implemented, the problem relating to the relatively few number of HIV positive inmates who were eligible and wanted to take part in the program still continued.

This resulted in a review of the guidelines covering how applications from inmates who had already participated in the program would be considered. This review resulted in the development of a revised set of comprehensive guidelines on this issue - see Appendix E.

This relaxation of the guidelines relating to the re-admission of inmates who had previously completed the program assisted in maintaining occupancy rates in the unit. An additional step was then taken to ensure the unit remained viable and close to its full operating capacity. This step involved the relaxation

of the strict sixteen week timeframe for the program so inmates were able to spend longer periods of time - in some instances their whole sentence - in the unit.

Unfortunately, while this has satisfied the operational requirements of the unit, it has been a major contributing factor (along with the lack of a program co-ordinator), to a fall in the quality of the program. This is because it has caused problems with the continuity, content and integrity of the original program - which had been designed to operate over a fixed time period. This fact is clearly supported by the findings arising from the review of the key stakeholders that was undertaken as part of this evaluation, details of which are contained in earlier sections of this report.

Recommendations 3, 4, 6, 8 - 11, 13,
16 - 22, 29, 31, 32, 34, 38, 39

Furthermore, it is because of the problems experienced in getting sufficient inmates to participate in the unit that the proposal to incorporate inmates with acute Hepatitis C infection was originally proposed and developed.

In essence, this has been seen as a possible way of maintaining the occupancy rate, and thus the operational viability of the LSU. While the intentions behind this proposal have been honourable, the idea has not proved to have received a high level of support amongst the key stakeholders reviewed (as part of this evaluation), despite its initial support, as described in the implementation report/proposal. [DCS, September 1995]

This then leaves the question of the viability of continuing the program and maintaining the unit in the balance, especially considering the problems the unit has experienced in maintaining viable occupancy rates. Should the program and unit be continued in its present form, changed or discontinued?

A discussion addressing these issues is contained in the conclusion to this report.

CONCLUSION

The aim of the study was to (i) conduct a review of the management of HIV positive inmates and, (ii) document an evaluation of the Lifestyles Unit and program.

The study was to include the following components:

1. review of key stakeholders;
2. brief history of the LSU;
3. literature search and review;
4. follow-up interviews with ex-residents;
5. identifying the limitations on the program structure, and;
6. to develop recommendations and options for the program.

A number of different strategies were adopted to undertake these objectives and these are detailed on page's 15 and 16 of this report. It should be noted that all these components were addressed by the study as required.

In conclusion, this evaluation has shown the establishment of the Lifestyles Unit and program has been an important step in meeting the needs of inmates who are HIV positive in the NSW correctional system. As such it has met what can be considered as the primary aim that was set for the unit when it was established in 1992 - the maintenance of the health and well-being of HIV positive inmates whilst in the NSW correctional system. The establishment and operation of the unit has resulted in the following primary outcomes - enabling HIV positive inmates to:

- learn about HIV and living with HIV, and coming to terms with being HIV positive;
- reduce their stress and anxieties by allowing them time out from the mainstream in a safe environment;
- access to better and closer medical services;
- supportive peer environment;
- make informed decisions relating to lifestyle choices, and;
- access to external groups, agencies and individuals.

Furthermore this evaluation has highlighted various operational and environmental factors which have impacted on the unit successfully meeting all of the aims and objectives set for it. These factors can be best addressed if we look at

the findings in relation to the three questions outlined below.

- i) What's wrong with the LSU ? -
 - limited space available in the unit;
 - sharing of facilities and yard with the Crisis Support Unit;
 - not enough briefing and training of staff;
 - staff not properly consulted regarding operational issues;
 - insufficient time allocated for staff to participate in program;
 - inmates of lower classifications must forgo most, if not all, of the privileges available to them if they attend the LSU;
 - insufficient information on the unit for HIV positive inmates to be able to make informed decisions on whether to participate;
 - unit and program not really suitable for HIV positive inmates who are women;
 - not enough information provided to, or education undertaken with inmates in the mainstream to about the issues surrounding being HIV positive, and;
 - program has had problems maintaining consistency and quality standards.
- ii) What stops inmates participating in the unit? -
 - lack of information on the unit;
 - concerns with confidentiality (sharing yard and facilities with CSU, being identified by being in the unit and having to go back into the mainstream);
 - not interested, or want to keep to themselves, and;
 - loss of/reduction in privileges.
- iii) What about the integration of inmates with acute HCV infection into the LSU ? -
 - groups have different needs and agendas;
 - cause problems with respect to maintaining confidentiality;
 - number of inmates who are HCV positive in correctional system;
 - LSU not large enough, they each need their own unit;
 - increased risk of cross infection;
 - program not set-up or suitable for both groups;
 - crowding out effect on HIV positive units, both directly by greater numbers of HCV

positive inmates and indirectly by serving as a disincentive for those HIV positive inmate considering attending the unit, and;

- greater demands on staff and training.

The points outlined above provide the answer the four key questions, and one implied objective, that were to be addressed by this evaluation. As such they raise the inevitable question of what should be done with the LSU program and unit.

While most of the recommendations made in this report are relatively straight forward, there are six key areas which, if addressed, would ensure the continued viability and existence of the LSU program. Thus, enabling the unit to continue providing important services to HIV positive inmates in the NSW correctional system. These key areas are -

1. **appointment of a program co-ordinator** - who could address recommendations relating to the program quality, structure and content, as well as provide training to staff (Recommendation 42);
2. **re-inforcing procedures and protocols relating to confidentiality of HIV status** - (Recommendations 19, 27 and 28);
3. **make the unit larger with its' own yard and visits areas, separating it from the CSU** - to overcome confidentiality and operational problems associated with having a shared yard and facilities (Recommendation 20, 22 and 23);
4. **inmates are able to remain in the unit for their sentence** - enabling them to maintain their confidentiality (by not having to return to or being in the mainstream), group cohesion and harmony while assisting in maintaining a high occupancy rate for the unit (Recommendation 4, 22 and 34);
5. **improve staff training and briefing and provide more information to inmates** (Recommendations 2, 5, 30, 33 and 40), and;
6. **proposal to incorporate inmates with acute HCV infection into the LSU be discontinued** (Recommendation 25).

As a final point it should be noted, that one of the principle reasons there has not been as great a

demand for the LSU as was originally anticipated, is that the HIV prevalence rate in the NSW correctional system (to date) has remained relatively low and has not escalated as it was once feared it might. This result can be contributed to three major factors which are outlined below:

- the Australian approach to the HIV pandemic, with the early and on-going implementation of comprehensive needle and syringe exchange, and education and preventative programs in the community, which resulted in the primary containment of the epidemic in Australia to the gay communities, with only a relatively small proportion of HIV infections recorded in the injecting drug using communities - who are strongly represented within the NSW correctional system;
- the development and implementation of a comprehensive inmate HIV peer education program; along with the provision of bleach, and a methadone program, for inmates within the correctional system, and;
- the contribution the LSU has made towards the education of HIV positive inmates in the correctional system, thereby minimising the impact they potentially may have had on infection rates.

Thus while the LSU has not been faced with having to provide a service for a large number of inmates, it has provided an important and unique service for the management of HIV positive inmates within the NSW correctional system, and as such can be seen as a model for other jurisdictions throughout Australia and the world.

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APPENDIX A

INFORMATION ON POLICIES AND MANAGEMENT OF HIV POSITIVE INMATES IN OTHER COUNTRIES AND JURISDICTIONS

Botswana [LNS, July 94]

2. Guiding Principles

- 2.2 The Prisons and Rehabilitation Service recognises that "controlling" measures such as mandatory HIV testing, segregation and discrimination towards people with HIV/AIDS neither serve the public health of the Prison community or the private health of those HIV infected individuals who live within it. Measures such as these discourage people from taking individual responsibility to protect themselves from HIV/AIDS whilst fuelling irrational fear and prejudice which inhibits education efforts and hastens illness and death for those already infected. They also infringe the human rights of members of the Prison community in a way which would not be tolerated in the general community.
- 2.3 At the same time, the policy takes account of the responsibility of persons living with HIV/AIDS to protect others from infection as well as the right of the rest of the prison community to that protection.

3. The Prison Community and AIDS

- 3.2 The principles underpinning this policy reflect those of the National Policy on AIDS because the Prison community is regarded as a part of, and not distinct from, the wider community.

10. Confidentiality

- 10.2 The HIV/AIDS status of inmates shall be recorded in files available only to health personnel. There shall otherwise be no visible sign put in other prisoners' records to indicate their HIV status.
- 10.3 Health personnel may provide prison management or judicial authorities with information regarding the HIV status of an inmate if such disclosure will assist in the proper health care and treatment of the inmate. Every effort will be made to obtain the informed consent of the inmate before any such disclosure is made.

- 10.4 Information regarding the HIV status of a prisoner shall also be disclosed to prison management if health personnel consider, with due regard to medical ethics, that this is done solely to ensure the safety/protection and well-being of other prisoners and staff. The HIV status of any inmate shall however not be communicated to management as a routine procedure. This disclosure shall be done in line with principles as applied to the general community.
- 10.5 Principles and procedures, relating to voluntary partner notification shall apply in the prison community as in the general community.

11. Management of HIV Infected Persons

- 11.1 General principles on management of HIV/AIDS persons shall be observed. That is, HIV infected prisoners (or staff) shall be encouraged to lead as normal a life as possible.
- 11.2 Segregation, isolation or restriction shall not be imposed on the inmate. They shall have liberty to work in industry workshop, kitchens or wherever their services shall be needed. They shall also have access to recreational and educational facilities.
- 11.3 Isolation for short periods shall only be done on medical grounds e.g. when the patient might have any other condition that requires isolation, e.g. pulmonary tuberculosis during the infectious stage.
- 11.4 Isolation shall also be done where an inmate needs protection and shall be implemented with the informed consent of the inmate.
- 11.5 Disciplinary measures of whatever nature which would normally be presented upon inmates shall be carried out on HIV infected prisoners without reference to their HIV status. The HIV status of an inmate should not in anyway influence the decision to discipline him/her.
- 11.6 Inmates shall be encouraged to support any suspected or known persons with

HIV/AIDS to prevent any discriminating attitudes, fear and prejudice towards these HIV infected persons.

12. Care and support for those with HIV/AIDS

- 12.1 The service shall endeavour to provide good quality care for those with HIV/AIDS in prison which will be no less than the one provided in the general community.
- 12.2 HIV infection related cases in prison shall receive appropriate and comprehensive medical and psychological treatment.
- 12.3 Co-operation with civil health facilities shall continue to be nurtured to facilitate needed referral care provision and for case keeping and follow-up.
- 12.4 Hospitalisation of prisoners with HIV/AIDS related illness shall be made only on medical criteria by health personnel. Access to adequately equipped specialist services shall be assured as availed to the general community.
- 12.5 Treatment, both prophylactic and therapeutic for HIV/AIDS infection and related illnesses shall be provided by prison health service applying the same clinical criteria and accessibility as in the community including ambulatory care.
- 12.6 As a right, prisons shall be informed of the available treatment options. They have the right to refuse treatment (in line with patient's Bill of Rights) as exists in the general community. Inmates shall however need to refuse treatment in writing and where possible under their advocates' hands.
- 12.7 Prisoners shall have access to and voluntarily take part in clinical trials on the treatment of HIV/AIDS and related diseases.

14. Female prisoners

- 14.3 Women prisoners, including the HIV infected ones, shall have access to information and services specifically designed for their needs regarding HIV ...

15. Young prisoners

- 15.6 In the case of HIV infected youth the same HIV confidentially principles observed for grown-ups (sic) shall apply. They shall need to give consent for notification of their parents about their HIV status.

16. Early release of prisoners

- 16.1 As provided by the Prisons Act, compassionate early release shall continue to be afforded to all terminally ill prisoners including those who are ill with AIDS. This is meant to facilitates contact with their families and friends so that they may go and face death in dignity and freedom.

17. External links

- 17.1 Linkage with external non-prison agencies at central and local levels are crucial to all aspects of the Prison AIDS Policy and practice. THIS shall facilitate appropriate referral and follow-up care as well as support form AIDS Support Groups where the patient may need or request such services.
- 17.2 All HIV infected prisoners shall be informed of these agencies and, if consent is given, a support group member or members shall be invited to visit them. It is hoped that this will further show the person that s/he is not alone in her/his problem. It shall also build up rapport with such support groups before the inmate is released. They will be encouraged to join such groups on release to fill up the desolate hours they might experience after release due to both imprisonment and HIV status stigmatisation.

CANADA [Correctional Service Canada - Various]

Information Supplied by Jacques, R. Corporate Adviser, Health Services, CSC

Management of Inmates with HIV Infections. Commissioner's Directive No. 821 (January 1988)

Penitentiary Placement

3. Inmates who have AIDS, ARC or who have antibodies to HIV shall be penitentiary placed in the same manner as all other inmates who do not have indications of the disease.
4. Regions may wish to develop penitentiary placement options to accommodate regional variations.

Placement Within the Institution

5. Once an inmate has been placed in an institution he/she shall be housed as follows:
 - a. if the inmate has antibodies to HIV or is diagnosed as having ARC, attempts shall be made to place him/her in the general population;
 - b. if placement in the general population is not feasible, attempts shall be made to place the inmate in protective custody;
 - c. if protective custody is not feasible, the inmate shall be placed in administrative segregation; and
 - d. if the inmate has AIDS he/she shall be housed in the health care centre.

Activities

7. Inmates with suspected HIV infections or diagnosed with HIV infection shall not be managed differently from other inmates unless medically indicated.
8. The Director may decide to isolate an inmate to maintain the security or good order of the institution.

Identification and Evaluation of HIV Infection

9. Inmates, upon entrance into the correctional system or during incarceration, shall not be routinely screened for presence of antibodies to HIV.
12. All testing shall be preceded by a period of counselling by health care staff regarding the possible implications of the test and test results.
13. Following testing, HIV seropositive inmates shall receive counselling from medical staff and shall have access to the full range of available institutional and community counselling services.

Infection Control

15. Disposable gloves and resuscitation equipment and gowns shall be readily accessible to all staff, to be used at their discretion. Staff should be encouraged to use these when contact with blood or body fluids is anticipated, regardless of HIV infection status.

Confidentiality and Disclosure

21. The HIV status of an inmate is medical confidential. This information shall not be

released to supervisory/agency staff without the inmate's consent. However, if there is cause to believe that offender's actions may constitute a danger to himself or others, and in accordance with the Privacy Act, health care staff shall provide information to the appropriate personnel without the offender's consent.

Health Services.

Commissioner's Directive No. 800 (May 1995)

Essential Health Services

2. Inmates shall have access to screening, referral and treatment services. Essential services shall include:
 - a. emergency health care (i.e. delay of the service will endanger the life of the inmate);
 - b. urgent health care (i.e. the condition is likely to deteriorate to an emergency or affect the inmate's ability to carry on the activities of daily living);
 - c. mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgement, behaviour, the capacity to recognise reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health services; and
 - d. dental care for acute dental conditions where the inmate is experiencing swelling pain or trauma; preventative treatment (i.e. necessary fillings, extractions, etc) subject to the motivation displayed by the inmate to take an active part in the process; and removable dental prostheses as recommended by the institutional dentist. All other dental care will be initiated and funded by the inmate.
3. Inmates shall have reasonable access to other health services (i.e. conditions not outlined above) which may be provided in keeping with community practice. The provision of these services will be subject to considerations such as the length of time prior to release and operational requirements.
4. In support of providing essential health services, emphasis will be placed on health promotion/illness prevention.

Health Care Delivery

6. Access by inmates to health services shall be available on a 24-hour basis. Access can be provided through on-site coverage, on an on-call basis, or through other Correctional Service of Canada institutions or other community services.
7. All staff shall be responsible for bringing to the attention of a health care professional, the condition of any inmate who appears to be ill, whether he/she complains or not.
8. A process shall be in place to allow inmates the opportunity to submit in confidence a request for health care services indicating the reason for the request.
9. An inmate's request for health services attention shall be relayed to a health care professional without delay.
10. Inmate requests for routine health services shall be screened by a nurse or other health care professional and referred to a clinician as appropriate.
 - a. are residual;
 - b. leave residual disability;
 - c. are caused by non-reversible pathological alteration; and
 - d. require a long period of supervision, observation or care.

HONG KONG [PANG S., April 1995]

Information supplied by Assistant Commissioner (Personnel), Correctional Services Department of Hong Kong - in correspondence and contained in "General Guidelines on the Management of HIV/AIDS cases detained in Institutions"

The Correctional Services Department in Hong Kong has been actively involved in handling the issue of HIV/AIDS in its education; prevention; and management amongst inmates and staff. The Department has developed some general guidelines based on the "WHO Guidelines on HIV Infection and AIDS in Prisons" issued by WHO in March 1993 and in consultation with the consultant of Special Prevention Programme, Department of Health, Hong Kong Government. The guidelines are divided into three main areas - prevention, detection and management. Those relating to prevention mainly deal with the standards and types of education and information to be provided to all staff and inmates on HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within the confined environments and to the need of inmates after release. Those relating to detection cover blood testing of inmates (voluntary with informed consent required) and confidentiality. The guidelines relating to the management of HIV positive inmates are detailed following:

MANAGEMENT

Consent

14. The informed consent of an inmate which may be written or implied is normally required for any health care assessment, examination, procedure or treatment (For exception to this policy, refer to Commissioner's Directive 803.)

Requirements - Reception

18. Procedures regarding prophylaxis, treatment and reporting of infectious or communicable diseases shall be in accordance with provincial health regulations.

Outside Consultation

25. Outside consultation or treatment for essential services may be sought by the institutional clinician. Consistent with community standards, treatment recommendations by consultants are subject to approval of the referring institutional clinician.

Terminal or Chronic Illness

33. If an inmate is terminally or seriously chronically ill, the Service shall consult with the National Parole Board to determine eligibility for parole. This would include those inmate-patients with incapacitation illness, who are chronically sick and have impairments which have one or more of the following characteristics:

12. HIV infected inmates should have equal access to workshops and other work areas. However, they must not be assigned to handle sharp tools or instruments such as knives, scissors and razors etc.
13. Isolation may be required on medical grounds for HIV infected inmates suffering from pulmonary tuberculosis in an infectious stage. Protective isolation may also be required for inmates with immuno depression related to AIDS. Decision on the need to isolate or segregate HIV infected inmates should only be taken on

the recommendation of the Medical Officer.

14. Information on the health status and medical treatment of HIV infected inmates is confidential and should only be recorded in files available only to the Medical Officer and staff on nursing duties. The Medical Officer may, subject to the consent of the inmate, provide judicial or other authorities with information that will assist in the treatment and care of the patient.
15. Information regarding HIV status may only be disclosed to staff concerned if the Medical Officer considers, with due regard to medical ethics, that this is warranted to ensure the safety and well-being of inmates and staff.
16. No marks, label, stamp or other visible sign should be placed on the inmate's files, penal records, cells or papers to indicate their HIV status.
17. Medical follow-up and counselling for HIV infected inmates (asymptomatic or symptomatic) should be available and accessible during detention. Similarly diagnosis and treatment of sexually transmitted diseases should be accessible to inmates irrespective of their HIV status.
18. The decision to hospitalise an inmate with AIDS or other HIV related diseases can only be made on the recommendation of the Medical Officer.
19. Unless otherwise recommended by the Medical Officer, HIV infected inmates are eligible for participation in the Detention Centre, Training Centre, Drug Addiction Treatment Centre and other correctional programmes.
20. Female inmates, including those who are HIV infected, should receive information and services specifically designed for their needs, including information on the likelihood of HIV transmission, in particular from mother to infant, or through sexual intercourse.

IRELAND [Dooley E., July 1995]

Information supplied by the Director of Prison Medical Services in Correspondence and contained in the "Report of the Advisory Committee on Communicable Diseases in Prison".

Ireland has a total prison population of around 2,200 inmates (98% male & 2% female), and has a disproportionately large number of inmates with HIV, particularly in the large committal prison serving the Dublin area. Of the approximately 1,500 cases of HIV seropositivity (of whom approximately 50% are IDU's) detected in Ireland to date about 250 are known to have passed through the prison system.

In 1985 a policy was introduced for the management of male inmates known to be HIV positive which involved the segregation and separation of these inmates in two special isolation units with a capacity of 40 inmates. Thus these units were developed to provide the necessary medical and other services these inmates required to manage their health status effectively. However, many of those who were segregated in the special units experienced isolation from the rest of the inmate population with feelings of discrimination and stigmatisation. In addition their management was primarily viewed from their health status viewpoint and not from the other factors that identified them, such as security classification etc. Female inmates who are HIV positive have not been subject to segregation and have remained in the general inmate population.

Thus, there was little enthusiasm or willingness from many inmates to disclose or be tested for their HIV status. Inmates in Ireland are not subjected to compulsory or mandatory testing for HIV, neither are they required to disclose their HIV positive status if it was already known by them. This resulted in many prisoners who were HIV positive not being segregated and remaining in the mainstream inmate population, where many held the mistaken view that all inmates were HIV negative.

The problems associated with the decision to segregate known HIV positive inmates led to the setting up of an expert group in late 1990. The Report of this group was much delayed and was eventually published in May 1993. One of the reports main recommendations being the discontinuation of the segregation policy. Since the reports release steps have been put in place to discontinue segregation on committal and this has occurred since 1 January 1995. The Department of Justice is now in the process of organising the re-integration of those known

HIV positive inmates held in the "old" isolation units back into the mainstream inmate population. This process will also involve the eventual upgrading of services in all prisons so they provide the level of medical and other services required by HIV positive inmates that had been previously offered in the isolation units.

NEW ZEALAND [Edwards A., July 1995]

Information supplied in Correspondence and contained in the NZ Department of Justice - Policy Guidelines

Testing, management & care policy developed, implemented and legislated in 1989. Policy has since been reviewed and recommendations made, but to date no decisions made on the adoption of the recommendations.

Generally follow a philosophy of mainstreaming except where there is requirement to isolate or segregate to ensure the HIV positive person is not at risk, or putting others at risk. On occasions they have cared for people in the inpatient area of the prison health clinic. This is usually for a short period and may be for 'time out' or need for extra counselling or care. Each decision is made on a case by case basis, dependent on individual need.

Try to keep HIV positive inmates in a prison within the region where they have been attending specialist consultation clinics to ensure continuity of care and monitoring of their health status. In most cases it enables the person whose HIV status has been identified prior to reception to continue with the specialist consultant who has treated them in the community and will most likely follow them up after release.

Treatment for HIV positive inmates is equivalent to that which is available in the community. Therefore treatment protocols developed by the NZ AIDS Medical and Technical Advisory Committee are available to them if they fit the criteria.

Where inmates request it, or are in agreement with the suggestion, NZ AIDS Foundation counsellors, or other community counsellors such as People Living with AIDS, are permitted

to come into the prison which also ensures follow-up after release.

Up until July 1995, there have been no inmates with serious AIDS conditions in the NZ Correctional system. There have been two who have had AIDS related conditions while in prison but both were released at the end of their sentence before further development was obvious. Therefore the policy on early release before the end of a sentence has not yet been tested.

Since late 1989 there have been 20 identified HIV positive inmates in prisons in NZ. Some of these have been in prison more than once. Because these numbers are few and spread throughout the county it has not been seen as necessary to have a special unit set aside for them. Given the mainstreaming philosophy, it is doubtful such a unit would be established.

It is expected that HIV positive inmates should be able to undertake all work and other programs available for them within the mainstream - within the scope of their capacity to cope and provided their activity is not contra-indicated because of their health status.

Mandatory testing is not done. Decisions to test inmates are made on clinical grounds, identification of risk behaviours related to transmission, or if an inmate requests it. Testing and results are conducted in order to maintain strict confidentiality provisions, and include full pre and post test counselling. Where inmates refuse to be tested, legislation provides that they can be dealt with administratively as if they were HIV positive.

Main policies covered by Prison Policy H.13 *Inmates Suspected or Diagnosed as having AIDS, HIV Infection or carrying HIV antibodies*. This policy covers many areas including testing, authority to test, assessing the need to test, pre-test counselling, procedure for testing, disclosure of test results & post-test counselling, confidentiality of test results, inmates refusing testing, counselling and support for partner, family &/or friends and the handling of statistical returns. The most relevant part of this section is -

H.13.2. Management and Care of Infected Inmates

- (1) Each medical officer is to adopt a case by

case approach in determining the appropriate management and care of any inmate who is found to be HIV antibody positive whether the inmate is asymptomatic, has HIV illness or has AIDS. The medical officer in determining the appropriate response will take into account that any infected inmate should generally be held in the mainstream population unless the individual's medical needs, safety or behaviours dictate otherwise. The difficulties of supervising inmates held in association cells should be borne in mind.

- (2) The adoption of this approach means that no infected inmate is to be treated any differently from any other inmate unless the inmate's medical condition, or security considerations indicate otherwise. As such infected inmates should generally be able to:
- be held in normal association
 - receive visitors
 - work
 - participate in case management and other activities within the institution
 - participate in escorted outings and all parole opportunities (including the home leave and release to work schemes) applicable to their security status, provided they meet the criteria.
- (3) Where an inmate's condition becomes symptomatic, the medical officer will recommend to the superintendent the appropriate care of the infected inmate. This may include a recommendation to the superintendent that the inmate requires single cells accommodation where, for example, he/she is too ill to achieve a satisfactory level of hygiene or displays altered behaviour as a result of central nervous system infection. In other instances the medical officer may recommend to the superintendent, pursuant to General Order H.1.2.6. that the inmate is placed in the prison infirmary or transferred to an institution where 24 hour nursing coverage is available, to ensure that the inmate's needs are met.
- (4) Where it becomes apparent that an inmate's condition is endangered because his or her infected status has become known or is assumed, arrangements are to be made to separate the inmate from other inmates. Where the inmate develops behavioural or emotional problems in dealing with his or her condition, the medical officer may recommend to the superintendent the separation of the inmate from other inmates with a further recommendation that the inmate be placed on regular watches with appropriate specialist and support intervention. In some instances, the medical officer may consider the inmate's condition warrants a recommendation to the superintendent that the inmate be placed in the prison infirmary or transferred to an institution where 24 hour nursing coverage is available.
- (5) Where an inmate has developed AIDS, the medical officer will recommend to the superintendent the appropriate care of the inmate. Depending on the inmate's needs this may include any of the options available under (2), (3) and (4) above. It may also be recommended by the medical officer pursuant to General Order H.1.2.6. that the inmate's condition is such that arrangements should be made to hospitalise him or her at a public hospital. Where the inmate's condition does not warrant hospitalisation, constant nursing coverage or separation from other inmates, the inmate should remain within the mainstream population as indicated under (2) above. The medical officer may recommend to the superintendent any measures he/she considers necessary to protect the inmate health.
- (6) Where any inmate progresses to the terminally ill stage, the medical officer may recommend release from prison. The use of the Minister's power under section 91(1)(d) of the Criminal Justice Act 1985 "to release a prisoner who is seriously ill and unlikely to recover" will generally be used. As the Minister's power does not apply to those serving indeterminate sentences or to those who are required to serve full sentence, if a case of this nature arose, an emergency meeting of the Parole Board would be arranged to consider release.
- (7) The medical officer will ensure that the inmate is kept informed of counselling and

support services available in the community which he/she considers may be of assistance to the inmate. Where the inmate seeks assistance from a particular organisation or group, the medical officer will make arrangements for the inmate to be seen any a member of that organisation or group.

- (8) The medical officer, in planning for the inmate's management and care, will ensure that medically unjustified precaution are avoided.

- (9) In all cases, the inmate's condition and needs are to be kept under continuing review by the medical officer.

NEW YORK STATE - USA

[New York State Department of Correctional Services, July 1990]

Policies, Procedures and Guidelines Manual

Section: Health, Subject: HIV Disease, Item: 57

Guidelines define the Department's policy with regard to HIV related issues. Significant sections of which are outlined below:

IV. Transfer/Transport of HIV Positive Patients

- A. Transfers of symptomatic HIV+ inmates will be made only upon approval of the Office of the of the Deputy Commissioner for Health Services and only if continuity of care will not be interrupted by a transfer.
- B. Asymptomatic HIV positives may move without approval by the Deputy Commissioner for Health Services.

V. Housing - Program Assignments

Inmates who do not require an infirmary setting will be housed in general population and have access to normal programming activities. There will be no restrictions with regard to programming assignments for HIV+ individuals. Specific physical limitations will be in writing from the Facility Health Services Director (e.g. heavy lifting).

XIII. Continuity of Care

- A. Ensuring the continuity of care is the responsibility of the Facility Health Services Director or their designee.
- All appropriate health care information must be communicated to the receiving facility by the sending facility in a confidential manner.

- B. Care upon release from the system. PPGM#63 addresses the issues of continuity of care upon release from the Department of Correctional Services. It is the responsibility of the Facility Health Services Director to ensure that appropriate discharge plans are in place prior to the inmates release from DOCS custody.

SCOTLAND [Scottish Prison Service March 1993]

Guidance on the Management of HIV/AIDS Prisoners

Guidelines contain thirteen action points, as outlined below:

1. HIV positive prisoners should not be segregated (paragraph 2.3).
2. Strict medical confidentiality must be observed (paragraph 2.3).
3. Those establishments with a significant number of prisoners with HIV/AIDS should set up a multi-disciplinary local management group to co-ordinate all aspects of managing HIV/AIDS prisoners (paragraph 4.2).
4. Blood tests should be available for prisoners on request (paragraph 5.1).
5. Blood tests must be both preceded and followed by appropriate counselling (paragraph 5.1).
6. Counselling on a continuing basis should be available for all HIV/AIDS prisoners (paragraph 5.1 and Appendix B).
7. All prisoners identified as HIV positive should be offered regular health checks (paragraph 5.2).
8. Prisoners with HIV/AIDS should remain in their own establishments if they are well (paragraph 5.4).
9. Arrangements should be made for proper community support on release (paragraph 5.9).
10. The incidence of HIV positive cases should be reported quarterly to Headquarters (paragraph 5.10).
11. Terminally ill HIV/AIDS prisoners should be managed according to the procedures for other terminally ill prisoners (paragraph 5.11).
12. Information and training should be provided for all staff and prisoners. In particular, every prisoner should be presented with the package "AIDS Inside

and Out” within 2 weeks of admission (paragraphs 6.1, 7.3 and Appendices C & D).

13. Prisoners being released, including those going on home leaves, should be given discreet access to a supply of condoms together with proper advice as to safe sex practices (paragraph 6.5).

SWEDEN [Kriminalvarden, 1992]

Information contained in policy document “Drug and HIV/AIDS Problems” published by the Swedish Prison and Probation Administration.

The Normalisation Principle (NP).

The NP shall be observed as much as possible. This means that the needs of the clients or correctional facilities for treatment and care shall primarily be attended to by the regular public health care, social services, and other external treatment facilities.

The NP can be implemented according to the following models:

- the inmate is placed outside the correctional institution (CI) “permanently” but is formally registered at the CI;
- the inmate lives at the CI, but during the day may in the form of access to treatment, authorised leave and/or in the form of short-term placements take advantage of social and health care services outside the CI;
- external health care services associated with the authority offer services there;
- the inmate is transferred via the “Nadeinstitut” to noninstitutional treatment and is allowed to rely totally on regular health care services.

Noninstitutional treatment clients are under probation, but should otherwise not receive different treatment than other citizens. The task of noninstitutional treatment is checking and relaying support and help while not assuming the responsibility of other authorities in the areas of care and treatment. This means that noninstitutional treatment must maintain a clear-cut role yet develop close cooperation with those primarily responsible, whose efforts are critical to successful resocialisation of many clients.

The correctional authorities shall not, based on the NP, develop their own complete, alternative treatment for drug abusers, and thus are

dependent upon the existing resources available.

Persons with HIV/AIDS

General: Persons with HIV and AIDS in correctional facilities are highly heterogeneous groups who can be separated into a number of subgroups on the basis of a number of factors such as health status, drug abuse, criminality, etc. Since it is impossible to make a sure prognosis on the development of the number of persons with HIV/AIDS and their medical care needs, the correctional authorities should not at this point start up separate departments or other special resources devoted to a very limited target group. Many people who have tested positive for HIV are both able and willing to stay in a non-HIV/AIDS department.

Objectives and Principles for Taking Person with HIV/AIDS into Custody: Persons who have tested HIV positive should be offered satisfactory medical care and be entitled to qualified long-term treatment aimed at independence from drugs and social adaptation.

These long-term treatment efforts/contacts should be introduced at the remand prison or at an early stage of the sentence at the CI or noninstitutional treatment.

Persons who have contracted ARC/AIDS should be offered support, satisfactory medical care, and a positive environment geared toward the highest possible quality of life for each separate individual. Medical care programs and support resources outside correctional facilities should be utilised as much as possible.

Social protection regarding these categories of persons must imply both discouraging continued criminal activities and preventing further spreading of the disease.

The following principles should be applied when caring for persons who have contracted HIV/AIDS:

- correctional authorities should strive for the creation of goal-oriented external treatments alternative and to establish cooperation with these units;
- persons with HIV and AIDS are entitled to respectful care without discrimination;
- treatment of persons with HIV and AIDS should be characterised by a long-term regular contact with a small number of persons and

build upon a well functioning cooperation between various specialties/principals of the medical field (social services, county council, etc);

- satisfactory treatment for drug addiction upon release or in a CI or remand prison environment that is drug free is the basis for satisfactory care of drug addicts carrying HIV.
- medical needs vary extensively among individuals and stages of the illness and thus, flexible health care services are necessary;
- individually tailored steps based on the needs and desires of the client should be the goal;
- the psychosocial care (including psychiatric care) in its various forms is very important in all stages of the illness;
- satisfactory somatic medical care shall be offered persons with HIV and AIDS. One should strive to minimise hospitalisation. Emergency and qualified hospitalisation must be offered by the county council with satisfactory security;
- persons with HIV but no serious symptoms should not be treated together with persons with AIDS;
- persons who are infected and who, through the risk factors in their behaviour, expose others to infection should be reported to the physician in charge or a contagious disease specialist.

Special Departments for Drug Abusers and persons with HIV/AIDS in Institutions

Motivation Department for Persons Infected with HIV/Drug Abusers: A motivation department can be defined as a department with a high degree of controlled abstinence from drugs where the inmate can participate in a specially arranged activity with the purpose of:

1. increasing insight, motivation, and knowledge;
2. offering satisfactory care;
3. creating the conditions and introducing more long-term treatment contacts to attain independence of drugs and adaptation to society.

The motivation and therapeutic department should be available to all those who need it - both drug abusers and persons infected with HIV. Each region should be able to offer their inmates placement on a motivational department. It is also possible, however, to work out a drug program for those who do not live together in a therapeutic department. A drug program does not need to be related to communal living.

Therapeutic Departments for persons with HIV/AIDS, etc: A special nation wide department for persons with ARC/AIDS is being put together. There, inmates are offered satisfactory medical care and a positive correctional environment. Programs for taking patients into custody and support resources outside the correctional facilities should be utilised as long as possible. Medical and hospital care, and social protection are integrated parts of the department. Clients with ARC/AIDS can come from all over the country. Some people with HIV shall, during their periods of illness, be offered placement in the department and both national and local correctional clients shall be placed there. In order for social protection to be satisfactory, the department's security requirements should correspond to at least the security level of a local closed CI.

Many differing efforts shall be included in the program, such as the processing of the set of problems specific to AIDS patients, including medical care, crisis management, psychosocial therapy, existential issues, and last, but not least, occupation, social readiness training, studies, and other occupational therapy. The individual's own desires should be satisfied as much as possible. If the department is to function, it should be based on freedom of choice.

Peace Seeking and Destructive Behaviour: Regarding "peace seeking" persons with HIV and AIDS patients, should be applied within the limits set by existing resources. Persons with HIV and AIDS patients with destructive aggressive behaviour cannot be placed together with other inmates in the same situation. Such inmates would emphasise each other's negative behaviour, and the occupational environment would thereby become unsatisfactory. If it appears necessary, placement should be made in according to S.20 of KvaL. In both cases, the goal should be to actively motivate the inmate to be placed on a motivation department or therapeutic department of ARC/AIDS patients.

SWITZERLAND [Bernasconi, S., July 1995]

Information contained in correspondence from the Federal Office of Public Health.)

The responsibility for the prison system in

Switzerland is in the competence of the Cantons and there are also important intercantonal organisations. Due to the lack of federal influence on policies related to prisons it is difficult to obtain complete information and to give you a general overview about the actual situation (such as treatments of HIV/AIDS and Hepatitis C). Some of the about 160 different Swiss prisons have their own physicians and health services or are co-operating with local medical facilities and if necessary with hospitals. In some cantonal hospitals there are special treatment facilities for inmates (eg in Bern, Zurich and Geneva). In some prisons special programs for HIV antibody positive inmates are available (e.g. methadone-maintenance programs for Injecting Drug Users or special work programs etc.) . The same public health strategy, AIDS policy and preventive measures as well as the availability of the same medical care and psycho-social counselling should apply to inmates as to the general population. As far as we have been informed by physicians, the policy, procedures and treatment of HIV positive inmates seems to be less a problem than HIV and Hepatitis prevention.

... Concerning the treatment of Hepatitis C, I must inform you that only very few and limited studies regarding the use of Alpha Interferon are in process at University hospitals in Switzerland.

“Care of AIDS sufferers in prison. An increase in the number of AIDS sufferers in prisons is to be expected. The practice of non-discrimination and non-segregation towards persons with HIV or AIDS is important, and remains the objective of the national programme. It is basic matter of human rights, ethics and humane principles that detainees have the same care and nursing as the rest of the population.”[Swiss Federal Office of Public Health, 1993].

MANAGEMENT OF HIV POSITIVE INMATES INTERNATIONAL SUMMARY TABLE

Country	Integration	Exceptions	Early Release	Health Care	
				Community Standard Available	Participate in Drug Trials
Austria	Full	Not generally	-	Yes	-
Australia	Some Juridictions	Medical	Not Generally	Yes	Mostly
Botswana	Full	Medical	Yes	Yes	Yes
Canada	Preferred	Medical	Possibly on merit	Generally Yes	Limited
England & Wales	Preferred	Medical	N0 specific HIV. Only terminally ill.	Yes	-
Finland	Full	-	Possible for serious illness.	Yes	Yes
France	Full	-	Pardon and liberation can be granted.	Yes	-
Germany	Varies Generally Single Cell	-	Early Parole possible for compassionate reasons.	-	-
Iceland	Full	-	Possible in cases of serious illness.	Yes	Yes
Ireland	Full	Medical	-	Yes	
Italy	Full (work restrictions in food prep. and distrib. areas)	-	Yes	Yes	-
Netherlands	Full	If warranted	Yes on Parole.	Yes	-
New Zealand	Full	Medical	Not tested.	Yes	Yes
Norway	Full	-	Possible on application.	Yes	-
Portugal	Full	Medical	Yes, within provisions of existing laws.	Yes	Yes
Scotland	Preferred	Medical	On merit/application	Yes	Yes
Spain	Full	Medical	Yes-serious illness.	Yes	-
Sweden	Preferred	Medical	-	Yes	Yes
Switzerland	Full	-	Yes-terminal phase of illness.	-	-
U.S.A	Varies (Mostly Full)	Generally Medical	Policies say yes, but it's rare.	Yes	Very limited

Primary Source of Information: Correctional Services Canada February [1994c] with additions from information contained in policy materials obtained from individual countries.

RASU

Stephen Taylor
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AUSTRALIA

4th April 1995

PH: 61 - 2 - 289 1522
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«ADDRESS»

Dear Colleague,

I am currently undertaking a research project to evaluate the Lifestyles Unit (LSU) in the New South Wales Department of Corrective Services for the Prison AIDS Project.

The LSU was established in 1991 as a voluntary unit for HIV antibody positive inmates in the NSW Correctional System. More recently its scope has been expanded to include HCV (Hepatitis C Virus) antibody positive inmates with chronic HCV infection. It is hoped that the first intake of HCV antibody positive inmates will occur before the end of 1995. Details of the services and objectives of the unit are contained in the "HIV/AIDS Policies, Procedures and Management Guidelines" that was sent to you by the Prison AIDS Project recently.

As part of my evaluation of the LSU I am trying to compile information on the management of HIV and HCV (Hepatitis C) antibody positive inmates in other countries and jurisdictions.

Consequently, I would very much appreciate it if you could provide any information on the current policies, practices, programs, facilities, procedures and management/treatment of HIV antibody positive and Hepatitis C antibody positive inmates within your country/jurisdiction(s).

If you would like a copy of the evaluation report of the LSU (which should be available for distribution later in 1996) can you please fill out the enclosed slip and return it to me.

I look forward to receiving some information from you soon.

Thanking you in advance for any information you can supply.

Regards,

Stephen Taylor

RASU

Stephen Taylor
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20th June 1995

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«ADDRESS»

Dear Colleague,

I am writing to you regarding a letter I sent to you on the 4th of April 1995 requesting information on the current policies, practices, programs, facilities, procedures and management/treatment of HIV antibody positive and Hepatitis C antibody positive inmates within your country/jurisdiction(s). To date I have received no reply to my earlier correspondence, and so am writing to you again in case your reply, or my original letter, have been misplaced, or lost in the postal system.

I requested this information because I need it to assist me in my current research project - which is evaluating the Lifestyles Unit (LSU) of the New South Wales Department of Corrective Services for the Prison AIDS Project. The LSU was established in 1991 as a voluntary unit for HIV antibody positive inmates in the NSW Correctional System. More recently its scope is soon to be expanded to include HCV (Hepatitis C Virus) antibody positive inmates with chronic HCV infection.

As part of my evaluation of the LSU I am trying to compile information on the management of HIV and HCV (Hepatitis C) antibody positive inmates in other countries and jurisdictions.

I would very much appreciate any information you could provide in assisting with this project and look forward to receiving some information from you soon.

Thanking you in advance for any information you can supply.

Regards,

Stephen Taylor

PAPERS REQUESTED FROM THE LAST TWO INTERNATIONAL AIDS CONFERENCES HELD IN BERLIN AND YOKOHAMA

National Program on AIDS
(PROCETS), Santo Domingo, DOMINICAN REPUBLIC

“HIV and Syphilis among Inmates of the Dominican Republic.”; Ducós, J., Ramirez, A., Pérez, J., Florencio, M., Perdomo, C.

M Carvalho
Penitenciária Masculina, do Estado S. Paulo, São Paulo, BRAZIL

“Prevalence of HTLV-I and II Infection Among Male Prisoners and Drug Use as a Risk Factor.” Lorenzo R., Minkoves R, Schechtmann M, Carvalho M, Piovesana M, Ferreira OC.

S Huscroft
Juvenile Hall, Dept. of Health Services, LA County, USA

“HIV High Risk Behaviour in Incarcerated Adolescents - A comparison of HIV+ Minors VS the General Population.”
Huscroft S. Baler CJ, Morris R.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in LA County.

SM Tanguay
Connecticut Dept. of Corrections (Hartford), Connecticut CT, USA

“Demographic, Risk Behaviour and Gender Difference of HIV+ Inmates in Connecticut.” Tanguay SM, Altice FL, Hunt DH.”

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Connecticut.

David Withum
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, USA

“High HIV Prevalence Among Female and Male Prisoners in the United States (1989-1992): Implications for Prevention and Treatment Strategies.” Withum DG, G_ereña-Burgueño F, Gwinn M, Sechman S, Petersen LR.

Stephen Machon
AIDS in Prison Project, Correctional Association of New York, 135 East 15th Street, NEW YORK NY 10003, USA

“The Alliance of Inmates with AIDS: An Effective Model for HIV/AIDS Education, Prevention, Treatment, Advocacy, and Empowerment in Prison and Release.” Machon SC, Mahon N.

L Frank
Pennsylvania AIDS Education and Training Centre, Pittsburgh, Philadelphia PA, USA

“Educating Primary Care Providers about HIV Disease and Tuberculosis at 10 State Correctional Institutions.” Frank L, Macher A, Gray J, Beatty R, Spence M, Ho M.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Pennsylvania.

R Jürgens
McGill Centre for Medicine, Ethics and Law, 3690 Peel Street, Montreal, Quebec H3A 1W9, CANADA

“HIV/AIDS and Prisons: Making Necessary Changes Possible.” Jürgens R, Gilmore N, Richard C.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Quebec.

Lifestyles Unit Evaluation Study

J Mayer
Spellman Centre, St Clare's Hospital, New York NY, USA

"Drug Relapse Among Recently Paroled HIV+ Individuals" Mayer J, Kane D, Rodriguez A, Rosado Y, Schiller J and Dougherty T.

AK Ali
Zanzibar AIDS Control Programme, PO Box 1300, Zanzibar, TANZANIA

"Prevalence of HIV Infection in Male Prison Inmates in Zanzibar: A Voluntary Program." Ali AK, Chwaya HM, Khatib OJ, Osei W, Shein AM, Othman AA.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Zanzibar.

Sonia Oquendo
Montefiore Medical Centre, Rikers Island Health Services, New York City, NEW YORK USA

"C.A.R.E. (Co-Partners in Advocacy, Risk Reduction, & Empowerment for Persons Living with HIV at Rikers Island) in the Incarcerated Setting." Oquendo S, Epifania C, Buchalter EN.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates at Rikers Island.

Harvey Siberman
AIDS Project Los Angeles, 6721 Romaine Street, Los Angeles CA 900038, USA

"Compassionate Release of Prisoners with AIDS." Siberman H.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in California.

Kimberly DuMont
Dept of Community Psychology, New York University, New York NY 10003, USA

"Assessing Health and Social Services used by Persons Living with AIDS." Du Mont K, Rapkin B.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and people living with HIV/AIDS at New York University.

Marie St Cyr Delpe
Director, IRIS House, New York NY, USA

"Iris House: A Comprehensive Model of Services for Women with HIV and their Identified Family Members." St Cyr Delp MM, Terada Ports S.

P Campos-Lopez
Western Biomed Research Centre, IMSS, PO Box 2-227, Guadalajara, Jalisco 44281, MEXICO

"Structure and Process Evaluation of AIDS Prevention and control Program in Guadalajara, Mexico." Campos-Lopez P, Canales JL, Lopez FC, Sierra JJ, and Vazquez-Valls E.

A Tellier
ARGOS 94, Hospital Henri Mondar, 51, av. Marechal, de Lattre de Tassiany 94000, Creteil FRANCE

"HIV positive IVDU's Perceptions of Health Care." Tellier, A.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and People Living With HIV.

Joseph Burzynski
c/- TP Flanigan, The Miriam Hospital, 164 Summit Ave, Providence RI 02906, USA

"Comprehensive Prison HIV Medical Care and Pre-Release Counselling." Burzynski J, Flanigan T, Kim J, DeCiantis ML.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Rhode Island.

Eileen Kelly

Coordinator of Research/Special Projects, AIDS in Prison Project, Correctional Association of New York
135 East 15th Street, New York NY 10003, USA

“Barriers to Prisoner Participation in AIDS-Related Clinical Trial in the US.” Kelly ET

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV, People Living With HIV/AIDS and prison inmates.

One last request. Would you please provide details on the current policies, practices, programs, facilities, procedures and treatment of HIV antibody positive and Hepatitis C antibody positive inmates in New York State.

Carlos L Magis Rodriquez

Carpio 470, Colonia Santo Tomas, Mexico City CP 11340, MEXICO

“HIV Infection in Prison in Mexico.” Magis C, Del Rio A, Gonzalez G, Garcia ML, Valdespino JL, Sepulveda J.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Mexico.

One last request. Would you please provide details on the current policies, practices, programs, facilities, procedures and treatment of HIV antibody positive and Hepatitis C antibody positive inmates in Mexico City and Mexico.

Birgitta Alexius

Department of Psychiatry, Danderyd Hospital, S-182 88 Danderyd, SWEDEN

“Compulsorily Detained HIV Patients in Sweden.” Wistedt B.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV, People Living with HIV/AIDS and prison inmates in Sweden.

One last request. Would you please provide details on the current policies, practices, programs, facilities, procedures and treatment of HIV antibody positive and Hepatitis C antibody positive inmates in Sweden. In particular, the relevant parts of your “Prevention of Infectious Diseases Act” .

Leonardo Perelis

Alsina 833 6²-(1087) Buenos Aires, ARGENTINA

“Comprehensive Prison HIV Medical Care and Pre-Release Counselling.” Burzynski J, Flanigan T, Kim J, DeCiantis ML., &;

“People in Detention, Protagonist of Change.” Vazquez N, Barberis D.

Scott Cozza LCSW

California Medical Facility, Vacaville, PO Box 2000, Vacaville CA 95696, USA

“STD/HIV Peer Education Incarcerated: Multimedia Model.” Cozza, S.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Vacaville.

Aleksei Albov

Dept. of Reformatory Affairs, Ministry of Internal Affairs, St Petersburg, RUSSIA

“Homosexual Contacts Among Male Prison Inmates In Russia.” Albov AP & Issaev DD.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and prison inmates in Russia.

Pamela Castro

Córdoba 76, Col. Roma, MEXICO

“Development of an Interview Model to give Results of HIV Positive Serologic Tests.” Castro P, Guerra A, &

Escalante A.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and in particular prison inmates in Mexico.

C Pradier & JM Nadal

Ministère de la Santé, 8 av de Segur, 75007 PARIS FRANCE

“Trends in Public Health Issues and Health Care Requirements Among HIV Infected Patients in France Between 1990 and 1993.” Pradier C, Nadal JM, Demeulemeester R, Antoine G.

“Health Issues and Care Needs in HIV Infected Persons in France - Results of a 1993 Survey” Nadal JM, Pradier C, Demeulemeester R, Antoine G.

I would also be most appreciative if you could forward information on any other work or studies that have been undertaken relating to HIV and People Living With AIDS in France.

One last request. If you are able, could you please provide details on the current policies, practices, programs, facilities, procedures and treatment of HIV antibody positive and Hepatitis C antibody positive inmates in the French prison system.

APPENDIX B

“TIME OUT LIFESTYLES” - PROGRAM OUTLINE

Program Philosophy:

The philosophical framework would be holistic strategy of optimising health and well being with a combination of therapeutic and educative strategies. These would be:

1. Tailored to the needs of each individual inmate;
2. focused on the medical, physical, emotional and psychological areas of a inmates ability to cope, and;
3. aimed at building self reliance and self responsibility.

Overall, the environment should be one in which the inmates would want to be voluntarily and all staff (support and security) would play an active, positive role in the implementation process.

Location and Accommodation:

The Malabar Assessment Unit presents the best possible, most cost effective location because

1. it is already established;
2. has adequate garden and physical surrounds;
3. and is centrally located to both the hospital and to community based AIDS services.

It can house up to 18 inmates (two to a cell) and can easily accommodate a kitchen, exercise, medication area.

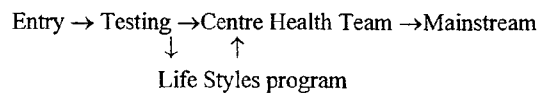
Discussions with the Assessment Prison personnel indicate that funds would be needed to:

1. secure the cells
2. build the kitchen
3. provide universal weight equipment

Staffing is currently adequate for up to nine inmates. the optimum size for such a program would be 12 - 15 inmates.

Referral Process:

In order to maintain a positive atmosphere, entry into the program should be on a volunteer basis. It is seen as an option offered to those inmates who test HIV positive through the compulsory testing program by the proposed multi-disciplinary Centre Health Teams.



Time Frame:

The length of the program should be strictly set to three (3) months, this emphasising the role of the program as preparation for coping in the mainstream inmate population and in the community. It will also avoid the problem of inmates wanting to use it as a means of hiding away.

Conditions of Entry and Exit:

Entry would be on assessment by the Centre Management Team and the Program Director with a three (3) month program mapped out according to the strengths and needs of the individual.

In order to encourage a sense of responsibility and focus on change, it was felt that the inmates should sign a contract of entry to:

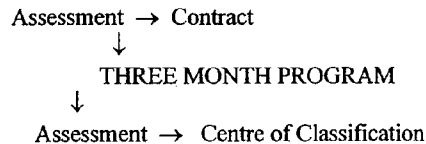
1. abide by the rules of the programs;
2. remain drug free;
3. return to their centre of classification;

If the contract is broken, the inmates should be removed from the program immediately.

A final assessment would again be completed towards the end of the program with a view to placing the inmate back into his centre of classification and committing him to the

support network of AIDS services, Inmate Peer Educators. It is envisaged that the Centre Health Teams in each of the centres would continue to monitor his progress.

Centre Health Teams:



Inmates should be able to re-apply for a second contract in due time.

Staffing:

The Unit would be run by a Custodial Officer with a non-Custodial Director of Programs.

Overall, all staff should be seen as a vital part of the program.

Custodial: A willingness to participate and interact with inmates should be a pre-requisite for working in the program.

Non-Custodial: All non-Custodial staff must abide by the rules of accountability of inmates, the security of the building and discouragement of drugs, alcohol and violence.

Role of Staff:

With staff participation in all programs, Officers can take part in controlled counselling sessions, group work and contract negotiation, thus making their role more stimulating and providing a more constructive relationship with the inmates.

Officer Selection and Training:

As it is important for the Custodial staff to be experienced, a minimum of twelve (12) months work experience would be necessary and entry would be voluntary by a selection process.

A training prerequisite would be completion of the Three (3) Day AIDS Training Program course offered by the Academy.

Performance assessment would also be completed by the Officer in Charge and the Program Director.

Non-Custodial Support Staff:

Specialists would be employed on a contract basis according to program needs.

On the Job Training - All Staff:

This should be a ongoing part of the program to be completed by the Program Director during a late 'lock in' twice weekly.

Program Content:

Counselling/Treatment

Issues to be Addressed:

- Personal Issues
 1. *HIV Related*
 - grief, death, dying
 - sexuality
 - self esteem
 - hopes, future goals
 - anxiety, fear
 - anger, guilt, shame
 - depression, suicide
 - powerlessness
 2. *Non HIV Related*
 - other psychological problems
 - drug and alcohol abuse
 - antisocial behaviour disorders
 - neuroses
 - sexuality
- Social Issues/Survival Skills
 1. *Integration into Prison Community*
 - dealing with discrimination and hostility
 - conflict resolution skills
 - communication skills
 - knowledge of correctional centre based support networks
 2. *Integration into Outside Community*
 - Integration/liaison with existing community groups and services, e.g. Ankali
 - Specific Ankali training for selected inmates to develop "buddy system", both inside and outside the correctional system
- Family Issues
 - how to tell the family

- linking family with support networks in the community
- family education nights
- Psychiatric Issues
 - psychiatric and neuro-psychological assessment, monitoring and treatment will be available as needed.
- Individual vs. Group Therapy

1. Individual Therapy

This may be provided by program staff (i.e. professional staff or trained and supervised custodial staff) or visiting counsellors. The counsellor will be assigned to the inmate by the Health Team, and not on the basis of inmate's personal preference. Issues to be addressed as listed above.

2. Group Therapy

To be conducted by skilled group facilitator/therapist with custodial co-therapists.

a) Therapeutic/Personal Issues (x1/week)

To address the specific issues mentioned above in a semi-structured way (i.e. personal, social, family issues).

b) Structured Groups (x 2/week)

e.g. Relaxation, meditation, bodywork, public speaking, communication and assertiveness groups.

c) Open/Community Groups (x 2/week)

To address community issues, housekeeping, open forum for discussion of variety of issues, etc.

Progress so far

- Assessment Correctional centre is assessing the costs of refurbishment of the MAU.
- Program Designer, Mr Mac McMahon has been contracted to provide a Program Curriculum.
- Funds have been requested as part of the compulsory testing Treasury bid.

Action steps

- Feasibility study to be submitted to the Director-General.
- Cells refurbished, kitchen built, equipment hired.
- Program Curriculum completed.
- Program Director employed. Staff employed and trained.
- Centre Health teams informed of assessment and entry process.

Centre Health Teams

- Psychologist
- Welfare Officer
- Drug and Alcohol Worker
- Education Officer
- Correctional centre Officer
- Nurse

Lifestyles Programs

- Exercise/Body Work
- Nutrition/Cooking
- Relaxation/Sleep Patterns
- Home Remedies
- Massage
- Communication
- Recreation

Spiritual Needs

- Although there will be no compulsion involved, there will be ready access to correctional centre chaplains to address issues of a religious or spiritual nature.

APPENDIX C

LSU INMATE INTERVIEW SCHEDULE QUESTIONS

1. How many times have you been in the LSU?
When & How Long were you there?
 2. When are you due to leave the LSU?
 3. Where will you be going when you leave - mainstream/release? (classo)
 4. Do you think you will come back to the LSU again?
No → Why not?
Yes → When & Why?
 5. Why did you come to the LSU and what did you expect ?
 6. How did your expectations compare to what it's been like at the LSU?
 7. What are you getting out of the program at the LSU?
 8. Which parts of the program have been of most benefit to you (& why)?
 9. Which parts of the program have been of little or no benefit to you (& why) ?
 10. Are there any things in the program which you think could be changed so they provided more benefit, help or information for inmates? (how could these be changed)
 11. What else would you like to get out of the program ?
 12. What services available in the community for HIV+ people, that you couldn't access inside, do you think would be useful to you?

What are the things that stop people coming to the LSU? eg's attitudes of guys in mainstream to LSU, location/security rating, loss of privileges, accessibility, integration of HCV+ inmates
 13. What could we do to make it easier for people to come to the LSU ?
 14. What do you think about the integration of HCV+ inmates into the LSU and program?
 15. What has been your experience with CHS? (*nursing staff, dentists & doctors*) *What problems did you encounter?*
 16. Do you think your confidentiality has been affected by coming to the LSU?
NO / YES → How & why?
 17. What about breach of confidentiality within the correctional system?
 18. Is there anything else you'd like to raise about the LSU and how it is run that you haven't already covered?
NO / YES → What is that?
- Background Information**
19. When were you first diagnosed as being HIV+?
 20. Since you were first diagnosed, how much time have you spent in prison ?
 21. How long have you been inside in this lagging ?
 22. How many laggings have you had ?
 23. Do you have any idea when you got HIV ?
No/Yes → When was that ?
 24. Do you know how you got HIV ?
No/Yes → How was that ?
 25. How old are you ?
- Thankyou for sharing your experiences and time.

SUMMARY OF LSU INMATE INTERVIEW RESULTS

How many times have you been in the LSU ?

- Six inmates had been in the unit only once. The average length of stay for this group was 22 weeks, with the shortest stay being 3 weeks and the longest 48 weeks.
- Three inmates had been in the unit twice. One had stayed in the unit 84 weeks, another 44 weeks and the other 26 weeks, on their first stay. While one had been in the unit for 12 weeks on their second stay, another 16 weeks, and the other had only just returned to the unit for one week when their interview was conducted.
- Two inmates had been in the unit four times. The first had spent the following periods of time in the unit for each of the four stays (1) 18 weeks (2) 14 weeks (3) 3 days and (4) one week - at the time of his interview. While the second had spent the following periods of time in the unit for each of the four stays (1) 1 week (2) 6 weeks (3) 7 months and (4) 15 weeks - at the time of his interview.

When are you due to leave the LSU?

From round one interviews, three of the inmates were due to be released before 20 August 1995, while the remaining five had more than four months remaining in their sentence and so did not know when or if they would be leaving the unit before their release. All of these five inmates stated they would prefer to spend the rest of their sentence in the unit.

Of the interviews conducted in round two, one of the inmates was due for release within one month, while one was due for release in two and a half months and the other in six months. All hoped to spend the remainder of their sentence in the unit.

Do you think you will come back to the LSU again ?

Of the five inmates interviewed in round one who were not due to be released before 20 August 1995

one hoped to spend the remainder of his sentence in the unit (3 months), and the remainder hoped to return to the LSU before ending their sentence for the following reasons:

- one stated if he had to leave the unit before the

end of his sentence that he would like to return if there was space available for him and he was offered because it was a nicer place to spend his sentence in and he wouldn't be as stressed out as in the main, or have the same advantages as provided for him in the unit.

- one stated if he had to leave the unit before the end of his sentence that he would like to return because he had learnt a lot of things he didn't know about HIV and AIDS, and the unit provided more access to things to get him ready for his release, and there was a better attitude in the unit.
- one stated if he had to leave the unit before the end of his sentence that he would like to return as there was no-where better to serve his sentence, received better medical attention and kept up to date with HIV information in the unit.
- one stated if he had to leave the unit before the end of his sentence that he would like to return and he was given the option.

Of the interviews conducted in round two, all three hoped to spend the remainder of their sentence in the unit. One was due for release shortly and so was unlikely to be moved out of the unit prior to release. Of the two who had been in the unit for the whole program and so could potentially be moved out to make room for others to enter the unit. Both preferred to spend the rest of their sentence in the unit and if moved out because of size restrictions would welcome any opportunity to return to unit before the end of their sentences.

Why did you come to the LSU and what did you expect ?

Reasons given why they came and what their expectations were of the unit (number giving reason in brackets) are outlined following:

- everybody works together and helps each other (x1);
- time-out place from mainstream (x5);
- expect support, awareness and education on HIV (x1);
- learn about HIV and how to look after myself (x5);
- told by other people it should be where I should be/go (x2);
- had problems being HIV positive, I was so busy helping everyone else out that I didn't have time to face up to my own problems (x1);

- didn't know/wasn't told much about the unit (x4);
- brought into the unit as no-one wanted me (x1);
- expected an "Albion Street Clinic" type of atmosphere (x1);
- thought it'd be full of gays and was apprehensive about it, but it's done lots to open my eyes especially with regard to issues surrounding sexuality (x1);
- I knew a couple of people in the unit, and they told me it was OK, though I didn't expect too much because it was still inside (x1);
- chance to improve my health and make some money in the industries offered here (x1), and;
- I'd had problems with other inmates in other gaols and no matter how hard I tried to keep my status a secret they'd always be a screw or someone that'd tell them, so I preferred to come here (x1).

How do your expectations compare to what it's been like at the LSU?

- helped me understand a lot more about HIV (x2);
- realised HIV and life is not as bad as it seemed (x1);
- been better than I expected (x2);
- didn't think it would be so small (x1);
- thought there would be more programs and things to do (x1);
- made me realise everybody's different and some people help you and others do their own time (x1);
- better environment than the mainstream (x3);
- pretty much what I expected (x3);
- attitudes of officers better than the mainstream (not us vs them mentality) (x2);
- been an experience (x1);
- provided an atmosphere conducive to HIV management in a safe area (x1);
- hard to put into words - half of my expectations have been met by the unit, on the custodial side, but the other half (the medical side) haven't (x1);
- the first time it was a shock as there were lots of gay guys in the unit then, but after a few days I started to realise how friendly and helpful they were (x1), and;
- I wanted knowledge of HIV & AIDS and to learn how to keep myself healthy and fit and I've got what I wanted (x1).

What are you getting out of the program?

- getting more out of the program than I thought I'd get;
- taught me how I can live and accept having HIV and how I can help others;
- calming me down, helping me sort things out, giving me a chance to sort things through;
- helping me with my relationship as I'm learning things I can tell her and it helps us work things out. She's not as afraid of getting HIV as we know more about it now;
- nothing in terms of knowledge, allowed me access to outside medical advice, information and services;
- learnt about different medications and treatments and stuff;
- nothing from the current program, the quality seems to have deteriorated, the program of the past was very good;
- learning about HIV and how to handle and avoid stress, and how to avoid conflict;
- learnt other skills, like painting and how to keep a journal, pottery etc. (x2);
- a mixture of things, sometimes I get scared by some of the things I find out about HIV. Though I have realised I can live a quality life with HIV and that it's not necessarily a doomsday saga. I don't feel like I can have a relationship with someone again, which is something I've always had, but I've also realised that people's attitudes are better than I thought;
- from the program very little, as I've done them before and now they're not really that relevant, I get a lot out of the industries and arts/crafts;
- HIV starts playing on your mind and it's good to be able to talk to others about it, and;
- what I was expecting - which is good;
- program has been good to occupy myself so my time hasn't been slow and boring which is the biggest killer in goal.

Which parts of the program have been of most benefit to you (and why)?

- conflict resolution, HIV specialists and Australian Federation of AIDS Organisation (AFAO) sessions, Kirkton Road Centre and Peter deRuyter groups have been very helpful, I've also enjoyed the creative writing sessions and most of the art sessions. I get a lot out of the program for myself and my own development and outlook;
- AIDS Council Of NSW (ACON), fitness, cooking are the sessions I get a lot from but it's also good to be able to see clinic and

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- psychology staff;
 - get a lot out of art & pottery; and the groups run by ACON and AFAO on treatments. I like the conflict resolution and psychology groups;
 - conflict resolution's good, psychology group very helpful and I enjoy the art sessions;
 - fitness/health program I learn a lot about the body and HIV, art sessions especially are very good and I also like the psychology and writing groups;
 - I think the general living environment has had a lot of benefit for me, plus I enjoy the fitness/health session that is run as I learn a lot about how the body works and the impact of HIV on it;
 - being here, the atmosphere, people and groups have all been good. The fitness/health group helps the most as you get to learn lots about your body;
 - people, staff and other guys in the unit. The fitness/health group is great - learn how HIV effects the body, psychologist is good for personal and group problems;
 - pottery classes and treatments sessions;
 - really liked the relaxation group as it helps you relax and tame down aggression, I also liked the pottery classes, and;
 - I liked Kris's groups (psych), treatments and ACON sessions.
- briefed about prison, so brought in his prejudice about prison;
 - I find massage and fitness/health not much use as I keep myself fit;
 - conflict resolution got boring, while the cooking/nutrition classes were good but I'd done them before;
 - Mens Health Group just didn't work, and;
 - conflict resolution - 'cause I've done it that many times.

Which parts of the program have been little or no benefit to you (and why) ?

- it depends on me, all the groups are relevant, so it depends on if I want to do them or not;
- none;
- I find a lot is not HIV related, a lot is about keeping the mind busy and not teaching or helping people about the disease. The program does not teach me how to understand and live with HIV, things like how to access and not abuse services; and how to make your own choices and decisions regarding treatments, life and other options available to you;
- conflict resolution as I feel I have no need for it;
- I like massage, but I find the guys aren't really into it. A few of the rules are petty and immature - mostly operational things , inconsistencies with treatments, different rules for different people by the staff;
- psychology group - mainly to do with how it's run and I didn't connect with the person taking it - it's a good idea though;
- tai chi didn't work because the instructor was inflexible and rigid and was not properly

Are there any things in the program which you think could be changed so they provided more benefit, help or information for you? (how could these be changed)

- can't really comment as haven't been here very long;
- ACON should be more involved in the unit - like the way they used to be. They used to come out every week and run a general information session which was very helpful;
- not all the groups should be compulsory, in the first week you should have to attend all the groups and then have the option to drop say two groups. Should have core units everyone does with the others optional, with people signing up their preferences;
- need more outside HIV/AIDS groups to come in and keep us up to date and informed on options, treatments and each person should get to see them all at least once during their stay at the unit;
- need more groups on things like how to handle life on the outside once you get out, setting personal goals and directions. Groups who can come in and help you with budgeting, resources available - getting you ready for release;
- does OK at the moment;
- needs more information on how to manage and live with HIV - how not to let it rule your life. Needs to be more focussed/structured, if people have problems with this then they can leave, they don't have to stay in the unit;
- when facilitators can't run programs they need to have someone who can take their place or have an alternative/substitute sessions which can be used to fill in the allotted time spot;
- need more sessions run by groups like ACON covering things like housing, entitlements, resources/contacts on the outside. Need more groups focussing on health and fitness - like meditation, stress management, relaxation etc;
- could gear the unit to be more educational so we could do constructive things to help us when we get out - depending on length of sentence;
- more psych/self development programs and more activism/political lobby groups coming to work with us;
- help with resourcing of personal/political agendas of inmates e.g., legalising drugs etc., and;
- more treatment sessions and access to be able to buy citrus fruits for vitamins.

What else would you like to get out of the program ?

- should be stages in the program (i) when you first come inside; (ii) pre-release (last 6 months), and (iii) general stage for people who'll be inside for a while;
- reintroduction of cooking/nutrition classes (x2);
- have a program where family/partners or significant people in the inmates lives can come in on certain days and get information on HIV and have discussion with inmates - like a workshop with the inmate(s), visitors and a group facilitator;
- have a person that inmate's close social contacts, partners and family can contact for help, advice or information about HIV;
- run groups on how to help deal with family, partners and friends and how to help tell them etc.;
- consider inmates interactions within their social structure - need to address the whole picture, individual and their interaction;
- program needs to be more focussed and have direction, program structure needs to be able to stand on it's own and have minimum quality standards;
- at the moment the program relies too heavily on the knowledge of people who are in the unit to maintain the quality of the information provided by the program;
- program needs to tie more into obtaining lifeskills associated with effective management of Hepatitis C Virus (HCV) and HIV;
- program needs to address the different space or place the different people come from to the unit who have HIV and take account of this in the groups offered;
- nothing (x2);
- an option to be able to easily access other interests/activities that are appropriate or feasible to run, e.g. if enough want to learn music then the program should be flexible enough so a new activity or group can be started, and so it can change to meet the needs of the different mixtures of groups that occupy the unit;
- not really, good to have the option to have more sessions with counsellor/psychology if you need them;
- to be kept up with what drugs/treatments are available by a regular treatments session where we can ask questions;
- more structure in the program to address living with HIV and talking about AIDS, death and other issues;
- have a skill program that helps you in telling

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- your family, friends, partners, etc. about your status;
- ought to be more in the program about treatments/drugs available and the options and choices available - both inside and outside;
 - more on anger management, and;
 - don't know.

What services available in the community for HIV+ people, that you can't access inside, do you think would be useful to you ?

- help with housing on release;
- improved vitamin service/access;
- HIV counsellor;
- access to the same treatments you can on the outside;
- don't really know (x2);
- adequate medical supervision;
- access to both traditional and natural treatment options and natural therapies;
- being able to make our own informed choices regarding treatments with those who treat us;
- more information on the services provided by outside groups such as the Bobby Goldsmith Foundation (BGF) and ACON;
- access to individual assessment by a nutritionist who can help with individual dietary requirements;
- greater access to ACON's services - housing, "how to", referral, food, accommodation, furniture and general services;
- a regular group/session run by NSW Users and AIDS Association to provide more education on safe using and harm prevention/reduction;
- access to the Minister for Health and the establishment of a special complaints service/unit within the Department of Health to deal with complaints about the Corrections Health Service;
- needs to be established a contact/support counselling service for (ex) inmates who are HIV+ which also has contact with the unit;
- access to Matraya/Drop in Centre staff;
- need to have resources updated and current information pamphlets put out by organisations - need some mechanism to get someone to chase up the information for you;
- not sure, I only found out I was HIV positive when I came to prison, but I know ACON can put me in contact with whoever I need;
- access to any positive support groups that cater for positive people who aren't gay, and;
- sessions by Positive Speaker Bureau

What are the things that stop people coming to the LSU ? eg's attitudes of guys in mainstream to LSU, location/security rating, loss of privileges, accessibility, integration of HCV+ inmates.

- other inmates finding out they're HIV positive;
- location of the unit having to share with the Crisis Support Unit and Special Care Centre leads to a lack and breach of confidentiality (x3);
- confidentiality, people who know they're positive but don't want anyone to know (x2);
- perceptions of straight vs gay;
- they're in minimum/low security and don't want to give up their privileges (x3);
- worried about having to re-integrate back into the mainstream once they've been in the unit (x3) especially given that other inmates in the Special Care Centre know who they are and these inmates go back into the mainstream without making any commitments to confidentiality;
- got mates/friends in the main and they don't want to be separated (x2);
- think they're going to be in segro or isolated from the mainstream ;
- family/people may not know their status and so don't want to come to unit;
- fear of prejudice of guys in the mainstream;
- don't know? if they only just found out maybe scared to find out about it. Don't want anyone else to find out they've got HIV;
- feel like they're being segregated;
- perceived fear and discrimination, not wanting other people to find out status;
- because it's run on a maximum security basis;
- fear, afraid of new beginnings/ideas or changing
- scared of facing up to being HIV positive, if they don't do anything it might go away, and;
- not allowed to because of their past record (s)

What could we do to make it easier for people to come to the LSU ?

- nothing really (x2), it's up to them;
- maybe extend the unit so there's more beds so people don't have to wait to come in - though not too big (x2);
- have another low security unit eg a farm for low classo inmates;
- have a system set up so there's more information/education on HIV for every inmate so that people know about it and it's not so hard for people to come into the unit;
- have a video and information guys can see before they're interviewed which explains how

the unit works, it's aims, what's expected and not expected, has comments from inmates etc (x2);

- separate us from the CSU, be able to reduce security and also reduce stress on staff; also reduce the breaches of confidentiality (x3);
- need better mechanisms to guarantee confidentiality;
- give guys the option to be able to spend the rest of their time in the unit (x3);
- have a video shown widely in the system so people aren't singled out for information and education on HIV and so guys who are thinking about the unit aren't singled out;
- let guys come into the unit for a day before they have to make up their mind so they can see what type of place it is;
- educate guys that all kinds of people come/are in the unit and it's not just full of gay guys;
- give people the privileges associated with their classification, that is ensure guys do not lose privileges by coming to the unit (x2), and;
- use voluntary segregation for HIV positive inmates, for the safety of everyone and to maintain their confidentiality - give people the option.

What's wrong with the LSU? (How could you change this) {Prompts: Location\CSU, Lockin Hrs, Staff, Size, Yard Space, Visits}

• **Location/CSU:**

- that we have to share the yard with CSU (x2);
- sometimes it's OK other times it's bad (x2);
- restricted by CSU (x2);
- location with CSU, they're trying to kill themselves and we're trying to stay alive (x2),and;
- sharing with CSU is a bit of a pain but there's no real problem with it, I don't really communicate with them, as if you become too friendly with them they ask you for things to help do themselves in.

Lockin Hours:

- lock-in should be at 9:30pm like the SCC (x4);
- lock-out hours limited because of CSU and staffing, and;
- lock-in is OK as it gives you time to relax.

• **Staff:**

- no problems with the staff at all;
- staff at the moment are excellent;
- staff pretty good;
- 90% of the staff are good, probably couldn't

get any better nothing really;

- staff who work in the LSU should have advanced HIV training and education before they come in and with refresher course run regularly;

- officers, where possible and appropriate should also have to take part in the groups, and;

- permanent staff are excellent but some of the rotation staff should not work in the unit especially those who have not been properly briefed/educated.

• **Size:**

- I think it's abit small, needs more room and would help if we had more inmates - say 14-16 inmates (x4);

- a bigger unit would give greater choice and options for people to do, and;

- outgrown the building with the activities we do.

• **Yard Space:**

- yards OK, though could be more exercise equipment;

- yard's too small (x2);

- need our own yard (x2),and;

- yard space not big enough, only get to go to the oval once a week if we can get there.

• **Visits:**

- should be able to apply for a special visit if someone can't make it on the weekend;

- visits alright;

- visiting section could be made more welcoming, it just has couple of plastic chairs and old plants and wire (x2);

- no toilets;

- have to share it with CSU no privacy to discuss important issues;

- visits need to be improved and out in the yard;

- hot in summer and cold in winter, and;

- not enough space for visits and not enough facilities plus we have to share it with CSU (no food or drink machines, like in other visits areas).

• **General:**

- need our own support group;

- I don't like the way the point system is used to enforce rules ;

- there needs to be greater thought given to the cause of any problems in the unit before jumping to conclusions and handing out points (punishment);

- should be able to have women in here like they have in the CSU;

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- too claustrophobic and too many petty rules and regulations that aren't really relevant, and;
- should be run like a half way house with a different mix of staff, some from ACON or other organisations, in a separate unit.

What do you think about the integration of HCV+ inmates into the LSU and program ?

- I think its a bad idea, because there are only eight places, if someone who's really sick and HIV+ they should have priority (x4);
- there's enough HIV+ inmates in the system to have our own unit, expand it and the program and let people stay here for their time if they want to;
- HIV & Hepatitis C are two totally different diseases;
- groups could be inappropriate;
- maintaining confidentiality will be a big problem, I think it will stop guys who are HIV+ coming to the unit even more (x4);
- not a good idea, if the HCV+ guys coming in are only those with acute illness, they may not be able to participate or contribute to the unit and so disrupt it's operation/integrity;
- cause lots of internal conflicts between the inmates in the unit (x2);
- good idea but need to make more room, HCV should be put into another unit, HCV should have the CSU and we could share a yard with them; the groups and activities that are of use to both groups could then be combined in the same area - mixing's OK as long as it's people who need it;
- I don't think its a good idea, they should have a Hep C unit for HCV+ guys (x3);
- many of the HCV+ guys are injecting drug users, and so there will be greater problems with drugs finding there way into the unit. I'm afraid they may just abuse the place and the trust established here and so cause trouble. In the past drug users have caused problems;
- visits would have to be tightened up to the detriment of everyone;
- got no real comment, my instinct tells me it's a bad idea, but until I know more about the proposal I'm not prepared to make a judgement;
- they are totally different diseases, I think it will cause problems as guys with HCV will treat you as if you've still got the dreaded. Circumstances of each illness is totally different and it wouldn't be fair to them or us (x2);
- afraid they will over run the unit;
- those guys who are HIV+ and Injecting Drug User's (IDU's) when they're in the unit get clean off drugs integration of HCV+ guys would make this very difficult;
- should be kept a small unit;
- they're going to provide more danger to our health than we are to theirs;
- different attitudes, outlooks and impact are the products of each illness;
- they're (HCV+ guys) are going to have to sign a contract saying they don't mind sharing with HIV+ guys - we're not going to be given that option/right (x2);
- I think it will be a disaster, they are totally different issues with totally different psychologies associated with self care and self worth;
- they have totally different lifestyle associations, carry with them perceptions of guilty (HIV) verses innocent (HCV);
- have different health requirements and constraints;
- if you have HCV and look after yourself you can live for a long time whereas with HIV it'll probably get you sooner;
- enough guys who're HCV+ to have their own wing in one of the mainstream centres, this wouldn't impact that much, just need some extra staff and a special program for them, like a HCV+ Lifestyles Program. With HCV they'd need some education to show them how to stay healthy until it's their time anyway;

- different groups will have different agendas;
- increased risk of exposure for both groups and other health risks;
- no real problems, and;
- anxious about it, going to be a chance that they could make us sick. Problems with hygiene re-infection or new infection with HCV, concerns over transmissions.

*What has been your experience with CHS ?
(nursing staff, dentists & doctors)*

General

- the quality of the CHS staff seems to be inferior to that on the outside, I guess that's the only way they can get people into the job(s);
- CHS does not seem to have any policies or the ability (knowledge and experience) to make a policy concerning treatments, access to treatments and access to medications for HIV+ inmates;
- provide no access to alternative therapies for consultation, yet we are able to access some for information on alternative treatments;
- the nurses can't/won't give you medication you can buy over the counter outside, you have to see a doctor to get them;
- Prince Henry Hospital annex - custodial and nursing staff and the annex itself are not suitable for HIV+ people; staff lack knowledge and experience with HIV or any emergency; annex itself is a filthy disease infested ward where HIV+ patients can't necessarily be isolated from other patients with potentially life/health threatening illnesses like TB etc.;
- CHS management either doesn't communicate with it's staff or isn't prepared to meet half way to make treatments for HIV+ inmates more accessible;
- I don't think many of the people in CHS care less, they've got the attitude "we've got a cushy job" & "f-k you";
- clinic staff are often obstructionist and don't want to give up their power and are patronising and treat you as though you have little knowledge;
- you can go and see the doctors as often as required, but this doesn't mean you are going to get appropriate treatment, and the nurses will often over-ride them by refusing to dispense what was prescribed;

- can't order or request our own blood counts/test it's up to the doctors discretion;
- CHS does not provide an adequate health monitoring service for people who're HIV+, and
- if they agree to let you try a different treatment you'd like to try or consult a doctor of your choice you have to pay 'up front' costs associated with it.

Dental

- useless need to have dentists who care enough to do something - I've had six fillings done, four fell out, one had to be redone and one went rotten;
- haven't seen any inside (x2);
- seen the guy twice he's OK, the woman's useless;
- there appears to be no communication between dental and clinic/nursing staff, especially when it comes to medication/treatment requirements;
- seen him once, he was alright, but I've decided not to go back to them even though I should;
- he's alright, knows enough about HIV, I've had no problems with him he does good work, the woman is very bad;
- dentist's OK, had no real problems, easily accessible;
- she likes to pull teeth, causes pain, apart from that she's OK;
- good when they're there, but they're not there enough, sometimes you have to wait a long time to see them;
- I feel a bit sceptical, they're paranoid about HIV and are not very good, and;
- OK had problems at the start with people waiting to see them for months but this seems to have sorted itself out.

Nursing/Clinic Staff

- most of them are pretty good, you get the odd bad one, but you get that where ever you go (x3);
- no real problems with any of them;
- need greater education on HIV and related treatments;
- problems are mainly with the Sexually Transmitted Diseases (STD) nurses, don't do anything, brush everything off and told to see the immunologist;
- clinic nurses are very good, with the STD nurses there often seems to be too many chiefs and not enough indians so not much gets done;
- some seem to be a bit afraid and some need some more education and information;

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- they need better bedside manner and professionalism;
- need better knowledge of treatments generally and what they're dispensing, how it's taken and what it does etc.;
- most of them are great, easy to cope with;
- been helpful and polite had no problems with them
- some are good, some don't seem to give a shit, basically alright do as much as able to;
- clinics and nurses in the mainstream are not well informed or up-to-date with respect to HIV and other blood borne communicable diseases;
- Long Bay Hospital nursing staff are HIV naive;
- thirty percent of them are no good, they need to be more polite and professional, some of them have power trips and bad attitude with the us versus them attitude;
- they treat the CSU inmates like idiots and think because we're from the same area they can/should treat us the same way; they have little respect for us and what we know, they seem poorly educated with respect to HIV and even when officers support us they pay little or no attention to problems we may be having;
- the Reception\Induction Centre clinic should employ a minimum of two HIV educated nurses (with high knowledge/experience); majority of them are incompetent and often hand out the wrong medications; are rude, unhelpful, don't give a dam, are inconsistent, late and unavailable, and ;
- STD nurses need to be rotated or changed, two of them have been here for 2-3 years and are on general STD nurses; of the other two (both started late in 1994) one's got HIV burnout because of the system and the other one's still OK .

Immunologists

- seem to base access on subjective markers on how sick you are, it doesn't matter if you've got a problem it depends on your CD4 count when you get to see them;
- OK, no problems (x2);
- don't seem prepared to let you know (or don't know) the latest treatments and trials available; or the trials you can access or are eligible for;
- availability and access is often a problem, no flexibility in access, based on when you've last seen them, not on a needs basis;
- put under pressure by CHS;
- the two I've seen have been excellent, they answer your questions and explain things to you, there are problems with getting to see

them, but they seem to be not so bad now;

- average, doesn't know his stuff 100%;
- immunologist is very good, excellent, he thoroughly briefed me on HIV and went out of his way to help me and treated me like a person - he even shook my hand, and;
- seen him twice, he's alright, only wants to see me every two months, but he mumbled and didn't really explain why he only wanted to see me every two months.

Doctors

- they're OK, but need to have more access to immunologists when you need them instead of having to wait;
- easier to get access to the doctors here, especially when compared to the mainstream - you may however have to wait 2 - 3 days, not allowed to jump the cue;
- do a great deal of fobbing off, unwilling to make a commitment to patient and consider themselves to be elitist, if you have a problem they say they'll organise you to see a specialist and then you here no more about it;
- not willing to research a topic/illness before they make decisions and have limited, or lack any, consultation with other (especially HIV specialists) colleagues;
- seem to be into band-aid solutions and the financial cost of a treatment not the health of the patient;
- unwilling to consider an opinion that may be in conflict or differs from their own;
- no follow up after prescription of medications and provide no explanations on what they are, side-effects and how they should be taken;
- provide no alternatives or treatment options especially natural therapies;
- refuse treatment(s) unless they fall within 'prescribed' guidelines without taking account of the different specialist needs of patients who are HIV+;
- haven't seen the doctors about anything related to HIV;
- doctors are hopeless, don't know too much about HIV, misdiagnose and mistreat things;
- right up themselves, don't care, I was prescribed something before I'd even finished telling him my symptoms, I wasn't examined and it took 3 days to see him;
- haven't had any problems with them, but then again I'm rarely sick;
- one of the doctors is so paranoid that he won't even touch you to do an examination, the other doctor(s) are good;

- I've only seen 1 or 2 of them and got no real problems or complaints;
- they prescribed medication for me for one year which is/was very bad for my liver, even though I'm HCV+ as well;
- I leave it up to them and hope they know what they're doing, though I don't feel confident in their abilities and skills, we're just guinea pigs for them because we're criminals and in prison;
- need better doctors and we should be able to see the immunologists more than once every six weeks; need doctors who know more about treatments relating to HIV & HCV and we need access to better medication, and;
- the doctor I've seen in the RIC is hopeless, I've seen him about a dozen times and he's never made a right diagnosis, he doesn't prescribe the right medications. He fobs it off by saying "I'm just a GP and know nothing about infectious diseases" and he doesn't appear to have made any effort to learn anything either. Plus you have to wait 2-3 days to see him/them anyway.

Do you think your confidentiality has been affected by coming to the LSU?

NO / YES → How & Why?

- yes, because we have to share with the CSU;
- no, not that I've noticed to any detriment, it's obvious if you're in the unit then people know why you're here, but it's caused me no problems;
- yes, just by being in the unit - lots of people (friends from outside) rang me up and found out I was in the LSU when they asked what it was they were told and so found out that I was HIV+;
- don't know, people come into the LSU and even though it's supposed to be a confidential unit anyone can walk in. Even though we can be locked-in, it's not really an option, we should have more say on who's coming in. It's "our unit" and we should have a say if people can come in, they should have a good reason to come in and also other officers should not just be allowed to wander in just because they wear a uniform. Also with the phone calls, for outgoing and incoming calls, be they for us or any other business, the unit is always identified which always gives it away where we are;
- no, because I was known as being HIV+ in the system before they had the LSU;
- because we have shared visits we get other prisoners telling their visitors;
- yes, because we share with the CSU and in the

past when we went to the oval we'd share it with the SCC;

- yes, my wife rang (we're separated) when she found out when I was inside to contact me and she was told I had HIV and was in the LSU, she freaked out and told me I couldn't see my son. So there it was totally breached. I didn't want to tell her (and I haven't told my family etc.) because we come from a small country town. Now everyone will know. Sharing the yard with the CSU worries me in terms of confidentiality;
- no, but because we're isolated and there's been no real contact with the rest of the system. It concerns me that if/when I leave that it'll be breached by officers who'll let it slip I've been in the LSU. The ones who don't know anything about it and want to cause problems. Prejudice is very hard to get around;
- yes, confidentiality is breach all the time because we have to share with the CSU, there was an officer working at the CSU who was from the main, plus the inmates in the CSU and those who can see into the yard from 10 wing; so while they offer confidentiality because of the location of the unit it's not possible to maintain it;
- doesn't bother me, and;
- no, I was pretty open about it before I came into the LSU, I didn't hide it and had lots of friends who supported me being positive. Most of them were happy about me coming here and hoped that I get something out of it.

What about breach of confidentiality within the correctional system ?

- had no problems while in Remand and then I can straight here;
- No, didn't tell anyone, a couple of other inmates have found out but they stay away, most were pretty cool, but I was only in the mainstream for one month before I came here;
- before LSU in the Malabar AIDS Unit (segregation unit) there was no confidentiality. Once when they ran out of room they put us in the top of A-wing and labelled the cells with big red A's. They'd take us out before anyone else was allowed out and take us back when they'd been locked in;
- when you go to court they put it on your court warrant;
- no, never;
- officers telling visitors;
- when you go into the mainstream all the officers know before you get there, often you'll

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get put straight into segro until or when they work out the best place to put you.;

- yes, when I was in Remand, by a member of the Inmate Development Staff (IDS), but they got in trouble for it, that's the only time;
- yes, in the RIC some officers told the sweeper and a couple of inmates I was HIV+. I had to wait 3 days for a shower before I was brought to the LSU. At meal times I had to wait until everyone had finished being served their food until I could eat and then I had to serve myself, I also had to wash my own clothes separately. While I was on remand though, for 2 months, I had no problems;
- I was told I was +ve in another correctional centre and when I was moved to the RIC there were no breaches of confidentiality. Officers didn't need to know;
- no (x2), not that I know of;
- had problems with welfare officers, knew why they were visiting me and were very unprofessional, they wanted to discuss my case/problems in front of officers. They need more education on HIV and protocols. Perhaps what we need is a team of IDS staff who have received specialised training to deal with HIV+ inmates;
- When I first came to the Remand Centre (1991) I had problems with the officers, they were afraid of me and set me up so they could put me in segro. But I've heard it's like that, because of the nature of remand (i.e. unsentenced) they're afraid guys in remand may cause them harm, and;
- A few years ago in police cells they put HIV+ on my cell and other guys who came into cells and came inside saw it so it followed me every where.

Background Information

When were you first diagnosed as being HIV+?

- late in 1983, June 93, 1988, February 95 (x2), 1989 (x4), 1985
- I was inside for 6 days on warrants in February 91 and was tested, my results came back positive and they didn't tell me until the next time I came inside in July 92 (currently under litigation)

Since you were first diagnosed, how much time have you spent in prison ?

- 11 months (x2), 10 months, 7 years 9 months, 3

years 2 months, 3 months, 5 months, 2 years, 26 months, 4 years, and 5 years.

How long have you been inside in this lagging ?

- 11 months (x2), 5 months, 6 years, 3 years 2 months, 3 months (x3), 7 months, 13 months, and 18 months.

How many laggings have you had ?

- one (x3), two (x4), three (x3), and four.

Do you have any idea when you got HIV? No /Yes → When was that ?

- yes in March 93;
- yes 31/12/80;
- yes 1987;
- yes 1990;
- yes, mid 1988;
- yes July 94 while in MRC
- yes Nov 94;
- yes Oct 89;
- yes 1989 (x2), and;
- no.

Do you know how you got HIV ? No/Yes → How was that ?

- yes - sex (x3);
- yes - sex 70%, sharing 30%;
- yes - sharing and sex with my girlfriend who was +ve and didn't tell me (x2);
- yes - sharing fits (x3);
- yes - sex - possibly blood spill, and;
- yes - o/s blood spill in caring environment.

How old are you?

- 22, 23, 26, 28, 29, 32 (x2), 35, 36, 38, and 49.

Other Comments

- People who are HIV+ should have greater consideration given to their sentencing and parole, though I know lots of guys have or could abuse that.
- Units a good place though it does depend on the guys in it, you still get guys that don't want to mix. Perhaps we need to try and get them involved in things more. Need to suggest things to them, like writing stories or use creative writing classes to help people express

themselves.

- Perhaps it would be a good idea to keep a Journal for the unit of writings, poems, stories and experiences of both inmates and staff, so a history is kept of the unit for people coming into the unit.

File: 93/1554 - Lifestyles Unit Evaluation Project

Subject: Survey of HIV positive inmates within the Correctional System

Dear Amanda,

Following is the proposal I talked to you about on Tuesday 7 November regarding contacting HIV positive inmates within the system.

Currently I am involved in evaluating the Lifestyles Unit at Long Bay. As part of this evaluation I have interviewed inmates within the unit on their feelings about the program and how the unit operates. In addition I need to contact other inmates who are HIV positive, but who are not currently in the unit, to see if there are any barriers to access for them and any comments they may have regarding the LSU.

In order to achieve this objective I have designed a short survey for these inmates to complete (attached) which needs to be distributed to them. As you are well aware, given the need to maintain confidentiality of the inmates HIV status, it is not feasible, or possible, for me to contact them directly.

Therefore what I propose is outlined as follows:

- You supply me with a up-to-date list of the number (not names) of HIV positive inmates located in each correctional centre - excluding the LSU.
- I will then send a letter to each clinic that manages HIV positive inmates (explaining the project and their role in it's completion) - see attached.
- The clinic will then be required to discretely arrange an appointment with the relevant inmate(s) and distribute them the survey with it's covering letter for completion (if they agree) while at the clinic.

I would most appreciate your earliest attention to this matter as I am working to a rather tight time frame for this project.

For your consideration and approval.

Regards

Stephen Taylor
Research Officer

Amanda Christensen
PHU

Phillip Brown
Director CHS



16th November 1995

Nursing Unit Manager
XXX Correctional Centre
[Address]

Dear Colleague,

I am writing to you for your help. At the moment I am evaluating the operation of the Lifestyles Unit (LSU) which is a voluntary unit for HIV+ inmates at Long Bay. As part of the evaluation it has been essential to get in contact with HIV+ inmates in the correctional system to find out their views and understanding of the LSU.

As you are aware there are strict guidelines on maintaining these inmates confidentiality, which I fully understand and respect, and hence I have not been able to contact them personally. Instead I have had to use CHS to get in contact with them and pass on my request for their help, and this is why I am writing to you.

I have obtained approval from Dr Phil Brown, Director CHS, to seek your co-operation in contacting the HIV positive inmates in your correctional centre, of which I have been told there are XX. What I need from you, is to discretely arrange for an individual appointment with each inmate at the clinic, and then to give them one of the survey packs enclosed so they can fill out a short survey while they are at the clinic.

When they have finished they will be able to seal their survey in the self addressed envelope provided so it can be returned directly to me. I would be most appreciative if you could place the completed surveys in the internal mail for me/them when they have finished. Of course, their participation is fully voluntary and if they do not want to complete the survey I would ask if you could write across the survey they were given "inmate declined" and send it back to me in the envelope provided.

I understand that you are very busy and thank you in advance for the time and effort you will need to contribute in order to make this important project a success.

Best Regards

Stephen Taylor
Research Officer



16th November 1995

Hi Guys,

I am writing to you for your help. At the moment I am evaluating the operation of the Lifestyles Unit (LSU) which is a voluntary unit for HIV+ inmates at Long Bay. As part of the evaluation it has been essential to get in contact with other HIV+ inmates, like yourself, who are in the mainstream so I can find out your views.

As there are strict guidelines on maintaining your confidentiality, which I fully understand and respect, I have not been able to contact you personally. Instead I have had to use the clinic to get in contact with you and pass on this request for your help.

What I need from you, is to fill out the short survey attached while you are here at the clinic. All you have to do is tick the boxes that most accurately reflect your answers and fill out your response to a couple of more general questions at the end - it shouldn't take you more than about 10 minutes or so to do.

When you have finished you can seal the survey in the self addressed envelope enclosed so it can be returned directly to me. As you will notice the survey asks no identifying information about yourself, and there is no way anyone can identify you from your answers.

As a bit of incentive, if you fill out the PINK slip enclosed, and return it with your completed survey form, you will be paid \$15 in your buy-up account. Unfortunately, this is the only way we are able to arrange payment for your participation, and I realise some of you will not want to disclose your personal details in order to be paid. I would however still greatly appreciate your participation in this project.

In order to maintain your confidentiality all slips and surveys will be separated when they are received and the slips will be used to make the payment for "*participating in a random inmate survey*".

I thank you in advance for helping out by completing this survey, and helping out with this important project.

Best Regards

Stephen Taylor
Research Officer

APPENDIX D



6th November 1995

«First» «Surname»
«Centre»
«Address1»

Dear «First»,

I am writing to you for your help. At the moment I am evaluating the Lifestyles Unit and its operation. After contacting the roster clerk, I was given your name as someone who has at some stage worked, or is currently working, at the LSU.

What we are hoping to achieve from the evaluation is a detailed review of the units operation since it was opened late in 1992. From this review we hope to make some recommendations on how to make the program and unit better for both the staff and inmates who are involved with it.

Therefore I am writing to you to for feedback on your experience with the unit. Enclosed is a short survey, which I would be most grateful if you could take the time to complete and return to me (via the internal mail), in the self addressed envelope enclosed **by FRIDAY 21st NOVEMBER 1995**.

As a bit of incentive, if you fill out the PINK slip enclosed, and return it with your completed survey form, you will be entered into a raffle draw for \$100. Only those of you who fill out the pink slip and return them with your survey by the deadline will go into the raffle draw - so it's pretty good odds. In order to maintain your confidentiality all slips and questionnaires will be separated when they are received. The winner will be notified in writing and sent a cheque, and the result published in the Bulletin.

In addition, if you would like to be put on the mailing list for a copy of the Evaluation report of the LSU (once it has been completed and approved for release) please fill out the BLUE slip enclosed and return it with your reply.

I thank you in advance for helping out by completing this survey, and wish you all the best in the raffle draw.

Best Regards

Stephen Taylor
Research Officer



22nd November 1995

«First» «Surname»
«Address1»
«Address2»

Dear «First»,

I am writing to you for your help. At the moment I am evaluating the Lifestyles Unit and its operation. After going through the program records, I noted that you have at some stage worked, or are currently working, as a sessional specialist at the LSU.

What we are hoping to achieve from the evaluation is a detailed review of the units operation since it was opened late in 1992. From this review we hope to make some recommendations on how to make the program and unit better for all those who are involved with it.

Therefore I am writing to you to for feedback on your experience with the unit. Enclosed is a short survey, which I would be most grateful if you could take the time to complete and return to me in the self addressed envelope enclosed **by FRIDAY 8th DECEMBER 1995**.

As a bit of incentive, if you fill out the WHITE slip enclosed, and return it with your completed survey form, you will be entered into a raffle draw for \$50. Only those of you who fill out the white slip and return them with your survey by the deadline will go into the raffle draw - so it's pretty good odds. In order to maintain your confidentiality all slips and questionnaires will be separated when they are received. The winner will be notified in writing and sent a cheque.

In addition, if you would like to be put on the mailing list for a copy of the Evaluation report of the LSU (once it has been completed and approved for release) please fill out the BLUE slip enclosed and return it with your reply.

I thank you in advance for helping out by completing this survey, and wish you all the best in the raffle draw.

Best Regards

Stephen Taylor
Research Officer

**Evaluation of the Lifestyles Unit Report
Implementation of Recommendations Summary**

Recommendation Number	Status	Comments
1	Underway	The HIV & Health Promotion Unit is currently providing outreach services to Mulawa and has developed a program for the therapeutic unit to address issues for HIV and hepatitis positive female inmates. The very low number of HIV positive women does not warrant further action.
2	Ongoing	Regular training days are now held with staff of the Lifestyles Unit and the philosophy of the Unit is addressed in this training.
3	Completed	The Lifestyles Unit now has set programs with a fixed time (10 weeks, 12 weeks or 16 weeks) depending on the status of the group entering. All inmates enter and leave at the same time now.
4	Rejected	Inconsistent with recommendation 3, unless another separate unit is established.
5	Ongoing	All inmates are assessed and interviewed prior to entry in the Lifestyles Unit . They are given all available information on the Unit at this time and have the option not to go to the Unit if they wish. The program is voluntary.
6	Ongoing	The Lifestyles Unit co-ordinator is responsible for the program and regularly reviews and updates the program as necessary

7	Ongoing	This occurs during the interview and assessment phase of the program
8	Ongoing	The Hepatitis C Council, AIDS Council, NSW Users and AIDS Association etc all participate in the program.
9	Completed	Although entry to the Lifestyles Unit is voluntary, participation in the program is compulsory for all inmates. Failure to participate in any program other than for legitimate reasons (sick, court etc) is not accepted. The only exception is during the industry component where inmates are not obliged to earn extra wages, though none have refused to do so to date.
10	Completed	This is now part of the program
11	Completed	This is now part of the HIV program in the Lifestyles Unit.
12	Completed	The Lifestyles Unit Co-ordinator works closely with the SEO of the SCC when developing and implementing the program
13	Under Consideration	A number of issues of security etc need to be considered yet
14	To be Completed	The HIV & Health Promotion Unit agrees with this recommendation but is yet to implement.
15	Completed	This is now part of the HIV program in the Lifestyles Unit.

16	Ongoing	The Lifestyles Unit Co-ordinator continually reviews and monitors the program including feedback from staff and inmates
17	Completed	This is done whenever possible although there are limitations
18	Completed	Where possible this is done, there are however restrictions on the access to some services such as drug trials etc which are the responsibility of CHS.
19	Accepted	This will be further investigated by the HIV & Health Promotion Unit
20	Planned	The re-development of Long Bay includes an agreement to provide the Lifestyles Unit with its own separate yard area
21	Completed	This is done where possible. The SCC is a maximum security centre and all inmates are advised of some of the restrictions this can impose despite their own classification being minimum or medium. The decision to enter is still with the inmate after this advice is provided
22	Not Considered	The redevelopment of Long Bay does not include an expansion of the Unit. There are severe budget implications for this proposal
23	Planned	See recommendation 20
24	Completed	A new system has been introduced after review by staff of the Lifestyles Unit and the HIV & Health Promotion Unit

25	Rejected	The development of a separate unit is not supported. The Lifestyles Unit now runs separate group programs for either hepatitis C positive or HIV positive inmates depending on need.
26	N/A	This is a matter for CHS
27	Completed	This has occurred in the past with Operations and the HIV & Health Promotion Unit providing information through the Department of Corrective Services Bulletin, it will also continue in the future
28	Ongoing	This information is provided to staff during training days and to inmates during their assessment and throughout their stay in the Lifestyles Unit
29	Accepted	This will form part of the next HIV positive inmate group program
30	Accepted	The HIV & Health Promotion Unit has developed a new pamphlet to promote the Lifestyles Unit to staff and inmates in the mainstream. The HIV & Health Promotion Unit inmate newsletter is also being used to promote the Lifestyles Unit and the new programs it offers
31	Ongoing	This has occurred on some occasions although it is not possible to provide these opportunities to all inmates
32	Accepted	This will be done where possible

33	Completed	See recommendation 2
34	Not Accepted	This has been investigated and been found to be very costly and difficult to implement. All HIV positive inmates are encouraged to apply to attend the Unit on a residential basis
35	Completed	The Lifestyles Unit Co-ordinator discusses this issue with each new group that starts and changes are made where possible and agreed.
36	Ongoing	This occurs in staff training which occurs every 3 months
37	Ongoing	Staff of the Kevin Waller Unit are invited to attend staff training
38	Ongoing	This is discussed at staff training
39	Accepted	Inmates are not to be "dumped" into the Unit, however, in some extreme cases flexibility is required to meet the needs of the system as well as the needs of the Lifestyles Unit
40	Ongoing	All sessional staff are encouraged to attend the staff training and are briefed individually by the Lifestyles Unit Co-ordinator on their role and responsibilities
41	Accepted	This can occur during staff training sessions although the HIV & Health Promotion Unit will investigate further the possibility of sessional staff only sessions

42	Completed	A position of Lifestyles Unit Co-ordinator is currently in place, it is expected to be formally established by May 1997.
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