HIV AND DRUGS IN BRITISH PRISONS

Drug-related HIV spread in prison is the great gap in Britain's response to the epidemic. How big is the problem, how hard to overcome?

With up to 20,000 drug misusers imprisoned each year, there is reason to believe that sexual and injection-related HIV spread in British prisons is a serious problem. However, the authorities face strong staff resistance and severe resource problems in providing information about HIV, and are unwilling to supply condoms or syringes. The only long-term answer may be to keep more drug using offenders out of prison.

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IN 1988 THE daily prison population in Britain exceeded 50,000 for the first time and it seems unlikely that this number will significantly drop in the foreseeable future.

Inevitably, a proportion of these inmates will be infected with HIV. Studies throughout Europe have shown that around 10 per cent of prisoners are seropositive,[1] but government figures for prisoners in the UK record a mere 0.1 per cent — 62 inmates.

There are various theoretically possible explanations for Britain recording one hundredth the average European level of HIV infection among its prisoners, but the most plausible is that the number of our prisoners known to be carrying the virus is only a tiny proportion of those actually infected — either because the prisoners themselves don't know it, or because they know it but aren't letting on.

We have a less widespread system of testing and monitoring than most European countries, and the fact that most known HIV-positive prisoners are segregated from other prisoners is a definite disincentive to admitting seropositivity to prison staff.

So low official statistics are no justification for complacency. Our prison system contains a disproportionate number of drug users because of the strong line taken by the courts. Around 5000 people a year are imprisoned for drug offences but the total imprisoned as a result of their drug misuse (including those convicted of offences committed to obtain money for drugs) is around 15-20,000 a year.[2] Many have injected their drugs regularly, and most have shared needles with others.

In prison syringes are in short supply, so those that are available are used as much as possible. I have reliably heard of a syringe in one prison being shared by around 100 inmates over a period of a year. Of three battered and broken syringes confiscated in Oxford prison in 1988, two were found to be carrying HIV.

Because of the tedium of prison life, many people who do not use drugs outside will do so during a sentence and many who prefer not to inject will be forced to do so by the need to get the maximum effect from the smaller amounts of drugs available.

Homosexuals are not disproportionately present in our prisons, but all the evidence suggests a high level of homosexual activity between inmates, the extent of which is unknown because it is such a covert subject. However, the combined reality of homosexual relationships (including rape), homosexual prostitution, and experimentation by those normally heterosexual, gives rise to fears that unprotected anal sex between prisoners is a significant route for transmission of HIV.

Homosexual experimentation by those normally heterosexual is the activity that's most excited fears that HIV infection could be extended into the 'decent', heterosexual, non-criminal population. This, if nothing else, has led to action by the authorities.

Britain's response

One benchmark against which to measure Britain's response to HIV in prisons is the combined recommendations of the Council of Europe and the World Health Organisation (WHO) — the actions *they* saw as necessary to minimise HIV spread.[3,4] These covered five specific codes of good practice (see opposite).

Another benchmark is the recommendations of the Advisory Council on the Misuse of Drugs in their two *AIDS and Drug Misuse* reports.

In relation to prisons, the council's first report endorsed the principles of the WHO statement and explicitly agreed with the recommendations on staff training, information for inmates, and HIV testing.

It was less forthright on providing condoms or sterile needles and syringes, and stopped short of direct criticism of the segregation and labelling of prisoners known to be seropositive. The council agreed with WHO that diverting many drug offenders from custody in the first place may be a good long-term strategy.

The second report from the Advisory

Council came out with a stronger statement against segregating prisoners with HIV under the Viral Infectivity Restrictions (VIR).

Taking each of WHO's recommendations in turn, we will see that in Britain some of this domestic and international advice has been followed, some ignored, and in some cases the best intentions have foundered in practice.

Staff informed?

Last year an HIV/AIDS training video and accompanying leaflet were made available to prisons for staff training. Being specific to the prison situation, the materials cover subjects not covered in general public health information, including the areas that most concern prison officers: the throwing of urine or excrement over officers; spitting and biting; and accidents involving the spillage of blood.

However, the material is perfectly explicit in saying that HIV can only be caught:
— by your blood coming into contact with infected blood;
— through infected semen or vaginal fluid passing into your bloodstream;
— from mother to baby in the womb.

Prison officers don't really believe what their bosses are telling them

Clearly ruled out are infection risks from casual contact (eg, via eating utensils, towels, bedding or toilet seats), through prison activities (such as physical exercise, education and workshops), or even through being drenched in infected urine or saliva. The leaflet points out that no US prison officer has ever been infected with HIV through their work. It gives sensible guidelines on dealing with blood spillage and how to help those infected with HIV, and points out the limitations of antibody testing.

But there have been logistical problems with getting the video and leaflet to all staff. Experience in most (but not all) prisons is that few staff have the interest to attend HIV training sessions even if they are held, and even if it is possible to find a time when officers aren't busy with some essential discipline duty. Most prisons have difficulty finding enough staff to do the basic jobs of guarding, feeding, exercising and controlling the inmates, without having to find time to sit down and discuss a training video.

Levels of interest are also low because service morale is low. Tackling issues to do with the humane treatment and welfare of inmates is not a priority for prison officers struggling with the containment of a largely uncooperative group in depressing and insanitary conditions.

This has been exacerbated by bad industrial relations due to the negotiation of new and, the officers say, less favourable working practices. Put simply, the officers don't really believe what their bosses are telling them.

The result is that, though the authorities distribute perfectly clear information in line with expert advice and scientific knowledge, still the officers at the sharp end hold attitudes and maintain practices totally at odds with what's known about HIV. The situation has definitely improved over the last two years, but most officers still vehemently demand infectivity restrictions for HIV infected prisoners and refuse to supervise them on work details or sports activities.

Prisoners informed?

Another video and accompanying leaflet has been made available to be shown to all inmates of British prisons, giving information on HIV and how to avoid its transmission.

Once again it's made clear that the two routes of transmission are through unsafe sex or by using a syringe or needle recently used by someone else, although the video does acknowledge that sharing razors or toothbrushes is also inadvisable. The leaflet also emphasises that you cannot tell by appearances whether a person is infected, so the best policy is to avoid risky practices with everyone.

Quite rightly, the leaflet says normal social or casual contact, sharing cutlery, clothes, toilet and bathing facilities, or being at the receiving end of coughs, sneezes or spits, all involve nil risk.

But, instead of acknowledging that drug injecting and homosexuality occur in prison, the leaflet gives advice on safer sex and injecting practices in a section on how to protect yourself *after* release.

While the information is generally succinct and clear on what is or is not risky behaviour, the problem once again is how this can be made accessible to the 100,000 prisoners a year who pass through Britain's prisons, and how we can be sure they are listening.

Prisons are so underfunded and understaffed that even achieving simple goals is difficult. In an establishment like Wandsworth with on average 50 receptions a day and 1500 inmates on eight separate wings, it is hard to see how the authorities could ensure all of them get a chance to see the video.

In some smaller long-term prisons with a relatively stable population, these problems do not exist. But in a tight situation where facilities and staff time are in short supply, welfare advice for inmates is the first thing to get shelved.

Where the authorities can arrange a showing, the information is presented by a member of the prison's staff, raising credibility problems. In many establishments, relations between staff and inmates are surprisingly good, but prisoners tend to be suspicious of pronouncements from any authority, let alone the one responsible for their incarceration. When the member of staff is a prison officer rather than a doctor or psychologist, the situation is particularly difficult, given that the officers themselves may not have full confidence in official information.

Another barrier to limiting HIV spread in prison is prisoners' supposed lack of responsibility. Even if they all had access to the information and trusted its validity, there are doubts over the extent to which some would change their high-risk behaviours. Most prisoners involved in such behaviour are drug injectors who belong to no tight-knit community; quite the opposite, they are marginalised and feel no need

WHO and Council of Europe guidelines

Separate documents from the World Health Organisation and the Council of Europe came up with very similar recommendations on HIV in prisons, summarised in the five points below.

◆ **Staff informed.** Information and training on HIV issues should be provided for all prison staff.

◆ **Prisoners informed.** Information on avoiding the transmission of HIV, and the help available to seropositive inmates, to be provided for all inmates.

◆ **Condoms provided.** Condoms should be made available to male prisoners.

◆ **Drugtaking controlled.** All efforts to be made to stop drugs and syringes being smuggled into prisons. If not possible, ways of enabling drug users to administer drugs safely should be investigated (eg, methadone, syringe exchanges).

◆ **Tests confidential.** HIV testing should be available but only with the consent of the inmate, and in a non-coercive atmosphere. Results should only be communicated to the authorities with the inmate's consent.

The World Health Organisation's statement went on to advocate no segregation of prisoners known to be HIV positive; to give guidelines on proper medical treatment of prisoners developing symptoms of AIDS or ARC; and to suggest governments look at their sentencing policies, particularly with regard to drug abusers, as a possible way of avoiding the problem.

See references 1 and 4 for sources

for social responsibility or even for personal health care.

Condoms provided?

The Home Office continues to resist calls for distributing condoms to male prisoners, for two reasons. First, it is claimed that their distribution will encourage homosexual activity, while giving inmates a false sense of security because of the risk of a condom breaking during anal sex.

Secondly, the authorities say they cannot be seen to be condoning illegal activities within the walls of part of the criminal justice system meant to uphold law and order. In Britain, homosexual acts are legal only between consenting adults in a private place. It is argued that prisons are entirely *public* places, so all homosexual acts are illegal and should be discouraged.

This dubious interpretation of an outdated law can hardly be claimed as the arbiter of so important a policy issue. Even if the government did interpret the law more loosely, no one would be likely to challenge it. Nearer to the truth is that the prison service finds it unpalatable to have to accept the reality of homosexual activity so long unacknowledged in prisons — together with the knowledge that the widespread presence of condoms in prisons would make drug smuggling a little easier.

The idea that distributing condoms will encourage homosexual relations is also questionable. Such activity remains frowned upon in open prison culture, but happens for the most part covertly between consenting partners, typically in a shared cell. In these situations condoms are likely to be used sensibly and I see no harm in encouraging such relationships.

The various coercive sexual relationships that can develop in prison are less healthy, but in these situations whether a condom is available or not is likely to be immaterial. Also, if fears about the reliability of condoms in anal sex are sufficiently well-founded to guide prison policy, why are gay men outside prison constantly advised to wear one?

Drugtaking controlled?

The smuggling of drugs and drug paraphernalia into prison was a problem long before fears about AIDS. Cannabis was largely tolerated but the mid-80s saw the setting up of micro-markets with all the disputes, recriminations and violence these entail.

Because of the difficulty of smuggling drugs into most prisons, quantities are limited and prices prohibitive. This makes it all the more important for users to get the maximum out of the minimum possible amount. Particularly with the opiates and amphetamines, this means administration by injection. Needles and syringes are therefore valuable possessions. Much harder to smuggle in than small bags of white powder, they are relatively rare in prisons, so each is much used and much shared.

There is a genuine policy dilemma here. The more successful the prison service is in stemming the flow of smuggled syringes, the more those that do get through will be shared and the greater the potential for transmission of blood-borne infections, including HIV.

Much can be done to stem the, even now, only gradual flow of drugs and syringes into prison, but most of the suggested actions involve further infringements on the limited freedoms available to prisoners — such as closer supervision of visits, less access to presents, books, and clothes from outside. Inmates in open prisons and remand prisoners are entitled to be relatively free from restrictions, so present even greater problems.

For these reasons, drug injection will probably never be anywhere near eradicated in prisons. Many, like myself, therefore grudgingly accept WHO's line that sterile syringes should be made available.

Prison medical officers are needlessly forced to breach confidentiality

However, there are problems with such a policy: the extent to which prisoners would care whether their works were clean; how far prisoners could get hold of equipment without letting staff know they were using illegal substances; fears that needles may be used as weapons to threaten or influence other inmates or staff; and, consequently, the undoubtedly adverse reception such a scheme would receive from staff.

One way forward could be the recent statement from Home Office minister Douglas Hogg advising prison medical officers to give increased prominence to methadone treatment for opiate dependent prisoners received into custody. This has considerable potential for limiting the use of smuggled drugs in prison. If it was generally known that a methadone reduction programme was available this would greatly increase the rate of identification of prisoners withdrawing from opiates. Once the programme was underway, the medical officers could regularly screen for illicit drug use. They would also have the chance to persuade the inmate to react positively to the opportunity of being drug free and to give advice on the risks of drug use inside and outside of prison.

The government eventually embraced the harm-reduction measures suggested by the Advisory Council on the Misuse of Drugs for outside prison. There is no reason why the same principles cannot be extended to prisons.

Tests confidential?

Prison service policy on HIV testing is to treat prisoners as having the same rights as people outside. This means they will only be tested with their informed consent, and will receive advice from a prison medical officer on the consequences both of taking a test and of the possible results.

Most medical officers have discretion over how these principles are applied. Generally it seems that testing is discussed on reception with prisoners thought to be in a 'high-risk group'. Among medical officers, the most common definition of high-risk groups seems to be injecting drug users and 'promiscuous' homosexuals. Most people who fall into these groups would not be in a hurry to admit it to prison authorities. More often the information is gleaned from probation or medical reports.

Some medical officers say that as part of their pre-test counselling they tend to discourage inmates from taking the test, particularly at the start of a long sentence. This is good practice. Finding out you have a potentially terminal disease for which there is currently no cure, and having to spend the next precious months or years of your life in prison, is the sort of depressing news that encourages extreme behaviour.

In any event, given the administrative problems surrounding the small number of diagnosed HIV positive prisoners now in the system (many establishments refusing to take transfers, staff and inmates protesting against their placement on normal location), the authorities have no wish for the number of diagnosed prisoners to

Denis Doran. Network.

An officer in Maidstone prison attempts to work out the weekend's duty rota but there just aren't enough people to fill the slots. Pressures like these mean 'extras' like HIV education for inmates and staff fail to get implemented.