Still Safe?

A review of Keeping Safe: Blood-borne Virus and Harm Reduction Information for Offenders in Western Australian Prisons.

Sexual Health and Blood-borne Virus Program

Department of Health
Government of Western Australia

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIMS	Australian Institutional Management Service
AIVL	Australian Intravenous League
AMS	Aboriginal Medical Service
BBV	Blood-borne Communicable Disease
BBV	Blood-borne Virus
DG	Director General
DOH	Department of Health
DOJ	Department of Justice
FCMT	Forensic Case Management Team
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immuno-deficiency Virus
IC	Infection Control
NSP	Needle and Syringe Program
SARC	Sexual Assault Referral Centre
STI	Sexually Transmissible Infection
WAAC	Western Australian AIDS Council
WAPOU	Western Australian Prison Officer's Union

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EXECUTIVE SUMMARY

The Commonwealth Department of Health and Aged Care has allocated $12.4 million nationally over a four year period (1999-2003) to lower the current rate of transmission of hepatitis C through the provision of improved education, prevention and health maintenance initiatives for those currently infected and those at risk of becoming infected.

The Commonwealth has established as a matter of priority the need for the development of initiatives for state/territory custodial services' education and prevention programs. The Sexual Health and Blood-borne Virus Program of the Department of Health was funded by the Commonwealth to initiate two projects in collaboration with the Department of Justice, commencing January 2001.

This document provides a report on the first project, which has as its key objective: increasing access of people in correctional facilities to up-to-date information regarding BBV prevention and health maintenance. The objective has been met through a review of the current Keeping Safe Program, with suggestions for adapting the existing program to better meet the information needs of special groups within custodial settings and to develop mechanisms to ensure the ongoing update of program materials.

The report has been divided into two sections. Part A provides information specifically relating to the review of the Keeping Safe Program, and Part B reports on associated issues in the prison system related to BBV's.

In Part A of the report, it was determined that all aspects of the program needed to be considered, not just the program content. The review demonstrated that a complete re-write of the package was needed and that it be re-formatted to provide an Entry and Exit program. There also needed to be an acknowledgment of the special needs of different populations in the prison system, as opposed to the generic program which is currently in place. The finding of the review was that the current provision of the program to juveniles was inappropriate and should be replaced.

The review clearly demonstrates the need to develop a framework for measurable program evaluation and monitoring processes to increase accountability for program delivery. In addition, the management of the project needs to be documented for all stakeholders: the review indicates that there has been an over-reliance on informal networking and verbal dissemination of information, which is unsatisfactory.

In Part B of the review, the intent was to provide a context for the environment in which the Keeping Safe Program operates. Issues raised within this section of the report highlight the need for training for staff working in the prison system in the area of BBVs and the need for information to be balanced with values clarification work to address sometimes discriminatory and fearful attitudes on the issue of BBV's. The report also looks at the current responses to risk practices in the system and proposes ways in which risk practices may be addressed.

It is intended that by presenting a perspective on the environment in which the Keeping Safe Program operates, the revised program will more effectively reflect prison realities, and give insights for the presenters who play such a valuable role in the prison and juvenile detention system in providing learning opportunities for offenders and detainees.

PART A: RECOMMENDATIONS

PROGRAM CONTENT AND DELIVERY:

1) That the specific BBV information needs identified by both male and female offenders be noted for inclusion in the revised program.
2) That the practical demonstration of cleaning injecting equipment be replaced by other strategies in the interest of increased security and safety for presenters.
3) That the current staging of the program be changed to provide an Entry and Exit Program for offenders in order to more accurately meet the information needs of offenders within the limited time available.
4) That the overhead foils be omitted from the new package.
5) That the laminated posters be omitted from the new package, and that they be replaced by a flip chart.
6) That funding be secured to develop a video on BBV's that could be used in WA prisons, with the involvement of offenders.
7) That as an interim measure, Health Services look to the development of a series of "video clips" that presenters could utilise as part of their program.
8) That steps be taken by Health Services to ensure that presenters have access to video equipment across all sites.
9) That Keeping Safe presenters make offenders attending programs aware of the availability of BBV information through prison libraries.
10) That the Reference Group established to design the new package addresses the identified need to format the package acknowledging the special needs of the offenders to whom the program is delivered.
11) That the certificates presented to offenders on completion of the program be retained.
12) That certificates for Aboriginal offenders be re-designed and that an Aboriginal graphic artist be contracted to do this work.

PROGRAM MANAGEMENT AND NETWORKING:

13) That each Prison Health Centre be provided with a copy of the revised Keeping Safe package for use in offender BBV education.
14) That the processes involved in the day to day management of the Keeping Safe program be formalised into a procedural handbook to increase the capacity of prison staff and presenters to manage the program effectively following staff changes.

15) That the development of a procedural handbook (referred to in recommendation 14) includes a section on presenter safety and security issues tailored to their needs.

16) That mechanisms be developed to strengthen linkages with other programs and follow up resources (human and print) in order to increase the relevance and significance of the program to offenders.

17) That Keeping Safe contractors, in collaboration with the DOJ, standardise the selection criteria for presenters and the recruitment process.

18) That the DOJ provides clearer directions regarding the costing and invoicing of service delivery.

19) That the DOJ make provision for all Keeping Safe training materials to be stored in the prison between programs in a secure place.

PROGRAM MARKETING:

20) That meaningful incentives be put in place for offenders to encourage attendance at the program.

21) That prior to the introduction of a revised program, a concerted and aggressive marketing program be implemented with the purpose of shifting the current attitudes of offenders towards the program.

22) That new posters and pamphlets be developed and made widely available in prisons in order to promote the revised program.

23) That the name of the program be changed to reflect the recommended changes to format and content.

24) That there be a parallel marketing program for custodial service staff when the Keeping Safe Program is revised.

QUALITY CONTROL AND PROGRAM EVALUATION:

25) That the quality control of the revised program be measured through the use of checklists to be completed by presenters at the end of each program that they deliver.

26) That the DOJ works collaboratively to develop strategies to more effectively monitor the competency of presenters to deliver the program.

27) That an appropriate instrument be developed for the ongoing evaluation of the program and that the instrument selected be appropriate for use by offenders with low or limited literacy skills.

PROFESSIONAL DEVELOPMENT FOR PRESENTERS:

28) That future skills training for presenters needs to address effective ways of working with Aboriginal offenders and demonstrate strategies designed to select a vocabulary that is acceptable to offenders in discussion on sexual matters.

29) That the DOJ increases the number of forums convened annually for networking and professional development of Keeping Safe presenters, contract managers and DOJ staff.

LOCATION OF THE KEEPING SAFE PROGRAM:

30) For each site to identify a dedicated space for the program, which could double as a base for peer educators.

SAFETY AND SECURITY ISSUES:

31) That Prison Health Services collaborate with DOJ Aboriginal Policy and Programs to address the safety and security issues of Aboriginal Keeping Safe presenters, to reduce both the attrition rates and the stress experienced by these presenters.

32) That protocols are developed for the provision of de-briefing for presenters following traumatic or stressful events.

JUVENILE JUSTICE:

33) That the delivery of the program to juveniles is deemed as unsuitable for many of those that attend and it would be more beneficial to deliver an expanded Promoting Adolescent Sexual Health (PASH) program than the Keeping Safe Program.

BBV RESOURCE ACCESS:

34) That the DOJ BBV Project Officer continue to disseminate information to Health Centres regarding new BBV resources as they become available.

35) That the Department of Justice BBCD Steering Group maintain control over the distribution of health promotion materials used in the Keeping Safe Program and that Nurse Unit Managers maintain control over the health promotion materials distributed through Health Centres.

36) That Health Services give consideration to providing the equipment required to show BBV videos in prison Health Centres.

37) That a designated person be appointed at each Health Centre to ensure that print resources provided in the waiting areas are current and available for offenders.

38) That AIVL and other organisations that develop print resources increase their awareness of making resources more available to the prison system. AIVL in particular needs to recognise that offenders can benefit from the general resources that they develop, they do not necessarily require prison specific resources, and therefore print runs should be increased to meet this need.

39) That the BBV Project Officer enters into discussion with the sites that produce calendars to explore the possibility of developing a health calendar.

ABORIGINAL ISSUES:

40) That the DOJ give consideration to increasing the pool of presenters drawn from the groups identified in Section 13.1 of the report.

41) That the revised program needs to more effectively work within Aboriginal terms of reference and that non-Aboriginal presenters should be skilled to work with Aboriginal offenders.

42) That the new program employ a problem solving approach that is considered to be a more appropriate learning style for Aboriginal offenders.

43) That the DOJ give consideration to implementing a BBV Peer Education Program.

44) That the DOJ in the first instance pilot a BBV Peer Education Program for Aboriginal offenders in the metropolitan area, with extension to the regional prisons if it is demonstrated as effective in the metropolitan area.

CALD OFFENDER ISSUES:

45) That the DOJ develop strategies to more effectively address the BBV information needs of CALD offenders.

PEER EDUCATION PROGRAMS:

46) That any plan developed by the DOJ to provide an offender BBV peer education program acknowledge Keeping Safe presenters as willing partners in the establishment of such a program.

PART B: RECOMMENDATIONS

STAFF BBV TRAINING:

47) That all categories of staff having direct contact with offenders require access to BBV training as a matter of priority.

TESTING ISSUES:

48) That the issue of informed consent for BBV testing be more accurately defined within existing testing policy. Consideration should also be given to obtaining written consent, especially for HIV Antibody testing, and that written consent should be retained on the medical records.

49) That strategies be developed to more effectively market BBV testing and STI screening.

50) That training in the area of pre/post-test discussion and sexual health be provided for nurses as a matter of priority.

51) That consideration be given to adopting some of the strategies suggested in the report to overcome the current limitations on the delivery of pre/post-test discussion as a result of time restraints.

52) That strategies be put in place to improve the dissemination of information on BBV's and STI's to Aboriginal offenders.

BBV RELATED DISCRIMINATION:

53) That strategies, for both staff and offenders, be developed by the DOJ to address BBV related discrimination in prison settings.

CONFIDENTIALITY:

54) That Health Services address as a matter of priority the at times very inadequate attention some nurses displayed during the course of the review in regard to the confidentiality requirements of offender health information. This especially applies to information related to the offender's BBV status.

55) There is a need for the DOJ to review policies developed out of the decision of the WA Industrial Commission that prison officers have the right to know the BBV status of offenders. Given the high prevalence of BBV's in the system, existing policy works against officers consistently applying standard precautions.

CASE MANAGEMENT FOR OFFENDERS WITH HIV/HEPATITIS C INFECTION:

56) That the DOJ give consideration as a matter of priority to improving the coordination of case management of HIV Antibody positive offenders by better utilising all community based services that can provide treatment and support to offenders.

57) That a key feature of improved case management be more effective discharge planning, involving all stakeholders in the offender's management.

58) That Health Services develop a sound business case for a budget increase to enable them to provide access to hepatitis C treatments at the level and quality of service available to people in the community.

59) That the DOJ review the provision of and access to low fat diets for offenders with hepatitis C.

60) That offenders be able to increase their access to non medical treatments for hepatitis C infection that are available to people in the community, at cost to the offender.

61) That Prison Health Services develop a framework for a continuum of care for offenders with BBV's, addressing the entry and release requirements for effective management.

62) That consideration be given to the DOJ establishing a Lifestyles Unit for those with HIV/hepatitis C infection as provided for offenders in NSW. Such a unit would enhance the education and support needed by infected offenders and also provide a central point from which case management and discharge planning could be coordinated.

OCCUPATIONAL HEALTH AND SAFETY AND INFECTION CONTROL:

63) That the DOJ review existing policy and protocols for occupational exposure management linked to staff training to provide a coordinated response to this issue.

64) There is a need for increased training of nurses to increase their competency to effectively manage the occupational exposure management of staff.

65) There is a need to provide training to prison officers to promote and skill officers in consistent application of infection control principles.

66) That the DOJ conduct a review into the current provision of protective clothing and equipment provided to reduce the risk of BBV transmission in prison settings.

67) That the DOJ give consideration to the establishment of multidisciplinary Infection Control Committees at each prison and juvenile detention centre to report through the Health Services BBCD Steering Group.

68) That officers be made aware in training/education forums that standard precautions apply not only to offenders, but also to the children of offenders when they are on prison property.

69) That the DOJ work with the DOH to bring the standard of infection control for the mother and baby units to the same standard as similar facilities in the community.

CONDOMS AND OTHER BARRIER PROTECTION:

70) That there be consideration of linking the Exit Kits to the Through-care Package, which would ensure that all prisoners received a kit on release.

71) That, given the high number of illicit drug users in the prison system, consideration be given to providing sterile injecting equipment on release together with additional information on overdose prevention as part of the Exit Kit.

72) That the number of condoms provided in an Exit Kit be increased.

73) Any BBV training for officers addresses the issue of homophobia as a barrier to BBV prevention strategies and addresses the importance of condom access as a BBV prevention strategy.

74) That the presenters of the Keeping Safe Program cover the issue of safe condom disposal at each session.

75) That the instructions currently provided with the dental dams be reviewed to ascertain if additional information is required.

PRISON SEX AND SEXUAL ASSAULT:

76) That the current management of sexual assault in prisons be reviewed and for the review to especially address reporting mechanisms and offender privacy.

77) That SARC be contracted to provide training for prison staff, to initiate organisational attitudinal change towards the issue of sexual activity and abuse in prison settings.

78) That strategies be developed which encourage offenders to seek support and treatment following episodes of non-consensual sex.

TATTOOING AND BODY PIERCING:

79) That the DOJ provide appropriate replacement materials to enable offenders to keep body pierced sites open when jewellery is confiscated on entry to the system.

80) That Keeping Safe presenters stress the importance of offenders not sharing body-piercing jewellery.

81) That, given the lack of support at this time to implement recommended strategies to reduce BBV risks associated with tattooing, Health Services develops a sound educational approach to this issue.

82) That a process be developed to facilitate tattoo removal (through out-sourcing) for offenders whose tattoos are impacting negatively upon their self-esteem.

HAIRDRESSING:

83) That the DOJ, in collaboration with the DOH, adapt the NSW Barber Shop program for use in WA prisons to reduce the risk of BBV transmission through hairdressing and barbering practices.

INJECTING DRUG USE:

84) That Health Services develops a drug treatment response that is holistic and reflects community standards and best practice.

85) That expert advice be taken to improve the current management of offenders with amphetamine psychosis, and that protocols developed have application for custodial staff as well as health staff.

86) That Health Services review and expand the current provision of methadone in WA prisons.

87) That any future use of naltrexone be linked for all offenders to adequate skills training and support.

88) That any proposal to introduce the use of naltrexone implants be carefully considered, with a special emphasis on the ethical and human rights considerations of introducing such an initiative.

89) That drug free units be expanded and that female offenders also have access to such a facility.

90) That drug free units also include a BBV education component with an emphasis on treatment and diet/lifestyle choices.

91) That Health Services in consultation with Next Step reviews its current drug detoxification management protocols, and that such protocols acknowledge the need for intra-sentence drug detoxification management.

92) That any offender or detainee who is still in the process of drug detoxification be excluded from the Keeping Safe Program until such time as they have completed their detoxification and are well enough to actively participate.

93) That overdose prevention programs link more closely with custodial management and Health Services to develop a more holistic and co-ordinated overdose management strategy.

94) That the means be found to educate partners and friends of offenders regarding the risk of drug overdose.

95) That the Keeping Safe program be expanded to address associated health risks of injecting, such as vein care.

96) That training be provided across the board in the DOJ to increase the ability of staff to effectively manage the drug related issues of offenders.

97) That there is increased information dissemination to prison based staff to reduce the amount of misinformation and fear regarding Needle and Syringe Programs.

98) That Health Services commence the development of a discussion paper for senior management at DOJ on the subject of needle and syringe provision for offenders, nominating a number of models that have been demonstrated as effective in other jurisdictions.

BLEACH PROVISION FOR OFFENDERS:

99) That, given newly released research that indicates that bleach may be effective against hepatitis C, and in the absence of needle and syringe programs in prisons, a Bleach Availability Program be piloted as a matter of urgent priority.

100) That proposed models for bleach provision are selected according to the security rating of the facility where the program is to operate from.

PART A: KEEPING SAFE REVIEW

1 Methodology:

1.1 Data Collection:

At the commencement of the review it had been determined that in addition to the Keeping Safe Program, it would also be useful to identify the current situation with BBV risk practices in the prisons and the prevailing attitudes of prison staff in relation to these. In addition, the review of the program was interpreted in its broadest sense, to address not only program content and effectiveness but also the logistical aspects of the program.

It had been hoped to formally interview offenders but this was not possible as the Research Advisory Committee of the DOJ considered that there had been too many studies directly involving offenders prior to the current request and were not prepared to support this project in that regard. There were also difficulties involved in gaining access to an Ethics Committee as neither the DOJ or the DOH have their own Ethics Committees.

A series of interview schedules were developed for the following categories of workers within the prison system:

- Superintendents and Assistant Superintendents
- Prison Officers
- Medical Officers
- Nursing Staff
- Forensic Case Management Team Workers (Psychologists, Peer Support Workers)
- Group Workers and Welfare Officers, Juvenile Justice.

The final interview schedule comprised two parts: the first being generic to be applied to all interview subjects, and the second part specific to the role and responsibilities of the interview subject.

The final drafts of the interview schedules were lodged for approval with each of the bodies responsible for each category of worker. This included lodgement with the Executive Committee of the West Australian Prison Officers' Union (WAPOU). The Union requested that questions pertaining to sexual assault in prisons be deleted as well as a question which sought to ascertain the current level of feeling from officers about the introduction of needle and syringe programs. Whilst no explanation was provided for excluding the question on sexual assault, the question on needle and syringe provision was deleted as it was considered provocative and had the potential to create a backlash (the question was hypothetical). There were no other significant questions deleted by stakeholders from the other worker categories. Copies of the interview schedules are provided as Attachments to this report.

For the interviewing process, interviewers made appointments with Prison Superintendents at the following facilities:

- Hakea Prison
- Casuarina Prison
- Wooroloo Prison
- Bandyup Women's Prison

- Nyandi Women's Prison.

Rangeview Juvenile Detention Centre was also included in the interview process.

The selection of persons to be interviewed was random across all sites and non-identifying to encourage frank and honest discussion on the issues to be addressed. Face to face interviewing allowed for additional information to be gathered and for direct quotations to be used in the final report. It is noted that there were no refusals to participate in the review and the majority of interviewees welcomed the opportunity to have input to the process.

Each interview took approximately 40 to 45 minutes, which limited the number of staff that could be interviewed within the timeframe of the review. However, it was noted by the conclusion of the interview period that little new information was being gained from each interview.

The breakdown of numbers interviewed by occupational category is shown in the following table:

Occupational Category	**Number of interviewees**
Prison Superintendents and Assistant Superintendents	9
Prison Officers	36
Medical Officers	3
Nursing Staff	20
Forensic Case Management Team Workers	5
Group Workers and Welfare Officers, Juvenile Justice	6
TOTAL	**79**

Approximately 30 Keeping Safe presenters and contractors were involved in the review in the following ways:

- Focus groups
- Phone interviews
- One to one discussions during monitoring visits.

During the course of the review, two groups were held in Perth inviting both presenters and representatives of contracted agencies to attend to discuss their views about all aspects of the program. The outcomes of these meetings are provided as an Attachment to the report.

As it was not possible for regional presenters to attend the Perth meetings, a questionnaire was forwarded to them which covered the key topics discussed at the first Perth meeting and invited their comment. Each completed questionnaire was followed up with a phone call from the interviewer to provide clarification and additional information.

Keeping Safe sessions were observed at all metropolitan sites which were followed by discussions with the presenters and notes made on those discussions.

It is considered that the feedback received from presenters formed the most useful information on the actual delivery and content of the program.

Informal discussions were also held with offenders during the course of the monitoring visits. In the first instance, it proved useful to observe reactions to the

information provided and in the second instance, at some groups presenters would ask directly how offenders thought the program could be improved.

A range of meetings were organised with other stakeholders and notes were recorded on their comments. These included:

- DOH Case Management Program
- Communicable Diseases Control Branch, DOH
- Environmental Health Branch, DOH
- WA Substance Users' Association (WASUA)
- Next Step Specialist Drug and Alcohol Services
- WA Skin Penetration Reference Group
- Eastern Perth Public and Community Health Unit.

1.2 Analysis:

Information gathered from the interview schedules was collated and analysed for inclusion into either Part A of the report which relates directly to the Keeping Safe Program, or to Part B which relates to the current response to BBV's and risk practices in WA prisons and juvenile detention centres.

2 Overview of the Keeping Safe Program:

The Keeping Safe Program was launched in November 1997 and aimed to provide BBV education for all adult offenders in the WA prison system and for juvenile detainees at the two juvenile detention facilities in Perth. It was deemed vital that offenders and detainees had access to BBV education given that many of those entering the system were at high risk of contracting BBV's such as HIV, hepatitis B and hepatitis C, and that prisons were considered to be an environment for the potential further spread of BBVs.

The manual for the program was developed by the Eastern Perth Public and Community Health Unit at the request of the then Ministry of Justice.

The manual was designed for use by trained persons with knowledge of BBV's, who were then further trained by the DOJ to deliver a two-hour program for all offenders and juvenile detainees on entry. The program was intended to be repeated as an annual refresher program for offenders.

Initially some prison officers were trained as presenters, but over time this role was handed over to external presenters. Key health services were invited to tender for a contract to deliver the program through the recruitment of suitable presenters. In Perth, the WA AIDS Council (WAAC) and the Hepatitis C Council of WA were the prime contractors and have remained so for the life of the project, with Derbarl Yerrigan Health Service being contracted two years ago to provide the program to Aboriginal women at Bandyup. The Perth based correctional facilities are shared between the two major agencies, with the WAAC also covering Nyandi Women's Prison, which was not in existence at the commencement of the program.

For the regional prisons, contracts are developed on the basis of "sole provider", given the limited services and resources to deliver the program.

At the initial implementation of the program, new presenters undertook two weeks of training with DOJ, but this has not been possible for new presenters since that time and an alternative system has been developed. Any new presenter will be partnered with a more experienced presenter for a period of some weeks, initially to observe the delivery of the program. Once a presenter has gained the confidence and expertise to lead a program under supervision, only then will they go to a prison alone to deliver the program.

The content of the program provides information on HIV, hepatitis B and hepatitis C, and the disease process for these viruses. Information is provided about unsafe practices in prison such as injecting drug use, tattooing, and unprotected sexual activity. Advice on harm reduction strategies for application in prison and for the offender's return to the community is also provided. At the time of the implementation of the program, the strategy of addressing intra-sentence and post-release behaviours and prevention strategies was seen as a unique approach.

The new program was marketed to offenders through the development of a poster which was displayed in different locations around the prison and a pamphlet that was made available to all offenders on entry.

A system was established to lodge offender attendance at the program onto the central computer system, together with a recording mechanism to track when an offender was due to attend a refresher program. In addition, all offenders attending

the program were provided with a certificate of attendance. The certificate did not identify Keeping Safe as being a prison-based program and it was deemed that an offender could use the certificate as proof of training accessed once released and seeking employment, should they wish to do so.

In terms of the instruments developed for the monitoring and evaluation of the program, a basic post program evaluation sheet was developed for offenders and a requisite that program presenters be monitored by the BBV Project Officer (there was no standardised monitoring process developed to assess the competency of presenters). The lack of formal monitoring and evaluation strategies is seen as one of the weaknesses of the program, and this issue is discussed in more detail in the main body of the report.

The program was one of the first in Australia to establish a comprehensive training package for a program that was ongoing and centrally managed by the DOJ. In other jurisdictions, prison staff provided programs and short courses (not ongoing) were provided by community-based services such as AIDS Councils. At the conception of the program there were few jurisdictions other than NSW that had programs in place at any level. Workers from the NSW Corrections HIV and Health Promotion Unit actively collaborated in the development of the WA program.

2.1 Support for the Keeping Safe Program:

Overall, 89% of Superintendents and Assistant Superintendents interviewed were supportive of the Program, and saw it as a positive initiative.

When these officers were asked if they considered that prison staff were generally supportive of prisoners attending the Keeping Safe Program, the result was as follows:

64% considered that they were supportive
17% were unsure
19% were not considered to be supportive of the program.

The main reason given for not supporting the program was that they considered that the DOJ could more effectively utilise its funds on a program that was more likely to impact positively on prisoner behaviour.

2.2 Staff Awareness of the Keeping Safe Program:

Whilst all prison managements were aware of the program, 17% of officers interviewed were unaware of the program. Both categories of custodial staff that were aware of the program also displayed a good understanding of the content of the program.

Forty percent of nurses interviewed were unaware of the program, which is disturbing given that it is a Health Services initiative. There is a need to increase awareness amongst nursing staff of the program and its content. Each Prison Health Centre should be provided with a copy of the program package so that it can be utilised for one-to-one education. In this way there should be consistent information provided to offenders, and reinforcement of information presented during the program.

Recommendation:
That each Health Centre be provided with a copy of the revised Keeping Safe package for use in offender BBV education.

3 Difficulties identified which impact upon the attendance of offenders at the Keeping Safe Program:

Keeping Safe presenters identified that it was consistently difficult to get the right offenders to the program on time, if at all. In addition there were problems with attrition once groups had commenced with offenders being called out for other appointments. Presenters acknowledged that the success of the program rested with securing the cooperation of officers and management staff. They raised the following points for consideration:

- Officers in general were not motivated to prepare lists prior to the arrival of the presenter,
- Officers being unclear of what days the program ran, especially over holiday periods,
- Officers holding an expectation that presenters would convene the groups and draw up the attendance lists,
- If prisoners are only called up to attend over the PA system, there may be prisoners who are out of hearing, such as kitchen and garden workers,
- Clerical staff and officers have not been skilled in how to access and generate lists,
- Data entry has not been lodged punctually, which has meant that a prisoner has been transferred prior to their completion of the program having been logged,
- There is no formal process for handing over responsibility for the program when officers move on or go on leave,
- There is a duplication of paperwork with the generation of lists and this needs reviewing,
- As the program is mandatory some prisoners elect to take punishment rather than to attend; however, there tends not to be any follow through on this by officers and so it becomes an “empty threat”.

A total of 50% of Superintendents and Assistant Superintendents identified that there were logistical problems with getting offenders to attend the program. Officers interviewed identified that it was not only logistical issues but also the attitudes of offenders that impacted upon attendance.

The main logistical issues identified by custodial staff were as follows:

- Insufficient staff to escort prisoners to the sessions,
- Prison staff not taking responsibility for collecting prisoners from their unit and taking them to the training area,
- Officers do not have the power to force offenders to attend, whilst it is a mandatory program, some offenders are willing to face charges rather than to attend,
- Unit Managers need more advanced notice of when the groups will be held,
- Some prisons have a problem with finding a suitable place to deliver the program with conflicting demands for limited space,
- Frequent turnover of staff often results in the requirements for the program not being handed over to new staff; for example, new staff not knowing how to generate the lists for the program or how to register completions of the program.

Staff perceived the key issues and attitudinal inhibitors for offenders to be as follows:

- Offenders don’t see a need for the program as they think they know it all already,

- There are many demands made on an offender's time, they will prioritise these,
- Passive resistance by offenders to compliance with prison programs,
- Offenders seeing it as an optional program,
- Many offenders view it as solely a program for homosexuals and drug users, this links to the stigma attached to discussing BBV issues. There is some evidence that peer pressure reinforces this perception of the program and discourages attendance,
- There is increased resistance from offenders to attending the refresher programs,
- It was considered that the program was not well marketed and offenders did not understand why they were being called up,
- It is considered that it is difficult for prisoners to come together early in their sentence to discuss these activities, many of which are illicit. There was the need to identify a different approach that offenders would be more prepared to engage with.

3.1 Strategies identified to improve the level of attendance at the Keeping Safe Program:

3.1.1 Marketing:

It was commonly felt that offenders considered that program was overly focused on sexual activity and drug use, both of which are covert and illicit activities in the prison system. Officers considered that following the review any new program needed to link to a strong marketing campaign that would break down the current misunderstanding of the program.

Any marketing campaign should also flag the incentives and advantages to offenders of attending the program. For example, at Bandyup women get one point towards a transfer quota if they attend the program, offenders see this as an easy way to get a point as it is only a two-hour program and this benefit could be used as a marketing tool.

3.1.2 Administrative changes:

Whilst there was a high level of support for the program from custodial management, there was less support from officers, which needs to be addressed. It is suggested that if the BBV information needs of officers were addressed through training then resistance to offenders having this information may be reduced.

Whilst some officers had suggested that the program be made voluntary, this is not appropriate given that the DOJ has a duty of care to inform offenders regarding BBV's. Whilst the current program is mandatory, in most settings there are no consequences for non-attendance. Hakea Prison addressed this issue during the course of the review, which impacted favourably on increasing attendance. Offenders are provided with an appointment slip issued 24 hours prior to the session. If for any reason they subsequently fail to attend, the matter is taken up with their Unit Manager as soon as possible after the scheduled group. The offender is informed that there will be an expectation upon them to attend the next program together with an explanation of the program content. If there is a further non-attendance, privileges are withdrawn. The time spent on this process has proven extremely effective, and is readily transferable to other prisons. This model has now

been introduced at Bandyup Prison, which was also experiencing attendance difficulties.

Given that offenders tend to mislay their certificates of attendance, presenters suggested that certificates to be photocopied and placed on the offender's file as evidence of attendance.

Data entry records of those who have completed the program has been an ongoing problem at a number of prisons. Presenters have suggested that if they could have access to TOMS (the central data base for prisoner details and movements) they would be prepared to enter the data. This offer cannot be considered for security reasons. Data entry is an issue that needs to be addressed with custodial and clerical staff who are currently responsible for this task. Presenters have also suggested that it may be more efficient to have a central data entry point to which they could forward their list of attendees. This suggestion is impractical as there is no available person who could take on this additional workload, and as with the previous suggestion, the responsibility comes back to effectively training those who are currently allocated that task.

It is noted that details regarding the day-to-day management of the program, across all sites, has been over-reliant on oral handovers between presenter to presenter and officer to officer. There is an identified need for a procedural handbook to be developed that would clearly define the roles and responsibilities of all staff and presenters who have responsibility for the program.

Formal incentives to attend have not been apparent, however, presenters have at different times tried introducing lollies and chocolate biscuits as incentives. Unfortunately, prison security ceased the provision of biscuits and this resulted in lower numbers attending the program.

It is considered that offenders are willing to attend any program that they know will go towards attaining their parole. Consideration of identifying the program as one to be attended for parole requirements would be a very positive step; especially if the need to reduce the further transmission of BBV's in the community is seen as a priority. In NSW prisons no offender can sign up for a work program until they have completed a BBV Program, and consideration of this should be taken up for WA prisons.

Consideration should be given to factoring the program into the orientation program at Hakea. This is especially appropriate given the recommendation of the review that the delivery of the program be changed to an Entry and Exit format (pending approval from Prison Health Services).

Finally, consideration needs to be given to the program being built into the prisoner's structured day on the computer system, rather than existing outside of this process.

3.1.3 Location of the Keeping Safe Program:

There was for most prisons a lack of space for programs and significant demands were made upon limited space. It was considered that the lack of an appropriate and consistent space created problems for offender attendance.

It was felt that the program needed to be conducted somewhere quiet and private, however, none of the rooms visited during the review met that criteria. Rooms allocated did not always have access to whiteboards for presenters and had a general lack of teaching equipment. Presenters have discussed how the program

has been delivered at the abattoir, under trees and in the compounds. Whilst this says much for the flexibility and commitment of presenters, it says less for the way that the program is valued in the prison. Given that there is a duty of care to inform prisoners about BBV's, better provision should be made to adequately house the program across the prison system.

A dedicated space for the program at each site could also be utilised as a distribution point for BBV resources and a base for BBV peer educators (should such a program be instigated).

3.1.4 Program Structure:

It was generally considered that if more focus was placed upon a problem solving approach than an information-giving model for the program that offenders would be more willing to attend.

It was also considered that this was a "stand alone" program and should be more effectively linked to other programs provided such as cognitive skills training. If the program was linked it was felt that it would be seen as more meaningful for offenders. An example would be the provision of the program within the Drug Free Unit, where offenders were likely to be more receptive to information.

Importantly the need to shift the primary focus of the program away from sex and injecting was identified. This is a current barrier to maximum attendance and the program needs to relate to other risky activities in prison such as fighting and sport.

There was a suggestion that if the groups were smaller this may create a safer environment for offenders to discuss the issues raised within the program. Whilst a valid suggestion, it is not cost effective due to restrictions upon the program budget.

To some extent the program operates in isolation and it was proposed by custodial staff that presenters be made available to follow up with offenders after the delivery of the program. There are some very committed presenters who have provided this follow up service despite not being paid for their extra time, and this effort is acknowledged. It is suggested that linkages need to be strengthened to encourage offenders to follow up with nursing staff. If a peer educator program were established, these workers could also play a key role in following up offenders after the program.

3.1.5 Summary of strategies to improve attendance at the Keeping Safe Program:

It was estimated by the BBV Project Officer that on average 60 prisoners and detainees attend the Keeping Safe program daily and it was felt there needed to be more attention paid to recording these attendances if the system was to work properly.

It is envisaged that the development of a procedural handbook would allow most of the logistical problems experienced to be overcome, especially if linked with an orientation program for prison staff responsible for the smooth running of the program.

Changes to the program linked with a marketing strategy and meaningful incentives to attend would effectively address attendance issues.

Recommendations:

That the processes involved in the day to day management of the Keeping Safe program be formalised into a procedural handbook to increase the capacity of staff to manage the program effectively following staff changes.

That mechanisms be developed to strengthen linkages with other programs and follow up resources (human and print) in order to increase the relevance and significance of the program to offenders.

For each site to identify a dedicated space for the program, which could double as a base for peer educators.

That meaningful incentives be put in place for offenders to encourage attendance at the program.

That prior to the introduction of a revised program, a concerted marketing strategy be implemented with the purpose of shifting the current attitudes of offenders towards the program.

4 Safety issues related to non custodial staff delivering the Keeping Safe Program:

When the Keeping Safe Program was first implemented there was an intention that in some settings the program would be delivered by prison officers. This is no longer the case, and the advantages of using outside presenters are discussed in a further section of this report. However, the use of non-DOJ staff to deliver programs is seen by some custodial staff as problematic and a threat to the security and safety of the prison. These concerns are further expanded upon in this section.

Keeping Safe presenters work in all WA prisons and juvenile detention facilities, although some presenters have been limited in the facilities in which they can present as a result of conditions placed upon their security clearances. In the instance of a presenter having served time in prison, their access may be restricted to a minimum-security prison. Each case is taken on its own merits and the final decision to accept or reject a presenter rests with the Superintendent of the prison. These measures are in place to safeguard both the presenter and the security of the facility they will work in.

Presenters are entering an unfamiliar environment and need to be very vigilant both of the behaviour of offenders and of their own behaviour. In the Keeping Safe orientation for new presenters they are made aware of the implications of working in a prison environment together with basic safety and security information.

No new presenter ever goes into a prison for the first time alone. A more experienced presenter, who can support and provide guidance on appropriate behaviour and conduct, always partners them for their first few sessions. Aboriginal presenters prefer whenever possible to take a colleague with them for support for all their sessions, not just for the orientation period.

Superintendents and Assistant Superintendents interviewed were satisfied that presenters were safe in their facilities as long as they had completed a security orientation.

However, some 25% of prison officers interviewed held concerns about the security of presenters coming into their facility. Of that group, their greatest concern was that presenters would bring contraband into the prison (22%) followed by concern around gender issues and risk to the presenter of physical or verbal assault (both 17%). On the issue of presenters bringing contraband into the prison, it would appear that the concern is more a case of perceived gullibility in presenters rather than wrong intentions. The officers considered that a presenter may innocently bring seemingly innocuous items in at the request of an offender, not seeing the item as a security risk or prohibited item. In their responses, there was not a sense that they perceived presenters as consciously smuggling contraband. Most commonly offenders who know that a presenter works across a number of prisons will ask the presenter to carry letters to another offender, and all presenters are cautioned that this is unacceptable.

Officers considered it of vital importance that each presenter had had a security orientation and were competent to know how to call for assistance and how not to overreact. In addition they thought that all presenters should carry an alarm. The following are direct quotes from officers on the issue of presenter safety:

- *“There are too many civilians moving around sites, it is only a matter of time before something happens.”*
- *“Anyone who comes into a prison is at risk.”*
- *“They don’t have a clue what goes on, they get offended when we want to do a bag search.”*
- *“They are too gullible, they will come unstuck.”*

Presenters considered that concerns regarding their safety fluctuated and the provisions made for their safety were inconsistent, and largely depended on who was on the front gate. They stated that sometimes they were escorted and sometimes not, sometimes given an alarm and sometimes not.

Presenters commented that during their initial orientation to the Keeping Safe Program they had been told not to give their full names, however, they are required to wear visible ID which displays their full names, so they thought there needed to be a more consistent approach taken. In addition it would be inappropriate for an Aboriginal presenter not to give a surname as in introductions it is culturally imperative that a surname is given so that the person can be defined by where they fit in the community and who their people are.

Male officers, based on experience of offender assaults on female official visitors, were especially worried about female presenters coming into male prisons and the need for them to dress appropriately. An example was given of a female official visitor (not a Keeping Safe presenter) who was denied access to a male prison as her clothing was considered by officers to be too revealing, therefore the issue of appropriate clothing is a significant one.

Aboriginal presenters have highlighted issues that they feel compromise their ability to work with the program. The greatest attrition of presenters and the hardest group to recruit are Aboriginal presenters and this is an issue that has been flagged with the Aboriginal Policy and Programs section of the DOJ to be addressed. Given the over-representation of Aboriginal people in the prison system together with extended family networks it is not uncommon for presenters to be related to offenders. As a result Aboriginal presenters have at times felt compromised by the demands of family members who are in the prison where they work. It appears that only one regional prison has formally acknowledged this problem with provision made to exclude family members from the presenter’s program and defer them until another presenter is available. To date it appears that several Aboriginal presenters have withdrawn their involvement or resigned from their primary employment, and it is only afterwards that it became evident that they were unable to manage the pressure they were put under by offenders. Strategies need to be developed to prevent this stress upon presenters, with clearly defined lines of reporting.

Although there is a section in the existing Keeping Safe package about working in a prison setting, this document was not developed with Keeping Safe presenters as the target group. Presenters would like to see the document re-written and for it to include information on the following:

- Holding keys
- Equipment checklists
- Protocol to follow if any training equipment is stolen or mislaid
- Advice on managing incidents of verbal and/or physical threats.

Recommendations:

That the development of a procedural handbook (referred to in Recommendation 14) includes a section on presenter safety and security issues tailored to their needs.

That Health Services collaborates with Aboriginal Policy and Programs to address the safety and security issues of Aboriginal presenters, to reduce both the attrition rates and the stress experienced by these presenters.

5 Working relationship between custodial staff and Keeping Safe presenters:

5.1 Satisfaction of custodial staff with presenters:

Overall management had no problems with non-Indigenous presenters and from observation, good working relationships appeared to have been established across a number of sites. There was a consistent concern, however, expressed by officers that they considered that some presenters did not have clear boundaries with offenders and they felt there should be far less personal dsclosure by presenters. One Superintendent stated that he was very happy with the presenters who attended his facility and that they made a good contribution to the education of prisoners.

There was, however, a reported lack of satisfaction with the Aboriginal presenters at both metropolitan and some non-metropolitan prisons, related to their perceived unreliability and lack of responsibility in regard to the program. It was considered that programs were frequently cancelled at short notice as the presenter would not arrive; neither did presenters contact the prison to inform them that they could not attend. There was a level of frustration from Program Managers that contacting Aboriginal presenters was often difficult and phone calls and emails were not responded to.

Whilst it should be noted that the above comments do not apply to all Aboriginal presenters, it is an ongoing issue and one that needs to be addressed. The perceived unreliability of the Aboriginal presenters may be due to specific difficulties that make attending sessions too traumatic. The new package needs to acknowledge stresses that may be specific to Aboriginal presenters.

5.2 Satisfaction of presenters with custodial staff:

This varied considerably across facilities and amongst individual officers; and a sense of frustration was expressed that the movement of officers made it difficult to maintain working relationships, with the constant shift of responsibility from one officer to another about the program.

Presenters described a range of negative behaviours that they faced from some officers, some of which are listed below:

- Being kept waiting at the front gate,
- Judgemental comments about their target group,
- Constantly being referred on to others without getting responses to their concerns,
- A lack of cooperation in getting prisoners to the program,
- Not passing on messages from their workplaces to presenters.

Whilst the more experienced presenters felt they had developed mechanisms to deal with these problems, it was considered that these issues needed to be addressed as a part of the orientation for new presenters. It was identified that if there is to be a shift from passive-aggression to tolerance of the program, the marketing approach to staff needs to be changed, not only the marketing to offenders. Officers need to be convinced that there are clear health and safety benefits to them by reducing the rates of BBV's in prison settings.

Recommendation:
That there be a parallel marketing program for custodial service staff when the Keeping Safe program is revised.

6 Perceptions of the impact of the Keeping Safe Program:

This section is based upon interviews conducted with custodial and health staff pertaining to both the positive and negative perceptions of the impact of the program.

Prison Officers interviewed rated the overall impact of the program as follows:

No Impact	5%
Minimal Impact	58%
Significant Impact	12%
Unsure	25%
TOTAL	**100%**

Nurses interviewed rated the overall impact of the program as follows:

No Impact	0%
Minimal Impact	35%
Significant Impact	25%
Unsure	40%
TOTAL	**100%**

6.1 Perceptions of the positive impact of the Keeping Safe Program:

Custodial staff noted an increased awareness of risk factors and consequences of infection as identified in the quotes and reported observations that appear below:

- "*I hear prisoners say after the program that they have decided not to use drugs in prison as too risky.*"
- *"A prisoner who had no previous BBV awareness was able to clearly identify her risk factors after attending the program."*
- *"A prisoner who's first injecting episode had occurred in prison and subsequently sero-converted for hepatitis C decided to cease further injecting drug use after attending the program."*
- *"A group of prisoners gathered after the program and were discussing how they had not realised the risks of tattooing in the prison setting."*
- *"For some it has a major impact and for others nothing, it is a very individual thing."*
- An increase in the number of offenders wanting to go to the drug free unit.
- Offenders making a conscious decision not to inject whilst in prison after attending the program.
- An offender handing in a cache of used syringes that he had found in the prison grounds.
- Offenders coming more regularly to change toothbrushes if concerned that someone else has used them.
- Appears to promote discussion around BBV issues.
- The program is seen as beneficial for offenders who are at the contemplative level of behaviour change.
- The program is seen as impacting favourably on the overall safety in the prison.
- Offenders are accessing more Exit Kits.
- Offenders are asking for gloves more.
- Offenders have stated that they pass on what they have learned to their families and children.

- Has increased offender awareness about treatments for BBV's.
- Offenders now more cautious about sharing cells with offenders who have BBV's.

Custodial staff provided responses which demonstrated that offenders do go away and discuss the program, extending that discussion to family and friends, which is extremely positive. The responses also demonstrate an increased level of blood awareness in those who attend the program. There was a comment that the program was good for those already contemplating behaviour changes, but it was also noted that not every offender has concerns either for their health or the health of others. One Superintendent commented:

> *"Even if only one prisoner moves out of denial about their risk behaviours it has been worthwhile."*

Nursing staff that viewed the program as having a positive impact saw it as having raised blood awareness in the prisons, especially amongst older offenders. Most significantly they identified that offenders who may have refused BBV testing on entry will request testing after attending the program. There is also an increased demand for hepatitis B vaccinations after attending the program.

Nursing staff reported that offenders were requesting more information about diet and during post test counselling would check information that they said they had received in the program.

From the feedback received in this section it is apparent that for a section of the prison community the program has had a positive impact.

6.2 Perceptions of the negative impact of the Keeping Safe Program:

The most consistent criticism of the program was of the model that had been selected for the delivery of the program. It was seen that as it was an information giving model, it did not assist offenders to develop skills to enable them to change or modify risk behaviours. As a result it was seen as failing.

Whilst acknowledging that the program increases awareness it was also seen to raise frustration in offenders, as they do not have the means to make the necessary changes to their behaviour, eg access to bleach and sterile injecting equipment. One Keeping Safe presenter described the program as *"it is just cosmetic, it is not really reaching what is needed."*

Officers noted that the refresher programs can create friction within the prison amongst inmates and can become a serious management issue when offenders are escorted to attend refreshers. In addition, the acting out behaviour of offenders at the program has the potential to compromise the safety of presenters.

Some officers were concerned at the image the program had in the culture of the prison. They considered that offenders still describe it as a program for "poofs and junkies", and this was a significant factor in the resistance of offenders to attend.

Some officers considered that in providing offenders with information on the transmission of BBV's, the information could be used against officers in conflict situations. This related to offenders using body fluids as 'weapons' against officers or in proclaiming themselves as having a BBV so that officers had "better watch out or I will pass it on to you" type scenarios.

Some staff, nursing staff in particular, were concerned the program could create high anxiety in offenders about past and current behaviours that may have placed them at risk of BBV transmission. If the offender did not then follow up with the Health Centre the growing anxiety could have very negative consequences for the person. It was considered that there needed to be some mechanism for follow-up after groups for offenders with high levels of concern regarding past or current risk behaviours.

There was a sense from many presenters that the impact of the program would be dramatically improved if offenders had some sense of ownership of it.

6.3 Summary on the impact of the Keeping Safe Program:

Overall the perceptions of the positive aspects of the program outweighed the negative. However, there were very valid concerns regarding the lack of follow up available to offenders after the program, and this issue is addressed in a recommendation posited earlier in the report.

7 Discussion regarding the use of non-DOJ staff to present the Keeping Safe Program:

7.1 Perceptions of the advantages of using non DOJ staff to deliver the program:

As outlined in Section 4 of the report, initially some prison officers were trained as presenters, however, this was not sustainable and all presenters are now contracted from community based services to deliver the program.

Nursing staff and officers interviewed considered that the program required professional people with a good level of expertise in the program issues, who were also a part of the community to which offenders would return. These points were seen as the main advantages to using outside presenters.

There was a strong sense that it was good practice to keep health and custodial issues separate, especially as there was a component on safer injecting within the program. By keeping the two areas separate, it was seen that there was more opportunity for frank and honest discussion about risk behaviours both in the community and in prison.

There was a general view that offenders tended to see outside presenters as having greater credibility, and that the information given was more likely to be believed than if it were provided by prison based staff. There was also an element of offenders appreciating seeing 'new faces' and that that could be an incentive for some offenders to attend the program.

7.2 Perceptions of the disadvantages of using non DOJ staff to deliver the program:

Overwhelmingly the disadvantages identified related to security issues and also the cost to the Department in paying agencies for work that could be done by nurses or officers already within the system.

The security issues identified were almost identical to those mentioned in Section 4 of this report that covered perceptions of the safety of presenters. Other security/safety concerns identified are as follows:

- Aboriginal presenters may be pressured by their relatives to breach the privileges of their position,
- Trafficking of drugs by presenters,
- Perception that some presenters have poor boundaries, and as a result share too much personal information with prisoners,
- Lack of awareness of prison culture and security,
- Concerns with the sheer volume of visitors moving through the system, and how movements are best managed,
- Offenders may "play up" if an officer is not present,
- Increased security demands,
- "How do we know what they are telling offenders?" – if officers are not to attend the program,
- Naivety in presenters in not realising how difficult offenders can be and not having the skills to "read" a situation and to know when to get assistance,

- Using female presenters with male offenders increases the security/safety risk.

Some officers had noted that there were presenters who appeared intimidated by the environment, and that this might impact negatively on their ability to handle a situation where their safety was compromised.

There were criticisms around the language used by presenters from both a cultural and professional perspective. Based on feedback from offenders, some nurses stated that the sophisticated level of English used by some presenters excluded Aboriginal offenders from increasing their awareness of BBV information. There had also been feedback to nurses and officers from offenders that the use of "street language and swear words to describe sexual issues" was not appreciated by some offenders who felt that it was unprofessional.

The issue of pitching a program at the right level is a difficult one, especially when there is no control in the make-up of the groups attending the program. The difficulties experienced by Aboriginal offenders with the language levels is acknowledged by presenters who have to run mixed groups, and strengthens the argument for separate groups for Aboriginal/non Aboriginal prisoners. The establishment of an Aboriginal BBV Prisoner Peer Education Program would also be beneficial in making information dissemination on BBV's more effective.

In the selection of an appropriate vocabulary to discuss sexual issues, presenters need to find a balance between being professional and conveying information in a way that will be understood by the target audience. As the use of "street language" has been identified as an issue of concern, it would appear that presenters should not presume that offenders will be comfortable with explicit language. Ground rules need to be set by the presenter at the commencement of the program around the acceptable use of language for that particular group. Other strategies can also be developed to address this issue.

Some staff considered that the use of outside presenters limits communication, and there should be a mechanism for officers to caution presenters about offenders and for presenters to feed back if they feel there is an offender at risk. In feedback from presenters, it would appear that this mechanism is in place on an informal basis. An example provided by one presenter was that on arrival at the prison, she was informed there had been a death in the prison the night before and that this had affected the general mood of the prison and she should be sensitive to that. It would appear that this sort of feedback is provided on a regular basis and presenters also report any concerns they may have about a particular offender, either to custodial staff or to the Health Centre. It should be noted that presenters assure offenders of the confidential nature of the program, and this needs to be upheld. For example, if an offender discloses their drug use or tattooing activity, this information stays within the group.

7.3 Summary: Discussion regarding the use of non-DOJ staff to present the Keeping Safe Program:

The points raised on the advantages of using outside presenters clearly demonstrate that this method should be retained. The main disadvantages relate to security issues, and now these are clearly identified, they can be largely resolved. The need for increased communication between custodial, health staff and presenters has been identified throughout the report and mechanisms need to be formalised to strengthen these linkages.

Comments noted regarding language used in the program need to be addressed by presenters.

Overall the use of external presenters has been an effective strategy.

Recommendations:

That future skills training for presenters needs to address effective ways of working with Aboriginal offenders and demonstrate strategies designed to select a vocabulary that is acceptable to offenders in discussion on sexual matters.

8 Feedback on the content of the Keeping Safe Program:

This section provides feedback from offenders and presenters regarding the actual material content of the program, identifying both areas for expansion and new topics for inclusion.

8.1 Feedback from presenters:

It appears that offenders are most interested in the transmission of BBV's section of the program, what the viruses look like and how they react in the body. There is also a high level of interest in the impact and potential for transmission to their children and partners.

In relation to the progression of infection with BBV's, offenders were interested more in the short-term effects. Many offenders had a good understanding of the impact of chronic liver disease having had friends and relatives affected with alcoholic cirrhosis.

Prisoners were least interested in discussing sexual assault in prison, a "no-go" area. This issue is further expanded on in Section 30 of this report.

The program touches on a number of sensitive issues and it was felt that the time allocated did not factor in the need for people to seek clarification and additional information after the completion of the program.

Presenters also considered that blending the three main BBV's together was confusing for offenders. Most tended to start with HIV, deemed to be the virus that offenders were most frightened of but least likely to contract in a prison, then go on to hepatitis B. They finished with hepatitis C as this is the virus offenders would be most likely to contract, and they are more likely to retain the information that is delivered last.

Presenters stated that at times they felt comfortable to share information about their BBV status with offenders as a teaching technique and that this was especially effective with juveniles. It was not uncommon for offenders to share their hepatitis C status in the program as so many people they knew had the virus, and from their earlier experiences had not been stigmatised on the basis of this.

Presenters would like to see the policies and protocols section of the package retained. They considered these documents to be a useful reference when offenders asked questions that were policy related.

8.1.1 Areas identified by presenters for program expansion/inclusion:

Expansion:

- The current level of information on harm reduction was considered inadequate, and it was suggested that it should be presented in chart form,
- Harm reduction should be tailored to match the security classification of the prison,
- Provide very clear direction on testing and vaccination access whilst in prison,
- Expand the section on STI's especially for Aboriginal groups to promote testing and treatment,
- Establish more clearly the link between ulcerative STI's and HIV transmission,

- Explore common myths about preventing STI's and BBV's (one presenter shared that examples of myths he has identified are rubbing a coin on the penis or inserting a cigarette butt into the vagina will prevent infections),
- A better approach regarding how to clean injecting equipment in prisons,
- Increase information on the blood rule for sport, hairdressing, fighting and general personal hygiene,
- Expand information provision on tattooing and body piercing.

New information:

- Be able to demonstrate how re-used injecting equipment in prisons increases the risk of BBV transmission,
- Updates on access to treatments,
- Updates on alternatives to drug use,
- Blood spills – how to clean up safely, right of refusal,
- Graphics on how the viruses act on the body; pictures of cells,
- Include drug information,
- Reinforce information given in other programs on overdose prevention and management,
- Include information on vein care and rotation of injecting sites – an increasing number of prisoners are coming for medical attention for infected sites,
- Provide statistics on the prevalence of BBV's in the WA prison system.

8.2 Areas identified by offenders for program expansion/inclusion:

8.2.1 Areas identified by male offenders for program expansion/inclusion:

A Keeping Safe refresher group conducted at a maximum-security prison during a monitoring visit asked male offenders how they thought the program could be improved. The following issues were identified:

- The correct handling of linen contaminated with blood and body fluids,
- The correct use of spills kits and the set procedure for cleaning blood spills,
- More information on the blood rule for sports,
- That first aid training be linked with BBV education,
- The appropriate use and cleaning of hair clippers and other hairdressing/barbershop equipment,
- Information on correct procedures for cleaning duties to prevent BBV exposures,
- Information regarding prisoner rights and procedures for needle stick injuries and other exposures such as fighting.

8.2.2 Areas identified by female offenders for program expansion/inclusion:

A Keeping Safe refresher group during a monitoring visit asked women offenders how they thought the program could be improved. In addition, presenters provided a list of topics that they had had requests for information on by female offenders. Both sets of information have been combined to provide a list of possible topics for inclusion in a women's program, as follows:

- Impact of BBV's on pregnancy, children and breast feeding,
- Effects of treatments on pregnancy and menopause,
- BBV's and menopause,
- Menstruation and infectivity of menstrual blood/safe disposal issues,
- Information on herbal and alternative treatments for hepatitis C, and access to same in the prison system,

- Relaxation and meditation techniques for health enhancement and immune system strengthening,
- Legal and personal responsibilities around disclosure of BBV status,
- More information on the health risks of body piercing,
- Managing relationships/families where one or more members has a BBV,
- Cultural issues for Aboriginal and Asian women,
- Same sex activity and BBV risk,
- The dynamics of sharing injecting equipment with intimate partners,
- Sexual safety in the sex industry,
- Skills training in decision making and sexual/drug safety negotiation skills,
- Basic hygiene information. Offenders acknowledged that poor early modelling had resulted in general hygiene (such as hand washing and cleaning equipment) not being viewed as important.

A learning style that was working well for Keeping Safe with women offenders was a more informal "round the table with a cup of coffee" approach. Presenters allowed women to tell their stories and the Keeping Safe information was woven into the stories using a problem solving approach

Presenters considered that there was a need to do some "myth breaking" around presumed safety of sharing equipment with partners and the power dynamics of women using drugs with their partners. In addition, presenters were concerned that women were able to identify the potential for BBV to be transmitted through episodes of external violence but could not identify the risk through domestic violence and/or marital sexual assault. It would be extremely beneficial to develop some strategies to challenge the denial around the aforementioned issues.

8.3 Summary: Feedback on the content of the Keeping Safe Program:

This section clearly identifies that offenders have a considerable interest in the topic and want very practical information that relates to themselves, their families and loved ones. It is also interesting to note the difference in the topics requested between men and women; which strengthens the case for making a shift away from a generic program to one that will more effectively meet the needs of the target group. Whilst there is no clear direction from juvenile detainees as to the changes that they would like to see to the program (owing to lack of access to this group during the review), their needs are addressed further into the report from a presenter's perspective.

Recommendation:

That the specific BBV information needs identified by both male and female offenders be noted for inclusion in the revised program.

9 The Keeping Safe Training Package and Implementation:

Presenters have called for a complete re-write of the package to more accurately reflect adult learning principles. In addition, the name of the program should be changed to more accurately reflect the changes recommended in the review.

There was a perception that the program:
"…appeared to have been written for kids, but we are in the main working with adults so the feel of the program comes across as patronising." (Keeping Safe presenter).

Presenters felt there needed to be clear acknowledgment that, whilst many offenders had limited literacy skills, this did not equate with low intelligence, and there should be more room for problem solving activities and open discussion than the current over-reliance on printed training materials.

It was considered by presenters that the activities provided in the package were inappropriate for their target group and they no longer used them with adult offenders, although they were sometimes used with juvenile detainees with varying degrees of success

Presenters who had extensive experience delivering the program considered that the existing format for program delivery "did not flow", that it was too prescriptive and did not allow time for discussion and questions. They considered that if they delivered the program as instructed it remained a didactic session with no time to move away from the program content.

Presenters were of the view that a problem solving approach with offenders would be far more effective, especially if the situations used were based upon "prison realities." A Prison Health Services Medical Officer had identified that discussing the potential risk of transmission of BBV's to the offender's partner and children had proven in his work to be a useful catalyst to getting offenders to start thinking about harm reduction. It was deemed that this was a far more appropriate model and more effectively utilised adult learning models than did the existing program.

Given the high level of dissatisfaction with offenders having to attend refresher programs, there was strong support for an Entry and an Exit Program, with interim information being provided by peer educators and/or increased access to information through a range of sources; including videos, pamphlets and newsletters. It was identified that a lot of the resistance by offenders to attending 'refreshers' stems from their dislike of discussion about services available to them and safer sex information to be applied when sexually active post release. For those who are serving lengthy sentences, reminders of "life outside" can be unpalatable and evoke the hostile responses often faced by presenters. Such hostility can form a significant barrier to learning for other offenders who are attending the program. With the abolition of refresher programs, the Entry Program can focus upon BBV transmission risk issues in prison and the Exit Program can focus upon the information offenders need to effectively reduce their risk of BBV transmission back in the community. An Exit Program would also provide information about support/treatment services in the community for those affected and at-risk offenders.

The package currently presents a generic session with attachments for special needs groups. Keeping Safe presenters would prefer to see a sessional outline provided for each special needs group supported with relevant information and resources.

It was determined that the revised program should not be so prescriptive, rather there should be a Session Outline and backup resources included in the package could be updated as required. All Attachments provided would need to be cross-referenced to the Session Outline. This format would make it easier to update the program on an annual basis and would avoid the need for a complete re-write in the future.

To maintain quality control and to enable the DOJ BBV Project Officer to respond accurately to enquiries from the Ombudsman about content delivered to offenders, a checklist linked to the key points of discussion in the Session Outline needs to be developed. It would be the responsibility of the presenter to return these completed checklists on a regular basis to the BBV Project Officer.

Presenters wished to retain the section on "Appropriate techniques for working with adult learners", however, they would like the section expanded, especially for strategies for working with hostile and resistant learners. They also wished to retain the section on Prison BBV Policies, which has proven to be a useful resource when offenders seek clarification on their rights and prison policy.

Presenters thought that it would be useful to have a Prison Glossary covering prison jargon and a drugs and sex glossary. There was consideration that offenders/ex offenders could be involved in assisting with the compilation of such a glossary. This glossary could be used to assist presenters to raise their awareness of the common expressions used, which would enhance their credibility with their target group.

Presenters held concerns regarding how the issue of injecting drug use is currently addressed within the program. The existing materials focus upon cleaning injecting equipment in a community setting rather than being based upon prison realities. It is considered that, as there is now much wider acknowledgment of the extent of injecting drug use that occurs in prisons, more honest discussion on this issue could be introduced to the program. Such discussion needs to address the reality that not all offenders have access to bleach and that the equipment shared has generally been used far more than would ever be likely to occur in the community. The covert and illicit practice of injecting drug use also means that injecting is a hurried event and it is unlikely that offenders will apply appropriate cleaning methods. To be able to discuss injecting drug use in a prison setting in honest and direct terms more accurately represents a duty of care to offenders than the currently prescribed program allows.

There has been a level of discomfort by both custodial staff and some presenters at syringes being taken into prisons and juvenile detention centres for demonstration purposes and some presenters have refused to do this. There are mainly concerns around safety and security with syringes being highly desirable commodities in the prison system especially. A secondary consideration is that offenders and detainees at times attend the program whilst still in drug withdrawal and demonstrations of syringe use are seen as counterproductive to the offender's mental state at this time.

There are a number of excellent examples of the correct method for cleaning shared injecting equipment on video, and it is considered it would be preferable to show a video rather than risk compromising the safety of presenters by taking injecting equipment into the prisons.

9.1 The Keeping Safe Training Package and Implementation: Juvenile Detention Centres:

Presenters reported feeling ethically and professionally compromised having to discuss drug use with minors. Keeping Safe presenters contributed the following as issues for consideration in the review of the delivery of the program to juveniles:

- Requires a much more interactive structure,
- Needs to be skills and problem solving based,
- The target group has a very short concentration span, a two hour training block is unrealistic,
- Need to increase the emphasis on the development of safety behaviours,
- Need to increase the emphasis on body piercing,
- Need to work with more basic concepts, clear prevention messages,
- Some presenters considered that they needed skills training in more effectively managing adolescent groups,
- Need to inject more humour to increase the comfort levels of participants,
- Need to retain the rewards system, i.e. presenting sweets as rewards for group involvement,
- Need to be working more from their "world view", need to build on their life experiences,
- More overlap with the PASH program and how this could be achieved,
- May be useful to develop approaches around Bradshaw's "family of origin" model linked to health enhancement/decision making, given that many of these juveniles are second or third generation drug users. For example, juveniles who have been shown to inject by their parents or who have lost parents to drug overdoses. The aspect of drug using behaviour having been very normalised in this group could be usefully challenged as a starting point.

Presenters had two key concerns around presenting the existing program to juveniles, which are as follows:

- Problems associated with presenting around a wide range of ages and life experiences,
- Ethical concerns at being seen to be promoting drug use to juveniles.

On the first point, an example was provided of a group which had a very vocal non-Indigenous 16 year old who was an injector and sex worker and an 11 year old from a remote Aboriginal community who presented as being naïve around sexual and drug use issues. The 11 year old did not return after the break and the presenter did not pursue the matter as they deemed it inappropriate for her to be there in the first instance.

On the second point it was considered that not all juveniles have drug issues and presenters are not convinced that the current program addresses drug use appropriately.

9.2 Summary: The Keeping Safe Training Package and Implementation:

Presenters have clearly identified the need for a complete re-write of the package. The new package should more effectively address the specific needs of identified target groups within the prison and juvenile detention system, and adopt a problem solving approach.

It is considered there is a more open environment now than when the program was first developed in relation to injecting drug use in prisons. Therefore it should now be

possible to educate on this topic in a way that more accurately reflects prison realities. The issue of practical demonstrations of the method for cleaning injecting equipment needs to be re-thought and alternative strategies developed.

Presenters felt it would be more appropriate to introduce an Entry and Exit BBV Program to more effectively tailor the program for offenders who are at different points in their incarceration.

There is a need to consider replacing the Keeping Safe Program for juveniles with an expanded PASH program, which is deemed to be more important. This is not to avoid the dissemination of information on injecting drug use but this task could perhaps be more effectively taken up by nursing staff who have an ongoing relationship with juveniles in their care.

Recommendations:

That the practical demonstration of cleaning injecting equipment be replaced by other strategies in the interest of increased security and safety for presenters.

That the current staging of the program be changed to provide an Entry and Exit Program for offenders in order to more accurately meet the information needs of offenders within the limited time available.

That the quality control of the revised program be measured through the use of checklists to be completed by presenters at the end of each program that they deliver.

That the delivery of the program to juveniles is deemed as unsuitable for many of those that attend and it would be more beneficial to deliver an expanded PASH program than the Keeping Safe Program.

10 BBV resource development: The Keeping Safe Package:

10.1 Overhead Foils:

Presenters considered that the overheads were rarely used given the difficulties in accessing projectors and the lack of a suitable venue in which to display them. There was consensus that there was no merit in retaining them in the new package.

10.2 Laminated Posters:

Presenters felt that the laminated posters used in the program, which duplicate the overheads, should be excluded from the new package. One presenter described them as being:

> *"Offensive to adults and inappropriate for juveniles."*

They were deemed by most presenters as especially inappropriate for Aboriginal males, females and juveniles. Other feedback from presenters was as follows:

- Too many,
- Too explicit,
- Badly drawn and confusing (many prisoners think that the poster depicting oral sex is someone using a bong),
- Too much detail on the posters covering sex and not enough detail on the other topics,
- Repetitive.

Whilst most presenters used the posters, few used all of them as recommended and they considered that they were only used in the absence of more appropriate resources.

There were also practical issues that limited the use of the posters, such as:

- Cannot be used in a venue with overhead fans as they cannot be secured on the walls and tend to blow off which is distracting to the delivery of the program,
- Some venues where the program is held do not have whiteboards or available wall space to display them,
- Not rigid enough to be used as a hand held resource.

There was considerable support for the notion of developing a laminated flip chart book of graphics for use in small interactive discussions rather than the posters. The development of such a resource could incorporate mixed mediums such as photography, graphics and other pictorial approaches (such as Aboriginal art work). The reverse side could provide the key points for presenters to address for each graphic.

10.3 Videos:

Presenters would like to be able to use videos more, but were experiencing problems such as:

- The videos approved for use are now dated and the information is inaccurate,
- VCR's are not always available in the venues where the program is held,
- In some prisons and juvenile facilities the presenter has no control over the video as it is played through a central console controlled by the officers. As a

result presenters cannot play sections of a video or pause footage to use the medium as an effective educational strategy.

Presenters identified that it would be beneficial to have a video specific to WA prisons on BBV's, actively involving offenders in its production as has been achieved in other states.

Alternately it is suggested that "grabs" of video clips from existing videos could be used in the program, such as the method for cleaning injecting equipment. This could be achieved at minimal cost and the "grabs" could be tailored to the target group that the program was being delivered to.

10.4 Format of the Package:

The existing package is generic: if it is to be meaningful to the target group for the program, it needs to be formatted to appeal to each group. There is a need to tailor the package for:

- Offenders of Aboriginal descent,
- Female offenders,
- Juvenile offenders.

Recommendations:

That the overhead foils be omitted from the new package.

That the laminated posters be omitted from the new package, and be replaced by a flip chart.

That funding be secured to develop a video on BBV's that could be used in WA prisons, with the involvement of offenders.

That as an interim measure, Health Services look to the development of a series of "video clips" that presenters could utilise as part of their program.

That steps be taken by Health Services to ensure that presenters have access to video equipment across all sites.

That the Reference Group established to design the new package address the identified need to format the package acknowledging the special needs of the offenders to whom the program is delivered.

11 BBV resource access for offenders outside of the Keeping Safe Program:

BBV related print resources are currently provided through all Health Centres in the waiting areas. Nursing staff are responsible for maintaining and ordering the stocks of these resources. It was noted during visits to Health Centres that some of the print stock was out of date and that there was limited availability of low literacy resources.

The BBV Project Officer with Health Services also provided resources, such as new pamphlets and posters when they became available. The most popular resource at the Health Centres was a selection of *Streetwize* comics, provided through the BBV Project Officer, however, demand exceeded supply.

Health Centres are provided with a range of print resources for staff to use during patient education on BBV issues. A useful resource has been provided in bulk copies from the Hepatitis Council of WA, which gives comprehensive information on hepatitis C infection, its treatment and management in lay terms.

The "Liver First" booklet produced by AIVL has been very popular with offenders but there are problems with accessing sufficient numbers because of the limited print run and cost factor. The Department of Health has greatly assisted with providing copies but they also have only limited stock.

Currently Health Centres do not have the capacity to use health videos in their waiting areas; a strategy used effectively in the community for many years. Budgetary restraints are a key factor in this method of informal education being prohibitive.

Prison libraries regularly order *Streetwize* comics on a range of issues including BBV's. In addition, the libraries receive the Hepatitis Council Newsletter on a regular basis.

Keeping Safe presenters are able to circulate limited print resources to offenders as part of their program. Unlike Health Centre staff who can order any resources that they consider suitable, Keeping Safe presenters need the approval of the BBCD Steering Group to provide print resources to supplement the program content. Recent examples of resources included in the Keeping Safe Program are the "Healthy Body Art" pamphlet and a fact sheet on hepatitis B vaccination programs in prison.

Recommendations:
That the DOJ BBV Project Officer continue to disseminate information to Health Centres regarding new BBV resources as they become available.

That the BBCD Steering Group maintain control over the distribution of health promotion materials used in the Keeping Safe Program and that Nurse Unit Managers maintain control the health promotion materials distributed through Health Centres.

That Health Services gives consideration to providing the equipment required to show BBV videos in prison Health Centres (these could also be used for showing videos on other health topics e.g. diabetes, nutrition, STI's).

That Keeping Safe presenters make offenders attending programs aware of the availability of BBV information through prison libraries.

That a designated person be appointed at each Health Centre to ensure that print resources provided in the waiting areas are current and available for offenders.

That AIVL and other organisations that develop print resources increase their awareness of making resources more available to the prison system. AIVL in particular needs to recognise that offenders can benefit from the general resources that they develop, they do not necessarily require prison specific resources and therefore print runs should be increased to meet this need.

12 Suggestions for future BBV resource development:

Those interviewed were invited to suggest ways by which BBV information could be more widely circulated in the prison system, with suggestions proposed as follows:

12.1 Health Calendars:

Hakea and Bandyup prisons currently produce calendars annually. It was considered that it would be useful to consider developing a health calendar to reinforce BBV prevention messages.

12.2 Posters and Pamphlets:

When the Keeping Safe Program was first introduced, a poster and pamphlet was developed to market the program for offenders. There was general consensus that these resources needed a more contemporary look, as they are currently considered too bland and not attractive to offenders.

There was feedback that offenders needed visual reminders of key points raised in the Keeping Safe Program. It was considered that offenders could be actively involved in the development of posters that could be displayed around the prison, thereby promoting a sense of ownership.

12.3 Electronic Resources:

Dr Noel Plumley from Next Step considered that as most offenders have access to a CD player, it would be useful to provide CD's with music messages about BBV's. He has expressed that this is an initiative he is keen to develop.

As more offenders gain access to computers through the Education Centres it was suggested that Health Services investigates the existence of interactive computer games with a BBV focus, to be made available to Education Centres.

Officers felt there were clear advantages to having BBV videos that could be used in the prison units. Unfortunately, the majority of BBV videos that have been developed for prison populations are now out of date and were originally designed to inform offenders about HIV rather than hepatitis B or hepatitis C. There is an urgent need for new videos to be developed that focus upon hepatitis C transmission, and it is understood that South Australia is currently in the process of developing such a resource.

12.4 Other:

Some nurses suggested that it would be beneficial for offenders to have activities that that are both informative and entertaining they can take back to their cells, such as games and quizzes.

Recommendation:

That the DOJ BBV Project Officer enters into discussion with the sites that produce calendars to explore the possibility of developing a health calendar.

13 Ways by which the Keeping Safe Program could be more effectively tailored for Aboriginal offenders:

Currently in all male prisons in the metropolitan area both Aboriginal and non-Aboriginal men attend the Keeping Safe Program together. This also applies in the regional prisons, but there Aboriginal men are in the majority.

For Aboriginal women in the prison system, separate groups are provided for Aboriginal women at Bandyup by Derbarl Yerrigan Aboriginal Medical Services. In the regional prisons that hold Aboriginal women, dedicated groups are provided for them either by a Health Worker from the local AMS or by a female community based nurse.

From direct observation of groups where there were both Aboriginal and non-Aboriginal men; it was very apparent that the Aboriginal men were extremely uncomfortable with both the setting and the subject matter. Aboriginal people are not a homogenous group and whilst some Noongyars might be able to cope with the program content, a Bunuba man from the Fitzroy Valley in the Kimberley may find it totally unacceptable on both cultural grounds and with the type of language used. It was noted at Broome Regional Prison that offenders had been given the right to be exempted from the Keeping Safe Program on cultural grounds, and that this also applied to presenters of the program. For example, if a female presenter noted that an older relative was booked to attend the program, she had the right to ask for that person to be excluded from the group, or else she could refuse to deliver the program.

Whilst the nurses overall identified the importance of segregated groups for Keeping Safe, this view was not shared by officers who were resistant to the idea of Aboriginal dedicated groups. From their perspective, there was no need to cater for cultural diversity which they tended to see as reverse discrimination. Officers discussed how from an offender perspective, hostility could arise if it was felt that Aboriginal offenders were getting "better" or "different" treatment in the system; and it was on these grounds that they opposed segregated groups.

In the regions, Aboriginal Health Workers delivering the program have made their own changes to the program to more effectively communicate the content. Any changes made are always put up in the first instance to the BBV Project Officer at the Department of Justice to ensure the changes are acceptable and retain the accuracy of information set down in the package.

13.1 Cultural Dimensions:

It was agreed overwhelmingly that the program needed to be delivered by Aboriginal people for Aboriginal people and that any delivery should be gender specific. The following categories of people were suggested as suitable presenters:

- Workers from the Aboriginal Visitors Scheme (AVS). One Superintendent who supported this group considered that the delivery of BBV education/information should be factored into the job descriptions of AVS workers once they had been trained,
- Elders, but only if those elders are acknowledged by offenders,
- Ex-offenders who "are doing well",
- Leaders in the system,
- Persons from the same skin group as the offenders,
- Aboriginal Health Workers, but only if properly trained.

13.2 Program delivery and acknowledgment of Aboriginal learning styles:

It was deemed important to ensure the cultural safety of both presenters and those attending the program. It was noted at one regional prison that if the older Aboriginal men left a Keeping Safe group, the younger men would follow: this demonstrates the importance of culturally appropriate content. It was also considered important to work within Aboriginal terms of reference and to acknowledge traditional interpretations of health and sickness from a holistic perspective.

Aboriginal presenters supported the idea of having session outlines as they considered this would enable presenters, especially those in the regions, to tailor their delivery in such a way as to ensure the cultural safety of all involved in the program. However, it was considered that if Aboriginal presenters were going to raise issues around ceremonial business, that they should first consult with elders to ensure the information they were giving was accurate, and that they had authority to be discussing such matters.

Another reason for support for the session outline model was that presenters could use local language and colloquialisms to convey the education messages. The proposed problem-solving model would enable Aboriginal presenters to tailor situations that would be of relevance to Aboriginal people.

The program needed to more accurately reflect Aboriginal learning styles, and there needed to be far greater sensitivity in how information was presented if the “shame factor” was to be minimised.

Given that many Aboriginal people have negative memories of the education process, there should be the option of presenting the program away from the classroom setting.

Aboriginal presenters considered it would be preferable to place the program in a family/community framework, thereby offenders would be encouraged to share the information they receive in prison with family and friends.

Strategies identified by presenters, custodial and health staff that were seen as facilitating learning about BBV’s were as follows:

- Art as a vehicle for conveying education messages,
- Peer education,
- Involving the partners of offenders,
- “Health Days” for offenders and their families which include a BBV component,
- Storytelling to disseminate information,
- Incorporation into other programs rather than dedicated information,
- Developing a video which involves Aboriginal offenders,
- Using Aboriginal designated areas in the prison to deliver the program rather than the classroom,
- Matching to programs provided on the outside,
- Visual re-enforcers around the prison (posters),
- Incentives to attend (eg a can of cool drink or lollies),
- Use of humour.

13.3 Resource development:

Resources need to be pictorial and to use Aboriginal designs or cartoons, and to be less explicit. As one presenter stated:

> *"…everyone knows what genitals look like; you don't need explicit pictures to talk about sex."*

There was harsh criticism of the current insert on working with Aboriginal offenders. It was considered that it was offensive to Aboriginal people and in the wrong hands, had the potential for harm if people operated on the instructions provided within it. This document needs to be deleted from the new package.

It was of interest that there was little support for the production of pamphlets. Videos and posters that could be displayed around the prison were seen as more appropriate resources.

13.4 Key issues to be addressed in Aboriginal Programs:

Staff and presenters alike expressed their concern at the increased prevalence of injecting drug use in the Aboriginal community. It was considered vital to discuss this issue with offenders in all prisons and to examine the risks of sharing injecting equipment. The revised program needs to address this issue from an Aboriginal perspective, especially in relation to prevailing attitudes about sharing equipment.

It would be useful to explore working with a model that examined the practice of "sharing" in Aboriginal communities. There has been some level of resistance to Aboriginal communities taking on board what they see as the western construct of harm reduction. This may be outside the scope of the program at this time but should be considered if at any time the Aboriginal community develops an alternative model.

BBV risk factors for offenders in same sex relationships also need to be discussed within programs. This is especially needed for women offenders, with staff noting a significant increase in the number of Aboriginal women entering the system who are either in same sex relationships prior to entry or who establish same sex relationships once in prison.

13.5 Summary: Ways by which the Keeping Safe Program could be more effectively tailored for Aboriginal offenders:

Whilst there have been effective strategies developed in some regional prisons to deliver the information in the Keeping Safe Program; it is more difficult to effectively reach Aboriginal prisoners in metropolitan prisons. There is a clear need to increase the cultural safety for Aboriginal prisoners who access the program.

Currently there is reliance upon Aboriginal Health Services to provide presenters and the review has identified that perhaps the pool of presenters has been too narrow. The DOJ should look to other people in the Aboriginal community who could be presenters, in order to increase the sustainability of Aboriginal involvement in the program.

A shift to a problem solving approach would be a more appropriate learning style for Aboriginal offenders.

Recommendations:

That the DOJ give consideration to increasing the pool of presenters, drawn from the groups identified in Section 13.1 of this report.

That the revised program works effectively within Aboriginal terms of reference and ensures that non-Aboriginal presenters are skilled to work with Aboriginal offenders.

That the new program employs a problem solving approach that is considered to be a more appropriate learning style for Aboriginal offenders.

14 Ways by which the Keeping Safe Program could be more effectively tailored for culturally and linguistically diverse (CALD) offenders:

Staff interviewed stated that over the last decade they had observed a marked increase in the number of offenders who do not have English as a first language, with a significant number of offenders from the Asia-Pacific region. Although there is a duty of care to provide the program to all offenders, this has proved difficult with offenders who do not have English skills and for whom the program content may be culturally offensive.

Three regional prisons have made the Keeping Safe Program available to CALD offenders through interpreters. The initiative taken to deliver these programs is acknowledged. For the regional prisons, the offenders were predominantly Indonesian and interpreters were only required for one language group.

Although the main languages spoken by CALD offenders are Asian languages, many other nationalities are represented in the prisons, most recently Iraqi, Afghani and Iranian offenders. The DOJ needs to identify how they can best meet their duty of care to these groups.

The Department of Health has greatly assisted the DOJ BBV Project Officer to access print resources on BBV information in different languages for offenders; but this does not help if the offender is illiterate.

Recommendation:

That the DOJ develops strategies to more effectively address the BBV information needs of CALD offenders.

15 Peer Education:

There were plans to introduce a BBV offender peer education program some years ago, at the same time as the introduction of condoms to the prisons. However, there was no funding at that time to action this.

Part of the brief for the Keeping Safe Review was to propose a suitable model for a BBV offender peer education program in WA prisons. As a part of this process, officers and nursing staff were interviewed to identify their level of support for this initiative and also their concerns regarding the introduction of such a program.

A precedent has been set in WA prisons leading from a recommendation of the Royal Commission into Aboriginal Deaths in Custody whereby each prison has a network of peer support offenders coordinated by Peer Support Officers. This program has been in place for some time and has been well received by staff and offenders alike.

Superintendents interviewed were of the view that the DOJ needs to introduce all means possible to enable offenders to be educated about safer drug use, with 100% support for the establishment of a peer program. They expressed concern that such a program not be a replacement for the Keeping Safe Program but rather an adjunct to it.

The Superintendents of Nyandi and Casuarina were interested in their facilities being selected as pilot sites for the program, however, the Superintendent of Hakea considered that it would be a difficult program to implement at this facility given the high turnover of offenders.

Prison Officers tended to be less supportive of peer education, and on being asked whether they would be amenable to offenders being trained as BBV peer educators, provided the following responses:

Supportive	58%
Unsure	17%
Not supportive	25%

Nurses interviewed registered 85% support for the establishment of a program to train offenders as BBV peer educators.

15.1 Identified advantages to establishing an offender BBV peer education program:

Superintendents considered this was a model that the system was familiar with and that had proven to be effective.

Whilst it was acknowledged that this would be a health initiative, they considered it would be important for custodial staff to be actively involved in the selection process and ongoing monitoring of potential peer educators. There was also a suggestion that offenders be involved in the selection process. Given that there is an existing peer support program, it may be realistic to recruit from that program, thereby drawing upon existing strong role models who have a good level of credibility with their peers.

Whereas the Keeping Safe Program is limited to two hours contact, peer educators would be available at all hours to offenders who may be considering risky behaviours such as injecting. Increased accessibility to information and support would provide a valuable linkage for new offenders.

Most importantly, as such a program draws upon existing human resources, it was seen as having the potential to be cost effective and to exist within a limited budget.

Another major advantage identified was that peer educators would have a sound knowledge of both the prison environment and drug using culture. If such programs worked effectively, it would provide an additional level of communication on BBV issues between the coordinator of such a program and the peer educators.

Officers and nursing staff identified similar advantages to those of the Superintendents. Additional advantages are as listed below:

- Would provide a source of employment for offenders,
- Peer educators could be seen as good role models for other offenders,
- Would breakdown barriers to discussion on these issues,
- The program would be on-site and ongoing,
- The program would increase the self esteem of those working as peer educators,
- The outcomes would be dependent upon the quality of training provided for peer educators.
- "Offenders would open up to their own kind and see the program as worthwhile",
- "The system would approve of offenders who undertook this work",
- "The program would be very good for Aboriginal offenders, especially if the peer educators were senior men and women that were respected by the offenders",

Some staff, especially those from facilities with a high turnover, suggested that ex offenders could possibly be used as peer educators to ensure sustainability, but acknowledged that it may be difficult to recruit people for this role.

Consistently staff identified that Aboriginal offenders would be clear beneficiaries of a peer education program. It was felt that Aboriginal offenders, especially those from the regions incarcerated in metropolitan prisons, were disadvantaged in the existing Keeping Safe Program and that in many instances the issues under discussion were culturally inappropriate. The provision of Aboriginal peer educators could be a valuable conduit for information and support for BBV testing.

15.2 Identified disadvantages to establishing an offender BBV peer education program:

Superintendents considered that as long as there was a sound infrastructure for the program the disadvantages could be markedly reduced; such as utilising existing contracted presenters of the Keeping Safe Program as monitors of peer educators. The key disadvantages identified by this group were as follows:

- Risk of peer educators passing on misinformation,
- The program not being taken seriously by offenders,
- The reality that offenders do not like to take advice from others,
- Might limit disclosure.

Officers and nursing staff identified the following additional disadvantages:

- *“It is not appropriate for offenders to teach other offenders”,*
- Gives offenders too much privilege, puts them on a pedestal,
- Potential for abuse of power, and to use the position for standover tactics,
- *“How would they maintain control, potential for aggression?”,*
- That the lack of trust between offenders would inhibit interactive learning and information sharing,
- As the peer educators were not professionals they were not bound to uphold confidentiality, which could impact negatively on the program,
- Would need careful selection, supervision, control and monitoring,
- *“Can’t tell people what to do – difficult dynamic for offenders”,*
- Those applying might see it as a joke,
- Racism: offenders may not be receptive to those of another ethnic background,
- *“Lack of quality, peer educators would only present the parts that they were comfortable with presenting”*
- Would need to be constantly re-educating peer educators owing to turnover of offenders, unless long-termers were used,
- Could not have young offenders teaching older offenders,
- Would need ongoing access to resources,
- Would not be able to provide them with syringes for demonstration purposes,
- *“Peer education programs have not worked before, why would this be different?”,*
- *“How to market and recruit to encourage offenders to sign up?”,*
- *“How would you access offenders with the skills to deliver the program?”,*
- *“How would you get offenders to engage with the program?”,*
- *“How could you overcome peer pressure and the knockers of the initiative?”,*
- Trivialises the seriousness of the topic,
- *“The crimes and behaviour of the peer educator may be worse than those of the offenders that he/she delivers to – prisons want squeaky clean presenters”,*
- *“Would provide an opportunity for drug trafficking/drug use if not supervised by officers”,*
- *“The problem with organised activities in prison settings is that they are usually a front for scams or sex”,*
- The logistics of how and where the peer education program will operate from would be difficult,
- If a peer educator is still using drugs in prison, that would be counter productive.

15.3 Keeping Safe presenters views on establishing a peer BBV education program:

Overall there was strong support for the establishment of a peer education program, especially for Aboriginal offenders.

They considered that if they received the training to do so, they would be comfortable supplementing their existing role in BBV education in the prisons to monitor, resource and support peer educators. They acknowledged their limited influence with offenders due to the short time available to them, however, peer educators would have unlimited time to provide ongoing information and to intercede when offenders were considering or had been involved in unsafe behaviours which placed them at risk of BBV transmission.

Some Keeping Safe presenters had been approached by long term offenders concerned at the young people coming into the system who were injecting and asking how they could get involved in preventative BBV education for their peers. Presenters acknowledged that peer education should complement the Keeping Safe Program, not replace it.

15.4 Incentives for offenders to become involved in peer BBV education:

All staff interviewed considered that if offenders were to be motivated to take up the role of peer educator, there would need to be meaningful incentives for them to do so. Suggestions such as extra phone calls or visits were proposed as the most meaningful incentives, or else their role being considered as paid work.

15.5 Summary: The introduction of a peer BBV education program:

The issue of the introduction of a suitable model for offender BBV peer education is to be expanded upon in a separate document to be prepared as part of a Commonwealth project, noting the information recorded within this report.

Overall there was a reasonable level of support for the establishment of such a program as long as the logistical issues were well thought through and custodial services were involved in the overall process.

The capacity of offenders to take up this role was consistently flagged as an issue, given that overall the educational standards of offenders are low, especially for Aboriginal offenders.

The key concerns of officers related to the potential for the position of peer educators to be abused by those selected, and thereby pose security and safety issues. As demonstrated in other programs developed in this area; these concerns need to be seriously noted and addressed. Once addressed, there is no need for the issues to be seen as impediments to the implementation of such programs.

One of the main barriers to the successful implementation of this type of program was seen as the relationships that exist between offenders. Repeatedly comment was made regarding the lack of trust between offenders and perceptions of a lack of credibility for one offender to be advising other offenders on matters related to harm reduction. This is an issue that would need to be very carefully addressed in the development of any peer education program in the future. Lessons could be learned from the existing peer support program to identify how they overcame these problems.

Recommendations:

That the Department of Justice give consideration to implementing a BBV Peer Education Program.

That the Department of Justice in the first instance pilot a BBV Peer Education Program for Aboriginal offenders in the metropolitan area, with extension to the regional prisons if demonstrated as effective in the metropolitan area.

16 Other issues directly related to the Keeping Safe Program:

There are a number of additional issues that impact upon the effective delivery of the program which are grouped within this section.

16.1 Presenter support and professional development:

The program has been fortunate to have attracted very committed presenters who have taken personal responsibility for self-directed learning. All presenters had had some teaching/presentation experience either being trained teachers or having attended skills training workshops in the training area.

When the Keeping Safe Program was first developed, presenters spent two weeks with the DOJ in a mix of lecture based training and work experience. Once this training was provided, it became the responsibility of the contracted agency to train new presenters. Presenters who have been trained since the original intake were critical that there was the potential for deterioration in the quality of presentations as their training had been far more limited.

Since the program was implemented, the Department has been fortunate in that there has been a very low turnover of presenters, but after three years this situation is changing and there are an increasing number of presenters who have not had access to the original detailed training. Clarification is required from the DOJ as to who has responsibility for the training of presenters. On one hand, if the program is to be delivered efficiently it could be seen that it is the responsibility of the DOJ. An alternative perspective is that DOJ contracts agencies and organisations to deliver the program and to provide presenters who are competent to do so; therefore the responsibility for professional development rests with the contractor.

There was criticism that during the life of the program there had been a five-month gap where there was no BBV Project Officer at the DOJ and there had been limited support for presenters during this time. It was considered that since the position had been filled again there had been increased support from the Department.

Since the program was implemented, there has been an annual provision for a one-day workshop to bring all presenters and their contract managers together with DOJ staff to discuss developments, concerns and to provide information updates. Presenters would like to see these forums convened more regularly.

Presenters are in a quite unique position in that they are sessional workers and do not have a workplace to return to that has a clear appreciation of the issues they may face whilst conducting groups. Whilst most groups pass uneventfully, there have been times when presenters have been on the receiving end of offender hostility or been involved in discussions with offenders who have disclosed traumatic information. One example of this was an Aboriginal presenter who arrived at the prison the day after an offender had suicided, the information that she was given by offenders deeply distressed her, and professional counselling was required to alleviate her trauma.

Presenters from the WA AIDS Council (WAAC) considered that there was support available to them to de-brief or to just share their work experience, however, the

presenters at the Hepatitis Council felt that it was less easy to access this level of support.

Presenters considered that a formal system should be developed for the de-briefing of presenters. This suggestion needs further consideration and discussion with contract managers to determine how this could best be achieved through existing mechanisms.

Presenters in the regional areas have needed to be more resourceful in how they access support, as there were no counselling services available to them. As a result they tended to de-brief with colleagues, family members or contacted the BBV Project Officer.

The following topics were submitted by presenters to be included in any training that the DOJ may conduct in the future:

- Aboriginal cultural training,
- Overview of DOJ BBV policies and protocols,
- Update on the availability of pharmacotherapies and treatments for those with BBV's,
- Insights into prison culture,
- Skills training in managing hostile and resistant learners,
- Skills training in program delivery to adolescent groups,
- Information around illicit drug use (request from a regional presenter who considered she did not have ready access to information in this area compared to her city counterparts).

There was some discussion with presenters about the introduction of a BBV Offender Peer Education Program by the DOJ, and that presenters could be seen as key support workers for the peer educators. Presenters were very supportive of the establishment of a peer education program but felt there would need to be a training component for them to enable them to effectively meet the requirements of their support and monitoring role.

16.2 Recruitment and appointment of new presenters:

During a forum with the DOJ, presenters had the opportunity to identify the skills and qualities that they considered were required of a presenter. The purpose of the activity was to provide information to contract managers to assist them in developing selection criteria for recruitment purposes. The qualities and skills required are listed in Appendix 2 to this report - Issues from Keeping Safe Presenters Workshop.

Contract managers would like to see a consensus around the recruitment process for presenters, across all services, and for selection criteria to be standardised.

16.3 Logistical and management issues of the program:

There were a number of issues that contractors required clarification on, and this emphasised the need for a procedural handbook which would assist both existing and new contractors. Issues that require clarification are as follows:

- The process of gaining approval to introduce new information to the program.
- The consideration of paying presenters "preparation time", and whether this is the responsibility of contractors or of the DOJ.

- Existing contracts specify that the program must be delivered as set down in the package with no variations. Contractors are concerned they are in breach of contract as they are aware that few presenters currently deliver the program as originally designed.
- Part of the role of the contract manager is to monitor the performance of presenters. To date there has been no instrument developed to monitor performance and as such evaluation tends to be subjective and not documented. For the purposes of quality control, it was suggested by contractors that a formalised monitoring process be established and that (especially for regional presenters) contractors could also be actively involved in the process once formalised.
- The program was developed to run over two hours with one break, however there are consistently problems with accessing the full two hours. Presenters are of the view that if they wait for one hour after entering the prison and there are insufficient numbers to run the group, the session should be cancelled. This mechanism needs to be reflected in the contract pay arrangement for cancellations.
- It was agreed at a workshop for presenters that certificates should not be provided for prisoners who left part-way through a session and that they would need to repeat the program.
- Concern was expressed by presenters who worked with juveniles that two hours was too long to retain their interest under the current structure of the program.

16.4 Marketing the Keeping Safe Program:

Posters had been developed to promote the program, but in the opinion of staff, offenders and presenters they were not eye catching and are not generally in circulation any more.

There was a strong sense that the name of the program needed to change and to be marketed accordingly. Presenters considered that the name needed to change as the existing title had negative connotations for offenders. Offenders also considered the name of the program was too conservative and did not reflect the content. In addition, as it is planned to make the move to an Entry and Exit program, the title should more accurately reflect this change.

It was generally agreed by presenters that the sexual focus of the program was one of the main deterrents to prisoners wanting to attend it. The focus of any marketing program should be one of “blood awareness”.

Presenters felt that officers and nurses could play an important role in effectively marketing the program. They felt that if officers had a better understanding of the program, they may have a more positive view of it. It was reported that at one regional prison officers calling offenders up for the program referred to it as “the condom program”. Given that this was a predominantly Aboriginal prison, this worked very actively against offenders being motivated to attend as it is culturally inappropriate to discuss sexual issues openly.

There is a need to shift the view of offenders that rather than this being a program they have to do, that it can be a positive experience and can provide them with useful information.

16.5 Certificates:

Presenters considered that although some prisoners put their certificate in the bin on leaving the program, most valued them. Some offenders had told presenters it was the first time they had ever had a certificate for anything, and presenters considered that this was an esteem raising activity. Presenters stated that in some instances, offenders had become motivated to attend other courses in the prison after receiving their Keeping Safe certificate. As a result presenters felt that the certificates should be retained.

Aboriginal presenters considered that certificates would probably be valued more by Aboriginal offenders if the certificates were re-designed using Aboriginal artwork.

16.6 Dedicated space for presenters and Keeping Safe equipment:

Presenters felt that rather than having to bring their Keeping Safe kits in and out of prison each time, there should be a safe place within the prison where this equipment could be stored. This already happens in most of the regional prisons but was especially an issue for Hakea where the program was run on almost a daily basis but where no provision for storage was currently made.

The requirement for dedicated space is essentially an issue for presenters at Hakea as they can be in the prison all day, unlike the other prisons where presenters attend for two hours only. The Hepatitis Council of WA has requested that an office and phone access be available to their presenters at Hakea. Phone access was requested as it is difficult for the Council to get messages to presenters and the phone may be needed for de-briefing if a presenter has had a difficult group.

16.7 Evaluation since commencement of the program:

This has proven to be a difficult program to review given that there has been no consistent evaluation conducted during its life. Originally there were evaluation sheets developed for offenders but these were ineffective for the following reasons:

- Low literacy in offenders made it difficult for them to be completed,
- There was no provision to measure pre-attendance knowledge levels and compare this against post-attendance knowledge levels,
- There was no formal mechanism in place to collate evaluation sheets and report on results,
- They were too time-consuming to complete.

There was also no instrument for impact evaluation, so there was no documentation regarding the short-term impact of the program upon offenders.

Given that each presenter had moved away from the original format and content of the program as prescribed, it was not possible to accurately review the program as it had been designed; as there were so many variations to its delivery across all sites.

There was also a lack of a formal process to monitor presenters, and this issue is addressed in more detail in section 16.3 of the report: Logistical and management issues of the program.

One presenter working in a metropolitan prison has developed his own evaluation sheets, which he finds work quite well with offenders, and other presenters should consider this instrument for adoption.

There is an obvious need for a very clear and user friendly evaluation methodology to be developed, given that DOJ make a sizeable financial outlay for this program and its validity needs to be justified through appropriate evaluation.

Recommendation:

That the program develops protocols for the provision of de-briefing for presenters following traumatic or stressful events.

That the DOJ increase the number of forums convened annually for networking and professional development for Keeping Safe presenters, contract managers and DOJ staff.

That any plan developed by the DOJ to provide an offender BBV peer education program acknowledge Keeping Safe presenters as willing partners in the establishment of such a program.

That Keeping Safe contractors in collaboration with the DOJ standardise the selection criteria for presenters and also standardise the recruitment process.

That the DOJ needs to work collaboratively to develop strategies to more effectively monitor the competency of presenters to deliver the program.

That the DOJ needs to provide clearer direction regarding the costing and invoicing of service delivery.

That new posters and pamphlets be developed and made widely available in prisons in order to promote the revised program.

The name of the program be changed to reflect the recommended changes to format and content.

That the certificates presented to offenders on completion of the program be retained.

That certificates for Aboriginal offenders be re-designed and that an Aboriginal graphic artist be contracted to do this work.

That the DOJ make provision for all Keeping Safe training materials to be stored in the prison between programs in a secure place.

That an appropriate instrument be developed for the ongoing evaluation of the program and that the instrument selected be appropriate for use by offenders with low or limited literacy skills.

PART B: PRISONS AND BBV'S

17 Overview:

This section of the report provides information gained during the course of the review related to issues which either directly or indirectly impact upon the Keeping Safe Program. The provision of condoms, testing and treatment access for BBV's are just a few issues that are addressed in the program and are raised in this section of the report. The feedback provided demonstrates that at times there are discrepancies between what is taught in the program and the realities of how goods and services are provided in prison environments.

18 Staff BBV Training:

Part of the overall brief for the Prisons Project was to identify the BBV training needs of both nursing staff employed by Health Services and prison officers. The needs assessments were developed as separate documents, and copies of these reports can be accessed through the DOJ Health Services Directorate.

At the time of the review, Prison Counselling Services were known as the Forensic Case Management Team (FCMT) and were included in the review process via interviews. It was the opinion of the then Director of FCMT that he would like to see all team members complete an equivalent of the Keeping Safe program to improve their working knowledge and heighten awareness about the potential for occupational exposure to BBV's. He deemed that this was important as their client group was those at risk of self-harm, those seen post self-harm and the mentally ill.

It is ironic that within the prison system, offenders in all probability have a higher knowledge level of BBV's than some staff, given that there has not been any dedicated training on this issue for staff since the introduction of the Keeping Safe Program. This is an issue that needs to be addressed as a matter of priority.

Recommendation:

That all categories of staff having direct contact with offenders are given access to BBV training as a matter of priority.

19 Hepatitis C transmission risk factors for offenders in prison settings:

Custodial staff were asked to identify what they considered to be the practices which posed the highest risk to offenders of hepatitis C transmission. A number of practices were identified and staff were to select which they considered as “high risk”.

The high-risk practices identified by Superintendents and Assistant Superintendents were as follows (results are ranked in order of the number of responses received):

1. Sharing injecting equipment,;
2. Tattooing,
3. Sex between offenders,
4. Body piercing,
5. Fighting,
6. Sexual assault of offenders,
7. Food preparation,
8. Contact sport,
9. Cleaning up after blood spills.

The high-risk practices identified by Prison Officers were as follows (as above, results are ranked in order of the number of responses received):

1. Sharing injecting equipment,
2. Tattooing,
3. Sex between offenders,
4. Body piercing,
5. Sexual assault of offenders,
6. Fighting,
7. Needle stick injury,
8. Use of hair clippers,
9. Cleaning up blood spills,
10. Deliberate inoculation,
11. Contact sport,
12. Administering CPR,
13. Food preparation.

Both groups identified the sharing of injecting equipment as the main practice placing offenders at risk of hepatitis C, and there was consensus on the top four high-risk practices.

Both groups identified food preparation as a high-risk activity, and this misperception is in all probability a result of limitations upon offenders with hepatitis A working in kitchen areas and confusion between the transmission routes of the two viruses.

Clarification is required for custodial staff around whether offenders with communicable diseases can work in food preparation areas.

An example was provided of the concerns of offenders towards peers with (or assumed to have) BBV’s working in food preparation. An offender whom his peers suspected of having HIV working in the kitchen was branded an “AIDS carrier.” Prisoners refused to eat porridge that he had prepared and it had to be discarded. The prisoner was shortly after transferred to another prison to remove him from the discrimination.

It is of interest that certain practices, which are readily preventable with appropriate infection control, were deemed high risk activities, such as cleaning up after blood spills. This is indicative of custodial staff not having confidence in the infection control measures that are currently in place to manage these situations.

There had been some criticism from offenders that officers were not consistent with the "blood rule" for contact sport and considered that there should be stricter adherence to that rule.

19.1 Perceptions of BBV transmission risk to staff:

Custodial staff were asked to rank which BBV they thought that they were most likely to contract in the workplace and rank the others through to the least risk of contracting. The results were as follows:

Superintendents		**Officers**	
1st	hepatitis C	1st	hepatitis C
2nd	hepatitis B	2nd	hepatitis B
3rd	hepatitis A/HIV (equally ranked)	3rd	hepatitis A
		4th	HIV

That hepatitis C is identified by both groups as the most likely to be contracted in the workplace was expected as staff are fully aware of the prevalence of the virus in the prison system. It was of concern, however, that HIV rated so low. It is suggested that in future education programs for custodial staff, awareness needs to be raised that HIV infected offenders are still in the system and that they cannot afford to be complacent about HIV.

20 Initiatives identified by custodial and nursing staff to reduce the risk of BBV transmission in prisons:

Education was seen as the key to reducing the risk of BBV transmission in prison, combined with strategies to reduce the supply of illicit drugs. On the issue of supply reduction the following initiatives were proposed:

- Contact visits only for non drug using offenders,
- Stop contact visits altogether,
- More diversion programs and decrease the size of the prison population,
- Increase staff levels,
- Increase strip searches on visitors,
- Restrict the number of civilians moving in and out of the prisons.

In the area of education, the following ideas were proposed:

- Make visitors more aware of the risks of bringing high quality drugs into the prison (i.e. increasing the risk of overdose),
- BBV and drug education should be mandatory for offenders,
- Provide basic personal hygiene information to offenders (especially women, care during menstruation),
- Development of a video about the risk of BBV's in prisons,
- That VCR's be available in all Health Centres for offender education on BBV's,
- More training for staff,
- Develop more resources to raise blood awareness on a daily basis,
- Develop a pamphlet for all offenders on entry about the risks of BBV transmission,
- Empower offenders to take more personal responsibility to reduce risk of transmission,
- Initiate a Cleaners Program to standardise all cleaning procedures,
- The Prison Officer Training Academy should better present drug issues, by striking a balance between custodial and public health responsibilities.

In relation to treatments and other initiatives, the following strategies were proposed:

- Provide incentives for offenders who cease drug use whilst in prison,
- Introduce acupuncture as a complementary treatment for drug users,
- Decriminalise the use of cannabis in prisons,
- Set up needle exchange programs, or provide Fitpacks ® on entry that could be exchanged once used,
- Increase access to pharmacotherapies,
- *"Stop the provision of Naltrexone – it is just another "hit" for them."* (Officer's quote),
- *"Set up an injecting room, but I would leave the job if that happened, the courts put them here for a reason."* (Officer's quote),
- Provide extra strength condoms in male prisons (this is an issue that has been raised with Health Services in the past. The strength of the condoms supplied in male prisons are deemed by the manufacturer as safe for anal sex),
- Provide offenders with the means to effectively clean shared injection equipment,
- Increase the availability of gloves in prisons,

- More effective and consistent monitoring of infection control in the prison system,
- There needs to be a balance between self harm and harm reduction strategies regarding the access of razors for women offenders,
- Increased provision of single cells and reduction of overcrowding in prisons,
- Allow professional tattooists to come into prisons, with offenders paying for the work done.

There have been some positive developments around reducing the risk of BBV transmission through boxing, which is a popular activity in male prisons. Offenders can now purchase their own boxing gloves at the very reasonable price of $21.70, to reduce the number of offenders having to share gloves. Sharing gloves was seen as a potential risk of BBV transmission because of bleeding into the gloves if knuckles were skinned whilst boxing. Previously offenders were advised to wear disposable gloves under their boxing gloves.

This initiative needs to go one step further, with a protocol developed and equipment provided to enable punching bags to be cleaned down after each use - there is currently no such system in place.

There was significant feedback regarding the lack of consistency with cleaning standards across the prison system. Some prisons have Cleaning Officers who train offenders (offenders are able to take a nationally accredited program in cleaning) as cleaners and maintain cleaning supplies, and this position needs to be extended across all prisons and juvenile detention centres.

Cleaning standards are monitored by Industrial Officers of each prison wing/unit who are responsible for cleaning standards and there are monthly inspections of standards by custodial management staff.

It is considered that the current standards could be improved upon to more effectively address the BBV infection control standards that should be applied in environments where there is a high prevalence of BBV's. The DOH Applied Environmental Health Program has a role in maintaining health standards in prisons and should be consulted with to lead any changes in the provision of improved cleaning standards.

21 Vaccination and BBV/STI testing issues:

21.1 BBV Testing of offenders:

In accordance with the National HIV Testing Policy, all BBV testing in the prison system is voluntary. Offenders are offered testing on entry to the system and again at their annual medicals. In addition, offenders are encouraged to seek testing if they have exposed themselves to a risk of BBV transmission.

Testing is also offered for sexually transmissible infections (STI's) on entry. Female offenders are very responsive to having sexual health checks, however, male offenders are more reluctant to test.

Prison Health Services Medical Officers currently order the tests and also provide the results. Although there is also provision for nurses to order tests, a positive result must be provided by the medical officer.

21.2 Test counselling and informed consent:

There is a requirement for the provision of informed consent to testing and to the delivery of pre-test information and post-test counselling.

On entry to prison, testing for hepatitis B, hepatitis C and HIV is offered to offenders, with approximately 45% uptake for HIV testing. Figures are not available on the uptake rates for hepatitis B and C. Medical notes include a cover sheet, which records all test results, in order to more accurately follow up on re-testing and courses of vaccination for hepatitis B.

Nurses have reported that whilst most offenders agree to testing for hepatitis B and hepatitis C, there is a reluctance to test for HIV, in part, this is seen to be attributed to the ongoing misbelief that only homosexuals get HIV infection. Feedback from Keeping Safe presenters indicated that offenders do not like the blanket approach to BBV testing and would prefer HIV and the hepatatoids to be tested separately, rather than being offered together.

It was considered by nurses and medical officers that offenders generally have a poor understanding of both their testing and vaccination history.

It is noted that some offenders are reluctant to test on entry but present at the Health Centre after attending the Keeping Safe Program, where the importance of testing is discussed.

With the majority of nurses interviewed, there does not appear to be a clear understanding of the importance of obtaining informed consent as a requirement of testing. This needs to be addressed given the impact a positive test result may have upon an offender.

In feedback from Keeping Safe presenters, there was a sense from some offenders that they felt they had been coerced into testing, or were just told they were being tested for BBV's and until they came to the program, had not realised what those letters stood for. The feedback from offenders within the program identified that they were unaware of the implications of testing and on that basis, it can be presumed that true informed consent had not been given.

21.3 Pre-test information:

Hakea Prison is the reception/orientation/remand facility, with a very significant number of offenders being processed through on an ongoing basis. It is considered that offenders are often on 'information overload' on entry to Hakea, which compounds the problem of identifying as to whether true informed consent has been given for BBV testing. There needs to be provision for them to have backup for clarification and re-enforcement of education messages. It is possible that effectively trained and monitored peer educators could fill this role.

Feedback from offenders and staff indicates that provision of pre-test information is not done well in the system, eg in Hakea, where a doctor may have in excess of 20 offenders to process in one day, there is no available time for effective pre-test information.

Some nurses considered there were problems with presenting BBV print resources to offenders who were either considering testing or awaiting results, as they:

- Compromise confidentiality (offenders don't like to be seen leaving the medical centre with BBV resources),
- Do not cater for low literacy levels,
- Do not provide access to other people who can clarify the information that they have read.

21.4 Post test counselling:

There is a legal responsibility for medical officers to provide notification of a positive result to a BBV and to set in place the necessary referrals and/or treatment. Again, time constraints seem to limit the capacity for this to be done well.

There did not appear to be a good understanding by nurses of the importance of post test counselling, and that it constituted more that just presenting the diagnosis. In some facilities, nurses did not consider counselling to be their responsibility, rather it was seen as being solely the responsibility of the medical officer.

Across all metropolitan facilities there appeared to be poor call-back mechanisms for offenders who had tested negative to access their results. Even when there is a negative result, post-test counselling is important to re-enforce prevention messages and to encourage the offender to re-test in three months if their risk assessment had indicated that they may have been in the window period on entry to the system.

Keeping Safe presenters identified that offenders were dissatisfied with the often lengthy delays in being called up for their test results, and many who had followed up, found that they were negative but had not been called up for post-test counselling.

There were also a small number of offenders who considered that they had not been asked if they wanted BBV testing and who lacked the confidence to ask for these tests from the Health Centre.

21.5 Offender knowledge of BBV's and STI's:

Effective pre-test information and post-test counselling can do much to correct misinformation and allay concerns of offenders. Below are some of the current misconceptions that commonly present:

- Not understanding the meaning of test results. Offenders may think that if they have antibodies, it means that they are safe from infection in the future,
- Not understanding what is meant by the 'window period', and the need for re-testing,
- Offenders who need a second HIV test not understanding the need for confirmatory testing,
- Not understanding about genotypes and the risk of re-infection,
- Poor levels of understanding of the current treatments for BBV's and recent developments in the treatment of BBV's, especially hepatitis C.

There appeared to be concern amongst most offenders regarding the risk of acquiring a BBV whilst in prison as it was common knowledge that there was a high prevalence of hepatitis C and hepatitis B.

Offenders also expressed concern regarding BBV's in family members and partners and it was not uncommon for male offenders who tested hepatitis C positive on entry to ring their partners at the women's prison to encourage them to access testing.

21.6 Presentation and management of STI's:

Nurses working with female offenders considered that they were seeing a marked increase in young women with STI's, especially amongst Aboriginal women entering the system. Most commonly they reported seeing gonorrhoea, Chlamydia, herpes and genital warts.

The mechanisms for contact tracing appear to work well, both between prisons and between prisons and the general community. When difficulties do occur it is usually because an offender has been transferred or released back to the community before contact tracing has been completed.

It was considered that nurses would benefit from professional development to increase their competency in the area of sexual health, especially in their management of Aboriginal offenders. Consideration should also be given to Health Services exploring less invasive means of testing for STI's (such as those developed for use in Aboriginal communities) to encourage more offenders to undergo testing.

21.7 Strategies to Improve BBV testing and STI screening:

First and foremost, there is a need for training in the delivery of pre-test information giving and risk assessment and post-test counselling. Nurses considered they had not received formal training in this area and they did not feel confident to provide input to this area of work. Whilst checklists and written materials had been provided on the provision of test information and counselling, they did not consider this was adequate to enable competency for them in this area.

It was also noted in the report, "*Training Needs of Nursing Staff in Relation to Blood-borne communicable diseases",* that nurses' perceptions of competency in provision of test counselling was not congruent with their demonstration of competency. During the interview process, nurses were asked to self-assess their level of competency to deliver test counselling and then to respond to a number of scenarios related to its delivery. The results of the self-assessment indicated in most cases an acceptable level of competency, whereas the results from the response to scenarios indicated an unacceptable level of competency.

Aboriginal people are over represented in the prison system and are drawn from urban, rural and remote areas of the State. Most nursing responses in the aforementioned report demonstrated an inability to provide culturally appropriate BBV and STI information for Aboriginal offenders. Given the disproportionate rise in HIV prevalence in Aboriginal people as compared to the non-Aboriginal population, the marked increase in prevalence of hepatitis C through injecting and high rates of STI's in Aboriginal people, there is a vital need for improved communication between prison nurses and Aboriginal offenders. An increase in the presence of Aboriginal Health Workers at Health Centres and the establishment of a BBV Prisoner Peer Education Program could be useful strategies to address this issue. In the absence of these measures, the provision of cross-cultural training would go some way to improve the current situation.

A lack of time was consistently given as the reason for poor performance in the delivery of test counselling, and a number of suggestions were made by nursing and medical staff as to how this could be addressed. These include:

- To have dedicated staff to coordinate and provide test counselling, plus follow through for repeat and further testing,
- Providing pre-test information en bloc for offenders as part of their orientation, which could effectively shorten the time required for further information when they presented for testing,
- Establishing a BBV Offender Peer Education program, where peer educators could clarify issues around BBV's and testing,
- That Hakea provide pre-test information only and that results be provided to offenders once transferred to the facility where they would complete their sentence.

21.8 Vaccinations:

21.8.1 Offenders:

It was considered by both nurses and medical officers that offenders had a poor understanding of the importance of hepatitis B vaccination. Female Aboriginal offenders appeared to have a better understanding as many of their children had been vaccinated and they had received more exposure to vaccination campaigns.

Table 1: Nursing perceptions of prisoner levels of awareness regarding the need for hepatitis B vaccination.

Aboriginal Offenders		Non Aboriginal Offenders	
None	5%	None	0%
Low	60%	Low	55%
Medium	20%	Medium	20%
High	15%	High	25%

There appeared to be a need for offenders to be able to access an accelerated schedule for vaccination, with some Health Centres already providing this. Given that most offenders serve sentences of less than 12 months, it appeared to be sound disease control management to ensure that offenders completed their vaccination course prior to release. Nurses reported that it was uncommon for offenders to complete their courses post release despite being provided with information on how to access vaccination sites. This was confirmed by the percentage of offenders re-entering the system who had failed to complete their course.

21.8.2 Prison Officers:

During the course of interviewing prison officers it became apparent that despite a high prevalence of hepatitis B in the prison system, not all officers had been vaccinated, or they had not completed their course of vaccinations. This is something of a surprise considering that when asked which BBV they were at greatest risk of contracting through their work, hepatitis B rated as the BBV that they were at the second highest risk of contracting.

As an occupational health and safety measure it would appear that officers would benefit from current information about hepatitis B and vaccinations, given that this is a preventable BBV.

Recommendations:

The issue of informed consent for BBV testing needs to be more accurately defined within existing testing policy. Consideration should also be given to obtaining written consent, especially for HIV antibody testing and that written consent be retained on the medical records.

That strategies be developed to more effectively market BBV testing and STI screening.

That training in the area of pre/post-test discussion and sexual health be provided for nurses as a matter of priority.

That consideration be given to adopting some of the strategies suggested in the report to overcome the current limitations on the delivery of pre/post-test discussion as a result of time restraints.

That strategies be put in place to improve the dissemination of information on BBV's and STI's to Aboriginal offenders.

22 BBV related discrimination:

Whilst there were no BBV discrimination related questions included in the interview schedules for custodial and nursing staff, there were clear indications of discriminatory attitudes in the feedback provided by both groups.

Most commonly those with BBV's were classified as homosexual if they had HIV infection or as injecting drug users if they had hepatitis C. Therefore, it was more a case of the offender being discriminated against by virtue of their perceived sexual preference or drug use than their infectious status.

Of considerable concern was that some of the nurses interviewed stated their reluctance to spend time on discharge planning and referral for offenders with hepatitis C as their disease was "self inflicted through their drug use", and it was assumed they would not follow through on their discharge plans.

It is suggested that through the BBCD Steering Group, which has representation from the Hepatitis Council of WA and the WA AIDS Council, strategies be developed to address BBV related discrimination in prison settings.

Recommendation:

That strategies for both staff and offenders be developed by the DOJ to address BBV related discrimination in prison settings.

23 Confidentiality regarding BBV infection status in the prison system:

The DOH Case Management team considered there was good provision for confidentiality within the prison system, and that they had not experienced any problems with officers breaching offender confidentiality. They felt there needed to be an acknowledgment that offenders may self disclose their infectious status at every opportunity (especially for HIV positive offenders with mental health issues). An example was provided of an HIV positive offender who was known by officers to be sexually active but was managed in a very discrete way so as not to compromise confidentiality.

Nursing and custodial staff observed that there did not appear to be any great concern amongst most offenders to uphold confidentiality about their hepatitis C status. This was especially true in the women's prison where the prevalence of HCV is close to 60% (as identified by Watson (2001) *Hepatitis C: A Study of Prevalence in WA Prisons*) and where women tend to share their diagnosis and receive support from other infected women.

With the introduction of DNA testing in 2002, offenders have become very suspicious of the purpose their blood samples are being used for. They are not convinced that blood samples taken for BBV testing will be used exclusively for that purpose. In the opinion of Keeping Safe presenters, there needed to be a statement given to offenders to the effect that blood samples taken at medical centres would not be used for DNA testing. They considered that unless some measure like that was adopted; there would be a continued decrease in the number of offenders who volunteer for BBV testing.

Offenders had discussed with Keeping Safe presenters that they considered that confidentiality was compromised at times by nursing staff who were indiscreet in discussing their medical issues in the hearing of officers. An example was provided by an offender who stated that a nurse had discussed the offender's new tattoo within officer earshot. Offenders need to have confidence in Health Centre staff if they are to disclose sensitive information about risk behaviours; and consideration should be given to excluding any discussion on offender health outside of a consulting or treatment area.

Whilst interviewing at Health Centres, on two occasions it was observed that nursing staff breached the confidentiality of offenders. The breaches were in the context of releasing the BBV infectious status of an offender to custodial staff who had sustained an occupational exposure to the blood of the named offender. This is totally unacceptable practice and nursing staff need to be advised of this. A breach within the same context was also reported by one of the Superintendents interviewed.

Keeping Safe presenters condemned the requirement for offenders to identify the reason they wished to attend the Health Centre on a form that was read by prison officers. This practice does not encourage offenders to come forward for BBV testing and an improved system needs to be put in place that would protect their privacy.

It has been found that offenders respect the rule that information shared in Keeping Safe groups must be kept confidential. As the program has become established and offenders appreciate that information is held within the group, it is now identified as a

place where their BBV risk behaviours can be discussed openly and trust is not betrayed.

Of the Superintendents interviewed, none were aware of breaches of confidentiality in recent times, however, they generally believe that officers should be told of an offender's status after occupational exposure. In the instance of an officer breaching confidentiality, the Superintendent would hold a discussion with the officer and a warning would be given.

As a result of a decision handed down by the WA Industrial Commission, officers can access through the Total Offender Management System (TOMS) system a BBV alert on each offender. In addition there is a policy in place that the Nurse Manager must inform the prison Superintendent if an offender tests positive to HIV. These processes have the capacity to place considerable limitations upon the confidentiality of an offender's BBV infectious status, and require review. Importantly, they serve no useful purpose as long as the DOJ upholds the right of offenders to voluntary BBV testing.

Recommendations:

That Health Services address as a matter of priority the at times very inadequate attention some nurses displayed during the course of the review in regard to the confidentiality requirements of offender health information. This especially applies to information related to the offender's BBV status.

That the DOJ review policies developed out of the decision of the WA Industrial Commission that prison officers have the right to know the BBV status of offenders. Given the high prevalence of BBV's in the system, existing policy works against officers consistently applying standard precautions.

24 HIV Case management and support

The DOH Case Management team considered there was good access to treatments and the ability for offenders to continue to see their outside specialists whilst imprisoned. They considered that for their clients, imprisonment actually afforded offenders time out from chaotic lifestyles, enabled health enhancement and improved compliance with treatments.

The DOH Case Management team considered more could be done in terms of peer support for offenders who were homosexual and/or had a BBV. Existing group programs were especially not meeting the support needs of homosexual men and women.

The establishment within the prison system of a Lifestyles Unit could provide offenders newly diagnosed with a BBV with intensive support and education prior to returning to the mainstream prison population. Such a Unit could be modelled on the successful NSW Corrections Program.

The DOH Case Management team considered that if a Lifestyles Unit was established, it would greatly facilitate the development of a case plan not just for the period of imprisonment, but also including discharge planning and through-care.

It was considered there is an urgent need for better coordination of through-care management, especially for the HIV positive prisoners. It is proposed these cases should be case conferenced and that offenders actively work towards their own plan.

There was some criticism of the perceived lack of networking across sectors and the lack of coordination between programs. It was felt this works against the best interest of the offenders in many instances.

25 Hepatitis C management:

Whilst the DOJ has mounted a very strong response to meeting the treatment and support needs of offenders with HIV infection, this has not been the case for offenders with hepatitis. With an average of one third of offenders in the system being infected with hepatitis C, a coordinated response to its management is long overdue. Health Services has developed a hepatitis C management policy; however, in the absence of drug treatment management this consists mainly of monitoring activities.

Access to treatments has been limited as a direct result of the costs associated with treatment, however, there should be an increase in access to accurate information for those infected and other activities to assist offenders to enhance their liver function that are low cost and effective.

Offenders are highly critical of the prison diet which they consider to be high fat, and when low fat menus are provided, they tend to be limited and monotonous. It was considered that less fatty cuts of meat should be used or else fatty meat trimmed and that there be less use of processed meat goods that were high fat.

Offenders also wanted increased access to vitamins and alternative therapies, herbal teas etc, to assist them to take responsibility for health enhancement

Recommendations:

That Health Services develop a sound business case for a budget increase to enable them to provide access to hepatitis C treatments at the level and quality of service available to people in the community.

That the DOJ review the provision of, and access to, low fat diets for offenders with hepatitis C.

That offenders be able to increase their access to non-medical treatments for hepatitis C infection that are available to people in the community, at cost to the offender.

26 Provision of Discharge Planning and Referral for Prisoners with BBV's:

This is an area where there is a need for significant improvement, given that 20% of the nurses interviewed did not see that they had any role to play in discharge planning, and only 25% considered they were able to coordinate this activity effectively. This issue is explored in more detail in the report, *"Training Needs of Nursing Staff in Relation to Blood-borne Communicable Diseases."*

From information received during the review it is considered it would be a sound strategy to more effectively involve stakeholders who are involved in health/welfare service delivery to the offender in the community.

Recommendation:

That Prison Health Services develop a framework for a continuum of care for offenders with BBV's, addressing the entry and release requirements of effective management.

That consideration be given to the DOJ establishing a Lifestyles Unit for those with HIV/hepatitis C infection as provided for offenders in NSW. Such a Unit would enhance the education and support needed by infected offenders and also provide a central point from which case management and discharge planning could be coordinated.

27 Mental Health Issues and HIV Infection:

The Case Management Unit of the Department of Health reported they are increasingly seeing HIV positive clients who also have mental health issues, and who by virtue of antisocial rather than criminal behaviour find themselves in the prison system. It was stated that this posed a range of management issues, especially in relation to modifying risk behaviours in prison. An example was provided of a HIV positive offender with a personality disorder plus intellectual disability who self-harms and is sexually active in the prison system.

Problems also exist when offenders, such as the one described above, are due for release. The Case Management Unit expressed concern that there was a lack of discharge planning on the part of DOJ and other agencies were reluctant to provide care/support for such clients. It was considered that such offenders tended to re-offend in order to return to prison where they feel safer and more supported than in the community.

Recommendations:

That the DOJ give consideration as a matter of priority to improving the coordination of case management of HIV antibody positive offenders; better utilising all community based services that can provide treatment and support to offenders.

That a key feature of improved case management be more effective discharge planning, involving all stakeholders in the offender's management.

28 Occupational health and safety/infection control:

28.1 Occupational exposures, custodial staff:

Superintendents considered that attending to offenders who have self-harmed ('slashed up') poses the greatest risk to officers of occupational exposure. In their opinion, officers were not donning protective clothing when attend 'slash-ups': there was a tendency to act first and think later about personal safety. In addition, they felt that officers were not consistent in the application of the set protocol for conducting a cell search, which often resulted in needle stick injuries. They considered that 90% of exposures occurred through non-compliance with protocols.

28.2 Occupational exposure management, custodial staff:

An officer described that offenders considered it a victory over officers if they could transmit a BBV to them. This belief must compound the stress experienced by staff post-exposure, and perpetuates the fear that surrounds sustaining an exposure.

Many of the officers interviewed were operating on out of date information regarding their medical management if they sustained a blood exposure during the course of their work. Their understanding was that they were to be transferred immediately to Royal Perth Hospital (RPH) and needed to be given post-exposure prophylaxis within one hour of the exposure. As this is no longer the management protocol, officers who did sustain an exposure became frustrated and anxious when their management did not follow that course. The current procedure to be followed is that officers are not referred to RPH unless they have sustained a significant exposure and not if it is a mucosal exposure.

Superintendents felt officers were not getting the support they needed from health staff at the prison post-exposure. An officer considered that the current response in his facility was somewhat "hit and miss" and that nurses should have a checklist to use when managing an occupational exposure to provide a consistent response to management.

Officers tended to be critical not only of the treatment they received through the Health Centres, but also of what they saw as a lack of support from custodial management; providing the following comments:

- *"Basically you look after yourself, administration does not give a stuff."*
- *"We do not get enough support post-exposure, either from Health Services or admin."*
- *"I consider that there needs to be more consideration of the long term impact of an occupational exposure. I had felt 'abandoned' by administration post-testing, still feel that I need support and reassurance."*
- *"I got an exposure three years ago; I am still not convinced that I am OK."*

The DOJ BBV Project Officer makes post-exposure kits available for officers which are distributed through Health Centres and prison administration. However, it was noted that many staff were not aware that these kits were available and requests were rarely lodged to re-stock the kits.

A formalised mechanism is required for the BBV Project Officer to be informed of occupational exposures, in order to better keep records, monitor and support those affected.

Superintendents considered that there needed to be increased provision of counselling for officers and their family members post-exposure. Certainly the greatest concern that officers held was how to raise the issue that they had had an exposure to their partners, and how to access support for themselves and their family members. It is considered that there needs to be better counselling support made available, possibly through an organisation such as Prime Corporate Psychology Services rather than the DOJ Counselling Service, together with the dissemination of accurate information about exposure management.

Officers need to be made more aware of the procedures to be followed post exposure and their rights on this issue. There have been reports of officers having to finish their shift before being able to leave the facility to seek medical attention following a needle-stick exposure. It is the responsibility of officers to ensure that they are tested following an exposure whether through Health Services, a public hospital or their own doctor, and that they present for re-testing three months after their initial exposure. A baseline test and reporting of the incident is essential if the officer sero-converts three months later on which to base their case for compensation. Unfortunately, not all officers report and some officers seek outside medical attention, with no index case testing. Officers are relying on their own risk assessments as to whether to report an incident or not. However, a Training Needs Analysis of custodial staff identified that officers have a limited capacity to accurately assess their level of risk.

28.3 Occupational exposures, nursing staff:

Thirty percent of the nurses interviewed had sustained an occupational exposure to blood in the last two years, which is a high proportion. The majority of incidents had been ‘slash-ups’ where protective clothing had proven inadequate.

28.4 Occupational exposure management, nursing staff:

Of the nurses who reported having sustained an occupational exposure, only 50% felt they had received adequate organisational support and training to cope with the incident. In all instances nurses reported that it was previous training outside of Prison Health Services that had enabled them to manage the situation.

28.5 The capacity of Health Services staff to respond to occupational exposures:

Nurses interviewed felt in the majority of cases that they were ill equipped to provide the information and support needed by Prison Officers post-exposure. They considered they needed training and test counselling manuals, if they were to be able to respond to the required level of service provision.

Lack of skills in this area has the potential for dire consequences as is illustrated in the following case study provided by a nurse who had considered that the situation had been managed appropriately:

An Officer provided first aid to an offender who had a workshop accident with significant blood loss. The officer was not wearing his Infection Control pouch and with his bare hands, applied direct pressure to the injury with paper towels that the blood soaked through. The nurse assessed his risk as low as no evident breaks in

the skin and advised a three-minute hand wash. She informed the officer that the offender was negative to BBV's and that there was no need for him to have a test.

The example indicates that the exposure had been sustained as a result of not applying the protocol to prevent BBV exposures. Whilst the first aid recommended was suitable, disclosing the BBV status of the index case was not and it was inappropriate to tell the officer not to test. The nurse had breached confidentiality and had provided wrongful advice regarding the testing of the officer. In short, it demonstrates there was a limited capacity to manage the situation and that the nurse was unaware that she had acted in an inappropriate and unprofessional manner. This is not an isolated example and during the course of the review several instances of inappropriate management were noted.

Where blood tests were being conducted in the prison, there was no separation of staff testing data from offender testing data, which skewed the data reporting system. This needs to be reviewed and staff BBV testing kept separate from offender BBV testing.

28.6 Strategies proposed by staff to more effectively manage occupational exposures:

Nursing and custodial staff identified the following to enable them to more effectively deal with the impact of sustaining an occupational BBV exposure:

- Increased support from management,
- Training and familiarisation with relevant policies and protocols,
- A designated staff member should be based in the Health Centre to manage occupational exposures,
- Improved on-site exposure management would avoid the need for staff to manage their exposure through their own doctors, who rarely provided counselling or knew the appropriate processes for effective management,
- That Health Services link with the DOJ staff counselling service to develop approaches to break down the resistance that staff have to using the counselling service post-exposure,
- More support for agency nurses from their agencies post-exposure, to reduce their sense of vulnerability,
- Support for staff should continue past the initial exposure until such time as there is complete clearance from the risk of infection,
- Mechanisms to be developed to support and educate the family members of staff who have sustained an exposure.

28.7 Protective clothing

Both officers and nurses identified the need for better protective clothing, such as eye protection and aprons for massive blood accidents. It was considered that the paper overalls provided are inadequate and very cold in winter, which is a disincentive to their use. Prison staff considered that the current provision of protective clothing is inadequate for prison situations where there may be physical resistance from the offender. There was also concern, in light of the number of exposures that have involved offenders spitting in the face of officers, that officers need to be provided with eye protection to prevent spray exposures.

There are an increasing number of reports from staff regarding sensitivity to latex and the talc in gloves provided: alternatives are needed to ensure consistency of Infection Control principles. In addition, there needs to be a selection of glove sizes, eg

smaller ones for female officers. Some gloves are not large enough and split which negates their effectiveness

It is unrealistic to expect that basic latex gloves will afford protection for some of the situations that prison staff find themselves in. Consideration is required for alternative gloves to be provided for cell searches, offender pat downs and retrievals.

There appears to be a lack of confidence overall in the quality of protective clothing provided. The gloves currently in circulation have been demonstrated by an officer to be permeable to food dyes, which casts doubt on their capacity to prevent viral transfer through the glove. A lack of worker confidence in the protective equipment and clothing provided by employers has been identified as a key factor in lack of compliance with their use.

28.8 Management of Blood Spills:

There is an expectation that Cleaning Officers need to be involved in spills management as part of overall cleaning programs, however not all facilities have Cleaning Officers and this responsibility then falls to Unit Managers who may not have the skills and knowledge necessary to address this.

Whilst most Superintendents did not support the practice of offenders cleaning blood spills, they acknowledged this was common; however, if this practice is in place, the following should be complied with:

- Offenders volunteer for the task and have the right of refusal,
- Offenders be supervised to ensure they do not place themselves at risk through inappropriate use of equipment,
- Offenders be provided with some reward for undertaking the task.

There was concern expressed by both offenders and staff that in some facilities the person who generates the spill is responsible for cleaning the spill. Aside from the psychological impact upon the offender, in more practical terms the necessary delay in cleaning taking place makes the task more difficult and leaves a site that is potentially infectious and could pose a risk to others.

The review identified that officers needed a training update on the management of cleaning blood spills, with officers demonstrating limited confidence to perform this task. Offenders fed back that some officers were unable to provide adequate information and supervision to offenders designated to clean up after blood spills.

Clarification is required as to which equipment needs to be discarded after a blood spill and what can be cleaned. It is considered by nurses and Occupational Health and Safety Officers that officers discarding bed linen and mattresses that only require cleaning rather than disposal are wasting a lot of money and this issue needs to be addressed.

There needs to be a review of existing policy about provision of clean uniforms if soiled as a result of a blood spill. There is also a need to provide clear instructions regarding the correct procedure for laundering of personal uniforms (nurses provide their own uniforms). An example was given of an officer whose uniform was heavily soiled with blood during an incident and he had to keep that uniform on for the rest of the shift as there was no other uniform in stock to change into. This is unacceptable.

28.8.1 Spills Kits:

Spills Kits are assembled at Greenough Prison and contain within a cardboard box all the requirements to clean up a blood spill: bucket, protective clothing, cloths and bleach solution. Each box is dated and sealed. There is an expectation that these kits are readily available at each prison and that officers are familiar with the location of the kits, which is usually in the duty office.

Officers were asked how accessible they thought Spills Kits were in their facilities. Their responses were as follows:

Very Accessible	47%
Accessible	44%
Limited Access	5%
Unsure	4%

Few of the officers interviewed for the review knew the exact location of the spills kit for their area. In the words of one officer:
"*They are accessible if you know where to look."*

With the movement of staff across sites it is vital that as a part of their workplace orientation they are made aware of the location of spills kits.

Superintendents considered that there needs to be a designated person across all facilities for the re-stocking of kits as currently the system is very ad hoc.

Given the fact that the kits have to come from Geraldton, staff with responsibility for re-stocking kits need to give consideration to increasing their stock levels, especially for women's facilities where the demand is greater, to ensure that adequate supplies are always available.

The protective clothing and equipment provided in a kit are only suitable for the cleaning of small spills; the eye protection in particular is unsuitable. If there is a need to clean down the walls of a cell that are sprayed with blood, the visor provided does not provide protection from side splashes.

There is a need for a smaller kit that could be used for spot cleaning or to remove used tampons that have been inappropriately disposed of as it is wasteful to use a whole spills kit for these purposes.

It is considered that there should be spills kits on prison transport, including non-AIMS vehicles used for transport of Section 94 offenders.

28.9 Infection Control pouches:

Pouches are provided to each officer with an expectation that they will be worn on their belts at all times, in order that they have the appropriate equipment on hand to manage an occupational exposure and/or incident, that may place them at risk. The pouches contain a pair of latex gloves, vials of sterile water for eye irrigation, a sachet of bleach powder and a two-way airway.

A key finding of the review was the reluctance of officers to wear the pouches at all times that they were on duty. It was noted that officers in maximum security facilities were more likely to wear their pouches than those in minimum security facilities.

Originally the pouches had been quite small, however, now that they include an airway they have become bulkier and uncomfortable to wear. For overweight officers it is difficult for them to sit down if they are wearing the large pouch. There needs to be a review of both the contents and the design of the pouches to encourage more consistent use as an infection control measure.

During the review, officers were invited to show the contents of their infection control pouches. It was of concern that few of the officers interviewed regularly maintained the contents of the kit. There were examples of perished gloves and water that had expired; in addition, pouches were used to store non-designated items. Officers need to take personal responsibility for re-stocking their pouches and ensuring that the equipment contained in them will be functional should the need arise. Not all of the officers were aware of the location of the Infection Control Cupboard, which is available in each unit to enable officers to re-stock their pouches. Inspection of the cupboards indicated there is a need to better maintain stock levels at some facilities and that a designated person is required to perform this task on a regular basis.

There appeared to be a lack of large pouches available, with most officers still using the small ones and this requires review.

There was a request from the nurses interviewed that consideration be given to providing them with infection control pouches. Whilst there is not a need for these when in the Health Centre, they felt that they would be useful for the times that they are moving around the prison as an added protection for them, should an incident occur.

28.10 Infection control protocols:

Officers were asked if they thought that the level of existing protocols to safeguard them from contracting a BBV in the workplace were adequate. The results were as follows:

Satisfactory	58%
Unsatisfactory	39%
Unsure	3%

It is considered that there is a need to increase the opportunities for staff to access information regarding protocols in this area - if this were achieved, it is likely there would be an increased level of satisfaction with the protocols provided.

28.11 Infection control standards:

A nurse expressed concern that there is no provision to adequately sterilise medical equipment in Health Centres. This is due to the fact that there was a policy decision to stop autoclaving on premises and to have all equipment requiring sterilisation provided in sterile packs to the Health Centres. There does, however, appear to be a problem with vaginal speculums in the women's prisons that are just soaked in Milton between uses, with some nurses questioning the efficiency of this in preventing the risk of cross infection (Milton is a sterilising solution commonly used for equipment that cannot be sterilised by the process of steam sterilisation).

The nurses at a number of facilities considered that there was a need to increase the number of sharps containers in the Health Centres to prevent accidents from transporting sharps from the point of generation to the point of disposal.

Officers considered that custodial management did not see the importance of good infection control, hence the perceived lack of attention to the provision of consistent infection control standards and provision of inadequate protective clothing and equipment.

28.12 Occupational Health and Safety Officers:

The Occupational Health and Safety Officers (OH&S Officers) at each facility are responsible for the day-to-day health and safety of staff, and BBV's are a key area for their concern. It is considered there should be stronger links established between the BBV Project Officer and OH&S Officers in each prison, and that those links should be formalised. Currently the links are ad hoc and usually comprise information requests on points of infection control. If there is to be a standardised approach to infection control in prisons, it would be beneficial to establish an Infection Control Committee at each facility that could respond to issues promptly and according to the needs of their particular facility. Such a committee could bring together OH&S Officers, Infection Control nurses, management and officer representation and work towards a more coordinated response to infection control issues.

OH&S Officers interviewed as a part of the review expressed their frustration with lack of consistent infection control compliance by officers. The establishment of a cross sector/discipline Infection Control Committee may well facilitate an improvement in infection control standards across the facility. Such a committee would provide all levels of workers with an increased sense of ownership on the issue of infection control.

28.13 Children of offenders:

Children come into the prison environment as visitors or accompanying mothers into prison (or have access for overnight stays). There was a sense from discussions with officers that there was a lack of blood awareness in dealing with these children, and this needs to be addressed.

It was also noted that for the women's prisons with mother and baby units, there was a somewhat laissez-faire approach to infection control and the management of cross infection. It is proposed that these units be operated at the same standards level as Child Day Care Centres that have very clear guidelines around infection control.

28.14 First aid kits:

Offenders considered there should be increased access to first aid kits in prison work areas as they were unable to provide first aid until an officer arrived on the scene of the accident. Rather than a full first aid kit, it may be adequate to make provision for basic protective equipment for those offenders who render first aid to their peers.

The existing first aid kits on prison transport vehicles were considered to be inadequate.

28.15 Summary on occupational health and safety and infection control:

Whilst the review identified high levels of fear regarding the possible transmission of BBV's to staff, there were strong indications that staff lacked consistency in their infection control practice and in many instances, were not taking sufficient self responsibility for their safety in the workplace. There are a number of areas that

need to be addressed if this situation is to change, such as training, a review of protective equipment and strategy development for more coordinated management.

Recommendations:

That the DOJ review existing policy and protocols for occupational exposure management linked to staff training to provide a coordinated response to this issue.

That training be provided to nurses to increase their competency to effectively manage the occupational exposure of staff.

That training be provided to prison officers to promote and skill them in consistent application of infection control principles.

That the DOJ conduct a review into the current provision of protective clothing and equipment to reduce the risk of BBV transmission in prison settings.

That the DOJ give consideration to the establishment of multidisciplinary Infection Control Committees at each prison and juvenile detention centre to report through the Health Services BBCD Steering Group.

That officers be made aware in training/education forums that standard precautions apply not only to offenders but also to the children of offenders who are on prison property.

That the DOJ work with the DOH to bring the standard of infection control for the mother and baby units to the same standard as similar facilities in the community.

29 Barrier protection for sexual activity:

29.1 Condoms:

29.1.1 Acceptance by custodial staff:

When condoms were first introduced to the prison system, there was significant resistance from custodial staff, mainly on the grounds that they would be used inappropriately. Given the taboo nature of any discussion on same sex activity in the prison system, it could be considered that this also was a contributory factor in the resistance that came from custodial staff.

Some officers remain opposed to condoms having been introduced, seeing the initiative as promoting homosexuality. One officer stated that a colleague had said he would assault any prisoner who he saw accessing the vending machine: this example of homophobia is of serious concern. Overall Superintendents and Assistant Superintendents were satisfied with the provision of condoms and did not see their presence in the prison system as a management issue.

Condoms are available through dispensers in all prisons around the State, which are generally located in ablution areas or other discrete locations. In the metropolitan area the machines are re-stocked by the company that provides the vending machines; in non-metropolitan areas they are re-stocked by a variety of service providers such as nurses and cleaning contractors. There continue to be issues around re-stocking as most officers still refuse to have any involvement with the vending machines.

Although condoms are available in the community to people of all ages, this is not the case in the WA prison system. It is an offence in the prison system to have sex with another offender and it is an offence for a male offender under the age of 21 to have access to condoms. There does not appear to be any record of an offender under 21 having been charged for possession of a condom, however, it does mean that officers will not distribute condoms on exit for any male offender under 21.

29.1.2 Acceptance by offenders:

Whilst offenders appear reluctant to discuss condom use in the Keeping Safe Program, there has been a steady use of condoms in the prison. Offenders at a minimum-security prison were asked their opinion regarding condoms being available in the prison: their general response was that it *"made them feel uncomfortable",* although they thought it was a good thing for the homosexuals who came into prison and established sexual relationships. This feedback emphasises again the taboo about men having sex with men who do not identify as homosexual. There is a double standard with male offenders who consider that it is acceptable for a woman to have a same sex relationship in prison, but not acceptable for men to do so.

Some offenders have questioned whether the condoms provided in the male prisons are strong enough given that they are to be used mainly for anal sex.

An anecdotal report from a prison nurse reported that men in one prison unit have started using condoms when they masturbate, as a hygiene measure, and to prevent the soiling of bed linen.

29.1.3 Issues related to condom access:

There have been times when the machines have not been re-stocked promptly, as the system often appears to rely upon offenders reporting the machines being empty.

There had been systems by which offenders could access condoms via the Health Centre or through Peer Support Officers but this did not work well as offenders felt embarrassed to have to ask for them. The machines seem to work well, and apparently offenders who are not worried to be seen accessing the machine will do so and obtain additional condoms for their cell/unit peers.

29.1.4 Issues related to the disposal of condoms:

At the introduction of condoms to the prisons there had been very clear direction provided regarding the correct disposal of condoms, plus the development of a kit for the removal of inappropriately disposed of condoms.

Officers interviewed noted that there were rarely instances of inappropriate disposal. Reports of some inappropriate disposal was reported at Bandyup Women's Prison where there were reports of blockage in the sewage system with women flushing the condoms down the toilet. This is a problem specific to Bandyup as their sewage disposal system does not have a macerator

29.1.5 Inappropriate use of condoms:

Prior to the introduction of condoms, custodial staff considered that they would be used as weapons against officers, eg filling them with sand. This has proved not to be the case, although there have been some reports of them being used as water bombs and balloons. More commonly the gel sachets provided with the condoms are misused, especially in the male prisons where they are used as a replacement for hair gel and the condom is discarded at point of access. One prison reported that offenders had from time to time covered door handles in lubricant as a nuisance making activity against officers.

More seriously is the widespread practice of using condoms to store contraband in body orifices; and the packaging for dental dams being used as a container to bury drugs and injecting equipment in the prison grounds.

In the women's prison it is apparently common for women who are transferred to the punishment cells to pack condoms with tobacco, cigarette lighters and illicit drugs, which are then packed into their vaginas. The use of the vagina for storage purposes has resulted in the expression, "the prisoner's purse." In addition to this being an unlawful practice, there are also health implications for women using their bodies in such a way.

There was a report of an offender who stockpiles condoms and sells them to offenders who are going to court, to hide their contraband internally.

In addition there were reports of offenders holding condoms in their mouths to dispense their medications into, for trading purposes.

Whilst officers discussed the above behaviours, none of those interviewed saw this abuse as a reason for removing condoms from the prisons.

29.2 Dental dams:

Dental dams were introduced to all prisons that hold women shortly after condoms were introduced, in addition to condom vending machines. They are available at all regional prisons through dispensers with the exception of the Eastern Goldfields Prison where they are available through the Health Centre.

The dams are dispensed through a vending machine and come in a small plastic box.

It is considered by staff of FCMT that there are women in relationships in the prison who are using dams on a regular basis.

Those interviewed considered that there needed to be better instructions provided for the use of dental dams if they were to be provided as a BBV prevention initiative.

29.3 Female condoms:

Presenters working with women offenders disseminated information regarding the female condom. It is reported that women who experienced difficulty in negotiating for safer sex were interested in using the female condom. Consideration should be given to piloting the availability of the female condom to women offenders on release in addition to male condoms.

29.4 Exit Kits:

29.4.1 Provision of Exit Kits:

Exit Kits are provided to offenders on release and contain one condom, one sachet of lubricant and packaging which gives the following information:

- How to clean a syringe,
- Overdose prevention,
- Contact number for Needle and Syringe Program locations,
- BBV services contacts,
- Transmission of BBV's,
- Testing for BBV's.

The WA AIDS Council is contracted to provide the kits and they are available to offenders as they collect their property on leaving the prison.

For women being released from Bandyup Prison they are also offered dental dams in addition to an Exit Kit.

29.4.2 Staff awareness regarding Exit Kits:

Only 28% of officers interviewed were able to accurately describe the contents of an Exit Kit, with a similar level of awareness from nursing staff. As the kits are only available on release, officers who have not worked in that area were largely unaware of their existence.

29.4.3 Support for Exit Kits:

Of the officers interviewed:

- 64% considered exit kits to be a useful initiative
- 6% were unsure
- 30% considered that the provision of Exit Kits was not worthwhile.

Of nurses interviewed 90% considered that it was a useful initiative.

Of those who were supportive of the provision of Exit Kits, it was considered that they provide continuity with protective behaviours and re-enforce positive behaviour

A Social Worker considered that Exit Kits remind offenders what they have been doing on 'the inside' and the need to protect partners on 'the outside'.

One officer considered that offenders were receptive to the kits, saying:
"They are all desperate for them when they leave, if you forget to offer them they will remind you; the majority that is."

Staff considered that Exit Kits should also be provided to women offenders who have home leave towards the end of their sentence, not just on release.

29.4.4 Criticisms of the provision of Exit Kits:

Some staff interviewed considered that providing one condom was a tokenistic initiative and that the kit should include additional condoms and a Fitpack ® (sterile injecting equipment). There were also criticisms of the cost of providing this initiative, money that some staff considered could be better spent elsewhere.

One worker considered that rather than Exit Kits being a separate initiative they should be provided as part of the offender's Throughcare Kit; in so doing the provision of condoms is normalised and it puts public health into a more holistic framework.

Some workers were not convinced that DOJ markets the availability of Exit Kits appropriately, and this could be improved upon.

Perspectives from staff in male prisons about offender response to Exit Kits:

- Peer pressure can inhibit offenders from taking an Exit Kit. Staff noted that offenders were more likely to take them when alone,
- Staff felt that the kits would be thrown away without use,
- *"Offenders say – only wooses use condoms, real men don't use condoms."* Officer quote.

Perspectives from staff in women's prisons about offender response to Exit Kits:

- Women see condoms as men's responsibility, not theirs,
- Women are offended.

29.5 Sexual preferences and condoms:

- *"Those who have "gate sex" would not want to use condoms with partners on release as might make partners suspicious of what they have been doing in prison."* Prison Officer.

- *“If they are not using* them *in prison why would they use them after release?”* Prison Officer.

The two quotes provided above sum up the key dilemmas about condom use in the prisons: secrecy about same sex activity and not seeing unprotected same sex activity as a risk for BBV’s /STI’s if you do not identify as homosexual. Keeping Safe presenters can play an important role in stressing that it is the behaviour that poses the risk, not the sexual preference of the person.

All those interviewed considered that there was a significant amount of consensual sex occurring in prisons. One nurse describing it as offenders being “touch hungry” but that the majority of offenders would not identify as homosexual; and that the same sex activity that they have in prison is not framed as homosexual behaviour. For this reason offenders do not see that they need to be concerned about condom use, and as a result place themselves at risk. They compound the risk to their partners in not disclosing information about sexual activity in prison and in their reluctance to use condoms on release.

Recommendations:

Any BBV training for officers addresses the issue of homophobia as a barrier to BBV prevention strategies and addresses the importance of condom access as a BBV prevention strategy.

The presenters of the Keeping Safe Program should cover the issue of safe disposal of condoms at each session.

The instructions currently provided with the dental dams should be reviewed to ascertain if additional information is required.

That Health Services pilot a program which provides access to female condoms as part of their Exit Kit.

That offenders having pre release leave be provided with Exit Kitsand that distribution not be limited to final release.

That there be consideration of linking the Exit Kits to the Throughcare package, which would ensure that all prisoners received a kit on release.

That given the high number of illicit drug users in the prison system, consideration be given to providing sterile injecting equipment on release together with additional information on overdose prevention as part of the Exit Kit.

That the number of condoms provided in an Exit Kit be increased.

30 Prison sex and sexual assault:

It should be noted that the West Australian Prison Officers Union (WAPOU) sought the exclusion of questions on sex between offenders and sexual assault from the surveys for prison officers.

30.1 Prison sex:

Nurses interviewed were invited to estimate the amount of consensual sex in WA prisons. Results are as follows:

Significant	55%
Unsure	20%
Minimal	25%
None	0%

It was considered by nurses that there was a large volume of condoms being used in the prisons and it was hoped that some were actually being used for sex.

Health staff were concerned that only prisoners over the age of 21 can officially access condoms and Exit Kits. Whereas consenting adults can have same sex activity in the wider community, in prisons it is a punishable offence, which makes such activity extremely covert.

An increasing number of Aboriginal women offenders are in same sex relationships both in and outside prison and these women need sexual health information around sexual safety in same sex relationships.

Although officers were not asked questions about offender sexual activity, many volunteered their concern and discomfort with the blatancy of female offenders in Bandyup in same-sex relationships openly displaying sexual affection. It was also considered that there was a significant amount of violence arising from relationship jealousies.

Nurses interviewed were invited to estimate the amount of sex for favours in WA prisons. The results are as follows:

Significant	60%
Unsure	5%
Minimal	35%
None	0%

It was considered that this was a widespread practice in metropolitan prisons and, to a lesser extent, in the regional facilities. Most commonly sex was offered in exchange for traded medications and illicit drugs. Sex was also offered in exchange for property, for example, one offender charged one can of Coke per oral sex act with male offenders.

30.2 Sexual assault:

Seventy five percent of nurses responding to the survey considered that sexual assault in the prison system was under reported.

Although in recent times a number of offenders have come forward and reported sexual assault, this is the exception rather than the rule. Nurses reported that offenders are extremely fearful of reporting sexual assault. Those who come forward for treatment often beg nursing staff not to report it to custodial staff, for fear of the assault being repeated.

Nurses generally felt that officers did not want to get involved in dealing with these issues.

There was an observation that often it was not until an offender "fell apart" that sexual assault would be identified.:

- *"Rape is something that always happens in other prisons, to other people, not in ours."*
- *"A homosexual prisoner once described prison to me as a smorgasbord – lots of lonely, desperate, frightened young men looking for comfort."*
- *"Young disturbed vulnerable boys of small stature get stood over but won't report."*

In the opinion of nursing staff, sexual predators are a more common feature of prison life than previously and feature in both male and female prisons.

There needs to be greater protection for young vulnerable males in the system from sexual assault. The Victorian Corrections system has adopted a process whereby vulnerable adult offenders under the age of 21 years can be detained in juvenile rather than adult facilities. Consideration should be given to introducing a similar approach in WA.

It was considered that the risk of BBV transmission cannot be underestimated in the increased number of sexual predators who exist in the system. It is also noted that vulnerable offenders will enter into quasi-consensual sexual relationships with offenders that they believe will give them protection from other sexual predators.

In the opinion of Superintendents and nurses, female offenders are more likely to come forward if they have been assaulted than male offenders.

During the review there were a number of disturbing reports regarding Aboriginal males in a metropolitan prison pack raping vulnerable non-Indigenous men, however, none of the victims had been prepared to disclose the names of their perpetrators.

A Superintendent reported that in his opinion non-consensual sex was significantly under-reported as there was an obligation on the victim to disclose the name of the perpetrator. He considered that the removal of this condition would be a very positive move in getting people to get medical checks post-assault.

30.3 Support for sexual assault victims:

Discussion on sexual activity and assault appear to be taboo in the prison system, and it is suggested that the Sexual Assault Referral Centre (SARC) should be contracted to initiate some organisational change in response around this issue.

SARC also could play a vital role in skilling nurses to manage this issue, as they are often the first point of contact post-assault. Nurses need training to increase their capacity to correctly assess offenders who may be sexual assault victims.

For offenders there needs to be increased access to SARC for victims, and the privacy of offenders must be protected if they chose to access these services. There have been incidents of offenders being called over the PA system to come for their SARC appointment.

There is also a need for SARC to review its policy of excluding males who are sex offenders from accessing their services. There are sex offenders who have also been victims of sexual assault either as children, youths or adults and the refusal of SARC to treat significantly narrows their treatment options.

Sexual assault should be managed as a Police issue, not be internally managed. In addition, victims should be able to move easily into protection or to another facility as soon as possible post-assault as long as there are support measures in place at the other facility.

Victims need to understand the limitations on confidentiality whilst acknowledging their need for privacy. In addition, nursing staff should be exempted from having to report to custodial services on the actual or suspected sexual assault of offenders, as an incentive for offenders to report sexual assault.

There is a need to make offenders more aware of their rights, however, this is difficult to achieve given the culture of prisons. There is a fleeting reference in the Keeping Safe Program to sexual assault but it was noted that presenters rarely include this topic. In feedback from presenters, they considered it was such a taboo subject in the prison that if they raised the issue they *"lost the group"* and participants withdrew. However, this issue needs to be raised, as it may be the only point at which offenders can formally get information on what to do if they are assaulted.

Nurses at Bandyup are piloting two strategies to increase the privacy of offenders wishing to access medical services:

- A confidentiality box – offenders lodge a request to be seen at the Health Centre in a box in the compound that only the nurses have access to. The nurses are then able to call up the offender without the offender having to have sought the permission of custodial staff.
- A weekend medical clinic where the nurse goes into the compound and sees offenders on a needs basis, which is seen as less confrontational than accessing the Health Centre.

These strategies could be very positive in facilitating discussion not only about sexual assault, but also other BBV risk practices. Consideration should be given to adopting these strategies at other prisons.

Given the perceptions provided in this section on the extent of sexual activity and assault in the prison system it is essential that extra encouragement to test for BBV's be provided on a regular basis.

A Prison Health Services Medical Officer commented that the issue of child and adult sexual abuse was often the basis for underlying mental illness and the development of addictive behaviours. In his opinion there needed to be better provision of one to one counselling, group work and victim support groups in combination with other life skills programs. Further, unless this issue in offenders is addressed, it is unlikely that they will be able to make much movement in any other of the programs offered. This is an issue that has been off limits for too long and needs to be properly addressed.

Recommendations:

That the current management of sexual assault in prisons be reviewed and for the review to especially address reporting mechanisms and offender privacy.

That SARC be contracted to provide training for prison staff, to initiate organisational attitudinal change towards the issue of sexual activity and abuse in prison settings.

That strategies be developed which encourage offenders to seek support and treatment following episodes of non-consensual sex.

31 Tattooing and body piercing:

Tattooing has been identified as a significant risk practice for BBV transmission in the prison system, and yet a risk that is seriously underestimated by offenders. Within the Justice System, tattoo guns and inks are created from products that are readily accessible to offenders. These "guns" are crude, and as such would be impossible to sterilise. The Keeping Safe Program identifies tattooing as a BBV risk factor, but it is considered that this section of the program should be expanded given the prevalence of this activity in prisons.

There are three levels of tattooing that have been identified as part of the Keeping Safe review, which are as follows:

- Tattoos provided by offenders identified as being competent, who may have worked as tattooists in the community (either professionally or underground) and use tattoo guns in the prison. For these tattoos there has usually been some attempt at infection control.
- Tattoos provided by offenders who are deemed "amateurs" by their peers, administered with a tattoo gun but with less effort to ensure a degree of infection control.
- Tattoos that are self inflicted or applied by a peer through piercing the skin with a sharp object and rubbing colouring solutions into the open wound. Level of infection control is unknown and this type of tattoo is most commonly seen in juveniles and women.

31.1 The occurrence of tattooing and body piercing in prisons:

It is an offence within the WA prisons to provide or to receive a tattoo. Given the covert nature of this activity, the prevalence of tattooing in prisons could only be estimated by the amount of equipment that had been confiscated. It is considered that this would provide some indication, but that any results would probably be an under estimation. Superintendents and Assistant Superintendents interviewed reported that 78% were aware of tattoo equipment being confiscated in the last 12 months. They considered that it would not be possible to assess the prevalence of body piercing by rates of confiscated equipment as offenders did not use specific equipment for body piercing.

Officers were also asked if they were aware of any tattooing equipment or body piercing needles having been found in their facility in the last 12 months. Ninety four percent were aware of tattooing equipment having been found in their prison in the last 12 months. Officers considered that body-piercing equipment would not be detected, as offenders utilise any available sharp objects to perform piercing.

Whilst most of the confiscated equipment had been found during cell searches, officers were usually alerted that tattooing was occurring when areas in the prison lose power because tattoo guns have been wired into the mains.

Custodial staff were asked to estimate the prevalence of tattooing and body piercing in their facilities. The results are presented below:

Custodial management assessment:

Prevalence of tattooing:		Prevalence of piercing	
None	33%	None	44%
Low	44%	Low	55% (goes in cycles)
Med	23%		

Prison Officer assessment:

Prevalence of tattooing:		Prevalence of piercing	
None	3%	None	14%
Low	44%	Low	58% (goes in cycles)
Med	30%	Medium	11%
High	19%	High	0%
Unsure	4%	Unsure	17%

Custodial staff overall estimated that body piercing was more prevalent amongst female offenders than males and that tattooing was more prevalent amongst male offenders than females.

31.2 Reasons for the continuing practice of tattooing and body piercing in prisons:

In the last decade there has been a universal renaissance in tattooing and body piercing which previously was seen an activity of marginalised groups in society such as bikies and offenders. Department of Justice records for 2001 indicate that in excess of 50% of people entering the prison system had one or more tattoos.

Tattooing is known to be an ongoing activity in prisons. FCMT staff interviewed considered that those who get tattoos in prison do so mainly for:

- Gang affiliation,
- Identity strengthening – symbol of time served, manly status,
- Alleviation of boredom,
- Peer affiliation,
- Rebellion against the prison system,
- *"Seemed like a good idea at the time."*
- Wishing to follow a fashion trend.

FCMT staff considered that most offenders were pleased with the tattoos they had received in prison.

It was considered by nursing staff that women at Bandyup were more likely to tattoo in prison than in the community. It is noted that women who tattoo in prison tend to tattoo the names of their children or partners rather than designs. Additionally, tattoos in female prisons tend to be performed with needles and colouring pigments rather than with tattoo guns that are the preferred method in male prisons.

Whilst there are offenders who tattoo gang affiliation symbols in prison, there is also a culture of prison symbols, which tend to be preferred by long-term offenders who have had multiple imprisonments. This was demonstrated by an offender at Casuarina who recorded each prison that he had been in with a tattoo. Juvenile offenders are commonly tattooed with a teardrop in the outer corner of the eye to indicate that they have served a period of detention, additional teardrops being added for each subsequent period of detention. Younger adult offenders tend to

prefer Celtic and primitive designs, and tattooed wording tends to be in gothic script. Traditionally prison tattoos have been just in blue or black, largely due to the lack of available colouring pigments and also as a preferred style thereby defining them as prison tattoos. This is starting to change with colour being used much more to meet the demands of the younger adult offenders.

31.3 Skin penetration infection control and prevalence of infected tattoos and piercings:

The tattoo equipment used in prisons is recycled from readily available items in the prison. The primitive nature of the equipment and restrictions on the availability of bleach, especially in maximum-security facilities, renders the equipment almost impossible to effectively clean/sterilise.

During the course of the review it was possible to interview a number of offenders who were recognised as "professional" tattooists in the prison system. They considered that they tried to keep the procedure as clean as possible by cleaning tattoo guns down with bleach. One offender stated that he asked his clients to bring their own needle with them, especially if that client was having a large piece of work done and needed to return many times to get the tattoo completed.

These tattooists did not consider that offenders saw tattooing as posing a risk for BBV transmission as compared to other practices in prison. There were reports that some of those performing tattoos would merely wash the tattoo gun down with water between clients.

Many offenders saw an opportunity to generate income or gain access to drugs through providing tattoos, and it was not uncommon that when a "professional" tattooist stopped working or was transferred there were always "amateurs" ready to fill the gap who had scant regard for providing even rudimentary infection control.

There is also concern regarding the colouring solutions and pigments used for prison tattoos. In the first instance, these solutions and pigments are hard to access and manufacture which increases the probability that they will be re-used over and over between clients, posing a transmission risk for BBV's and other infections. Secondly the mixes created may pose health risks in their own right.

There were reports of the following being used as mixes for tattoos:

- Saliva mixed with cigarette ash,
- Burnt rubber from thongs mixed with water,
- Solder dust mixed with water,
- Ink from pens pilfered from the education centre.

One "professional" tattooist stated that clients would often present with their own mix, and that the composition of the mix would not be disclosed to them.

The "needles" most commonly used for prison tattoo guns were wires stripped from guitar strings, which the "professional" tattooist would file to try and keep it as sharp as possible to reduce skin damage. Whereas professional tattooists in the community use single use needles grouped in blocks of up to 14 needles and penetrate the skin only shallowly, this is not the case for prison tattoos. In the prison tattoo there is only one needle, which may be blunt and penetrates more deeply, which increases bleeding to the area being tattooed. The amount of blood and

tearing of skin rather than puncturing of skin increases the risk of BBV transmission and other infections.

Nurses interviewed reported that it was not uncommon for offenders to ask for healing creams for new tattoos; and this afforded the opportunity for staff to encourage the offenders to seek BBV testing. There was concern amongst offenders that if they sought medical advice about a tattoo or piercing that they would be reported to custodial services, as it is an offence to be tattooed in prison. Nurses felt that this was not the case and their responsibility rested with the health concerns of the offender.

Surprisingly nurses reported a low rate of infections following tattooing or piercing. Infected piercing sites most commonly seen were mainly ear lobes, navels and eyebrows. One nurse reported seeing an offender with trauma induced Bells Palsy following an eyebrow piercing. Another reported having seen a badly infected penis after an offender had inserted two ball bearings under his foreskin.

Piercing noses and tongues were popular practices in female offenders, and there were reports of women attending the Health Centre with infection and excessive bleeding/swelling to those sites.

Nurses interviewed reported that they seldom saw infected tattoos, and of those that had (10% of respondents), they were in non-Aboriginal offenders. Infections were more commonly seen with body piercings: 10% had seen infections in Aboriginal prisoners and 15% had seen infected body piercings in non-Aboriginal prisoners.

Existing policy regarding jewellery access for offenders is counter-productive for BBV prevention. Offenders are expected to remove body-piercing jewellery on entry to the system. This results in offenders using any available materials to keep piercing sites open, such as the teeth of combs and safety pins; which, although not especially a risk for BBV transmission, can cause bacterial infection. If the policy is retained then there needs to be provision for offenders to receive clean/sterile materials to keep their piercing sites open. A body piercer consulted on this matter has suggested that nylon fibre could be provided to offenders.

The other problem with piercing jewellery is the amount of sharing that takes place in prison, especially in the women's prisons. There is a risk of BBV transmission if uncleaned shared jewellery is inserted into a new piercing. Keeping Safe presenters should caution offenders regarding this transmission risk.

Nurses reported it was not uncommon to see skin infections in Aboriginal males who have been through law business. A high level of sensitivity is needed to manage these cases, and male nurses are always delegated management of these cases.

31.4 Provision of sterile tattooing equipment:

The public health community has for some time been advocating for strategies to be introduced to prisons to reduce the risk of BBV transmission through tattooing in prisons. To date there are no Australian prisons that have taken up any of the proposed strategies, although NSW has conducted significant investigation into introducing some strategies to address prison tattooing. Examples of these strategies are as follows:

- To allow professional tattooists to come into prisons to provide tattoos to offenders,
- To provide sterile tattooing equipment for offenders,

- To provide vials of sterile tattoo inks for offenders,
- To provide training to offenders in tattooing.

In light of the demand for prisons to address this issue, nurses interviewed were asked their views on the introduction of such strategies. The results are as follows:

Very Worthwhile	15%
Worthwhile	50%
Unsure	20%
Not Worthwhile	0%
Totally Inappropriate	15%

Those who were supportive of the introduction of such strategies, considered that: *"We will never stop tattooing in prisons so we might as well give people the means to do it safely."*

It was seen that the introduction of these strategies would reduce the rate of BBV infections. However, nurses qualified their support by stating that such strategies should be carefully monitored with limited access for offenders. In addition, tattooing should be conducted in a designated area, not in cells.

Of those that objected to the introduction of these strategies, objections were based upon the following concerns:

- Offenders should wait until they get out and have it done professionally,
- May cause long term regrets,
- May increase the number of tattoos being performed,
- Should not be available to prisoners in maximum-security prisons,
- Are a luxury in the community, should not be for free in prison.

31.4.1 Process for tattoo provision:

Currently in WA prisons tattooing is an offence. Tattoos are used as identifiers and the addition of new tattoos is seen as "changing appearance" which is the main ground for prohibition. It is unclear whether body piercing is subjected to the same process. Therefore, if safer tattooing was sanctioned on public health grounds in prisons, there would be a need for existing policy to be changed, and processes put in place to register new tattoos.

Custodial staff considered that the introduction of such a program would be costly and also would be demanding of officer time. Especially in maximum-security prisons, the tattooing would need to be supervised by an officer to ensure that all the security requirements for the program were being adhered to.

There are also concerns from a policy perspective of implementing tattoo programs, such as:

- Would the prison have control over what could be tattooed on the offender's body? It was deemed inappropriate for prison to sanction offenders having tattoos that were linked to gang affiliation or were offensive.
- Would such programs make prisons vulnerable to litigation if an offender later decided that they did not like the tattoo or developed an infection from a prison endorsed tattoo?
- What additional security measures would need to be put in place if tattoo areas were set up in prisons, or if tattooists came into the prison? It is

suggested that tattooing would need to be retained as an offence if conducted outside of the designated area/program.

The strategy that offenders be provided with access to vials of tattoo ink proposed in this review is flawed for the following reasons:

- There is currently no set standard for tattoo ink in Australia, and none used professionally are sterile.
- There would be a significant cost involved in manufacturing single use vials of tattoo ink for use in prisons as tattoo ink is currently decanted from large stock containers to ink trays. Single use vials do not exist in the professional tattoo industry.
- Such vials would be a valuable trading commodity for the "black economy" of prisons; therefore the introduction of vials would be contributing to illicit activity in the prison system and unlikely to get the support of custodial services.

The proposed strategy to allow professional tattooists to come into prisons to provide tattoos is not viable in WA for the following reasons:

- A Reference Group was established to discuss this issue with the two professional tattoo associations that operate in WA. They categorically rejected the strategy and stated that they would not be prepared to participate in any way.
- Some tattooists may be prohibited from entering prisons as they would be unable to meet the security clearance requirements.
- The group did not consider that it was an economically viable strategy. Most tattooists are sole operators and spending a day in a prison would not cover the costs of them having to close their businesses for a day. They also disputed that offenders would be prepared to pay the market rate for tattoos given that most have very limited income in prison. Currently in prisons, although an offender can pay upwards of $100 for a tattoo, it is more common for tattoos to be provided in exchange for goods such as tobacco or drugs, thereby avoiding the cash economy.
- Tattooists felt that, unless a dedicated space was provided for the tattooing to take place, their professional standards and infection control standards may be compromised.

The proposed strategy to train offenders as tattooists was in the opinion of the professional tattooists associations not a viable strategy. This opinion was based on the following:

- There is currently no accredited training program for tattooists. Competency to work as a tattooist is gained through serving an apprenticeship with an experienced tattooist working out of a tattoo studio.
- If a training program was developed especially for prisons it would require the cooperation of the associations, and they were not prepared to be involved with such a strategy.
- The tattoo associations considered that if basic training were provided, it would give offenders a false sense of confidence about establishing a business back in the community. The associations considered that they have worked hard in recent times to raise the standards and professionalism of their industry and that this strategy would take away from the work that they have been doing. They were aware that ex offenders had a preference to get their tattoos done post release by those who had tattooed them in prison (commonly referred to as "backyarders" and "scratchers").I It was deemed that if there was basic training provided, the risk to the community of the

transmission of BBV's would increase and negate the public health benefits that it had set out to achieve.

The proposed strategy to provide sterile equipment to offenders for tattooing was seen as a difficult one to achieve on the grounds of cost and availability of time to maintain stock of this equipment. Currently there are no operational autoclaves in Health Centres, therefore sterilisation would have to be performed off site. Additionally, if proper equipment was provided there would still be a need for a training component to instruct offenders on the preparation of the tattoo gun together with access to soldering equipment to apply needles to the gun. This strategy is flawed, as it is not just about providing sterile equipment, it also includes a training component and a designated area and equipment to prepare the tattoo gun for use and therefore is not logistically possible.

31.5 Tattoo removal:

This section was included as there was some consideration by Health Services of purchasing the equipment required to remove tattoos.

It is noted that internationally there are a number of prisons that make provision for tattoo removal for offenders. These strategies have been endorsed primarily to remove gang membership identifying tattoos, but also to remove tattoos that can be identified as prison tattoos. Prison tattoos tend to be of poor quality and the images used define the person as having served a period of imprisonment. Tattoo removal programs are seen as esteem-raising for offenders and also increase the likelihood of securing employment post release.

In WA there have been a number of offenders who have had tattoos removed whilst in prison, on the grounds of improving the esteem of the offender. There is also provision for Centrelink to cover the costs of tattoo removal for people who they consider would have their employment opportunities improved by tattoo removal.

Nurses interviewed were asked to consider whether they thought that the provision of tattoo removal in prison was a worthwhile activity. The results were as follows:

Very worthwhile	15%
Worthwhile	60%
Unsure	0%
Not worthwhile	25%
Totally Inappropriate	0%

Whilst the majority of nurses were supportive, they were also concerned regarding the cost of such an initiative and felt that the limited Health Services budget funds could be more appropriately used. One nurse felt that there could be some community backlash if offenders could get tattoos removed for free, as people in the community have very limited access to free removal and removal is usually cost prohibitive.

It was considered that access to prison based tattoo removal should be determined on a case-by-case basis, and essentially be for offenders whose self esteem has been damaged by the tattoos that they have. It was also felt that access should be limited to the removal of tattoos that had been acquired in prison, not on the outside.

It was considered that if tattoo removal was made available to offenders that it should be out-sourced. This opinion was based upon the fact that demand for such a

service was likely to be small and it would be more cost efficient to out-source than to purchase the equipment and train health staff in its use.

It is also noted that the results from laser removal are often inadequate, it may take many treatments to remove the tattoo and scarring to the area may result. This is especially true for prison tattoos as standard tattoo inks are not used and the colour pigments used may not be identifiable.

Recommendations:

That the DOJ provide appropriate replacement materials to enable offenders to keep body pierced sites open when jewellery is confiscated on entry to the system.

That Keeping Safe presenters need to stress the importance of offenders not sharing body-piercing jewellery.

That, given the lack of support at this time to implement recommended strategies to reduce BBV risks associated with tattooing, that Health Services develops a sound education approach to this issue.

That a process be developed to facilitate tattoo removal (through out-sourcing) for offenders whose tattoos are impacting negatively upon their self esteem.

32 Hairdressing and barbering:

The review noted a general lack of consistency regarding protocols for hairdressing and barbering practices across sites. The Applied Environmental Health Branch of the DOH has responsibility for ensuring that standards are maintained, however, prisons are exempt under the Prisons Act 1981 from adhering to legislation and regulations relevant to hairdressing.

Across sites there are some prisons that contract hairdressers and barbers from the community to provide services, whilst others have a designated area for these practices that are staffed by offenders. Additionally male prisoners have access on their units/wings to hair-clippers. Therefore any standardisation of standards would need all three levels of service provision to be addressed.

Feedback from custodial staff during the review identified that there needed to be stricter control over equipment and greater compliance with the appropriate cleaning of equipment:

> *"Scissors have been stolen from the barber's shop and the blades attached to a broom handle to use as a weapon."* (Prison Officer).

NSW Corrections has established a Barber Shop program, which would be easily transferable to the WA prison system and which provides for a designated area and ensures that practice and safety issues are adhered to.

Recommendation:

That the DOJ, in collaboration with the DOH, adapt the NSW Barber Shop program for use in WA prisons to reduce the risk of BBV transmission through hairdressing and barbering practices.

33 Injecting drug use:

33.1 Overview of the current situation:

There was significant feedback that the profile of offenders had markedly changed in the last few years, and that this was attributed to their drug using practices. The prevalence of amphetamine users entering the system had created additional management problems for custodial staff. Offenders tended to be younger with low self-esteem and defeated attitudes; they also presented with psychological and anger management issues which have manifested in decreased respect for authority and increased attacks upon officers.

It was considered that standover tactics and drug use in prison were contributory factors in the increasing number of drug overdoses seen in the system.

One Superintendent interviewed considered that there was a clear difference between subjective perceptions of the amount of drug use in prisons and actual usage levels. Drug use in prisons is cyclical, depending on the availability of drugs in the community and who is in the prison at any given time. For example, when there are convicted drug dealers in the system there are always more available drugs, with this being achieved through the application of standover tactics on other offenders, family members and visitors to make them bring drugs into the prison.

Superintendents largely reported that less than 40% of prisoners had injected in the month prior to the interview, however, at Bandyup the percentage was estimated at 80%.

Officers interviewed agreed that Bandyup had the highest percentage of offenders presumed to have injected in the last month. However, for other metropolitan facilities over half of the officers interviewed estimated that the percentage of offenders who had injected in the last month was between 6 - 25% of the total muster.

33.2 Identification of illicit drugs currently used in the prison system:

Superintendents considered that marijuana is the most commonly used drug in prison, followed by opiates, traded prescription medications and then amphetamines. For officers there was agreement with the list proposed by Superintendents, also ranking “brews” (fermented fruit and vegetables to make alcohol) and solvents.

There were reports of seasonal trends in terms of availability and access, such as an increase in the number of brews in summer as they ferment more quickly then. It was also noted that there is an increase in drug trafficking in the summer months. At the time of the interviews Perth was experiencing what was known as the “heroin drought”, however, it was of interest that the supplies of heroin available to offenders had remained constant. One officer reported that an offender had confided to him that he had deliberately breached his parole as he could not get heroin on the streets, but knew that he would be able to secure a supply in prison.

Whilst the consumption of brews and inhalation of solvents do not pose the direct risk of BBV transmission through sharing injecting equipment, there is still risk due to uninhibited behaviour whilst intoxicated which may lead to an offender taking part in risk behaviours that they may not otherwise have considered.

33.3 Prescribed medications and the trading of prescribed medications:

Nurses interviewed estimated the following breakdown of offenders currently prescribed psychiatric medications.

Aboriginal Offenders		Non Aboriginal Offenders	
Estimated % of prisoners prescribed psychiatric medications.	% of responses	Estimated % of prisoners prescribed psychiatric medications.	% of responses
0	0	0	0
5-10	40	5-10	40
11-20	15	11-20	15
21-40	30	21-40	30
41-50	5	41-50	5
51-60	5	51-60	5
61-70	0	61-70	0
71+	5	71+	5

Further, nurses estimated overall that 70% of offenders were on long-term medications and that 60% of offenders were on some form of mood altering medication.

Given the high percentage of offenders who are prescribed mood-altering medication, it is not unexpected that there is a strong black market in prescription medications. Health Services have introduced a number of measures to ensure that offenders do not trade their medications, however, the practice continues.

Nurses and officers working with female prisoners reported that benzodiazepines are the preferred traded medication. This does not appear to be the case in the male prisons where traded medications are far less a feature than at women's facilities.

Standover tactics for prescription medications, especially any mood altering medications, may result in an offender requiring a transfer to protective custody.

There are concerns regarding the health risks that may be incurred when offenders retrieve and use drugs that have been swallowed or inserted in orifices. An example was provided of an offender who was made to vomit after getting her medications, the vomited drugs were then rinsed in water and injected by the other prisoner who had forced the offender to vomit.

33.4 Offender perspectives on drug use in prison:

FCMT staff were asked to provide information on the reasons offenders most commonly gave for continuing their illicit drug use in prison. The results are as follows:

- Boredom,
- Inability to cope with prison environment,
- Perceptions of failure regarding previous treatment interventions,
- Locked into an addictive pattern of use,
- Peer pressure from friends and family,
- Easy access to drugs,

- Not ready to "get clean",
- Lack of treatment options,
- Fatalism.

The same staff were asked to provide information on the reasons offenders most commonly gave for ceasing illicit drug use in prison. The results are as follows:

- Away from partners who pressure them to use (female offenders),
- Limited access to drugs,
- Tired of the drug lifestyle,
- Want to get parole,
- Have commenced treatment,
- Want to get their kids back,
- Don't want to share injecting equipment,
- Want to make a fresh start,
- Sick of ending up in prison on drug related offences,
- Family pressure.

33.5 Supply reduction strategies:

Overwhelmingly officers would like to see contact visits stopped. This sentiment is reflected in the following quotes:

- *"The visits areas are a joke, most of the drugs and fits come in through the visits area."*
- *"Human rights get in the way of supply reduction."*

Officers would like to see more sniffer dogs, and gave an example of the number of visits going down by 50% following a dog check. They would also like to see an increase in visitor searches, including car searches, and that visitors who brought contraband should be banned from further visits.

There is also an issue regarding the drugs that offenders bring into the system with them. An example was provided of a female offender who had the following retrieved from her vagina on entry to prison:

- 12 syringes,
- 50 Rohypnol,
- 50 Mogadon,
- 5 gms of cannabis,
- 1 gm of heroin.

There were also examples of the following means of getting drugs and syringes to offenders:

- Drugs hidden in fruit,
- Tennis balls over the wall at Hakea,
- Drugs in the anus of a baby,
- Drug money being paid into outside accounts,
- Standover tactics unless the offender organises family members to make a 'drug drop',
- Visitors and family members dropping off injecting equipment on the boundaries of prison farms and work camps.

Clean syringes are a costly and scarce commodity in the prison system and it is estimated that $100 is the going rate to rent a syringe for an injecting episode. Every time a syringe is confiscated in the prison system it means that available syringes will

be shared by even more offenders, potentially adding to the risk of transmission of BBV's and other infections.

33.6 Indigenous offenders and injecting:

There was feedback across all categories of workers interviewed that a marked increase in the number of Aboriginal offenders who injected drugs had been noted; and that this was a component of polydrug use that had not been so widespread even five years ago. One officer stated that:

"Ten years ago when I was in Geraldton the Aboriginal women would not even take a pill, not wanting to put drugs into their systems. Now there is widespread polydrug abuse in Aboriginal prisoners."

A prison doctor considered that although there were still a lot of Aboriginal offenders with alcohol issues, there was increasingly an issue with polydrug misuse, with the drugs used in order of preference being marijuana, heroin and amphetamines.

Concerns were expressed in regard to prison initiated injecting drug use, with one doctor stating that if injecting behaviour is initiated in the prison system, poor patterns of safe injecting are established which are continued post release. The doctor interviewed was also concerned regarding the potential spread of injecting drug use when offenders are released back to rural and remote communities and continue their use.

Several nurses across sites reported that they were aware of between two and five offenders who had initiated drug use in prison. A Peer Support worker reported that some Aboriginal male offenders had switched from cannabis use in prison to injecting, to avoid detection of their drug use. This shift had followed the offenders having to provide urine for drug testing and subsequently being charged for the use of cannabis.

A Peer Support worker from a women's facility estimated from her experience that there were on average up to four Aboriginal women sharing equipment per injecting episode. She also indicated that these women tended to use in family groupings and that whilst the older women (25 years and over) preferred heroin, the preference for the younger women was amphetamines.

A factor for consideration in this group was raised by a prison doctor, stating that:

"Many Aboriginal prisoners enter the system with poor levels of self care, emanating from despair and hopelessness. Given this situation it would be unlikely that they would be rigorous with cleaning injecting equipment that they use in the prison which increases their risk of contracting a BBV."

This could be equally applied to all persons entering the prison system, however, is likely to be more pronounced in some Aboriginal offenders. The recommended personal hygiene aspect of the Keeping Safe Program could assist offenders to see some relevance in the cleaning of injecting equipment when placed in a context of general hygiene.

One regional Keeping Safe presenter considered that it was important to provide drug overdose prevention information for Aboriginal offenders as in her region injectors tended to "go bush" when they wanted to use, which isolated them from emergency services should an overdose occur.

Keeping Safe presenters and others interviewed felt strongly that a peer BBV education program would be very beneficial for Aboriginal offenders who continued with, or contemplated, injecting drug use whilst in the prison system. The issues of tailoring programs for Aboriginal offenders and the provision of peer education programs are expanded upon in sections 13 and 15 of the report.

33.7 Treatments:

Health staff clearly identified a need to increase access for offenders to pharmacotherapies and treatment programs, including counselling and skills training. However, whilst some officers supported treatment programs, they were not the majority. More shared the views of officers as represented below:

- *"(They) should not have access to pharmacotherapies, (offenders) should just be de-toxed on entry."*
- *"If we give them bleach and needles, they can't have it both ways; if they OD we should not give them Narcan."*
- *"I am totally against a "soft approach on drugs"… after the riot everyone was off medications, and nobody was asking for them. If you make things available they will just want more and more, if (medications are) not available they just get on with it."*

Any pharmacotherapies program offered must be holistic in its delivery and not based around containment of recalcitrant behaviour of offenders as a selection criterion for entry (as was reported having been the case for an earlier drug trial).

One doctor interviewed considered that the provision of pharmacotherapies to date had not been well planned and that the following issues were emerging as a result:

- An assumption that nurses only had to administer the medication, therefore no training had been provided to address the therapeutic dimensions of a Methadone program, or to work with the negative attitudes nursing staff may bring to working in Methadone and Naltrexone programs.
- That the programs are not linked in a coordinated way to other programs in the system that could assist prisoners to maintain their place on a drug program and get the best possible outcomes from their participation.
- The ongoing costs attached to maintenance pharmacotherapies, especially in maximum security facilities where offender turnover is significantly less than at a minimum-security prison.

There has been a significant emphasis to date on opiates, however, there is a growing management problem in the prison system with young offenders having amphetamines as their drug of choice. There is a need to identify and put in place effective strategies and protocols for offenders with amphetamine psychosis.

There is an identified need to strengthen and develop more alternatives to drug use programs. Non-chemical interventions should be a starting point rather than medication.

Treatment focus has been to date heavily focused upon medical management. There should be increased openness to techniques such as acupuncture and other alternative therapies that are available to drug users in the community who are in early recovery. Most would be low cost techniques and would greatly enhance a holistic response to drug treatment.

33.7.1 Methadone:

Currently there is a limited availability of Methadone in the WA prison system, with maintenance Methadone officially only available to those on short-term remand, the pregnant and to those with HIV infection. Whilst there are a small number of offenders outside of those recommended for maintenance Methadone accessing methadone, not all meet with the recommended maintenance dosage of 60mgs per day – the dose which is deemed to be effective and reduces the risk of other drug use occurring.

A doctor reported that he had offenders coming to him begging to get on Methadone as they were fearful of contracting a BBV if they continued to inject in prison.

The practice of maintenance Methadone accessed in the community being ceased after a rapid weaning off in prison would appear to be counterproductive to the effective drug management of offenders. Many of the offenders who had input to the review discussed how they had ceased injecting drug use in the community whilst on Methadone but had re-commenced in prison after being taken off their Methadone.

A doctor who had been involved in an early Methadone trial at a male prison stated:

> *"Although there are economic issues around the increased provision of Methadone this needs to be balanced against cost savings as Methadone-managed prisoners are a reduced management risk, are less likely to demand time of the medical centre and also the risk of transmission of BBV's is reduced."*

33.7.2 Naltrexone:

Naltrexone has been used on a limited basis in WA prisons, and the administration in the male prisons was linked to an education program.

Female offenders who had taken part in a Naltrexone trial were highly critical of the process with one offender stating that she felt she did not get the counselling and support she needed and also disliked the accompanying medications as she felt they left her non-functional.

There was a high degree of criticism of the use of Naltrexone implants from the community sector but also from nurses working in the prison system. One nurse reported that when offenders entered prison with implants, there was ineffective through care from the service provider that had inserted the implant. The nurse described how a female offender had attempted to cut the implant out of her body as she stated she had never wanted it. Although this is an isolated example provided in the prison system, it raises concerns regarding the ethical use of implants in prison.

33.7.3 Drug Free Units:

Health staff were very supportive of an expansion of the number of Drug Free Units. Such units were not discarded as a therapeutic strategy by officers but there was less support for their expansion than that identified by health staff.

Health staff considered it would be very beneficial for offenders in the Drug Free Unit to have an expanded BBV education program, with possibly an increased focus on treatments and diet/lifestyle choices for those that have a BBV.

33.7.4 Drug withdrawal:

Offenders considered that if more humane detoxification regimes were available to prisoners it would be a significant move towards reducing the level of drug use in prisons.

A Prison Health Services Medical Officer suggested the establishment of a transition unit for post drug detoxification offenders to enable them to stabilise before moving into the mainstream prison environment. Such a unit could possibly reduce the risk of offenders re-commencing drug use. However, this would only be possible if, as identified above, rapid detoxification regimes were abolished.

FCMT staff were asked to make an assessment of the percentage of women who entered prison with drug withdrawal symptoms: overall the rate was estimated as being 40%. There was no equivalent response as relates to males entering the system.

Nurses and FCMT staff identified that intra-sentence drug withdrawals were seen most commonly after weekend contact visits. Offenders and some nurses voiced their concern that whilst there was a protocol for the drug detoxification of offenders on entry to the system, there was not an equivalent protocol for those who required a full drug detoxification intra-sentence. It was considered by female offenders that the intra-sentence detoxification was inadequate and at times punitive, and that little pharmaceutical or emotional support was provided to help them through the episode.

FCMT staff interviewed considered that there is a punitive approach from some health staff to the management of intra-sentence drug withdrawal, and reported that there have been instances where offenders have been refused withdrawal medications.

Nursing staff and offenders expressed their concern regarding the impact of rapid withdrawal from benzodiazepines upon prisoners. They considered that the current regime (three day detoxification) caused significant distress in offenders and in some cases had resulted in offenders self harming.

There was concern from regional presenters and those who conducted the program in juvenile facilities that offenders and detainees were called up for the program whilst still undergoing drug detoxification. They considered that this was counter-productive and officers should not send those who are detoxing to the program.

33.7.5 Drug overdose:

FCMT staff thought that offenders see drug overdose as an “occupational hazard” and are pragmatic about it. They felt that many offenders overdose without the knowledge of either custodial or health staff, that it is kept hidden to also hide the fact that they are using drugs. Some offenders have discussed with FCMT staff their concerns regarding the risks to them of brain damage if they have had frequent untreated drug overdoses.

It was noted that there is provision to alert offenders when there are “bad drugs” in the prison, in order to raise awareness of the risk of a *“dirty hit”* or of drug overdose. This is seen as a very positive initiative.

Officers considered that offenders were reluctant to get involved when they came across an overdose in case they became implicated in that drug use episode or were

suspected of administering a "hot shot" (deliberate overdosing of a person by another).

Officers considered that there should be more information made available to the visitors of offenders of the risks of bringing in high quality drugs for the exclusive use of their family member or friend. As the quality of drugs usually available in prisons is poor, having been cut to make it go further, when uncut or high quality drugs are made available then the risk of overdose is markedly increased.

Next Step provides an overdose prevention program for offenders, and reference is made to overdose prevention in the Keeping Safe program. There is nothing in place at this time for partners of offenders.

33.8 Drug education for offenders:

There was a degree of concern from those interviewed that offenders tended to have in most instances a poor understanding of safer drug using practices, and that efforts to address this should be increased. For example, it is not uncommon for offenders to believe that they need to use hot water to clean needles and syringes effectively (whereas current best practice recommends cold water is used) and there is also a limited understanding about the potential for hepatitis C transmission via equipment associated with injecting.

Needles used in the prison system to inject are often blunt due to repeated use. This increases bleeding and tissue damage to the injection site, and nurses reported that they are seeing an increasing number of abscesses on injecting sites.

Whilst the Keeping Safe Program provides information on the cleaning of needles and syringes, it does not address the need to have all associated equipment as clean as possible; neither does it address vein care. Presenters have included this information during their programs but it needs to be formally included in any subsequent package that is developed. Nursing staff would also probably benefit from current information on these issues so that they can best advise their patients.

33.9 Training Issues:

33.9.1 Health staff:

- There is a need to recruit more doctors with specialist knowledge in the AOD field, or to actively train existing staff. Offenders need to be able to access non-judgemental, accurate and up to date information on a range of concerns connected to their drug use, whether past or continuing.
-
- There is a need to attract more doctors to work in prison health who are willing to be trained as Methadone prescribers to assist offenders in the management of their drug issues.
-
- The program by which nurses from DOJ can do clinical placements with the Central Drug Unit to gain insights and skills in the management of drug affected clients should be expanded. This is a training opportunity that nurses in Juvenile Justice facilities should be actively encouraged to participate in.

- That if there is an increase in access to pharmacotherapies via increased programs for offenders, then nurses need dedicated training in the provision of these drugs and the support required.

33.9.2 Keeping Safe presenters:

- Regional presenters identified a need for increased access to training in the drug awareness area.
- There is a need for presenters to be trained to more effectively discuss drug use with Aboriginal offenders.

33.9.3 Custodial staff

- There needs to be training provided to custodial staff to assist them in acknowledging the roles of both harm minimisation and zero tolerance in custodial settings.

- Any training for prison officers should include an attitudinal component to address negative attitudes towards those who use drugs.

33.10 Needle and syringe programs:

- *"I imagine that we will be forced by management to provide needle and syringe programs, on the grounds of it being a duty of care issue. We were overruled on the segregation of HIV+ prisoners and it is only a matter of time before a prisoner takes legal action on the issue of lack of sterile injecting equipment in prisons."* (Prison Superintendent).
- "*I feel that needle and syringe programs will be introduced as public health concerns will outweigh security /zero tolerance concerns."* (Prison Superintendent).

The two quotes presented above acknowledge that needle and syringe programs will in all probability be introduced firstly through public health concerns, and secondly to reduce the risk of litigation. It was these factors that were mainly referred to by custodial management in discussions on this issue.

There was some level of support from officers as long as the implementation plan was carefully tailored to the environment in which it would operate and was developed in conjunction with sound policy and protocols. Officers who demonstrated support stated the following:

- *"I can see that there are health benefits."*
- *"I don't like the idea but in some respects it is positive if it lowers the risk of transmission of BBV's from them to us."*

Of officers that were resistant to the introduction of such an initiative, the following comments were received:

- *"How can officers turn a blind eye to drug use in their prison?"*
- *"I am against such programs, we should not assist to (sic.) put the needle in their arms."*
- *"I am opposed as it will only encourage drug use, I will oppose it even though I know it will reduce BBV's in prisons.'*
- *"It would add to the problems that prisoners with needle fixations have."*
- *"Prisoners would use them as weapons."*
- *"Would increase our risk."*

- *"(I) would not be happy, (I) would worry about disposal issues."*

The review also sought to identify the level of support that could be expected from nurses for the establishment of needle and syringe programs (NSP's) given that Health Services may well drive the process in prisons, with the following result:

40% supported the introduction of NSP's
10% were unsure
50% were against the introduction of NSP's in prisons.

Much education will be required if a shift is to be seen in this area. It would seem that until such time as there is a marked change in staff beliefs and attitudes, it would be foolhardy to attempt to introduce any form of NSP as there would not automatically be a commitment from all nursing staff to make it work. The comments presented below provide indication of the level of resistance to such an initiative:

- *"I am morally opposed to people with self inflicted problems being given things when diabetics have to pay."*
- *"I would be horrified."*
- *"I can see the need but it would create huge problems."*
- *"Would be political suicide, there would be public outrage, DOJ cannot be seen to be endorsing drug use."*
- *"I would object to my tax dollar being used for this purpose."*

Offenders considered that injecting posed the greatest risk for BBV transmission in prisons, however, there were ways to get clean injecting equipment into prisons in order to reduce their risk of BBV infection. Some stated that injectors would try to bring their own equipment in on entry. They thought there should be a system for the provision of needles and syringes on entry and used needles and syringes could be exchanged through the Health Centre. Keeping Safe presenters have stated that one of the greatest problems that they experience with learner resistance is on the issue of the unwillingness of the DOJ to make provision for safer injecting.

33.11 Legal:

- *"Illicit drugs are not acceptable in prisons, penalties for use need to be more strongly enforced."* (Prison Officer).

This tended to be the dominant view of custodial staff interviewed, although there was a growing acknowledgment that the goal of drug-free prisons would never be achieved.

There had been an attempt to deter offenders from injecting drug use by reducing the penalty for the use of cannabis. However, one Superintendent noted that although the penalty for offenders found in possession of cannabis had been reduced, it did not appear to have impacted on drug use overall.

There was concern expressed by some officers that health policy may override custodial policy in the area of drugs, however, as one officer stated:

> *"If prisons are looking to introduce harm minimisation strategies then we need to review and amend the regulations. Officers are bound by regulations, if things are set down in the regulations then officers will comply."*

Some officers considered that initiatives to date such as condom provision dealt them a two-edged sword. At one level they were expected to co-operate with the program whilst on the other hand, had the power to charge an offender who they believed had

been sexually active with another offender. Therefore, if other strategies were to be introduced, there needed to be a considered approach to the associated policy development.

Recommendations:

That Health Services develop a drug treatment response that is holistic and reflects community standards and best practice.

That expert advice be taken to improve the current management of offenders with amphetamine psychosis, and that protocols developed have application for custodial staff as well as health staff.

That Health Services reviews and expands the current provision of Methadone in WA prisons

That any use of Naltrexone in the future be linked for all offenders to adequate skills training and support.

That any proposal to introduce the use of Naltrexone implants be carefully considered, with a special emphasis on the ethical and human rights considerations of introducing such an initiative.

That drug free units be expanded and that female offenders be given access to such facilities.

That drug free units include a BBV education component with an emphasis on treatment and diet/lifestyle choices.

That Health Services in consultation with Next Step reviews its current drug detoxification management protocols, and that such protocols acknowledge the need for intra-sentence drug detoxification management.

That any offender or detainee who is still in the process of drug detoxification be excluded from the Keeping Safe Program until such time as he/she has completed the detoxification and are well enough to actively participate.

That overdose prevention programs link more closely with custodial management and Health Services to develop a more holistic and co-ordinated overdose management strategy.

That the means be found to educate partners and friends of offenders regarding the risk of drug overdose.

That the Keeping Safe Program be expanded to address associated health risks of injecting, such as vein care.

That training be provided across the board in the DOJ to increase the competency of staff to effectively manage the drug related issues of offenders.

That there be increased information dissemination to prison based staff to reduce the amount of misinformation and fear regarding Needle and Syringe Programs.

That Health Services commence the development of a discussion paper for senior management at DOJ on the subject of needle and syringe provision for offenders, nominating a number of models that have been demonstrated as effective in other jurisdictions.

34 Bleach provision for offenders:

The BBCD Steering Group has had the issue of formalised bleach access for offenders via a Bleach Availability Program on its agenda for a number of years. A draft implementation plan to pilot such a program across two prison sites of differing security ratings has been developed and awaits endorsement to proceed.

There is currently limited availability to bleach for offenders to clean injecting and tattoo equipment, especially for those in maximum-security facilities. However, bleach is used in most facilities for general cleaning purposes with the exception of juvenile justice facilities and one prison farm. Bleach may be available for cleaning in solution or powder form and in some cases as part of a detergent/bleach mix. It may be dispensed from drums (powdered form) or domestic size bottles of bleach at full strength.

Offenders reported that if they were able to access bleach they were reluctant to use it at full strength, on the basis that they want to make it last. They also considered that if homemade (prison) syringes are cleaned with full strength bleach they perish more quickly, so weaker solutions are used. Increasing bleach access would address their first concern, but their second concern would remain valid.

Custodial and nursing staff were asked to assess their level of support for the introduction of a Bleach Availability Program, with the results listed below:

	Superintendents and Assistant Superintendents	**Prison Officers**	**Nursing staff**
Strongly agree	34%	3%	0%
Agree	33%	14%	10%
Unsure	11%	22%	15%
Disagree	11%	25%	55%
Strongly disagree	11%	33%	20%
Don't care	-	3%	-

Of the three groups interviewed, it was evident that management demonstrated the least resistance to the initiative. There was significant resistance from nurses and this indicates that if Health Services is in due course to drive the introduction of Bleach Availability Programs, the training of nurses would need to be the starting point for education.

Of those who had stated some degree of support for the introduction of bleach, the following comments were made:

- *"Twelve months ago I would focus on "catching" drug using prisoners. Now, if the injecting equipment is there, we should not obstruct safe using methods as long as it has Ministry approval."*
- *"Given the amount of injecting drug use in prisons we need to be introducing bleach programs."*
- *"In principle I would support the introduction of bleach if it was dispensed discretely."*
- *"If we monitor programs carefully it would probably be OK".*
- *"If there were bleach programs I would be likely to be safer if I got a needlestick so it's OK."*

- *“We are not going to stop them using drugs so we might as well let them do it safely.”*

Of those who opposed the introduction of a Bleach Availability Program, most objected on the basis of such a program being a risk to security and safety, such as:

- Offenders would use bleach as a weapon,
- Bleach masks drugs in urine,
- It is a toxic chemical, there is a risk from fumes and over use, it would not be controllable,
- Bleach can be used to change the colour of hair and clothing, which could be used as means to assist escape,
- Bleach would confuse the sniffer dogs as it masks the smell of marijuana,
- Had to be removed from units in some prisons as offenders were ingesting it.

There were also concerns from a zero tolerance perspective, such as:

- A bleach program would encourage offenders to continue drug use in prison,
- Seen as conflicting with the policy of drug free prisons,
- *“Makes it too easy for prisoners, another evil.”*
- *“They will use it for brews.”*
- *“How will we control (the bleach supply), where will it all end?”*
- *“Just another agent for them to abuse.”*
- *“Condones drug use, it would be like giving up.”*
- *“Prisoners are in jail for a reason, (we) should not help them to continue behaviours that they do on the outside. I’m unsure as I’m aware it would afford safety to some degree.”*
- *“May lull prisoners into a false sense of security and re-commence use where previously the thought of dirty shared equipment had been a disincentive to use.”*

Finally, there were objections based upon the cost to the system to establish such a program, and that money could be better spent on drug treatment to enable offenders to cease rather than continue their drug use. Another cost consideration was the risk of litigation if the DOJ promoted the use of bleach as a risk reduction strategy and then a prisoner sero-converted with a BBV. Nurses especially were concerned that bleach had not been scientifically proven to be effective against the hepatitis C virus and had based their resistance to setting up bleach programs upon this fact at the time of the survey. However, an article by Kapadia, et al (2002) reports a study that indicates that bleach may help to prevent the transmission of hepatitis C amongst people who inject drugs[1].

34.1 Implementation of a Bleach Availability Program:

The provision of bleach to offenders needs to be standardised across all prisons in WA. Whilst bleach, as mentioned previously, is available to offenders at most prisons they are not provided with accurate information as to how to use it which needs to be addressed (eg the risk to the offender of using powdered bleach to clean injecting equipment if not filtered first).

[1] Kapadia, F., Vlahov, D., Des Jarlias, D.C., Strathdee, S.A., Ouellet, L., Kerndt P., Morse E. E.V., Williams, I., Garfein, R.S., (2002) Does Bleach Disinfection of Syringes Protect Against Hepatitis C Infection Among Young Adult Injection Drug Users?, *Epidemiology*, 13(6): 738:741

Offenders considered that although bleach was difficult to access, it was not impossible. Some offenders, however, had been charged for possession of bleach or had to undergo drug screening for being in possession of bleach. As a result they were not supportive of bleach dispensers, and did not trust that officers would not monitor and charge offenders accessing the dispenser. Offenders thought it would be better to get a supply of bleach on entry and routinely thereafter, such as getting a small bottle with their laundry bundles.

Of the staff that supported the introduction of a bleach program, they saw the provision of bleach as needing to be a discrete initiative. They considered that dispensers needed to be located in areas of the prison that would not draw attention, such as cleaning stations or ablution blocks, as for the condom dispensers.

If drug treatment programs were increased, there is still a case to proceed with the introduction of bleach to prisons as there will always be offenders who wish to continue their drug use during imprisonment and need the means to reduce their risk of BBV transmission whilst in prison.

Those interviewed also considered that there would need to be significant changes to existing policy, in order that possession of bleach by an offender no longer constituted an offence.

Recommendations:

That, given newly released research that indicates that bleach may be effective against hepatitis C, and in the absence of needle and syringe programs in prisons, a Bleach Availability Program be piloted as a matter of urgent priority.

That there may be a need to select different models for bleach provision according to the security rating of the facility where the program is to operate.

35 Policy Issues:

The profile of offenders has changed dramatically in the last five years and policy review and development has not kept pace with these changes. Attention needs to be paid to the following policy areas:

- Reduction in penalties for cannabis use,
- Detoxification protocols for offenders, not just at entry but also intra-sentence*,
- Provision of follow up test information counselling for offenders,
- Standardised benzodiazepine reduction programs based on best practice,
- Clearly defined selection criteria developed for entry to drug programs such as Methadone and Naltrexone,
- Bleach availability,
- Strategies for safer tattooing in prisons, supported by policy.

*Currently DG Rules specify that if an offender is experiencing severe drug withdrawal they must go on the “at risk management system”: this does not, however, cover the medical management of same.

Appendix 1. Keeping Safe Review Survey Instruments:

Appendix 1.1: Department of Justice – General:

INTERVIEW SCHEDULE FOR MINISTRY OF JUSTICE EMPLOYEES REGARDING THE REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT ON THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN CUSTODIAL SETTINGS

The Interview Schedule is divided into the following sections:
Section A Generic (All respondents)
Section B Prison Superintendents/Acting Superintendents
Section C Prison Officers
Section D Peer Support Workers
Section E Prison Health Services Nurses

SECTION A (ALL RESPONDENTS)

CLASSIFICATION OF WORKER:___________________________________

1. Are you aware of the "Keeping Safe" Program being delivered in WA prisons and juvenile detention facilities?

   ð Yes ð No (move to Q6)

2. Can you describe what issues you think are covered in the "Keeping Safe" Program?

a)
b)
c)
d)
e)
f)

3. What impact would you consider the Program has had on prisoners?

   ð None ð Minimal ð Significant ð Unsure

4. Could you briefly describe an example of the positive impact on prisoners who have attended the Program?

5. Could you briefly describe an example of any negative impact on prisoners who have attended the Program?

6. Can you describe for me the contents of an "Exit Kit"?

7. Would you consider that the provision of “Exit Kits” is a useful health safety initiative?

ð Yes (Move to Q9) ð No

8. Can you outline your reasons for responding in the negative to the previous question?

9. Can you identify one or more advantages to using outside presenters to deliver blood borne virus education?

10. Can you identify one or more disadvantages to using outside presenters to deliver blood borne virus education?

11. Would you be supportive of prisoners being trained as peer educators to deliver BBV education?

ð Yes ð No

12. Can you identify one or more advantages to prisoners becoming BBV peer educators?
1.
2.
3.

13. Can you identify one or more disadvantages to prisoners becoming BBV peer educators?
1.
2.
3.

14. In what ways do you think we could make BBV information more accessible to Aboriginal prisoners?
a)
b)
c)
d)
e)

15. From your experience rank the infections listed below according to risk of transmission (1= Highest risk, 4= Lowest risk) in custodial settings

Prisoners		Prison Staff	
HIV	( )	HIV	( )
Hepatitis A	( )	Hepatitis A	( )
Hepatitis B	( )	Hepatitis B	( )
Hepatitis C	( )	Hepatitis C	( )

16. In your opinion what would be the likely main causes of prisoners becoming infected with hepatitis C during their sentence? (Circle response - Multiple responses acceptable)
Use of Hair clippers
Fighting /Assault
Body Piercing
Sports Injuries with bleeding
Sexual Assault
Tattooing
Sharing Injecting Equipment
Being physically restrained – use of handcuffs and other restraints
Self Mutilation
Deliberate inoculation
Sexual activity with other prisoners
Sexual activity with non prisoners
Cleaning blood spills
Needlestick injuries
Working in the laundry
Performing CPR

17. Are you aware of any of the following being found during cell / prisoner searches or in the grounds of your facility in the last twelve months? (Tick which apply)
Tattooing Equipment ( )
Body Piercing Needles ( )
IV Injecting Equipment ( )

18. What is your perception of the illicit drug most frequently used by prisoners in your facility?
Marijuana (Dope, grass)
Alcohol (including homebrew)
Amphetamines (Speed)
Opiates:
- Heroin (Smack)
- Morphine
- MS Contin

Ecstasy (E's)
LSD (Trips)
Tranquillisers (Downers)
Traded prescription medications:

Methadone
Naltrexone
Antidepressants
Sleeping Tablets
Analgesia (Pain killers)

Other (Describe)_______________________________

19. Could you provide an estimate of the percentage of prisoners currently in your facility that have injected drugs in the last three months?

ð 0-5%
ð 6-10%
ð 11-20%
ð 21-30%
ð 31-40%
ð 41- 50%
ð 51% plus

20. With condoms and dental dams readily available in most prisons now, have you noted any problems with them being available?
Prompt:
Re-stocking of machines
Inappropriate disposal
Used for inappropriate purposes

21. Would you estimate the incidence of tattooing in your facility as being:

ð None ð Low ð Medium High Unsure

22.Would you estimate the incidence of body piercing in your facility as being:

ð None ð Low ð Medium High Unsure

23. There is a national move to increase access to bleach for prisoners in order to facilitate improved cleaning methods for injecting and tattooing / piercing equipment. Please state your reaction to bleach being made freely available to WA prisoners.

ð Strongly Disagree
ð Disagree
ð Unsure
ð Agree
ð Strongly Agree

24. In your opinion what would be the most important initiatives that could contribute to reducing the risks of BBV transmission in prisons?

Conclusion: Invite further information which may not have been addressed by the schedule, and record in the space provided below. Advise that the next section of the interview relates directly to their role and responsibilities within the prison, and allows for expansion of issues raised in the opening section.

Appendix 1.2: Department of Justice – Superintendents:

INTERVIEW SCHEDULE FOR MINISTRY OF JUSTICE EMPLOYEES REGARDING THE REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT ON THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN CUSTODIAL SETTINGS

SECTION B: PRISON SUPERINTENDENTS AND ACTING SUPERINTENDENTS

1. Do you consider that Prison Officers support the delivery of the "Keeping Safe" Program?

   Yes No

2. Are you aware of any difficulties getting prisoners to attend the "Keeping Safe" Program? (if no, move to Q5)

3. Can you provide specific examples of problems with prisoner attendance?

a)
b)
c)

4. Can you identify strategies by which attendance rates could be improved?

a)
b)
c)

5. Do you consider that the current venue for the delivery of the "Keeping Safe" is suitable for the purpose? If not are there any viable alternative venues within your facility?

6. Do you have any security / safety concerns regarding contracted presenters coming into your facility? (If no, move to Q 8)

   Yes No

7. Please describe the security concerns identified in Q6.

   Verbal or physical assault
   Confidentiality breaches
   Contraband issues
   Location during lock downs
   Gender issues
   Cultural issues

Availability of staff to supervise presenters
Other (describe)

8. In your facility, have you been satisfied with the way the cleaning up of large blood spills has been managed, by:

Officers	Yes	No
Prisoners	Yes	No
Health Staff	Yes	No

Comments:

9. Is the number of large Blood Spill Kits adequate for your facility?
Yes No

10. Who has responsibility for the re-stocking of large Blood Spills Kits?
The last person to use the kit
Prison Officer
Prisoners
Health Staff
Other (Describe)

11. In the last twelve months have you received any reports regarding staff breaching confidentiality about a prisoner with a BBV? (If no, move to Q 13)

Yes No

12. Can you describe any instances where the confidentiality of prisoners with BBV's has been compromised by staff, and what was done to address the issue?

13. Are you satisfied with the existing management of staff's occupational exposure to blood and body fluids? Could you identify any means by which this could be improved upon?

14. What, from your perspective, do you see as logistical problems with having prisoners working as BBV peer educators?

a)
b)
c)
d)

Conclusion: Invite further information which may have not been addressed by the schedule, and record in the space provided below.

Appendix 1.3: Department of Justice – Prison Officers:

INTERVIEW SCHEDULE FOR MINISTRY OF JUSTICE EMPLOYEES REGARDING THE REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT ON THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN CUSTODIAL SETTINGS

SECTION C: PRISON OFFICERS

1. Gender of Officer
   Female
   Male

2. For how many years have you worked as a Prison Officer?

ð 6 mths or less
ð 6 – 12 months
ð 1 –2 yrs
ð 3 – 5 yrs
ð 6 – 10 yrs
ð 11- 15yrs
ð 16yrs plus

3. Have you attended training* in the following areas?

* Defined as workshops, seminars, short courses provided by the employer at no cost to the respondent. May be useful to include informally on the Interview Sheet any self directed learning the worker has undertaken.

Topic	¯ 12mths ago	Never	- 12mths ago
General Health Issues			
Overview of BBV's			
Infection Control, eg spills management			
Managing an occupational exposure			

Topic	¯ 12mths ago	Never	- 12mths ago
Overdose management			
Naltrexone management			

Methadone management

4. Do you consider that you have the professional competency to:

a) Judge whether a person is mentally ill?

Strongly Agree
Agree
Unsure
Disagree
Strongly disagree

b) Describe to a prisoner the safety requirements involved in cleaning up after a blood spill?

Strongly Agree
Agree
Unsure
Disagree
Strongly disagree

c) Tell a prisoner of the first aid necessary if they sustain a significant blood exposure to another prisoner's blood?

Strongly Agree
Agree
Unsure
Disagree
Strongly disagree

5. You find yourself in the position of knowing the HIV status of a prisoner. Your colleagues are putting pressure on you to disclose that information, how will you respond?

Disclose
Not Disclose
Remind colleagues about confidentiality
Unsure
No response given

Comments:

6. Do you think that Prison staff are generally supportive of prisoners attending the "Keeping Safe" Program? (if yes or unsure move to Q8)

Yes No Unsure

7. Can you please provide examples that led you to reply in the negative to the previous question?

8. Are you aware of any difficulties getting prisoners to attend the "Keeping Safe" Program? (if no, move to Q11)

Yes No

9. Can you provide specific examples of problems with prisoner attendance?

a)
b)
c)

10. Can you identify strategies by which attendance rates could be improved?
a)
b)
c)

11. Do you consider that the current venue for the delivery of the "Keeping Safe" is suitable for the purpose? If not are there any viable alternative venues in your facility?

12. Do you have any security/safety concerns regarding contracted presenters coming into your facility? (If no, move to Q 14)

Yes No

13. Please describe the security concerns identified in Q12.
    Verbal or physical assault
    Confidentiality breaches
    Contraband issues
    Location during lock downs
    Gender issues
    Cultural issues
    Time restraints
    Other (describe)

14. How accessible are large Blood Spill Kits in your facility?
    Very accessible
    Accessible
    Limited access

15. Who has responsibility for the re-stocking of Blood Spills Kits?
    The last person to use the kit
    Prison Officer
    Prisoners
    Health staff
    Other (Describe)

16. With each of the examples provided below, assess whether you consider them to be high, low or no risk of transmitting hepatitis C:

Sustaining a needlestick injury during a cell search
High Low No

In the course of restraining a violent prisoner
High Low No

Being spat upon by a prisoner (no visible blood in the saliva)
High Low No

Being injected with a syringe of blood by a prisoner
High Low No

Having the urine or faeces of a prisoner in contact with your skin
High Low No

Sustaining a skin laceration during a body/cavity search
High Low No

Resuscitating a prisoner without the benefit of a two way airway
High Low No

Sustaining manual contact with a used condom / dental dam during a cell search
High Low No

17. Are you satisfied with the level of existing protocols to safeguard you from contracting a BBV during the course of your work? (If yes, move to Q 19)
    Yes No

18. What perceived gaps can you identify that detract from you feeling safe in your workplace, in regard to the transmission of BBV's?

19. What, from your perspective as an Officer, do you see, if any; as logistical problems of having prisoners working as BBV peer educators?

a)
b)
c)
d)

Conclusion: Invite further information which may have not been addressed by the schedule, and record in the space provided below.

Appendix 1.4: Department of Justice – Peer Support Workers:

INTERVIEW SCHEDULE FOR MINISTRY OF JUSTICE EMPLOYEES REGARDING THE REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT ON THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN CUSTODIAL SETTINGS

SECTION D: PEER SUPPORT WORKERS

1. Gender of worker
   Female
   Male

2. For how long have you worked as a Peer Support Worker?

ð 6 mths or less
ð 7 – 12 months
ð 1 –2 yrs
ð 3 – 5 yrs

3. Had you worked with offenders in any capacity prior to your current position?
   Yes No

4. Have you attended Ministry of Justice training* in the following areas?

* Defined as workshops, seminars, short courses provided by the employer at no cost to the respondent. May be useful to include informally on the Interview Sheet any self directed learning the worker has undertaken.

Topic	¯ 12mths ago	Never	- 12mths ago
General Health Issues			
Overview of BBV's			
Infection Control, eg spills management			
Managing an occupational Exposure			

Topic	¯ 12mths ago	Never	- 12mths ago
Pre-test information BBV's (counselling)			

Post-test result information
on BBV's

Alcohol and other drug
awareness

Alcohol and drug counselling

5. Do you consider that you have the skills to:

a) Provide prisoners with basic BBV information at a level appropriate to their cultural background and learning needs?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

b) Actively promote and discuss the advantages of early testing and treatment for BBV's?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

c) Deliver basic pre-test information to prisoners seeking BBV testing?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

d) Deliver basic post-test advice to prisoners seeking BBV testing?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

e) Provide adequate discussion on discharge and referral options to prisoners with BBV's?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

f) Where of an appropriate age and tribal/clan affiliation, be able to advise prisoners about the BBV transmission risks associated with men's business/women's business?

Strongly Agree
Agree
Unsure
Disagree
Strongly disagree
Do not wish to answer

NOTE: This next group of questions were asked earlier, however, this time I would like you to respond on Aboriginal prisoners only.

6. What is your perception of the illicit drugs used most frequently by Aboriginal prisoners in your facility?

Marijuana (Grass, gunja)
Alcohol (including homebrew)
Amphetamines (Speed)
Opiates:
  Heroin (Smack)
  Morphine
  MS Contin
Ecstasy (E's)
Tranquillisers (Downers)
Traded prescription medications:
  Methadone
  Naltrexone
  Antidepressants
  Sleeping Tablets
  Pain Killers
Other (Describe)________________________________

7. Could you provide an estimate of the percentage of Aboriginal prisoners currently in your facility that have injected drugs in the last three months?

ð 0-5%
ð 6-10%
ð 11-20%
ð 21-30%
ð 31-40%
ð 41- 50%
ð 51% plus

8. Would you estimate the incidence of tattooing amongst Aboriginal prisoners as being:

ð None ð Low ð Medium High Unsure

9. Would you estimate the incidence of body piercing amongst Aboriginal prisoners as being:

ð None ð Low ð Medium High Unsure

10. In what ways do you think we could make BBV information more accessible to Aboriginal prisoners?

a)
b)
c)
d)

11. Do you think it would be achievable to recruit Aboriginal peer educators to deliver BBV education?

Yes No

Comments:

12. Currently BBV education programs are integrated for all prisoners; what changes in format do you think might be needed for Aboriginal peer educators to function effectively in that role?

Comments:

Conclusion: Invite further information which may not have been addressed by the schedule, and record in the space provided below.

N.B. Elicit if the Support Worker interviewed would be prepared to act as an interviewer of prisoners for the next stage of the Project. If in agreement lodge contact details separately to the interview schedule – interviews not to be linked to individuals, by work classification only.

Appendix 1.5: Department of Justice – Prison Health Service Nurses:

INTERVIEW SCHEDULE FOR MINISTRY OF JUSTICE EMPLOYEES REGARDING THE REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT ON THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN CUSTODIAL SETTINGS

SECTION E: PRISON HEALTH SERVICES NURSES

1. In what capacity are you employed?

ð Full Time
ð Part Time
ð Relief
ð Agency
ð Casual

2. How long have you worked for Prison Health Services?

ð 6 mths or less
ð 6 – 12 months
ð 1 –2 yrs
ð 2 – 5 yrs
ð 5 yrs plus

3. Have you attended training* in the following areas?

* Defined as workshops, seminars, short courses provided by the employer at no cost to the respondent. May be useful to include informally on the Interview Sheet any self directed learning the worker has undertaken.

Topic	**¯ 12mths ago**	**Never**	**- 12mths ago**
Overview of BBV's			
Intake Assessment Skills			
Updates on treatment and management of BBV's			
Hepatitis Vaccination Schedules			
Overdose management			

Topic	**¯ 12mths ago**	**Never**	**- 12mths ago**
Drug withdrawal Management			
Naltrexone Management			
Methadone Management			

Occupational exposure
(counselling)
Pre-test information BBV's
(counselling)
Post-test counselling BBV's

Standard Precautions

4. Do you consider that you have the professional competency to:

a) Provide prisoners with basic BBV information at a level appropriate to their cultural background and learning needs?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

b) Actively promote and discuss the advantages of early testing and treatment for BBV's?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

c) Provide emergency care to a prisoner with an amphetamine induced drug psychosis?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

d) Deliver comprehensive pre-test information to prisoners seeking BBV testing?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

g) Deliver comprehensive post test counselling to prisoners seeking BBV testing?
   - Strongly Agree
   - Agree
   - Unsure
   - Disagree
   - Strongly disagree

f) Provide adequate discharge planning and referral for prisoners with BBV's?
Strongly Agree
Agree
Unsure
Disagree
Strongly disagree

5. From your experience and knowledge, what would be the main advice that you would provide to a young Aboriginal male prisoner who is hepatitis C + on entry, to prevent further transmission of hepatitis C within the prison?

6. From your experience and knowledge, what would be the main advice that you would provide to a newly sero-converted HIV+ female prisoner who has just returned a positive pregnancy test?

7. From your experience describe the incidence of prisoners presenting with infected tattoo sites:

Aboriginal Prisoners
Never Rarely Frequently Unsure
Non Aboriginal Prisoners
Never Rarely Frequently Unsure

8. From your experience describe the incidence of prisoners presenting with infected body piercing sites:

Aboriginal Prisoners
Never Rarely Frequently Unsure
Non Aboriginal Prisoners
Never Rarely Frequently Unsure

9. From infections you have seen as a result of tattooing/body piercing, what sites were most commonly infected? (Rank, 1= Most infected)

Aboriginal Prisoners	**Non Aboriginal Prisoners**
Tattooed skin (any site)	Tattooed skin (any site)
Ear Lobe	Ear Lobe
Upper ear cartilage	Upper ear cartilage
Navel	Navel
Nose	Nose
Eyebrow	Eyebrow
Tongue	Tongue
Lip	Lip
Nipple	Nipple
Male genitals	Male genitals
Female genitals	Female genitals
Other (Describe)	Other (Describe)

10. To assist in the prevention of hepatitis C some prisons outside WA are providing sterile tattooing equipment for prisoners via a variety of means. Would you consider the provision of tattooing equipment to prisoners to be:

    Very worthwhile
    Worthwhile
    Unsure
    Not worthwhile
    Totally inappropriate

11. Given that prison made tattoos are often of poor quality or advertise prison affiliations, some prisons outside WA to are making provision for tattoo removal under sterile conditions in order to assist in the rehabilitation of prisoners. Do you consider this strategy to be:

    Very worthwhile
    Worthwhile
    Unsure
    Not worthwhile
    Totally inappropriate

12.Some researchers have suggested that sex without consent in prisons is significantly under reported. Would you care to comment on this statement?

13. Would you estimate the incidence of consensual sex in your facility as being:

    None   Minimal   Significant   Unsure

14. Would you estimate the amount of sex occurring in exchange for favours in your facility as being:

    None   Minimal   Significant   Unsure

15. In your opinion what could be done to encourage prisoners who have been exposed to sex without consent in prison to come forward for STI /BBV screening?

16. Approximately what percentage of the prisoners that you dispense medications to would currently be prescribed psychiatric medications? (Note: this is to include anti-depressants, anti-anxiety medications, hypnotics and anti-psychotics).

Aboriginal Prisoners	**Non Aboriginal Prisoners**
0%	0%
5 –10%	5-10%
11- 20%	11-20%
21 –40%	21-40%
41-50%	41-50%
51 – 60%	51-60%
61 – 70%	61-70%
71% +	71% +

17. What level of awareness do you think prisoners have regarding the need for hepatitis B vaccination and testing for BBV's on entry?

Aboriginal Prisoners

ð None ð Low ð Medium High Unsure

Non Aboriginal Prisoners

ð None ð Low ð Medium High Unsure

18. There is a strong push in the International Public Health arena for prisons to establish Needle Exchange Programs; given the reported high prevalence of hepatitis C within the prison system. **Hypothetically,** if you were told that a Needle Exchange was to open in your facility by the end of the year, what would be your response?

19. In the last two years, have you had an occupational exposure to blood or other body fluids in the workplace? (If no, this concludes the interview schedule)

Yes No

20. Can you briefly describe the incident?

21. Do you feel that you had received adequate training and organisational support to effectively cope with this incident? (If yes, there are no further questions)

Yes No

22. What were your unmet needs that would have helped you to both personally and professionally cope better with the incident?

Prompt: Professional training
Knowledge of a protocol to manage the issue
Access to information (depth of information)
Adequate provision of protective equipment
Adequate instruction on the correct use of protective equipment
Availability of organisational support
Provision of counselling

Conclusion: Invite questions from the respondent and document additional information received as an Attachment. Thank the respondent for their input.

NB Elicit if the nurse interviewed would be prepared to act as an interviewer of prisoners for the next stage of the project. If in agreement lodge contact details separately to the interview schedule – interviews not to be linked to individuals.

Appendix 1.6: Regional Keeping Safe Presenters:

SURVEY FOR NON - METROPOLITAN "KEEPING SAFE" PRESENTERS

PRISON WHERE DELIVER THE KEEPING SAFE PROGRAM:

PART A: PROGRAM PROCESS AND IMPLEMENTATION

1. Can you provide three qualities that you think are needed by a presenter of the Program?
   1)
   2)
   3)

2. Can you provide three skills needed to be an effective presenter of the Program?
   1)
   2)
   3)

3. Please identify any difficulties you have experienced with prison security?
   Having groups cancelled at the last minute because of a lock down
   Being locked into the teaching room with prisoners
   Feeling at risk from behaviour of prisoners
   Inconsistency of security arrangements
   Time delays
   Other (please describe)

4. Whilst in the prison, overall how have you found the attitude of Prison Officers towards you?
   Very helpful and supportive
   Helpful
   Unhelpful
   Hostile

5. In your discussions with Prison Officers about the "Keeping Safe" Program do you find them
   Supportive of the program
   Don't know what the Program is
   Disinterested
   See it as a waste of time
   Other (please describe)

6. Please comment on other issues around security and safety that have arisen.

7. Is the training area you are allocated suitable for your presentations?

   Yes (move to Q10)   No

8. If answered "No" to the previous question, please provide reasons

   No privacy
   Lack of teaching resources, eg. whiteboard
   Too small
   Poorly ventilated
   No continuity (different space each time)
   Other (please describe)

9. Are there any alternative venues in the facility that could be used, if so please describe?

10. In general, describe what influences:

    Levels of attendance:

    Levels of participation:

    Levels of attrition:

11. What could be done to improve things in these areas?

12. Do you find that there is adequate time to cover all the information provided in the Program?

    Never   Occasionally   Usually   Always

13. Given limitations of time and your experience with training, which part of the Program do you tend to not cover?

Training Activities
Introduction to BBV's
Transmission of BBV's
Signs and symptoms of BBV's
Treatments of BBV's
Safe drug use
Demonstration of cleaning a needle and syringe
Demonstration of the use of a condom and/or dental dam
Sexually transmissible diseases
Overdose emergency management
Other blood to blood contact
Safer sex
Rape/sexual assault in prison

14. In practice, does the content of the manual reflect adult learning principles?

    Yes No Unsure

15. Do you consider that the existing program promotes a sense of ownership of the process for the prisoners?

    Yes No Unsure

16. Could you provide any suggestions as to how prisoner ownership of the program could be increased, given the compulsory nature of the program?

17. Is the level at which information is presented (in the manual) appropriate to prisoners?

    Yes No Unsure

18. Do you think that the program gives due acknowledgment to different cultural learning styles?

    Yes No Unsure

19. Do you think that the program gives due acknowledgment to gender specific learning styles?

    Yes No Unsure

20. How much do presenters do the exercises/activities outlined?(Discuss)

21. If used, how do prisoners generally respond to the exercises/activities?

    Refuse to participate
    Resistant
    Participate
    Enjoy and participate willingly

Other (Describe)

22. Generally, how do prisoners respond to the content of the program?
    Refuse to participate
    Resistant
    Participate
    Enjoy and participate willingly
    Other (Describe)

23. What do you think prisoners find the most/least useful information, and why?
Most useful is:

Least useful is:

24. In the sequencing of the information, does it flow smoothly from one topic to another?
    Yes No Unsure

25. Can you identify any gaps in the provision of information? (If yes, describe)

26. Are there any sections of the content that should be expanded upon? (If yes, describe)
    Yes No

27. Does the content provide presenters with material that allows them to discuss sensitive issues in a way that is acceptable to both the presenter and the prisoners? (If no, what changes would you like to see in this area)
    Yes No Unsure

28. Metropolitan presenters have identified that they find it very difficult to raise the issue of male rape and sexual assault in prison presentations, to the point of not discussing it at all. Has this been your experience, please describe.

    Yes No Unsure

29. Do you think the inclusion of Ministry of Justice policy statements and protocols should be retained in the new training package ?

    Yes No

30. Do you think the inclusion of teaching strategy notes should be retained in the new training package?

    Yes No

31. Do you consider that the way that the program is set out makes it easy to use, if not how could that be improved upon? (Discuss)

32. What process have you adopted if you have wanted to introduce new information to your presentations? (Describe)

33. In the Appendices of the manual are information sheets on working with special needs groups, do you find these sheets useful in your work?

    Yes No Unsure

34. What changes do you think are needed to assist presenters to work more effectively with Aboriginal prisoners? (Discuss)

35. What changes do you think are needed to assist presenters to work more effectively with juvenile offenders? (Discuss)

36. What changes do you think are needed to assist presenters to work more effectively with women prisoners? (Discuss)

37. Of the posters provided as part of the manual, please provide feedback on:

The suitability of the artwork used

The content of the posters

Any changes they have personally made to the posters

Any new posters that need to be developed to address gaps in the current program.

38. Can you describe the frequency with which you use the posters?

Every presentation
Most presentations
Seldom
Never
Other (Describe)

39. Are there any posters that you never or rarely use? Describe which, and your reasons for not using them.

40. Can you describe the frequency with which you use the overheads?

Every presentation
Most presentations
Seldom

Never
Other (Describe)

41. What print and electronic resources are currently used by you in the Program? (Describe)

Pamphlets
Posters
Audio tapes and CD's
Videotapes
PowerPoint presentations
Other (Describe)

42. Have you experienced any difficulties with the prison to introducing new resources into the program?

Yes No

43. Can you provide feedback on how certificates are received by prisoners, are any changes required?

44. Do you consider the distribution of Exit Kits to be:

Very useful
Not useful
Unsure
Other (Describe)

45. In your opinion, do you consider that "Keeping Safe" is meeting the learning needs of prisoners?

Totally
Somewhat
Not at all
Other (Describe)

46. Can you suggest how the program could more effectively meet the needs of prisoners? (Discuss)

47. A lot of prisoners are dissatisfied with having to repeat the program annually, do you consider annual refreshers to be a worthwhile use of time and resources?

Yes No Unsure

48. When do you consider are the best times during a prisoner's sentence for them to access the "Keeping Safe" Program? (Multiple responses OK)

When on remand
At orientation
After sero-converting with a BBV
Annually
Pre release
Other (Describe)

49. What do you see as the advantages of recruiting prisoners as BBV peer educators? (Discuss)

50. What do you see as the disadvantages of recruiting prisoners as BBV educators? (Discuss)

PART B: IDENTIFICATION OF TRAINING NEEDS

1. How long have you worked as a presenter in this Program?
   - Less than six months
   - 7 –12 months
   - 13 mths to 2yrs
   - 2 – 3yrs

2. Have you received training via the Ministry of Justice to deliver this Program?

   Yes No

3. If you received training via the Ministry of Justice, how long ago is it since you received training?
   - Less than six months ago
   - 7 –12 months ago
   - 13 mths to 2yrs ago
   - 2 – 3yrs ago

4. If trained elsewhere what kind of BBV education have you accessed in the last twelve months? (Multiple answers O.K.)

   - In house training via employer
   - Conferences
   - Workshops/seminars
   - Self directed computerised learning

Journals and pamphlets
Videos and/or TV

5. Have you ever received training in presentation/teaching skills?

Yes No

6. If responded "Yes" in the previous question, tick which box below is applicable:

Through "Keeping Safe" training
Have trained as a teacher
Have trained as an adult learning presenter
Have a health promotion background
Through Aboriginal Health Worker training
Attended workshops on teaching / presentation skills
Other (please describe)

7. In order to identify areas to be addressed in future training, please tick which topics you would like to see included:

Effective ways of teaching Aboriginal groups
Aboriginal cultural awareness
Management of resistant and hostile learners
Managing sensitive issues in training
Teaching strategies to facilitate behavioural change
Effective use of teaching resources
Treatment updates for blood-borne viruses
Information updates on blood-borne viruses
Changes to prison policy and protocols
Other (please describe)

8. Please respond to the following statement using the code provided: "I would feel confident to train and support peer educators in the prison setting".

Strongly agree
Agree
Unsure
Disagree
Strongly disagree

9. Do you consider that you would require additional training to operate effectively as a trainer of peer educators?

Yes No

10. If answered "Yes" to the previous question, would any of your training needs differ from those outlined in Q 7. If so please describe.

Strongly agree
Agree
Unsure
Disagree
Strongly disagree

11. If you have had a difficult day presenting, how do you manage your associated stress/frustration?

Discuss with another presenter
Discuss with prison staff
Discuss with your employer
Discuss with friend/partner
Other (please describe)

12. In what ways do you think the program could support you better?

Establish a de-brief system
Convene regular support meetings
Provide more training
Other (please describe)

Thank you for taking the time to answer these questions. Please consider other issues around professional development and support that may not have been addressed by the questionnaire to raise with the interviewer now.

Appendix 1.7: Juvenile Justice

INTERVIEW SCHEDULE FOR JUVENILE JUSTICE EMPLOYEES REGARDING REVIEW OF THE "KEEPING SAFE" EDUCATORS MANUAL AND INPUT TO THE PREVALENCE OF SKIN PENETRATION PROCEDURES IN JUVENILE JUSTICE SETTINGS.

SECTION G: EDUCATION SERVICES AT JUVENILE JUSTICE

1. Gender of worker
   Female
   Male

2. For how long have you worked for Education Services at Juvenile Justice?
   6 mths or less
   7-12 mths
   1 – 2 yrs
   3 – 5 yrs
   5 yrs plus

3. Had you worked with detainees in any capacity prior to taking up your current position?
   Yes
   No

4. Describe the education programs you currently deliver.

5. Would you consider that the programs you teach could make linkages with the Keeping Safe Program? (if YES, please explain)
   Yes
   No

6. Have you attended training* in the following area?

*Defined as workshops, seminars, short courses provided by the employer at no cost to the respondent. May be useful to include informally on the Interview Sheet any self directed learning the worker has undertaken.

Topic	**¯12 mths ago**	**Never**	**- 12 mths ago**
Alcohol and other drug Awareness			

Self directed learning, describe:

PART B

Drawing from your working experience please respond to the following:

1. Detainees give their reasons for continuing with illicit drug use in the community as: (multiple responses are acceptable)

    Easy access to drugs
    Lack of rehabilitation/treatment options
    Lack of access to Methadone program
    Lack of access to the Naltrexone program
    Perceptions of failure regarding treatment interventions
    Boredom
    Peer pressure
    Not ready to get “clean”
    Generational drug use in the family system
    Other (please specify)

2. What percentage of detainees would you estimate enter the juvenile justice system withdrawing from illicit drugs?

    None
    0 –5%
    6-10%
    11-20%
    21-30%
    31-50%
    50%+
    Other (please specify)

3. In the last twelve months have you been aware of instances where detainees in your care have been harassed by other detainees for their prescribed medications?
   Yes (please provide details)
   No

4. Of the detainees that have tattoos and/or body piercings, what would you identify as the most common reasons given for having this work done in the community? (multiple responses are acceptable)
   boredom
   peer affiliation
   gang affiliation
   peer pressure
   rebellion against the system
   identity strengthening
   self mutilation
   other (please specify)

5. Have you been aware of any detainees that have had **infected** tattoos and/or body piercings and who have been reluctant to access medical services?
   Yes (please provide details)
   No

6. In the last twelve months have any detainees approached you regarding sexual health concerns, such as:
   Fear of pregnancy
   Infection with sexually transmitted infections, blood-borne viruses
   Past sexual assault
   Risks associated with sex work, sex for favours
   Past incest
   Unprotected sexual activity – risk to self and others
   How to negotiate for sexual safety
   Physical changes associated with adolescence
   Other (please specify)

PART C

This section invites input based upon your experience of teaching juvenile detainees.

1.The Keeping Safe Program is delivered in two parts, each of one hour's duration with a fifteen to thirty minute break after the first hour. Do you consider that this format is appropriate to the target group?

Yes (please provide details)
No

2. Currently a large part of the Program is didactic (instructional) - how could this be improved upon to be more effective with the target group?

3. The Program is currently delivered by external presenters from the WA AIDS Council and the Hepatitis Council of WA. From an educational perspective do you consider the use of external speakers to be an appropriate model for the delivery of sensitive material?
   Yes
   No (provide reasons)

4. Would you be supportive of Blood-borne Communicable Diseases education being provided "In-house" by existing staff? Yes (move to Q5)
   Yes
   No (provide reasons)

5. In order to change the model of delivery, what would be required?
   Recruitment of sessional staff with an interest in the area
   Financial support (sessional fees and resource development)
   Input by selected staff to the re-development of program materials
   Training to improve the knowledge base of staff in the BBV area
   Other (please specify)

Please provide any other information that you consider would better inform this review process.

Appendix 2: Issues from Keeping Safe Presenters Workshop

ISSUES FROM KEEPING SAFE PRESENTERS WORKSHOP

This workshop was held on Sept 16th 2002 at the request of contractors who felt that presenters needed an update of BBV information. This was only for metropolitan presenters and their contract managers, with the event hosted by WAAC and attended by the Hepatitis Council of WA and Derbarl Yerrigan Health Service. The following agencies provided guest speakers:

WA AIDS Council	- Treatments Officer
DOH	- Hepatitis C Policy and Planning Officer
RPH	- Hepatitis C Treatments Officers.

The workshop provided not only the opportunity for presenters to update their knowledge but also to flag emerging trends and prisoner perspectives on BBV's in the prison system. It was generally considered by participants to have been a very worthwhile day, and an event that they considered should be provided twice a year. The costs were minimal for the day as no guest speakers charged fees, so it was only catering and potentially a room hire charge, which is nominal.

BBV TESTING:

All the comments which appear below are based on the feedback KS Presenters get from prisoners across all metro prisons.

Lack of Informed Consent: prisoners felt that they were either coerced into testing or were just told that they were going to be screened for BBV's – they did not consider that testing in most cases was conducted with informed consent as they were not understanding the implications of testing.

There was a **reluctance of prisoners to test for HIV**, still seen by most prisoners as a disease that only affects homosexuals, did not want blanket screening for BBV's.

On the other hand there were **prisoners who felt that they were not being offered testing** and who lacked confidence to raise the issue when seen at the clinic.

The biggest complaint was that prisoners were not being informed of the results of their BBV tests. There appeared to be lengthy delays in prisoners being informed of their test results. There was also a perception that only prisoners with a positive result got called up; it was very rare for prisoners to be called up who had a negative result and then to have access to post test counselling.

Confidentiality of test results – feedback that prisoners are not convinced that blood tests are used solely for purpose documented – concerned re blood samples being used for DNA and drugs testing. Presenters also thought that we needed to have a statement built into the consent form (if signed consent for BBV testing is implemented) that declares that blood samples will not be used for DNA testing. Unless this issue is addressed it was considered that we would be unable to increase the rates of testing.

Confidentiality by nursing staff – feedback from prisoners that their confidentiality was compromised by nursing staff – eg health issues discussed in the hearing of prison officers. Report that a prisoner who had a new tattoo was singled out in the hearing of an officer and asked when they had had that new piece of work done. Prisoners do not appear to have much faith in nursing staff at Hakea and Casuarina.

OTHER BBV ISSUES:

Boxing Gloves – prisoners can apparently buy their own gloves now at a very reasonable price of $21.70. This avoids prisoners having to share their gloves. This would still be out of reach for some prisoners though, who do not have the necessary funds.

Punching Bags – there needs to be a system by which the bags are cleaned down after every use (e.g. wiped down with a bleach/detergent solution).

Booking to be seen at the Medical Centre: KS presenters condemned the process by which prisoners had to identify their reasons to attend the medical centre on a form that was read by Prison Officers. This did not encourage prisoners to come forward to request to be seen if they had BBV issues – felt that there needed to be a better system.

Prisons produce calendars – it would be useful to explore doing a health calendar. To our knowledge Hakea and Bandyup do calendars.

Herbal Products – Hakea now stocks Dandelion Tea and other herbals for improved liver function – need to support this and extend to other prisons.

KEEPING SAFE:

Prisoner attendance – the system introduced earlier this year is now working well at Hakea, no problems at all.

The Hakea system has also been adopted at Bandyup but is not working so well as there is no follow through if women do not attend (it is this component that makes Hakea work so well).

Casuarina would benefit from this system.

Data Entry – this is not being done as well as it could be, needs follow up.

Security: security orientation needed for Derbarl Yerrigan workers – has not happened despite being booked.

Information Updates: KS presenters would appreciate knowing what pharmacotherapies are available to prisoners, also what the process for access to hepatitis C treatments is so that they can report this accurately to prisoners.

There was some concern that whereas presenters used to have some variation to the program, they are now completely off doing their own thing. This was raised by one of the contract managers as a concern as the contract specifies that the presenters will adhere closely to the program provided.

It was agreed some time ago that the program was not working in the form it was developed and that as long as presenters covered the key objectives of the program they would be able to provide their own input to make groups more interesting.

There was extensive discussion on the following topics:

- The existing contracts specify that the program shall be delivered as set down in the training package: are Managers in breach of contract if presenters do not adhere to the package verbatim?
- There are sometimes requests from the Ombudsman in relation to information that has been provided through Keeping Safe to different prisoners. This emphasises the need for consistency of delivery and how this could best be achieved.
- Issues around quality control of program delivery.
- Queries as to why we do not factor into the contracts preparation time for presenters as they need to regularly update their knowledge.

The outcome from these discussions were as follows:

- Monitoring sessions of presenters to be conducted in November.
- Need for review of existing contracts and necessary variations included.
- Consideration of payment for preparation time.
- To try to finalise the review of the KS Program.

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