Harm Reduction in Italian and UK Prisons:
The Gap Between Policy and Implementation for HIV and Drugs.

by

Morag MacDonald & Daniele Berto

Paper presented at

**The 13th INTERNATIONAL CONFERENCE ON THE REDUCTION OF DRUG RELATED HARM, LJUBLJANA, SLOVENIA,
3-7 MARCH 2002**

Introduction

The notion of equivalence of health care provided for in International Guidelines (WHO and EU), is undermined in the prison system by the application of prison rules, structural impediments and political ambivalence. In addition, the initiatives which seek to address other priorities, notably the crime rate and Government strategy to combat drug use exacerbate the difficulties of applying sensitive and effective drugs and HIV prevention and treatment measures in prison.

This presentation, drawing on research in both prison systems, will discuss the current situation in Italian and UK prisons regarding the implementation of harm reduction materials and drug treatments available to prisoners. Both prison systems have a high number of prisoners who have drug problems and related issues with communicable diseases.

The acknowledgement of the extent of drug use and HIV in prison differs between the two countries. Italy acknowledges that there are a high number of prisoners who are HIV-positive but does not officially acknowledge that there is extensive drug use within prisons. This is somewhat ironic when contrasted with the cases of prisoners who have died from heroin overdoses whilst in prison, the fact that syringes are found in prison and the deployment of 'drug dogs' used to find drugs! It is interesting to note that research has been commissioned by the Italian Prison Department (DAP) to study the prevalence and incidence of the use of drugs within prison (in two sample prisons). The results from this study are, as yet, not available. Whereas the English and Welsh prison service do acknowledge drug use in prison but underplay the extent of HIV. This has resulted in different approaches to drugs and HIV and other communicable diseases evolving in the two prison systems.

HIV/AIDS Treatment

In England and Wales there are no national guidelines for the treatment of prisoners with HIV and AIDS. The Prison Service argues that there is no need for national guidelines because all prisoners are entitled to the same health care as any other member of the community, as was made clear in Circular Instruction 30/1991. Primary care services are provided by the medical officer of health within the prisons and secondary care by local NHS providers. However, there is a world of difference between the theory and the practice. Many prisons have not established links with healthcare specialists in this field. Many are even denying that there are any prisoners with HIV infection (NAPF, 2000). In reality the drug strategy takes precedence with the advent of the Mandatory Drug Training (MDT) and Counselling, Assessment, Referral Advice and Throughcare (CARAT) strategies. The drug strategy has to some extent led to the neglect of HIV and AIDS in prison.

The response to HIV and AIDS in Italy is different to the UK. The actual HIV treatment to be provided by the prison for prisoners is not set down in law but the guiding principle is that it should be equivalent to that provided in the community. In theory, it should be possible for HIV-positive prisoners to have the same treatment opportunities as is provided by the Health Service in the community. Individual treatment programmes are managed by a contracted infectivologist. The Ministry of Justice pays for the convention with the infectivologist and for the cost of combination therapy. Non-Italian national prisoners also are entitled to the same treatment as Italian nationals but they may experience difficulty in continuing treatment after release due to their lack of documents. The treatment that prisoners who are HIV-positive receive is not always consistent depending on the location of the prison and on the medical staff working in the prison and their

prison medical staff did not have good relations with the hospital in the community resulting in infrequent access to the infectivologist and an unwillingness of the hospital to accept prisoners who were HIV-positive when they were released from prison.

This lack of provision in some regions is of concern considering most of the Italian sample prisons had a high number of prisoners who were HIV-positive. In one prison out of 346 prisoners who had a drug addiction, 152 were HIV-positive. In one prison medical staff argued that even though the number of prisoners who were HIV-positive was high this was still an underestimate of the actual numbers of those who were HIV-positive because not all prisoners ask to be tested for HIV.

Impact of the drug strategy

Although not directly part of the policy and strategy for HIV and AIDS, the policy around drugs is intrinsically linked to HIV and AIDS policy because intravenous drug use, especially in prison, is a major means of transmission of HIV. Thus drugs policy has an important impact on the prevalence of HIV. The predominant approach to drugs policy is suppression, which ultimately resulted in the introduction of mandatory drug testing in February, 1996 in the UK.

In England and Wales, under the mandatory drug testing programme (MDT), 10% of each prison population is to be randomly tested each month. A concern voiced by prisoners, prison workers and some medical and drugs researchers is the potential MDT has for shifting some prisoners' choice of drug from cannabis to opiates, some of which will be injected, because of the relative lengths of time these drugs remain detectable in the blood stream

Drug treatment for prisoners is provided by outside drug workers, known as CARAT teams. The treatment component of the MDT strategy (introduced in 1999) is a multi-agency approach to tackling drug abuse in prison and it also has the aim to co-ordinate support for prisoners after release. The stated aims of the CARAT service is to: 1) identify drug (mis)users as soon as possible; 2) provide ongoing support and advice throughout their time in prison; 3) work in conjunction with agencies inside and outside the prison to ensure prisoners are properly assessed and directed to the most appropriate intervention to tackle their problem; 4) link the various departments and agencies that deal with prisoners in order to provide continuity between treatment in prison and that available on release.

The implementation of drugs policy has affected the way that HIV policy has come to be no longer a priority as shown by the amalgamation of the AIDS management team to also include communicable diseases and then drugs. Although, it is clearly stated that HIV/AIDS is not solely a medical matter (DPMS, 1990) gradually this is what it has, in effect, become. New policies for drugs and communicable diseases do not appear to have taken account of the lessons learned from previous policies. For example, MDT and the introduction of CARAT workers as part of the drug strategy has raised issues of prisoner confidentiality and the dissemination of knowledge about communicable diseases.

The CARAT policy has, in effect, ignored the confidentiality strand of policy introduced for HIV/AIDS and the training that was implemented for prison officers to enable them to deal effectively with the issues surrounding HIV. In addition, the issue of the lack of prisoners' confidentiality has made it difficult for prisons to adhere to the World Health Organisation and the European Standards of Health Care. This lack of confidentiality can be explained by a number of factors, such as lack of training about HIV for prison officers and the low entry requirements to the service for prison officers.

In summary, the MDT process is counterproductive. It deflects attention from the real issue of the purposes and funding of the prison system. Drug testing also deflects attention from other crucial areas like the spread of HIV and AIDS in prison. MDT increases tension in prisons, appears to be encouraging a shift from 'soft' to 'hard' drugs, is adding to the workload of an already overburdened staff, is costing a lot of money that could be better spent and is failing to provide adequate treatment and follow-up procedures. (MacDonald, 1997; Duke, 2002). It is, thus, primarily an indiscriminate punitive regime that is adding to the overcrowding in British prisons by effectively adding extra weeks to prisoners' sentences.

In the Italian prison system treatment for drug addicts has been improved in some regions. Drug treatment programmes are controlled by the National Health System and delivered by the community drug addiction teams called SERT. Drug treatment started in the community can be continued in prison or new treatment programmes can be started. The use of multi-disciplinary teams to work with prisoners with a drug addiction is seen as the cornerstone of the drugs policy within prison. Unfortunately, only a very few prisons have such a dedicated team or a written drug policy. The link between the SERT and the prison is seen as good practice as it guarantees the continuity of therapy and enables innovative approaches to working with addicts. However, not all the prisons have a contract (convention) with the SERT. This depends on local regional policy. Only a few regions, for example, the Veneto region, specifically stress that that SERT must collaborate with the prisons in their region. Most SERTs go into prison only 'on demand' if requested by medical staff or by a previous patient now in prison. In the south of Italy, the SERT does not enter the prisons.

Harm reduction in prison is different to that provided in the community

Even when there are effective harm-reduction measures in the community it is often difficult to apply them to the prison environment. One of the aims of the Department of Health Care in the UK, since its inception in 1993, was to place more emphasis on the promotion of heath to move prison medicine away from the treatment model to the health-promotion model. This reflected the national trend in health care. The Health Advisory Committee for the Prison Service supported the idea of health promotion (Rhodes, 1994) and considered the prison setting to be a site where WHO guidelines should apply.

Despite the emphasis on health promotion, the development of HIV prevention in prison has been quite different to how it developed in the wider community. In the community, the starting point tends to be:

> education and training to encourage a change of behaviour to that of little or zero risk. It is accepted that risky behaviour does occur and that people should be enabled to limit the risk. Thus, in the wider community, HIV prevention embraces harm reduction, in terms of encouragement towards safer sexual practices, including the use of condoms, and in terms of clean needle use for those who inject drugs. (Sexton, 1997, p. 3)

HIV-prevention work in the community has evolved through three stages beginning with the *awareness-raising* stage, followed by the *prevention* stage, which makes use of such strategies as training to enable informed choices about behaviour to be made, and lastly the *harm-minimisation* stage. The latter:

> operates within a context of individual risk assessment and rigorous intervention by those

> the experiences of the previous stages, and perhaps, more importantly, has taken place within a changing political context. (Sexton, 1997, p. 14)

In prisons, the political context is different from that of the wider community. Training and awareness raising are emphasised in prison. However, the tendency is to favour a preventative strategy rather than embrace the third stage, that of harm minimisation. The emphasis on prevention can be explained by the difficulties of openly acknowledging that risky behaviour is occurring in prisons (even when this is acknowledged by prison staff). The problem is made more complex with the added question of the legality of certain behaviour while in prison. Whilst it is illegal to use drugs inside and outside prison, sex between consenting adults, whilst legal outside prison can be considered problematic in prisons due to the debate about whether a prison cell can be considered to be a 'private' rather than 'public' place and thus a legal space for consenting sexual relations. This debate has implications for the opportunities for harm-reduction strategies, such as condom provision. In addition, there are moral as well as political objections, which compete for priority with health considerations when it comes to the implementation of prison policy and practices.

Although legislation and policy relates to the entire prison system, in practice, implementation varies considerably between establishments. Hence, it is problematic to talk about 'the prison system' when discussing HIV and AIDS and drugs policy in prisons in England and Wales and Italy. It is important to acknowledge that different groups of prisoners have different health needs, for example women prisoners' health needs are very different from those of male prisoners and in prison there is one approach (usually based on needs of male prisoners) to cover all social groups.

Available harm reduction measures in prison

The political context of prisons has led to variable provision of harm-reduction measures where neither prison system provide needle exchanges, consistent harm-reduction literature or courses. Although condoms are available, in theory, in English and Welsh prisons, in reality, provision is patchy and the majority of prisoners do not have access to them. In Italy, condoms are not available. In Italy, the prison service view that there is a need for a harm-reduction strategy is, in effect, an acknowledgement of the failure of the treatment and programmes available for addicts. This is also reflected in current community policy about harm reduction. The current thinking in Italy is that there should be a special 'cure' for addicts who have committed a crime, based on compulsory treatment within a therapeutic community.

1. Condoms

Although, in theory, condoms are available in UK prisons, in reality, they are not available in the majority of prisons (BMA Foundation for AIDS, 1997). Even when they are, it is usually very difficult for prisoners to access them in a confidential manner, which negates the implementation. Confidential access is a key issue where the taboos regarding sex between men is so strong. In some situations, although available, the process of obtaining condoms is very slow. Ex-prisoners have said that there had been delays up to six months between an application for a condom and receiving one (NAPF, 2000). Italian prisoners do not have access to condoms in prison.

2. Methadone treatment

In the English and Welsh prison system, in 1991, The Directorate of the Prison Medical System, now the DHC, produced a resource pack for people working with drug users in prison (*Caring For*

including the use of methadone *detoxification* at the time of reception into the prison, for new prisoners who are identified as opiate addicts. To what extent this treatment is available for drug problems varies considerably between prisons. Some provide only short detoxification programmes or counselling and advice and in others there is little or no treatment provided (Turnbull *et al.*, 1994). Although some doctors, in some of the English prisons, do prescribe in response to withdrawal, there is little consistency in their practices. In Italy, the prison medical staff in general provide medical help to control the symptoms of withdrawal. If a prisoner is suffering with withdrawal symptoms they can detoxify following a therapeutic protocol with SERT within the prison. One doctor argued that, outside the prison, withdrawal symptoms are very hard, but in prisons they are not so hard and go more quickly. In another prison, the main prevention strategy is to use drugs for detoxification and then to locate prisoners in a drug-free section as a way to stop them using drugs again.

In Italy the policy for methadone treatment in prison is, as a general rule, either continuing treatment or reducing dosage. The official treatment of drug-addicted prisoners is agreed and managed by the SERT. The methadone treatment that is available depends on individual prisons. In one of the Italian sample prisons there were some prisoners receiving either methadone maintenance or reduction programmes, which were controlled by SERT. It is possible for a prisoner to be on a methadone programme for the whole of his or her sentence. The more common approach, though, is that addicts, who are known to SERT in the community, can continue the prescribed methadone treatment but only on a decreasing dose.

This situation is not the same for migrant prisoners who do not normally have contact with SERT before their imprisonment. In some prisons, non-Italian national prisoners are also able to have the same treatment provided by SERT. The dosage of methadone, and how long it is prescribed for, is decided by SERT. However, it will also be possible, in a few of the sample prisons, to begin the use of methadone while in prison with no prior involvement with SERT.

Figures provided by one of the sample prisons illustrated the extent of prior non-contact with the SERT, especially among non-Italian nationals. Between 1996 and 1998, there was an increase in the number of non-Italian national drug users needing urgent health care in the prison. A total of 1726 drug-addicted prisoners were treated and of these 840 (48.6%) were non-Italian nationals of whom 66% were polydrug-addicted and 59.9% had been in prison more than once in this period. Most (93.3%) of the male prisoners and 75% of female prisoners in this group had never been to SERT in the community for treatment prior to imprisonment because they did not have a residence permit. Also, within the Italian prisoner population, 20.7% of the men and 45% of the women said they had never been treated by SERT before.

3. Needle exchange

The risk of infection is much higher for injecting drug users if they reuse or share injecting equipment. There are currently no plans to introduce needle exchange programmes into the English and Welsh prison system. This was stated forcefully in Circular Instruction 30/1991 ‘the Prison Service cannot contemplate such schemes for prisoners’. The 1995 Review argued that ‘to recommend needle exchanges in prison would be fraught with difficulty and would fit uneasily with the duty of prison authorities and staff to detect the smuggling of drugs into prison and to prevent drug misuse in custody’.

Prisoners may well be aware of the risk of using and sharing needles in prison but some will still use a needle that may not be sterile because there is no alternative available.

There are no needle exchanges available within Italian prisons. Despite the prevalence of risk behaviours such as the use and injection, of drugs and the sharing of injecting equipment there is no intention to introduce syringes into Italian prisons (Stannini, 2001). LILA (Italian League for the Fight Against Aids) submitted a study to health ministers and to Giancarlo Caselli (Director of DAP), indicating that 40% of prisoners who are addicts continue injecting themselves in prison and that 7% of the addicted prisoners first injected themselves in prison (LILA, 2000).

There are legal obstacles in the Italian system to the free distribution of syringes for drug-addicted inmates. In Italy, while drug abuse is not a crime, it is illegal to transfer drugs. The distribution of syringes might, therefore, constitute a form of complicity with whoever has unlawfully provided drugs to the inmates. In addition, there is concern that syringes may be used as a weapon or might be used in self-harming.

The research (MacDonald and Berto, 1999) showed that, some staff thought that needle exchanges were a good thing, in theory. However, in practice, they were of the view that the best harm-reduction within the prison were the methadone programmes.

4. Sterilizing Tablets

Rather than needle exchanges, sterilisation of equipment was deemed the most appropriate risk-prevention strategy in UK prisons. In July, 1995, the Home Office Advisory Committee recommended that disinfectant tablets be made available for prisoners with which to clean injecting equipment. The recommendation was accepted by the Government in Autumn, 1995. After an initial decision to issue tablets in 1996, they were almost immediately withdrawn in England and Wales for further testing for health and safety reasons and have not, as yet, been reissued despite the fact that the tests results found that the tablets cannot be used in an offensive way.

In Italy despite the lack of needle exchanges, the possibility of supplying decontaminates with which to clean injecting equipment is currently being considered. Although, in Italy some needles and syringes have been found in some of the sample prisons and there has been evidence of overdoses in prison, there were no decontaminates inside any of the sample prisons nor was there any information provided about cleaning injecting equipment. Prisoners who want to inject drugs in prison will improvise if syringes are not available by, for example, using a modified bic pen to make the barrel of a syringe as a way of circumventing prison policy (Martino, 1994).

5. Multi-disciplinary approach

Policy makers have been aware that the management of HIV within the prison setting is not solely a medical issue, which can be confined within the narrow context of health care rather ‘it is an issue which potentially impacts upon the whole of prison life. This view underpins the multi-disciplinary approach to HIV work in prisons’ (Sexton, 1997, p. 13). The Prison Service intends multidisciplinary teams to be the cornerstone of HIV and drug strategies in the prison setting as they are considered to offer the most effective way of implementing the diverse policies to ensure there are no gaps in provision. However, the Prison Service refers to the effectiveness of multi-disciplinary working without considering the problems involved when professionals with different occupational cultures meet together to implement policy. Multi-disciplinary teams in prisons may include outside agencies and this can bring a different set of values to the working of the group.

One of the key obstacles to multi-disciplinary work has been the isolation of the prison medical

departments in prisons which at times give rise to fierce territorialism' (Robertson, 1995, p. 33). There are a range of different professional cultures amongst the different departments within prison that can place obstacles in the way of multi-disciplinary work. Although multi-disciplinary working is seen as important in Italy, in practice, as stated earlier, few prisons actually have successful multi-disciplinary teams in place.

6. HIV prevention strategy

In Italy, in the community the focus of HIV prevention strategy is on changing behaviour to minimise risk. Thus, HIV prevention encompasses harm reduction that encourages safer sex practices and drug using practice. In prison, though, training and awareness raising are prioritised, resulting in a preventative strategy rather than harm minimisation, which is similar to the approach in England and Wales.

HIV prevention and harm-reduction in Italian prisons is dominated by an individual treatment approach. Although there are some health education and group initiatives, there is a tendency to focus on the specific needs of identified prisoners, particularly those identified as engaging in high-risk activities. The result is that there are no formal central policy or written strategies for the implementation of prevention initiatives in prisons. However, DAP encourages such initiatives as separate sections for drug addicts, as well as the provision of sporting activities and courses.

The lack of clear central guidance or specific programmes for prevention means that professionals working in prison are constrained in any attempt to inform prisoners about prevention and harm reduction in a consistent, planned way. Furthermore, it was argued by some staff that the initiatives suggested by DAP do not address the reality of overcrowding in prison. It is not possible, for example, to provide separate sections for drug addicts, sporting activities and courses. It was argued by some staff in one of the sample prisons that basic hygiene was a serious problem in their prison as there were nearly 2,000 prisoners in a prison built for 800. In this situation, prevention and harm reduction is an idea not a reality. Due to a lack of staff it was also considered problematic to deal with the everyday problems, let alone programmes of harm reduction and prevention. In addition, in some prisons, there is a strong belief among the majority of professionals that an individual approach with prisoners is more effective than small-group work.

7. Information Provision

In Italy, leaflets about HIV and AIDS are available from DAP and the Ministry of Health and Local Healthcare Units (ASL) in a variety of different languages, which should be given to all prisoners at the time of induction. Furthermore information about harm reduction in particular for HIV and the risk of infection, should be provided in each prison by the medical service to the guards, civilian staff and to the prisoners.

In some prisons in Italy, the workers from SERT are used to provide information concerning prevention to prisoners with whom they are working. They give information to the prisoners about the risks of the HIV/AIDS virus at the first meeting.

In the early 1990s, just at the beginning of the HIV/AIDS epidemic, there were informal meetings about HIV with prisoners in some prisons run by medical staff and this was important as the first cases of HIV in prisons caused alarm to other prisoners about the risk of infection. Also at this time there was very little information available from the media about the HIV virus. This level of provision of information about HIV is no longer considered to be so necessary as prisoners are more

regular programme of harm-reduction and prevention information as at the current time the media are no longer providing as much information as they did when HIV first became an issue. Non-Italian speaking prisoners can be at an even greater disadvantage as they are unable to understand the information that is provided. Although leaflets should be available in a range of languages this is often not the case.

In the UK there is harm reduction information available but not in all prisons. These are also not generally available in any other languages. Similiarly there are drug awareness courses, but again these are not provided in a consistent manner across the prison estate.

Conclusion

In Italy there is a clear need for prisons to provide education and information about HIV/AIDS and drugs in a way that both engages prisoners and meets the needs of non-Italian speakers. Most Italian prisons have many prisoners who come from other countries and the majority of professionals are aware that the available leaflets need to be translated into other languages. The stress on treatment for individual addicts, which operates in most prisons in Italy, often works to the detriment of harm-reduction and prevention strategies. It appears that the prevention and harm-reduction measures that are in place are geared towards those prisoners identified as known drug users. This tends to ignore the rest of the prison population who may either be ignorant of what constitutes risk behaviour or be engaging in risk behaviour (tattooing, sexual contact or injecting drugs) but who receive no information about drug use or harm reduction, HIV or AIDS.

This is not to say that there are no prevention and harm-reduction initiatives, apart from the special projects, operating in the Italian sample prisons for some groups of prisoners. In most prisons it was evident that a range of staff provided useful information to prisoners about prevention and harm reduction. However, this was done in an *ad hoc* way for individual prisoners, who either asked for information or who were known to be involved in risk behaviours (for example, intravenous drug users) prior to coming into prison. For example, in one prison, seminars that provide information about drugs are organised by the prison school in the education department and approximately 90 prisoners have attended them. This demonstrates that prisoners want this chance to learn more about drugs and the accompanying risks.

The way that methadone treatment is implemented or not implemented in different prisons can have serious repercussions for prisoners. For example, in November, 2000 the death of a prisoner, Marco Giuffreda, resulted in a letter to prison authorities with the directive that methadone should be made available to prisoners. Even when there is a formal directive implementation may still not occur. The president of LILA, Vittorio Agnoletto, noted that the directive is being ignored, adding that ‘The absence of methadone causes drug addicts to look for heroin, even using syringes which have already been used, increasing the danger from hepatitis B, C and AIDS’ (LILA, 2000).

There is no mandatory drug testing within Italian prisons. There has been some discussion in the Italian media about whether mandatory drug testing should be implemented in prisons. The left-wing press is not in favour of it as mandatory testing is seen as discriminatory.

The existence of risk behaviour, which is occurring in all of the sample prisons, indicates the need for consistent and effective prevention and harm-reduction strategies in each of the prisons.

This analysis has shown that the implementation of HIV/AIDS and drug policy in prison is not straightforward. In general, harm reduction material is provided in a partial and inconsistent way

in information and help being given to prisoners who have an acknowledged drug problem, rather than being made generally available. Although there are established mechanisms for health and drug protocols to be agreed with the relevant agencies in the community, these are not always translated into effective policy within prisons. The lack of written strategies is one factor that can hinder implementation of policies across the prison. The make up of the prison population, which currently has a high number of non-Italian nationals, raises barriers, due to language difficulties, to successful implementation of both harm-reduction information and successful drug-treatment programmes.

Neither system has a fully operational harm reduction strategy operating effectively in prison. In both countries it is those prisoners who disclose a drug addiction who are most likely to receive prevention education either from the medical doctor or workers from SERT in Italy or from the CARAT workers in England and Wales. The assumption is that prisoners in both systems who are perceived not to be drug users are aware of harm reduction or that they are not engaged in risk behaviours while in prison. A further group who are at a disadvantage in the Italian prison system are the high numbers of migrant prisoners who are less likely to receive alternatives to custody, who may not be eligible for treatment programmes provided by the SERT and who may have problems communicating in Italian with prison staff. In very few prisons in Italy were harm reduction materials provided in other languages.

Despite the emphasis on health promotion, the development of HIV prevention in prison has been quite different to how it developed in the wider community. The lack of prevention measures, for example condoms, reflects the taboo surrounding the issue of sex in prison. Even where prisoners may rationally be aware of risk behaviour this does not necessarily stop the behaviour.

The above discussion has revealed that there is still a significant implementation gap in the delivery of policy within prisons in England and Wales and Italy where basic harm-reduction measures, such as cleansing tablets are not available, needle exchanges, are not available nor is there any intention in the near future to introduce them and condoms are not available in practice.

All these factors lead to inconsistent provision across the prison estate. In addition prison overcrowding places strains on staff and reduces the amount of constructive activity available to prisoners and the effective implementation of policies for HIV.

The recommendations from the All Party Parliamentary Group on AIDS (APPGA, 2001) give a useful summary of what is needed in prison to provide harm reduction:

- pilot provision of cleansing tablets be expanded to all prisons in England and Wales;
- needle exchanges should operate inside prisons in parallel to other health promotion measures;
- condoms should be made available in an effective and confidential way;
- the Prison Service in conjunction with the Department of Health to develop clear guidelines and implementation mechanisms across the prison system, to ensure that, as far as possible the treatment of people with HIV in the prison system reflects practice outside and works towards equivalence.

References

All Party Parliamentary Group on AIDS (APPGA), 2001, *The UK, HIV and Human Rights: Recommendations for the Next Five Years*. London, APPGA.

BMA Foundation for AIDS, 1997, *Prescribing of Condoms in Prisons: Survey Report*. London, BMA Foundation for AIDS.

DUKE, K., 2000, 'Evidence-based policy making? The interplay between research and the development of prison drugs policy', *Criminal Justice*, 1 (3), Vol. 1(3): 277–300

LILA [Italian League for the Fight Against Aids], 2000, '"Inexcusable negligence" but no charges at Regina Coeli', *Statewatch Bulletin*, March-May 2000, 10(2).

MacDonald, M., 1997, *Mandatory Drug Testing in Prison*, Birmingham, UCE.

MacDonald, M. and Berto, D., 1999, Relazione comparativa delle rilevazioni effettuate in 10 carceri italiane e 10 inglesi. Research Report funded by EC and SCODA.

National AIDS and Prisons Forum (NAPF), 2000, *Steering Group Minutes*, November.

Rhodes, T., 1994, *Risk, Intervention and Change: HIV prevention and drug use.* London. Health Education Authority and National AIDS Trust.

Sexton, S., 1997, *AIDS Management in Prisons: Factors Leading to Effective Health Care for Prisoners.* London, National AIDS and Prison Forum.

Staninni, J., 2001, 'Communicable diseases and harm reduction', conference paper at *Carcere e Tossicopendenza*, Verona, March, 200*1*.

Turnbull, P., Stimson, G. and Stillwell, G., 1994, *Drug Use in Prison.* Horsham, AVERT.

Contact details for:

Morag MacDonald
Centre for Research into Quality
University of Central England in Birmingham
90 Aldridge Road
Birmingham
B42 2TP
E-Mail: morag.macdonald@uce.ac.uk
Tel: 0044 121 331 6757

Daniele Berto
SERT
C/O Ospedale dei Colli
Via Dei Colli, 4
31543, Padova
Italia
E-Mail: bertopsy@libero.it
Tel: 0039 049 8216931