his paper is about juvenile corrections and more specifically, Youth Training Centres (YTCs). It is aimed primarily at those working in the juvenile area, though many of the issues raised will be of interest and relevance to those in other correctional settings.

The paper will outline the response of one organisation, Community Services Victoria (CSV), to the issues HIV presents. Rather than focusing on a single area such as testing or education, it is the totality of Victoria's approach with which this paper is concerned. We will trace the HIV policy development process, examine issues which we have found particularly difficult to deal with, discuss initiatives that are in place in YTCs at present and look at what needs to happen next.

This paper is based on the premise that the juvenile corrections system has features that make it different from adult corrections, both in a general sense and in terms of responding to HIV. In Victoria, some of these features are as follows:

- Regulation 248 of the Community Welfare Services Regulations 1985, provides that:

  All officers and employees who have responsibility for the care, management or supervision of trainees in a remand centre or youth training centre shall, consistent with community safety, regard the welfare of trainees as the first and paramount consideration and any provision made for their physical, intellectual, emotional or social development shall be such as good parents would make for their child.
This Regulation adds a clear 'care' imperative to youth corrections. It distinguishes the adult and juvenile systems most clearly.

- Staff in YTCs are given the same pre-service training as staff caring for children and youth in the protective services stream of the Department of Community Services. They are educated and encouraged to deal with client issues from a welfare perspective that places emphasis on client rights.
- Youth corrections are administered by the Department for Community Services, not the adult correctional authority. These arrangements are found in most States. Administration within a community service framework is likely to reinforce the 'care' and 'rights' orientation of responses to HIV.
- At some time in their sentence, most youth trainees are entitled to regular weekend leave. This ongoing contact between trainees and the community has implications for youth corrections policies and practice regarding HIV testing, education and the provision of harm minimisation equipment.

These are just some of the features that indicate the need to consider HIV issues in YTCs separately from HIV issues in prisons.

The broader social value in promoting discussion and activity around HIV in youth corrections is clear. Although adolescents show a relatively low incidence of AIDS, the sharp rise in incidence among people in their twenties indicates that HIV is frequently contracted in the teenage years. Since many trainees practise behaviours that place them at risk of contracting HIV, their presence in an institution affords an excellent opportunity for YTCs to educate young people who may be otherwise hard to reach. The aim that youth trainees will use information to protect themselves and to spread the message to peers when they leave the institution, underlies every HIV initiative within YTCs.

On one level, CSV is at a very early stage in dealing with HIV. As yet, we have not had a youth trainee who is known to be HIV positive. This may simply be a product of our voluntary testing policy. On another level however, CSV has developed HIV education and prevention programs and has planned for the care of clients with HIV.

Discussion with program staff from youth corrections services around Australia indicates a great variation in the nature and amount of activity that has occurred in relation to HIV. Some States and Territories have developed detailed responses while others are just beginning to address the issues in a planned way. By presenting a total picture of CSV’s response so far, it is hoped that other services will be able to focus on the issues that are relevant to them.

CSV has responsibility for an extremely wide range of human service programs. These include juvenile corrections, child protection, pre-schools, child care centres, home care services, supported accommodation, adoption and a wide range of services for people with an intellectual, physical or sensory disability.

CSV provides some of these services directly and partly resources the provision of others in the non-government sector. It directly employs some 8000 staff.

It became clear at a very early stage that HIV/AIDS would raise significant issues for CSV as a human service organisation and as a large employer. CSV began responding in a planned way to these issues in 1986. Early initiatives, however, came from individual program areas and lacked coordination across the Department. Recognising the potential for duplication of effort, or worse, the pursuit of inconsistent approaches, the CSV executive elected to appoint a Policy Officer to coordinate the development of a broad-based policy.
Policy Development Process

Work on the HIV/AIDS policy began in July 1989 and was completed in February 1990. A Departmental Reference Group was formed, comprising seventeen senior management representatives from the range of CSV programs outlined above. This group drafted a series of principles that underlined the broad Departmental HIV/AIDS policy. The Reference Group identified major areas to be addressed and formed working groups to develop detailed policy covering:

- personnel practices and HIV/AIDS;
- infection control for blood borne viruses;
- staff education and training;
- client education and counselling;
- client access to condoms, needles, syringes and bleach;
- client HIV antibody testing and informed consent;
- client privacy and confidentiality;
- case management and treatment of HIV infected clients.

Working groups brought their policy statements back to the Reference Group for discussion, coordination and consultation with executive-level managers and relevant unions. The policy package was finally endorsed by the Minister for Community Services and a broad-based distribution and marketing strategy put in place.

This policy development process worked well for CSV. Firstly, it resulted in a comprehensive document within a reasonably tight time-frame. Because of the wide representation of the Reference Group, the policy was well-tuned to the range of issues that arise in CSV's many program areas. The number of participants involved meant that many parts of the organisation knew the policy was developing and had some investment in its content and application. Most importantly, as we have approached implementation issues in the months since, the Reference Group members have continued to 'own' the issues, acting as change agents and role-models within their respective programs.

CSV HIV/AIDS Policy Principles and Youth Training Centres

That HIV related policies and programs be developed in the wider context of communicable diseases and human relations programs.

Adoption of this principle requires CSV to provide youth trainees with education regarding health, sexuality, communicable diseases, self-esteem, assertiveness and communication to ensure trainees have the skill and knowledge base to apply safe behaviour messages.

It requires CSV to train youth officers in similar areas so that they can properly resource clients. Recognising that not all staff will be comfortable or effective in this role, CSV is required to ensure that specialist, often external services are available to YTCs.
That the development and implementation of appropriate education programs concerning HIV and communicable diseases be incorporated in any future CSV policies and programs.

Adoption of this principle requires CSV to entrench messages about HIV prevention and care of infected people in the range of programs to which youth officers and youth trainees are exposed, and in the policies and guidelines covering YTC management. For staff, this includes incorporating infection control and HIV content into pre-service training in the post-secondary sector, and normal induction and in-service training programs in CSV. It means placing HIV in the broader context of CSV's occupational health and safety responsibilities as an employer. For trainees, the principle requires educational programs and materials to address HIV issues and day-to-day interactions with staff to reinforce safe behaviour messages.

That policies and programs developed for communicable diseases maximise the rights of all individuals to:
- self-determination
- the least restrictive living environment
- access to appropriate protection against infection.

While sentencing reduces a young person's right to self-determination and the least restrictive living environment, this principle ensures that CSV's policy response to HIV does not in itself, further minimise these rights. It is a reminder that the sentence is the punishment and that CSV's broad duty of care requires an empowering approach to all health and personal development issues.

The principle of maximising the individual's right to access protection against infection, that is, condoms, needles, syringes and bleach, is worth special consideration in the youth correctional setting.

CSV sought detailed legal advice regarding the balance between its duty of care to protect trainees from infection and its obligation to work within Victorian laws covering the drug usage and sexual activities of minors. The essence of the advice received was that if counselling were provided to young people about the danger involved in sexual activity and drug use and if illegal sexual activity and drug use were actively discouraged, the provision of harm minimisation equipment to youth trainees by CSV would be considered part of the discharge of its duty of care.

Within this legal framework the ethical, political and practical implications of providing trainees with condoms, needles, syringes and bleach were considered. Given the critical stage many trainees are at in terms of their personal development and identity formation and the potential for exploitative activities in enforced group living situations, sexual activity between trainees is prohibited. As an illegal activity, intravenous drug use is also prohibited. Within the broader context of weekend leave however, it is clear that some trainees use intravenous drugs and practise sex in ways that may place them at risk.

CSV has decided not to provide condoms explicitly for use within YTCs. However, condoms and educational material are made available to trainees within an overall educative framework and procedures for distributing condoms at times of weekend leave are being piloted. CSV will not provide needles and syringes to trainees at any point. However, educational material including information on the location of needle exchange centres is provided prior to weekend leave. Needles and syringes have remained banned items within YTCs while condoms brought into the section by a trainee, as part of his or her personal property, are allowed.
That no routine HIV antibody testing or screening be conducted and that testing only be conducted

- with the informed consent of the individual
- where recognised pre- and post-test counselling is provided.

This principle acknowledges the dilemmas associated with the decision to be tested for HIV and locates decision-making responsibility at the individual level. Its adoption requires CSV to ensure that specialist counselling is provided to assist trainees to sort through the issues and to ensure that the test is available with pre- and post-test counselling to any trainee who requests it.

CSV is very clear that youth trainees should not be tested to allay workers' concerns about their own risks of infection. Youth officers are trained in infection control procedures and urged to treat every client as potentially infectious. This approach promotes the health and safety of staff more thoroughly than a simple testing procedure in that it protects them from a range of blood borne viruses including hepatitis B and from HIV that may not be detected in an initial client screening process.

That HIV related policies for clients and staff uphold the principles of confidentiality.

Because CSV policy and practice encourage the same treatment of trainees regardless of their HIV status, staff and management do not automatically need to know if a client is HIV positive to protect themselves or to offer optimum care. There are, of course, situations where youth officers will need to know a trainee's HIV status. This is important where it has implications for the care of an infected person or where the behaviour of an infected person is placing other trainees or staff at significant risk.

In cases such as these, information about a trainee's HIV status will be given to the smallest number of staff possible. The trainee concerned will be told in advance who will be notified.

That HIV related policies for clients and staff reflect the principle of non-discrimination.

Adoption of this principle within a YTC means that staff and clients who are HIV positive or who are presumed to be HIV positive will not be automatically excluded from any regular activity or duty within the institution. Where an HIV infected trainee is placed at risk or places others at risk through specific behaviours, intensive counselling and education will precede any move to restrict the activities of that person. CSV does not support routine isolation or segregation of trainees with HIV infection.

HIV/AIDS Unit

Translation of these policy principles into practice is of course, the ultimate challenge. To work towards this end, an HIV/AIDS Unit has been established within CSV. It has four staff members, including a doctor, a social worker and a teacher. The Unit is time-limited. It works closely with the program direction areas of CSV to develop and promote on-going:

- staff education and training;
- client education and counselling; and
- infection control practices.

The HIV/AIDS Unit works in close cooperation with the Youth Support Program Direction Branch of CSV to ensure that the HIV/AIDS policies are implemented in YTCs.
Before looking at current initiatives in this regard, a brief introduction will be given to the Victorian YTC system.

**Victorian Youth Training System**

The YTC system in Victoria deals with male and female young offenders and young people on protective orders between the ages of ten and twenty-one. There are four YTCs, one for females and three for males.

Winlaton is a female institution and it holds fifteen to twenty-one year old offenders and those on protective orders. Turana holds mainly fourteen to seventeen year old young male offenders and a few young men on protective orders. It is the remand centre for the Children's Court and holds seventeen to twenty-one year old convicted offenders before they are classified to one of the two country adult YTCs.

These two adult centres, at Langi Kal Kal and Malmsbury are part of Victoria's unique dual track approach to imprisonment of the seventeen to twenty-one years age group. The Victorian courts have the sentencing options of adult prisons or YTCs when they wish to incarcerate convicted offenders.

**The Problem for Juveniles**

A quote from Professor Brent Waters' (1988 p. 9) final report from the Youth Working Party of the Australian National Council on AIDS, gives an insight into the place of young people, in the overall picture of HIV/AIDS in our community:

Many Australian teenagers engage in unsafe sexual activities. At least a third of boys and quarter of girls in the final years of high school have had intercourse. Many teenagers do not protect themselves against pregnancy or sexually transmittable diseases. As many as 5 per cent of teenagers may be homosexual. About 4000 Australian teenagers run away from home each year and many of them become involved in drug use, prostitution and drug trafficking. While intravenous drug use is uncommon amongst Australian teenagers, the rate of HIV infection among those who use IV drugs has increased rapidly in the last eighteen months. Moreover, it has been suggested that teenagers are more likely than older IV users to share needles.

Teenagers who use IV drugs, or are gay or bisexual, or are homeless, or are involved in prostitution, should all be considered target groups for special efforts that will help them develop safer sexual and drug use behaviours.

The 1989 YTC census gives a picture of a typical young offender. The offender is most likely male. He has offended under the influence of, or to obtain, drugs or alcohol. He is unemployed and probably homeless at least some of the time. In 75 per cent of cases, he comes from a family where death, separation, divorce and/or remarriage has occurred. It is most likely that he did not successfully complete Year 9 and in many cases, not even Year 8. Many of the young people we see have lived as what the media call 'Street Kids', amongst whom crimes such as prostitution and drug taking, are a way and sometimes even a necessity, of life (Youth Support Branch 1989).
System Dilemmas

Having established the fact that the Victorian young offender population falls into the high-risk group, we then need to consider some of the other issues which make the youth training system in Victoria, a difficult place in which to implement educational strategies to promote and support behaviour changes, aimed at stopping transmission of HIV/AIDS.

Some of the dilemmas associated with confidentiality, testing, issuing of condoms and bleach, and the temporary leave program have already been mentioned.

Young offenders are not merely locked up for the period of their sentence, they are reintegrated into the community and into their families, through a graded release system. Weekend leave, special leave and work release are all part of this system.

Temporary leave is a strength of the system, but it presents special problems in terms of risk-taking behaviour. Young people are released for weekends after eight weeks in the institution and then each four weeks after that time. This places these young people in an extremely high-risk situation because after enforced abstinence, they tend to have a 'binge' mentality. Binge drinking amongst underage drinkers is a well-documented phenomenon, and is often extended into drug taking and sexual behaviour by the young offenders. CSV has some supervision in place, but a balance must be established between this and allowing the young people enough freedom to maintain and, when necessary, rebuild their relationships with their families and the community. The chances of high-risk behaviour in areas such as needle sharing and unsafe sex are especially high during these periods.

CSV's education strategy takes this and other factors into account. Health education in the institutions has been plagued by problems which affect all aspects of institutional life. Many different players can have inputs into the health education of young people in institutions. Some of these include youth officers, education staff, nurses, doctors, chaplains and volunteer agencies. To provide a common approach is a difficult and at times, impossible task.

It is in the area of preventative education that CSV, through its HIV/AIDS policy and through its work in institutions on health and personal development, plays a role in the 'New Public Health' approach to dealing with issues such as HIV/AIDS. A key part of the policy for our juvenile institutions is in the client HIV/AIDS education and counselling area. CSV has an education and advocacy role for its clients and the policy reinforces this role and gives the institutions the mandate to operate in these two areas.

The New Public Health Approach - Advocacy and Education

The Ottawa Charter developed through the World Health Organization suggests new approaches to old problems. This is today referred to as the 'New Public Health'. It gives communities and people responsibility for health. This is a basic shift in focus on health thinking, so that health education becomes a 'bottom up' rather than a 'top down' approach. CSV has a responsibility to the community to be part of the process and it must become an advocate for its clients.

It must also help the young people in its care to develop their own advocacy skills, which they need both in the institution and even more so, on their release. CSV is not solely responsible for all the education of its clients, but is responsible for that which they receive in its institutions and in part, for what happens when they leave. CSV must advocate on its clients' behalf with other government departments, so that these services are available to them on their release. Education as a preventative measure is one of these services which must be available to all young people and in particular to the high risk groups into which many of our clients fall.

Youth Support Branch is at present fulfilling its advocacy role through the work it is doing with other departments such as Health Department Victoria (HDV) and the Ministry of Education (MOE).
With HDV, CSV is building community links so that young people leaving institutions, have real access to community health services. This is being augmented through joint HDV/CSV processes and in particular, the proposed formation of the Young Offenders Health Board. This Board is modelled on the Corrections Health Board which operates between HDV and the Office of Corrections and which has worked successfully to improve health services for adult prisoners. The Young Offenders Health Board has, as one of its proposed terms of reference, to develop systems for young offenders to link them to community-based health resources.

In the education sphere, CSV has worked with the MOE to give young offenders much more access to mainstream education, both during and after their stay in our institutions. This is a broad field and health education is one part of the overall picture.

The 'New Public Health' tells us that almost everything in our lives affects our health and there are direct links between things such as educational level, employment, housing and people's health status. CSV's advocacy role extends into all of these areas because the work it can do with and for young offenders to improve their overall situation, can have a direct effect on risk-taking behaviour. It is often not the health authorities who solve health problems. Action by the police and the justice system has reduced death rates on the roads and in developing countries, the provision of clean water does much more to reduce illness and infection than truckloads of penicillin.

As well as our advocacy role for young offenders, we have taken a role in preventative education. Education in its many forms is, of course, the basis of the world strategy against HIV/AIDS and correctional institutions are a part of this whole process. The institution cannot control the problem but as a subset of the broader community, it can have some effect in terms of preventative education.

Current Initiatives

Many people are now working together to try to provide a more common approach to health and all other issues in the institutions. I will outline some of the more promising co-ordinated responses which currently exist or will be implemented in the near future.

In 1989, Turana School, in consultation with its local School Support Centre, developed a comprehensive personal development program for its students. This program provides education for young offenders on a broad range of health issues including HIV/AIDS. The program is designed to be delivered to all young people going through Turana School. It also forms the basis of education around the Condom Issue Program, currently operating at Turana for trainees going on weekend leave.

The Health Access Program (HAP) has been a joint HDV/CSV initiative, which has run for the last three years. However, while it will not operate in its present form in the future, it is worth mentioning the excellent work which the HAP has done with both trainees and staff on health issues, as this work forms the basis of valuable, current and future programs.

The HAP has operated with five workers statewide in the youth health area with a particular focus on young offenders. One highly successful YTC program providing HIV/AIDS education for young offenders has been held at Langi Kal Kal with the new intake trainees each week. The Health Access worker has run a three hour session with the trainees on a broad range of health issues including HIV/AIDS, STDs and drug and alcohol use. An integral part of this process has been the adoption of a 'train the trainer' model where youth officers have sat in on each session with a view to eventually running these sessions themselves.

The Health Access team has also been working on a 'Release Kit' of information for trainees. Some health issues covered in the kits include community health links, a general health information and needle exchange program and condom distribution points. Although the HAP program is shortly to finish, this development will be picked up by Youth Support Branch. The kit will be part of an overall pre-release program for trainees.
Youth Support Branch is currently initiating a new approach to health education within the YTCs, based on the idea of having a small interdisciplinary team of people within the institution who have responsibility for health issues, promotion and education. The Institutional Health Team will use the skills of the existing staff in consultation with doctors, outside experts and professionals. The institutional nurses will be taking a greater health promotional role as part of these teams, as we see the nurses as a valuable resource which has been under-utilised in the past. The teams will also include two youth officers and a senior youth officer, who have received their basic health training course. The teacher in the institutional school who has health responsibility will be included and finally two trainees will be included in meetings and activities of the teams.

Members of these teams will be given all available health related training and in the HIV/AIDS area this will be provided through the CSV HIV/AIDS Unit. This training will be across the range of CSV HIV/AIDS policies and will again be based on the 'train the trainer' model so that the information will be passed onto other staff by the Health Team members.

Health Team members will deliver HIV/AIDS information sessions to trainees within a personal development program, based on the Turana model mentioned previously. Youth Support Branch places a high priority on the provision of information to both staff and trainees as there are many common myths to be explored and that is part of the overall strategy of education in all health areas in YTCs.

The staff training which is such a vital part of the process is aimed not only at the Health Team members. The HIV/AIDS Unit has implemented a thorough Infection Control Training Program. At this stage 85 per cent of first line supervisors in our institutions and all senior managers have been trained in infection control procedures. These supervisors are now training their staff and this process is being closely monitored by the HIV/AIDS Unit. The Unit is also working with TAFE to have HIV/AIDS training included in pre-service training for Youth Officers. CSV’s Staff Development Branch is including the training in all induction courses run internally. Finally, the Unit provides an in-house consulting service and training in response to case-specific queries.

The final educational approach I wish to mention, is a pilot project going at Winlaton at the moment. The project is a Peer Education Program being coordinated through Winlaton YTC, CSV’s HIV/AIDS Unit and Youth Support Branch. The success of peer education amongst homosexual males and prostitutes cannot be questioned and this educative approach is one which is already used for many purposes at Winlaton. The project will be seen as a pilot for other YTCs and it is particularly attractive as it reaches not only institutionalised young people, but also their community networks as well, when they are released.

Conclusion

I wish to draw some conclusions and make some observations about our approach. We are very much at the beginning of a continuum of education in not only the specific HIV/AIDS area, but right across the health spectrum. CSV’s response is part of a total ‘New Public Health’ response and must be seen as such. It is not the final solution, merely part of it.

We must ensure that the initiatives I have outlined become firmly entrenched in the institutional culture. They must become institutionalised. At the same time, we must be flexible. We must respond to the changes in thinking, knowledge and strategies which will, without doubt, occur in the HIV/AIDS area in the years to come.

Health and health education are the ‘flavour of the month’ at the moment, not only in institutions, but throughout the community. CSV has the responsibility along with other government departments to see that it remains on the agenda and that programs are resourced at a level which will allow this to happen. It is sometimes difficult to imagine that YTCs could be healthy places but they must be both healthy and health promoting. Youth
Support Branch and the institutions are at the moment developing institutional health plans which are aimed at making the institutional environment as healthy as it can be, given that in the end, it is a detention centre and that depression and stress are a part of a detainee's life. Issues such as nutrition, physical exercise, stress reduction, anger management, cleanliness and personal space all affect the general health of trainees. If we can work in these areas, then we can have an effect on young people's health and hopefully reduce their risk-taking behaviour. This, together with education, is our approach.

Let us conclude then by going back to my profile of an institutionalised young person. All of these issues - drug-taking, alcohol abuse, employment, accommodation, family life, community life and education - can be tackled in part by the institutional program. However, the whole community must play a role. Government Departments such as Health, Education, Police, the Department of Employment, Education and Training, Labour, Social Security and many others must all be active because the 'New Public Health', whether it be in HIV/AIDS education or anything else on the health agenda, is the whole community's responsibility.

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