

third edition

HIV/AIDS

SENTENCING KIT

3rd Edition

HALC

HIV/AIDS Legal Centre

New South Wales

CONTENTS

1. AIDS and HIV: General Facts

- 1.1 HIV
- 1.2 Transmission
- 1.3 Life Expectancy
- 1.4 The Progression from HIV to AIDS
- 1.5 Treatment Information
 - 1.5.1 Drug Regimes and Drug Resistance
 - 1.5.2 Side Effects of Treatments
 - 1.5.3 Alternative Treatments

2. Burden of Imprisonment for HIV Positive Prisoners

- 2.1 The Nature of HIV/AIDS
- 2.2 Effect of the Prison Environment on Immune Functioning
- 2.3 Issues of Confidentiality
- 2.4 Likelihood of Psychological Trauma
- 2.5 Problems of Access to Medical Care

3. Relevance of HIV Status to Sentencing: General Health Issues

- 3.1 HIV as a Mitigating Factor
 - 3.1.1 Relevance of Impairments in Health to Sentencing
 - Legislation: Commonwealth Offences
 - New South Wales Offences
 - Cases: Mitigating Factor – HIV
 - Other Factors – Seriousness of Crime
 - Where a Determinate Sentence is a Life Sentence
 - The Stage of HIV Infection: HIV v AIDS

4. Relevance of HIV to Sentencing where HIV Status is Relevant to the Crime

- 4.1 Personal use Cannabis Offences: HIV Status as Mitigating Factor for Therapeutic Drug Use
 - 4.1.1 Therapeutic Benefits of Cannabis
 - 4.1.2 Leniency from the Courts for Therapeutic use of Cannabis
- 4.2 HIV Status as an Aggravating Factor
 - 4.2.1 Being HIV Positive may Increase the Culpability of the Offence
 - 4.2.2 HIV Status Overestimated as Factor Increasing Culpability
 - 4.2.3. Victim's Fear of Transmission as a Factor Increasing the Length of the Sentence

5. Non-custodial Sentencing Alternatives

6. Evidence

- 6.1 Medical Evidence
 - 6.1.1 Don't be Vague
 - 6.1.2 Estimate Likelihood of Progression and Relevant Factors
 - 6.1.3 Put Facts in Perspective
 - 6.1.4 Describe Treatment
 - 6.1.5 Account for the Effects of Prison Life
- 6.2 Raising Fresh Evidence on Appeal Against Severity of Sentence
- 6.3 AIDS Council of New South Wales Evidence (draft letter)
- 6.4 Checklist of Evidence

ACKNOWLEDGEMENTS

HALC owes a debt of gratitude to the People Living with HIV/AIDS Legal Working Group, and to Douglas Barry in particular, for acting as a go between and negotiating with the Attorney General's Department. Douglas also provided a copy of his paper "Treatments and Positive Prisoners in New South Wales", which added significantly to this kit. Barrie Harrison -Treatments Officer at the AIDS Council of New South Wales - provided proof reading and valuable comments in relation to treatment information. Andrew Haesler of The Attorney General's Department provided further proof reading, and checked the legal content. The Attorney General's Department also provided assistance with the production of the document. Lorraine Clark at the Law Society organised all the ingredients necessary for a launch. We are indebted to His Honour Justice Kirby for once again championing the rights of people with HIV and agreeing to help us launch the kit. A thank you also goes to Jenny Wong for all her research, writing, and reviewing skills.

David Puls

Principal Solicitor

The first edition of this kit was written in 1992 by John Goodwin for the ACON Prisons Working Group. The second edition was written in 1995 by Amanda Hall, Geoffrey Bloom, and Alida Stanley. The third edition was written by David Puls and Jenny Wong.

If you have any comments or enquiries regarding this kit, feel free to contact the HIV/AIDS Legal Centre on 02 9206 2060.

This Sentencing Kit can be made available in alternative formats, for example: Braille, audio tape, large print or computer disk. Please contact the NSW Attorney General's Department for information regarding this matter on 02 9228 7281.

DISCLAIMER

Every effort has been made to ensure the accuracy of the information in this kit. HALC understands the information to be correct at the time of publishing. This kit is aimed at legal representatives. Any person using or consulting this kit who is not a legal practitioner is urged to seek further legal advice. All users of this kit should check for further updates in the law or other legal developments, and are urged to check current medical and treatment information from appropriate sources.

FOREWORD

This kit presents arguments why people with HIV/AIDS facing a custodial sentence should sometimes receive a reduced sentence or a non-custodial sentence. It is aimed at legal representatives of people living with HIV/AIDS.

Chapter 1 – gives basic information about the transmission of HIV, life expectancy, and the progression of HIV to AIDS.

Chapter 2 – details the ways in which imprisonment may be more burdensome for people with HIV/AIDS than people without (for example, for reasons such as the weakening of the immune system).

Chapter 3 – discusses the legislation and case law relevant to sentencing a prisoner with HIV in light of the burden of imprisonment placed on that prisoner due to health considerations.

Chapter 4 – discusses the relevance of HIV to sentencing where HIV is relevant to the crime, such as sentencing considerations where someone with HIV has been charged for using cannabis for medical purposes. In some crimes a person's HIV status may be an aggravating factor, such as where the victim of the crime has a real fear of infection.

Chapter 5 – discusses non-custodial sentencing for people with HIV/AIDS.

Chapter 6 – discusses the evidence that may need to be adduced when an HIV positive client is being sentenced, including a draft letter from the AIDS Council of New South Wales, and a checklist of evidence.

1: AIDS AND HIV - GENERAL FACTS

1.1 The Human Immunodeficiency Virus

AIDS or Acquired Immune Deficiency Syndrome is a disorder of the immune system. AIDS is caused by a retro-virus known as the Human Immunodeficiency Virus or HIV. Once HIV is present in a person's body, it invades certain cells in the body and takes over and reprograms some of the genetic functions on those cells. CD4 cells, also known as T-cells, are the main type of cell invaded by HIV. These cells are a critical part of the human immune system responsible for identifying any infective agent. Once an infective agent has been identified, CD4 cells then trigger other cells that make up the immune system to fight the infection. The virus attacks the CD4 cells from the time of infection, gradually overpowering them and so impairing the immune system. As a result, a person with HIV becomes susceptible to a wide range of infections, cancers, and other disorders, which in turn may lead to the person's death.

When a person is referred to as being HIV positive, it means that they have come into contact with the virus, and the immune system has produced anti-bodies to try and fight the virus. Accordingly, a person who has these anti-bodies is said to be HIV anti-body positive or, more simply, HIV positive.

A person may be infected with HIV but still have a well functioning immune system, and be otherwise healthy. There are two main tests that are used to measure the effect of HIV on a person. The "T-cell count" measures the damage to a person's immune system. It measures the number of CD4 cells in one millilitre of blood. It was once the only test available and was used to indirectly measure the level of viral activity by measuring the rate of change of CD4 cells over time. It is also a measure of how well a person is doing on treatments. A T-cell count of more than 500 indicates little or no damage to the immune system from HIV. A T-cell count of between 200–500 shows some or moderate damage. Finally, a T-cell count of less than 200 indicates significant or severe damage to the immune system from HIV, and also indicates that the person is liable to more serious life-threatening opportunistic infections.

The "viral load test" is a measure of viral activity. It measures the amount of virus present in the blood. This information can then be used to assess how actively the virus is replicating and how actively HIV is attacking the immune system. It measures the number of copies of HIV in one millilitre of blood. For a more accurate result the test should be repeated a couple of weeks after the initial test. A rough guide to viral load results is that a viral load of 50,000 copies or more shows that the virus is very active, and that damage to the immune system is likely to occur (the damage will occur as a result of the active virus). 10,000–50,000 viral copies shows that damage is still occurring, but at a less rapid rate. Less than 10,000 viral copies indicates slow damage to the immune system. Below 400–500 viral copies is termed "undetectable", which means that standard measures cannot detect the amount of activity accurately. A non-detectable viral load means that the virus may be still replicating, but at a very low rate.

With a healthy immune system a person does not have AIDS, but is still infected with HIV. A diagnosis of AIDS is made when a person becomes ill from one of a number of specified clinical conditions, which includes opportunistic infections, tumours, neurological disorders, or wasting.

1.2 The transmission of HIV

HIV can only be transmitted through exposure to blood or to some body fluids of a person who is infected with the virus. This can occur in three ways:

- (a) sexual contact;
- (b) contact with HIV infected blood; or
- (c) transmission from an infected mother to her unborn child before or during birth, or afterwards during breast feeding.

Some forms of sexual contact have been classified as “high risk” with regards to the potential for the transmission of HIV. These included unprotected anal and vaginal intercourse. Other forms of sexual contact, such as unprotected oral sex or protected anal intercourse, have a low level of risk.

HIV cannot be transmitted through other types of contact. Kissing, hugging, sneezing, coughing, breathing, touching or the sharing of eating utensils have not been shown to transmit HIV.

In order to be infected by contact with HIV infected blood, that blood must be able to enter the body. This usually occurs through exposure to an open wound or a needle stick injury. In the past, it also occurred as a result of using HIV infected blood for transfusions or the production of other blood products. This no longer occurs following the introduction of comprehensive screening of all donated blood.

Transmission of HIV between prisoners is not a relevant consideration in sentencing, and the practice of segregating HIV positive prisoners was stopped after the 1996 case of *X & Y v State of Western Australia* [1996] HREOC 32 (26 November 1996), in which it was found that the chance of infection was non-existent in relation to “work or recreation” opportunities, and the policy of segregation, “misconceived and unfair”.

1.3 The life expectancy of persons with HIV/AIDS

It is difficult to give meaningful statistics on the life expectancy of someone with HIV. Prior to 1995 the average period between infection and the development of an AIDS defining illness was approximately 10 years. Approximately 50% of people with an AIDS defining illness, diagnosed at that time, would die within 2 years.

Since late 1995, early 1996, there has been widespread introduction of new treatments for people living with HIV/AIDS. Combination therapy (which is explained in more detail below) has been successful in stopping or slowing disease progression in many people with HIV/AIDS. While combination therapy has improved the quality and expectancy of life for many people with HIV, a small but still significant number of people with HIV have experienced no or only a small benefit from combination therapy. People on combination therapy often have difficulty following the complex drug regimes or are unable to tolerate the often debilitating side effects. The success or otherwise of combination therapy is difficult to predict. This in turn makes it difficult to predict such matters as life expectancy, and medical evidence for the client may be of major importance in each case.

1.4 The progression from HIV to AIDS

Australia currently uses the system developed by the US Centre for Disease Control (CDC) to classify the categories of HIV infection. The categories are as follows:

Group 1 – (Seroconversion) Occurring up to three weeks after infection, 50–90% of people will experience an acute viral infection manifesting symptoms similar to glandular fever. Viral load is generally high in this stage.

Group 2 – (Asymptomatic stage) A prolonged period of “asymptomatic” infection in which HIV antibodies are present but clinical symptoms of the infection are absent.

Group 3 – (Symptomatic stage) Individuals will have persistently enlarged lymph nodes or other non specific symptoms, but no opportunistic infections warranting an AIDS diagnosis.

Group 4 – (AIDS) A number of clinical manifestations of the disease may be experienced, including constitutional, neurological and secondary infectious disease, secondary cancers, and other HIV related conditions.

HIV is an ongoing condition. It persistently attacks the immune system and has a gradual detrimental effect on it. Although the last stage of the disease is known as AIDS, a separation of AIDS from HIV is to incorrectly understand the disease. Since the development of the viral load test, it has now been shown that the virus is always active within the body of a person infected with HIV. Consequently effects of sentencing on the health of an HIV positive person will be important at all stages of HIV infection.

1.5 Treatment information

There are now numerous different anti-viral drugs that work at different stages of the life cycle of the virus in order to inhibit its reproduction. Taking several drugs (usually 3 or more) from different classes in combination is referred to as combination therapy. Combination therapy has resulted in the drastic slowing of viral reproduction in a large number of people with HIV. Once viral reproduction has been slowed or stopped, the immune system will stabilise and in some cases damage to the immune system will be reversed.

There are still many things not known about combination therapy, particularly the long term side effects of combination therapy.

There are a number of other factors that are important to note in terms of combination therapy that potentially impact on sentencing considerations.¹

1.5.1 Drug regimes and drug resistance

Drugs are taken in combinations of at least two, and usually three or four different drugs. This has the effect of lessening the likelihood of the virus developing a resistance to the drugs.

Compliance with drug regimes is of utmost importance. Compliance must be strict – drugs must be taken at the exact times they are prescribed to be. Even small variances outside of those times may lead to the virus developing drug resistance. Drug resistance occurs quickly. In turn, if drug resistance occurs it lessens the effectiveness of the treatment, and lessens the treatment options that may then be available to that person. The ability of a person to follow their drug regimes will obviously be of crucial importance in a prison environment where access to drugs at the appropriate times may not be possible.

Different drugs are required to be taken at different times and under different conditions. Drugs often need to be taken two or three times a day, and some drugs need to be taken with food, some without. In some cases it is better to have a particular type of food with particular drugs (eg: some drugs work better with fatty foods). Some drugs are required to be stored in the fridge. With still other drugs it is necessary to drink an extra 1.5 or 2 litres of water a day. This means that some HIV positive people will need to take drugs up to eight times a day, some with food, some without, drink extra water, and have access to a fridge.

Drug resistance occurs when the genetic code of HIV changes in response to the drug therapy. This allows HIV to multiply in the presence of that particular drug combination. Viral load increases. When drug resistance occurs it is usually necessary to change the combination of drugs. Obviously this can only be done a limited number of times due to the limited number of anti-viral drugs that are available. Alternative combinations may not be as optimal in terms of effectiveness, side effects, or ease of compliance. Drug resistance is much less likely to occur when a person complies with their drug regime. Drug regimes can be difficult for most people to fit in to their day in such a way as to ensure compliance. The ability for an HIV positive person in the prison system to comply with their drug regime is obviously a major consideration.

In addition not all combinations work the same for different people, and in some people combination therapy does not work at all. In order to effectively manage a person's treatment it is necessary for them to have access to regular ongoing assessment of their condition, with the opportunity to vary the drug regime accordingly.

¹Treatment information in this section and below was distilled from regular treatment information published by the AIDS Council of New South Wales, and the Australian Federation of AIDS Organisations. In particular see "Taking Care of Yourself" (AFAO/NAPWA 1999).

1.5.2 Side effects to treatments

Many of the drugs produce side effects in some people, including nausea, diarrhoea, headache, lethargy and insomnia. Often these side effects will be short term and disappear after weeks or months. In other cases, side effects may be ongoing or recur intermittently and in such cases can often be severe or debilitating. The possibility of side effects poses problems for prisoners with HIV.

First, prisoners with HIV will need easy and regular access to medical services – both doctors and drugs - in order to diagnose, monitor and treat the side effects of combination therapy.

Secondly, side effects can obviously be extremely stressful and more difficult to cope with in a prison environment, particularly side effects that may be noticeable to other prisoners. The effect of stress on the health of a prisoner with HIV is discussed in greater detail below, but obviously stress will have a negative impact on the immune system and health of the prisoner, which can in turn increase the side effects.

Thirdly, some side effects may identify a prisoner as being HIV positive. For example, a long-term effect of drug treatments can be lipodystrophy, or fat wasting, which may identify the prisoner as being HIV positive through their appearance.

Alternative therapies are often used to alleviate side effects. It is impossible to get alternative therapies in the prison system. Alternative treatments are discussed in the next paragraph.

1.5.3 Alternative therapies

There are numerous alternative therapies such as acupuncture, massage and yoga that can compliment the more traditional drug therapies,. They have an effect on general health and well-being, and can form an integral part of overall treatment for many HIV positive people, boosting their immune systems. They can also alleviate side effects of combination therapy. There is currently no scope for these types of treatments in custody despite their recognition by medical practitioners as complimentary treatment options. Additionally there are some HIV positive people who find drug side effects debilitating or who, for other reasons, do not want to be treated through conventional drug therapy. These prisoners are unable to make the choice to treat their HIV through the use of alternative therapies.

2: THE BURDEN OF IMPRISONMENT FOR HIV POSITIVE PRISONERS

2.1 The nature of HIV/AIDS

It is usually advantageous to familiarise the court with the medical information on HIV (see Chapter 1). The court should be made aware that it is damage to the immune system, leading to a high risk of contraction of opportunistic infections, which presents the gravest threat to the health of a person with HIV. The court should also be made aware of the difficulty of complying with complex drug regimes in the prison environment and the problem of drug side effects.

2.2 Effect of the prison environment on immune functioning

It is commonly recognised that stress can constitute a serious risk to healthy immune functioning, and can increase the likelihood of opportunistic disease. The effect of stress on the immune system is generally accepted, but should be confirmed by a medical practitioner. Stress, depression, anger and fatigue are inherent characteristics of prison life. HIV positive prisoners must not only deal with these, but also with circumstances involving HIV/AIDS related issues of confidentiality, stigma, discrimination, harassment and/or violence. These combined, added to the stress induced by isolation from support networks and partners, can produce a situation seriously damaging to an HIV positive prisoner.

Similarly, the inadequate diet common to prison life can prove equally damaging to immune functioning and may promote progression of HIV illness. In addition it is necessary for some HIV positive prisoners to have access to special dietary requirements in order to get the best effect from drugs they are taking, and consideration may also need to be made as to the availability of food at times outside the normal meal hours so that drugs can be taken on an empty or full stomach.

2.3 Issues of confidentiality in the prison environment

Since 23 December 1994, HIV testing in prisons has no longer been mandatory. Instead a Comprehensive Voluntary Testing Programme has been put into place. Prisoners are educated on the risks of transmission of sexually transmitted diseases, are offered the option to test voluntarily at any stage, and are encouraged to do so.

Where a prisoner does take an HIV test, there are strict rules on disclosure of results. Results may only be disclosed to specific officials at the top levels of the Department of Corrective Services, and in the institution where the prisoners are held (see Prisons Regulations 1989). Staff are told to obtain written consent from an inmate before disclosing to others.

Notwithstanding these guidelines, HALC's experience is that a prisoner's HIV status will in most cases become known to the rest of the prison population. This may occur where the prisoner self discloses to an inmate. However, even where a prisoner has not done so, the HIV specific services offered inevitably mark them out (unless they refuse those services). HIV positive prisoners are housed alone in cells unless they are willing to disclose their HIV status to their cellmate. Depending on their stage of illness progression, they may need frequent medical consultations. Combination therapy may be an intrusive and obvious part of the prisoner's routine. HIV positive prisoners get extra rations of milk and clothing. Assumptions are soon made, rumours circulated and the prisoner is soon identified as HIV positive.

The court should be made aware of the inevitability of identification as a person with HIV/AIDS in prison, especially for those prisoners serving lengthy sentences.

2.4 The likelihood of psychological trauma

Identification to others as a person with HIV exposes prisoners to psychological trauma through stress, stigma, harassment, discrimination and possible violence from other inmates, and perhaps even from staff. As indicated in paragraph 2.2, psychological stress can impair the body's immune system and can contribute to the quick progression of HIV disease.

It should be noted however that the level of tolerance of HIV/AIDS in prisoners has to some extent increased as a result of the Prison HIV Peer Education Programme and reports of violence against prisoners on the basis of HIV have been infrequent.

2.5 Problems of access to medical care

Medical care for prisoners is arranged through the Corrections Health Service.

The large majority of HIV positive prisoners at the moment are held in Sydney gaols, and can therefore easily access the HIV clinic at Long Bay Correctional Centre for monthly visits to the immunologist (which can be more regular if necessary). Normally prisoners who are at risk of falling ill (who are in category four) are held in Sydney gaols. In circumstances where prisoners are held outside the Sydney metropolitan region (perhaps by choice, e.g. for reasons of family) monthly travel to Sydney or Newcastle is arranged. HIV experienced doctors are scarce in the smaller regional centres, making medical monitoring difficult for prisoners in these areas.

A prisoner's access to treatments and to new drugs varies depending on where they are likely to be imprisoned. By virtue of clinical trial ethics, it is impossible for prisoners to participate in clinical trials of any new drugs. These trials have often been the only way anyone in Australia has had access to the most promising drugs. The delay between the start of clinical trials and approval of a drug has frequently been over two years. The range of treatments available in prison is much smaller. Prisoners rarely have enough money to buy treatments that are not available through the Pharmaceutical Benefit Scheme. They have no access to alternative medical treatments.

The special dietary needs of people with HIV are often not met in prison. Many HIV specialists recommend dietary supplements to alleviate symptoms such as wasting syndrome.

3: RELEVANCE OF HIV STATUS TO SENTENCING – GENERAL HEALTH ISSUES

3.1 HIV status as a mitigating factor

3.1.1 Relevance of impairments in health to sentencing

Legislation and case law recognise that impairments in a person's health may be relevant to a court considering sentencing options.

LEGISLATION

Commonwealth offences

In relation to sentencing for Commonwealth offences, section 16A(2) of the Crimes Act 1914 (Cth) provides:

"In addition to any other matters, the court must take into account such of the following matters as are relevant and known to the court: ...

(m) the physical or mental condition of the person" (s16A(2)).

In determining whether a sentence or non-custodial order is appropriate, the court "must have regard to the nature and severity of the conditions that may be imposed on, or may apply to, the offender, under that sentence or order" (s16A(3)).

New South Wales Offences

As of 3 April 2000 with the commencement of the Crimes Legislation (Amendment Sentencing) Act 1999, laws in relation to sentencing have been revised and consolidated. How sentences are administered by the Corrective Services Department, the Parole Board and the Serious Offenders Review Council was similarly revised by the Crimes (Administration of Sentences) Act 1999 which also commenced on April 3.

The Crimes (Sentencing Procedure) Act 1999 contains all relevant sentencing laws and sets out the various sentencing options; bonds, fines, community service, suspended sentences, home detention, periodic detention and full time detention. Provisions allow for sentencing reductions for guilty pleas (s22) and assistance to law enforcement authorities (s23), however no specific provision is made which allows a court to take into account a person's medical condition. Case law governs what matters are to be taken into account both in mitigation and aggravation of sentence. Much is left to the individual discretion of the Judge or magistrate. A number of important provisions are set out below.

A new innovation is the suspended sentence (s12). A court can now, where appropriate, impose a sentence involving detention but suspend it and place the offender on a bond. The maximum available sentence is two years and the period of the bond is limited by the length of the sentence. If the bond is breached at any time the offender must serve the full period of the detention ordered, however it can be served by full time or periodic detention, and the court must still consider whether and to what extent there should be a non-parole period (s99).

CRIMES (SENTENCING PROCEDURE) ACT 1999 (NSW)

5 Penalties of imprisonment

- (1) A court must not sentence an offender to imprisonment unless it is satisfied, having considered all possible alternatives, that no penalty other than imprisonment is appropriate.
- (2) A court that sentences an offender to imprisonment for 6 months or less must indicate to the offender, and make a record of, its reasons for doing so, including its reasons for deciding that no penalty other than imprisonment is appropriate.
- (3) Subsection (2) does not limit any other requirement that a court has, apart from that subsection, to record the reasons for its decisions.

6 Periodic detention

- (1) A court that has sentenced an offender to imprisonment for not more than 3 years may make a periodic detention order directing that the sentence be served by way of periodic detention.

7 Home detention

- (1) A court that has sentenced an offender to imprisonment for not more than 18 months may make a home detention order directing that the sentence be served by way of home detention.

12 Suspended sentences

- (1) A court that imposes a sentence of imprisonment on an offender (being a sentence for a term of not more than 2 years) may make an order:
 - (a) suspending execution of the sentence for such period (not exceeding the term of the sentence) as the court may specify in the order, and
 - (b) directing that the offender be released from custody on condition that the offender enters into a good behaviour bond for a term not exceeding the term of the sentence.
- (2) An order under this section may not be made in relation to a sentence of imprisonment if the offender is subject to some other sentence of imprisonment that is not the subject of such an order.
- (3) Subject to section 99 (1), Part 4 does not apply to a sentence of imprisonment the subject of an order under this section except to the extent to which it deals with setting the term of the sentence.

21 General power to reduce penalties

- (1) If by any provision of an Act an offender is made liable to imprisonment for life, a court may nevertheless impose a sentence of imprisonment for a specified term.
- (2) If by any provision of an Act or statutory rule an offender is made liable to imprisonment for a specified term, a court may nevertheless impose a sentence of imprisonment for a lesser term.

- (3) If by any provision of an Act or statutory rule an offender is made liable to a fine of a specified amount, a court may nevertheless impose a fine of a lesser amount.
- (4) The power conferred on a court by this section is not limited by any other provision of this Part.
- (5) This section does not limit any discretion that the court has, apart from this section, in relation to the imposition of penalties.

A sentence involving full time, home or periodic detention is normally split into a non-parole period, which is the time a prisoner must spend in detention, and a parole period which is the time a prisoner may spend in detention – but more usually on parole. Fixed term sentences can be imposed (s45). Normally the non parole period is $\frac{3}{4}$ of the total sentence unless a court is convinced that there are special circumstances warranting reduction of the non-parole period. As set out below, significant health factors such as HIV/AIDS can be a “special circumstance”:

44 Court to set term of sentence and non-parole period

- (2) The non-parole period must not be less than three-quarters of the term of the sentence, unless the court decides there are special circumstances for it being less, in which case the court must make a record of its reasons for that decision.

As set out below in the Crimes (Administration of Sentences) Act 1999, dependent on the circumstance, early parole can be granted on “compassionate grounds” or in “exceptional circumstances”:

CRIMES (ADMINISTRATION OF SENTENCES) ACT 1999 (NSW)

92 Commissioner may grant exemptions for health reasons or on compassionate grounds

- (1) For health reasons or on compassionate grounds, the Commissioner may order that one or more detention periods yet to be served by an offender be regarded as having been served if satisfied that the offender is unlikely to be able to serve them within a reasonable time.
- (2) In determining what is a reasonable time, the Commissioner must have regard to the number of detention periods yet to be served and the likely duration of the offender’s inability to serve them.

160 Parole orders in exceptional circumstances

- (1) The Parole Board may make an order directing the release of an offender on parole who (but for this section) is not otherwise eligible for release on parole if the offender is dying or if the Parole Board is satisfied that it is necessary to release the offender on parole because of exceptional extenuating circumstances.

CASE LAW

Mitigating factor – HIV

In some cases, the courts have reduced the length of an HIV positive person's sentence in recognition of the relatively greater toll of imprisonment on their health:

“Generally speaking ill health will be a factor tending to mitigate punishment only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health”

per King J in *R v Smith* (1987) 44 SASR 587; 27 A Crim R 315.

In *Smith's* case, the South Australian Court of Appeal was required to consider an appeal against the severity of a sentence imposed upon a man with HIV. The court reduced the non-parole period, retaining the head sentence on the basis that:

- (a) the subjection to any extended period of stress would cause the appellant's medical condition to deteriorate; and
- (b) the appellant had a good chance of rehabilitation.

The decision in *Smith* has been approved by the High Court in *Bailey v DPP* (1988) 78 ALR 116; (1988) 34 A Crim R 154. See also *Eliassen* (1991) 53 A Crim R 391; *McDonald* (1988) 38 A Crim R 470.

The NSW Court of Criminal Appeal has affirmed that AIDS is a “special circumstance”, and that the period in detention should be reduced to account for the harsher effects of imprisonment: *R v Dwyer* (unreported, NSW CCA, 23 February 1994).

Other factors – seriousness of crime

If the prisoner's offence and/or criminal record are very serious, they may be disentitled to the ill health reduction in sentence: *R v Jones* (unreported, NSW CCA, 15 December 1993).

The applicant in *Jones* had been convicted in the District Court on numerous counts of assault, aggravated sexual assault and assault with intent to have sexual intercourse. The offences were committed whilst the applicant was on parole. On appeal fresh evidence was tendered that the applicant was infected with HIV in custody prior to sentence. It was argued that the initial sentence imposed was in effect a life sentence, and that the applicant should be re-sentenced upon the basis that he had a life expectancy of 10 years.

Carruthers J (*Sheller JA* and *Sully J* concurring)

- (a) Distinguished this case from *Smith* because of the seriousness of *Jones's* offences and on the basis that the applicant had an “appalling” record and no prospects for rehabilitation.
- (b) Held that the Offenders Review Board could allow for decreases in *Jones's* health by directing his release on humanitarian grounds. His Honour referred with approval to the English case of *R v Starke* (1992) 13 Crim App R (S) CA 548, in which it was held that HIV is a matter for the executive to deal with, and not the courts.

Appeals to the NSW Criminal Court of Appeal and the High Court both failed.

In the more recent case of *R v Gezim Reci* [1998] SASC 6786 a convicted murderer failed in an appeal against his sentence of life imprisonment with non-parole period of 17 years. Medical information provided to the sentencing judge noted that the appellant had a life expectancy between four years and six months and eleven years. On appeal Millhouse J noted:

“I accept that because of his anxiety about his health the appellant may do it harder in gaol than a man who is not HIV positive. I accept, too, that it is likely the appellant will be dead within the next 17 years. It is a tragic situation. Yet being HIV positive does not give a man (or a woman) a licence to commit crime, in the expectation that an otherwise appropriate penalty will be greatly reduced because of his or her condition.”

With reference to reducing the non-parole period:

“Bearing in mind the gravity of the crime and the requirement ‘to satisfy the punitive and deterrent and preventative purposes of punishment’ a non parole period of four years or less would be so derisory as to put such a short period completely out of mind. The appellant, despite his HIV status, must suffer a penalty to fit his crime.”

Where a determinate sentence is a life sentence

It has been argued that a prisoner’s determinate sentence should always be set at less than their life expectancy; otherwise a determinate sentence becomes a life sentence.

This argument did not succeed in *R v Gezim Reci* [1998] SASC 6786 (21 August 1998) (referred to above) or *R v Barry* (unreported, Qld CCA, 19 September 1990; noted in (1991) 2 (49) *Aboriginal Law Bulletin* 20). In *R v Varner* (unreported, NSW CCA, 24 March 1992) McInerney J rejected this argument. Gleeson CJ did not consider it.

The stage of HIV infection: HIV versus AIDS

A further relevant issue for sentencing courts is the stage that the person’s HIV infection has reached. The old approach, as used in *R v Donald* (unreported, SA CCA, 17 July 1989), was that an asymptomatic HIV condition would not be sufficient to deem the sentence burdensome, and that it would only be found so if an AIDS defining illness had developed. However since *Donald*, the NSW Court of Criminal Appeal has reviewed the relationship between HIV infection and AIDS. In *R v Dollwett* (unreported, NSW CCA, 6 July 1993), the Court stated that the hardship imposed on a person with HIV by imprisonment should not be ignored simply because the prisoner has yet to develop an AIDS-defining illness. This approach is further supported by current medical arguments that the disease be seen as a continuum of HIV infection rather than focusing on AIDS as the final stage.

4: RELEVANCE OF HIV TO SENTENCING WHERE HIV STATUS IS RELEVANT TO THE CRIME

4.1 Personal use cannabis offences: HIV status as a mitigating factor for therapeutic drug use

Some people living with HIV/AIDS use cannabis for medicinal purposes. The illegality of this act in NSW results in some of them being charged with offences of cultivation and possession: Drugs Misuse and Trafficking Act 1985 (NSW) ss10, 11 and self administration: s12. However there have been recent moves to have cannabis recognised as a legal herbal medicine for people suffering cancer and HIV/AIDS.² The NSW Premier, Mr. Bob Carr, has mooted changes to drug laws by establishing an “Expert Working Group”, a working party to examine the possibility of legalising cannabis as a prescribed medicine for pain relief. The working party consists of representatives from the AMA, ACON, the National Drug and Alcohol Research Centre and NSW Health.³ The group is due to report its findings to the Premier’s “Expert Advisory Committee on Drugs” in June 2000.

While the current drug laws do not take into account people using cannabis for medicinal purposes the NSW Attorney-General, Mr. Jeff Shaw, has noted in response to calls for legalisation – “If there is a bona fide medical case for the use of any drugs for the use of palliative care or the like then I personally think it ought to be seriously considered.”⁴

4.1.1 Therapeutic benefits of cannabis

Medical research increasingly supports the therapeutic use of cannabis (marijuana) or its synthetic form, Dronabinol (commercial name Marinol).⁵ In Australia, a major study has been conducted on the drug by researchers at the Royal Children’s Hospital Melbourne.⁶ The study found that THC (the active compound in cannabis) was an effective means for treating nausea in patients receiving cancer chemotherapy. Since then American studies, using the synthetic Dronabinol, have confirmed the drug’s use in relieving common side effects of HIV disease, namely nausea, vomiting and weight loss.⁷

Dronabinol is now available to some people with HIV in NSW through a special access scheme. While the clinical benefits of THC have been accepted, Marinol remains a drug that is expensive and difficult to obtain. Becoming an approved recipient is a complex process. There are delays of more than one month from the date of ordering and treatment costs patients \$200.00 per month. Orders are made per patient through hospital pharmacies.

Timothy Moore, Convenor of the Australian Committee for the Medical Use of Cannabis has responded cautiously to the regulated availability of Dronabinol and noted that only a small percentage of people with HIV are using the drug. Anecdotal evidence suggests that marijuana is more popular in reducing nausea in people with HIV. Mr. Moore believes legal access to marijuana would be preferable for people with HIV.

² Whelan J “Lawyers, Doctors back Cannabis”, SMH, 01.10.99, p.4.

³ Dent J “Cannabis Accepted as Pain Reliever”, SMH, 05.01.00, p.3.

⁴ Whelan J “Lawyers, Doctors back Cannabis”, SMH, 01.10.99, p.4.

⁵ Some of this research is summarised, along with personal accounts of the therapeutic effects of cannabis, in Grinspoon L Cannabis as Medicine, 1994, pp85-92.

⁶ Caswell “Marijuana as Medicine”, Medical Journal of Australia Vol. 156, April 6 1992 at 497.

⁷ Plasse et al. (1991) “Recent Clinical Experience With Dronabinol”, Pharmacology Biochemistry and Behaviour, Vol. 40 at 695-700. A recent authoritative report from America Marijuana and Medicine - Assessing the Science Base can be found online: **ERROR! Bookmark not defined.**

4.1.2 Leniency from the courts for therapeutic use of cannabis

In the past few years there has been some success in persuading Australian courts to take account of the fact that offenders with HIV often use cannabis for therapeutic rather than strictly recreational purposes.

In *The Appeal of Terrence Lee Falconer* (unreported, Lismore District Court 22 March 1991) the appellant had been convicted by a magistrate of charges of cultivating six cannabis plants and being in possession of less than one gram of cannabis. Fines totaling \$500.00 were imposed by the magistrate.

On appeal before a District Court Judge, the appellant's doctor gave evidence that the appellant was category 4 HIV (ie. AIDS) and that because of that condition he needed to take numerous highly toxic drugs with serious side effects. The doctor referred to studies published in the USA regarding the benefits of marijuana use in the treatment of the side effects of both HIV infection and cancer. The doctor formed the view that the appellant's use of the drug was personal rather than commercial.

The judge noted that there seems to be a practice in the United States of making marijuana available to people with AIDS to ease pain and reduce effects of the disease.⁸ The judge sympathised with the appellant's view that it is anomalous that morphine and pethidine could be lawfully prescribed yet cannabis use is unlawful.

In upholding the appeal, the Court had regard to the appellant's prior good character as well as the health factor. Although finding the offences proved, the Court quashed the magistrate's order of conviction and fine. See also *R v McCulloch*.⁹

More recently an appeal to Lismore District Court in May 1999 saw a 40 year old woman's conviction and fine of \$1000.00 set aside. The appellant was convicted for cultivation and possession of seven marijuana plants. An appeal was lodged on medical grounds as the woman suffered lymphatic cancer and used cannabis to cope with symptoms related to the disease such as nausea and bone pain. In Alice Springs a Magistrate sentenced a man to 28 days home detention and random drug testing for possession and cultivation of cannabis for medicinal purposes and in February 1999 the Supreme Court of Queensland recognised cannabis as a pain reliever in a case where a man had grown 150 marijuana plants for his own use to relieve back pain.¹⁰

As this kit goes to print the police in New South Wales are trialing a cannabis cautioning scheme. The scheme applies to adults apprehended by police in possession of half of the statutory small quantity of cannabis leaf. Currently that converts to 15g. The scheme allows police to caution an offender by providing the offender with a caution notice that includes information regarding the health and legal consequences of cannabis use. The trial will run for 12 months.

⁸ As reported in "Doctors at odds with DEA over usefulness of marijuana", *Bay Area Reporter* 2 May 1991; "US letting AIDS patients use marijuana to ease pain", *New York Times* 23 November 1990.

⁹ "Drug was for AIDS victim", *The West Australian*, 15 September 1992.

¹⁰ Dent J "cannabis Accepted as Pain Reliever", *SMH*, 05.01.00, p.3.

4.2 HIV status as an aggravating factor

Where there is a possibility of HIV transmission in the criminal act, an offender's actual (or even assumed) HIV status may increase the culpability of the act. Examples of these crimes are assault, prostitution offences and sex with minors.

4.2.1 Being HIV positive may increase the culpability of the offence

In *R v Wright* (unreported, Tas SC, 27 Sept. 1990) the offender was charged with 163 counts including homosexual indecency and sexual assault. The accused was aware that he was HIV positive at the time of committing the offences. In sentencing, Cox J took into consideration the victims. Cox J weighed this against the burden of imprisonment on a person with HIV but decided that it would be inappropriate to reduce the sentence on account of the possibility of a deterioration in the accused's health.

In *R v Barry* (unreported Qld CCA; noted in (1991) 2 (49) *Aboriginal Law Bulletin* 20), the accused committed an assault on a police officer which involved exposing him to faeces. The accused was aware that he was HIV positive. It was unclear whether or not the accused had intended to infect the police officer. When interviewed, he stated that he was not aware that HIV transmission could occur through exposure to the faeces of an infected person. However when asked "By throwing shit at me, did you want me to catch HIV?" the accused replied "Yes". The initial sentence given was for a total of three years. Despite producing evidence that Barry's life expectancy did not exceed two years, the Queensland Court of Criminal Appeal refused leave to appeal against the severity of the sentence. McPherson J regarded Barry's recklessness as to the risk of infecting the officer as sufficiently serious to justify the sentence imposed.

4.2.2 HIV status overestimated as factor increasing culpability

Where it appears that a court may find an act to be more culpable due to the convicted person being HIV positive, the court should be informed of the actual risk of transmission of HIV in the particular circumstances. It is common for courts to overestimate the risk. In a recent Victorian case, expert evidence of the very low risk of transmission of HIV from particular sexual acts was accepted, resulting in charges of endangering another's life being dismissed.

In *R v B* (unreported, Teague J, Vic Sup Ct, 3 July 1995), B was a prisoner held in a police cell where he had unprotected oral and anal sex with another prisoner. B allegedly told the other prisoner that he had tested negative for HIV. In fact, B knew that he was HIV positive. He was charged with engaging in conduct which places another person in danger of death and in danger of serious injury. The other prisoner subsequently tested HIV negative. On a submission by the defence, evidence was given by a doctor specialising in HIV that there is only a one in 200 chance of HIV transmission in a single act of heterosexual or homosexual intercourse, the court dismissed the charges on the grounds, given that the legislation required that there be an "appreciable danger of death or injury" there was no case to answer.

More recently in *R v Matthews* [1998] SASC 6555 (19 February 1998) a case involving indecent assault, the South Australian Supreme Court of Criminal Appeal held that the Trial Judge erred in stating that the victim had been exposed to the risk of HIV infection. The Appellant had pulled down the victim's trousers and jocks and placed a condom on his penis and masturbated him and had then forced the victim to do the same to him. As noted by Williams J:

"The sentencing judge considered that the victim had been put at risk of contracting the sexually communicable disease from which the appellant suffers. This was apparently a reference to the fact that the appellant is HIV positive. In fact, as the Director of Public Prosecutions concedes, there is no evidence that the victim was placed at risk by the appellant's actions in this behalf."

The Appellant's sentence was reduced from three years six months with a non-parole period of eighteen months to twenty months and a non-parole period of nine months.

4.2.3 Victim's fear of transmission as a factor increasing the length of the sentence

A further dimension has been introduced in cases where the victim of an assault fears transmission of HIV, regardless of whether the offender does in fact carry HIV or not. English courts have recently recognised that with the increasing community awareness of the risks of HIV transmission, the victim's fears can be an aggravating factor in sentencing.

R v Malcolm [1988] Crim LR 189 involved a rape charge to which the accused had pleaded guilty. In sentencing, the judge considered the growing community awareness of the risks to rape victims of HIV infection and accordingly gave very little credit for the guilty plea. He failed to consider the reasonableness of the victim's fear and whether there was any physical evidence that she had contracted HIV. On appeal the Court of Appeal found that the weight of evidence against the appellant justified the absence of the usual discounting for a guilty plea. The issue of increasing the sentence on the basis of the victim's fear of AIDS will probably require further consideration by the courts in the future.

5: NON-CUSTODIAL SENTENCING ALTERNATIVES

Presenting arguments about the relatively harsher effect of imprisonment on a person with HIV need not necessarily lead to a plea of a reduced custodial sentence. For lesser crimes, it may also ground an argument for a suspended, deferred or non-custodial sentence.

Convincing the court that a scheme of rehabilitation, combining medical and social support, exists outside of prison may prove crucial to a decision to order a non-custodial sentence.

Drug and alcohol agencies, specialist AIDS agencies and other bodies may be able to provide the court with information on programs which both address behavioral concerns (eg drug use) and health requirements. A management plan to which a person may be bonded, which addresses the person's HIV related physical and psychological needs, as well as addressing individual problems such as drug dependency, homelessness, illiteracy etc may convince the court that a prison sentence can be avoided.

The presentation of evidence by HIV support workers (counsellors, social workers etc) from bodies such as the AIDS Council of NSW (ACON), the NSW Users and AIDS Association (NUAA) or the Sex Workers Outreach Project (SWOP) as to available programs would be an important consideration.

6: EVIDENCE

6.1 Medical evidence

What medical information is relevant and necessary for sentencing decisions?

(You may find a medical specialist to give evidence by contacting the medical practitioners HIV specialist body, the Australasian Society for HIV Medicine).

A case in the United States dated 19 December 1995 has demonstrated the need to ensure that sentencing courts have adequate and comprehensible information on which to base sentences for offenders with HIV. In a majority decision, a federal appeals court in *US v Johnson* (Eighth Circuit Court of Appeals, noted in (1995) 10(19) AIDS Policy & Law 1) the court dismissed an appeal from a man who had pleaded guilty to selling methamphetamine, who had AIDS related complex and, on his physician's report, had only four years to live. He was sentenced to eight years gaol. The sentencing judge refused to reduce a sentence already reduced for co-operation with the authorities, saying that the medical evidence presented failed to support Johnson's claim that he had an "extraordinary physical impairment", which is the relevant criterion in US Federal sentencing guidelines.

In his dissenting judgment, Justice Wilson criticised the affidavits supplied by an AIDS service organisation and a physician as being too vague to assist the court. His comments form the basis of a "how to" for defence lawyers assembling medical evidence relevant to reducing the length of a sentence.¹¹

A summary is set out below:

¹¹ Summarised from an article by D Buchanan, "Sentencing People with HIV" 6(4) HIV/AIDS Legal Link 16 (Dec 1995).

6.1.1 Don't be vague

A local AIDS service wrote on Johnson's behalf, saying the onset of AIDS depends on "his nutrition, his exposure to infection, amount of sleep and amount of stress". Wilson J stated that the letter did not explain how those variables pertained to Johnson's case.

6.1.2 Estimate likelihood of progression and relevant factors

Johnson's doctor's report relied on dated information on his patient and appears, therefore, to have been less persuasive. In deciding the length of the sentence, the court needs to understand not only the current state of health of the prisoner, but also rate and nature of likely disease progression, including their life expectancy. That means, do not give dated reports about the accused's current state of health, and do get a prognosis on the future state of health of the accused speculating on the effects of imprisonment.

6.1.3 Put facts in perspective

Johnson's physician wrote an affidavit of only a few sentences and provided little explanation that could have helped the court. For example, the doctor cited Johnson's T-cell count without explaining what a T-cell count was and how it relates to the progression of HIV illness. (See *R v Dollwett NSW CCA, 1993 4(4) HIV/AIDS Legal Link 22-23* for an Australian case on the significance of T-cell counts.)

6.1.4 Describe treatment

A judge needs to know about the kinds of treatment the defendant currently requires. Johnson was not taking the antiviral drug AZT or other strong medications. He testified that he wanted to stay away from AZT as long as possible, to get maximum treatment benefit when he needed it the most. Johnson's point was lost on the sentencing court. The court apparently reasoned that because Johnson was not taking medicine, he must not be very ill. Also possibly relevant is the fact that prisoners cannot participate in clinical trials of new drugs – often the only way to get the currently most effective treatment.

6.1.5 Account for the effects of prison life

The prison environment can be harsher for inmates with HIV compared to those with other terminal illnesses, such as cancer. "In some prisons" Wilson J stated "inmates do not receive adequate dietary care, counseling and other medical treatment; one researcher on this question estimated that deterioration of HIV-positive people in prison may be twice as rapid as for people outside prison".

6.2 Raising fresh evidence on appeal against severity of sentence

It is acceptable to raise as fresh evidence on appeal a defendant's HIV condition which was unknown to the sentencing court, as long as the defendant was infected at the time of sentencing: McDonald *supra*; Eliassen *supra*; Cooper (unreported, NSW CCA, 9 November 1990).

But see Jones *supra* for a finding that the sentence will not be reviewed if a prisoner's HIV status is discovered while they are in custody. Rather, any review falls to the Offenders Review Board.

6.3 AIDS Council of New South Wales (evidence draft letter)

Set out below is a draft letter from the AIDS Council of New South Wales that may be used as a starting point when considering the evidence that ACON may be able to give in relation to sentencing.

TO WHOM IT MAY CONCERN,

I have been requested to express an opinion to the sentencing court on the effect of imprisonment on the health of a person who has HIV/AIDS.

ACON has had unique experience in dealing with the special problems faced by prisoners with HIV or AIDS in NSW prisons. This experience has been gained through direct contact between ACON's Legal and HIV support client services and gaol inmates. ACON services have had access to inmates since 1990, albeit intermittently.

HIV is the virus which causes AIDS. AIDS is a disease of the immune system. AIDS is the most advanced stage of HIV infection, being the most serious of the four recognised stages of HIV related disease.

Death from AIDS generally occurs as a result of the body's inability to fight infections because of damaged immunity. People with HIV become susceptible to "opportunistic" infections, such as pneumonia and cancers, which are often fatal.

There are well recognised health care needs for people with HIV/AIDS. I offer the following comments in relation to the current availability of services in NSW gaols to meet these needs.

1. Regular and timely access to an HIV experienced general practitioner

People with HIV can suffer a variety of health problems associated with their condition. These include minor problems such as skin, gastrointestinal and gum disease and potential major problems such as early signs of major opportunistic illnesses (cancers and pneumonia) associated with AIDS. In order for treatment to be most effective it is imperative that diagnosis occurs at the earliest opportunity. Although there is no cure for AIDS, there are an increasing number of drugs and therapies which, under appropriate supervision, are known to delay the onset of illness. These include the use of what is known as "combination therapy". Combination therapy is treatment of HIV through the use of different drug combinations. The taking of the different drugs in combinations is a person's drug regime. It is essential that people with HIV/AIDS are able to regularly monitor their health. This generally requires monthly check ups with an HIV experienced practitioner.

It is the experience of ACON services that prisoners generally have difficulty in accessing HIV experienced doctors on a regular basis. Only in the case of prisoners hospitalised within prisons within the Sydney metropolitan area is regular access to an HIV experienced practitioner guaranteed. Unfortunately, it is often only after considerable damage has already occurred to the prisoner's health resulting in hospitalisation that appropriate diagnosis and treatment occurs.

2. Access to drugs and ability to comply with drug regimes

Combination therapy has been successful in reducing death rates and lessening the impact of HIV on infected people. Combination therapy is not successful for everyone. In each case a person needs to have access to medical practitioner for regular monitoring, so that dosages can be adjusted and side-effects monitored. Different combinations may have to be tried.

Medical research shows that it is extremely important for a person using combination therapy to be able to stick to their drug regime. This can mean having to take numerous drugs (up to 30 pills a day or more), which may need to be taken at different times and under different conditions, such as some before and some after eating, some with different types of food, some requiring extra water. When drug regimes are not complied with, drug resistance develops. Drug resistance occurs where the virus becomes resistant to the drugs being used. This can occur very quickly. This in turn lessens the effectiveness of treatment, and often the types of drugs that can be used in treatment. It is very important, therefore, that a person has the ability to follow their regime exactly, taking their drugs at the precise time required, and under the correct conditions.

It is ACON's experience that it can be difficult to follow drug regimes in the prison system. It is obviously difficult within a prison system to allow for any flexibility to a daily routine that may be necessary in order for drugs to be taken correctly. It is also ACON's experience that prisoners do not have access to their own drugs, but must rely on drugs being dispensed to them.

3. Speedy access to HIV specialists when necessary

HIV related illnesses often require urgent specialist medical care. Failure to be placed under specialist care at the earliest manifestation of an HIV related condition can promote progression to terminal illness. Current drug treatment options require specialist monitoring of side effects and assessment of optimal dosage levels.

Again, the experience of ACON is that only in the case of prisoners hospitalised within prisons within the Sydney metropolitan area can HIV specialists be readily accessed.

4. Access to new drugs and treatments

Many drugs which have been demonstrated to improve both quality of life and life expectancy in overseas studies are only available to NSW residents through participation in drug trials or through personal importation from overseas sources. Whilst an increasing number of Australians with HIV are enjoying the benefits of access to these drugs and therapies, it is impossible for prisoners to access them.

Prisoners cannot participate in clinical trial programs for new drugs. These trials are usually the only way to access new drugs. Importation of drugs from overseas requires financial and organisational resources beyond the reach of virtually all NSW prisoners.

5. Diet

A carefully managed and specially balanced diet is important to maintaining the health of people with HIV.

Dietary supplements, such as increased vitamin intake and protein enriched foods, are recommended by HIV specialists to alleviate many symptoms associated with HIV, such as wasting syndrome.

Consistent problems have been experienced by many prisoners with HIV in obtaining adequate dietary requirements. Special diets have to be justified regularly by the prisoner's physician, a requirement which presents a significant barrier when the prisoner's contact with HIV experienced physicians is frequently limited.

6. Avoiding Stress

Stress avoidance is recommended because it is known that psychological stress may impair the body's immune system and can contribute to quick progression of HIV illness. The psychosocial factors of depression, anger and fatigue often experienced in prison life have been demonstrated in US studies to have a link to AIDS illnesses.

The current well publicised problem of overcrowding in NSW prisons creates considerable stress.

Additionally, it is ACON'S experience that prisoners' HIV status is impossible to keep confidential within prisons. In some cases a prisoner will be able to be identified as being HIV positive because of side effects from treatment, such as lypodystrophy – a redistribution of fat in the body that can be a side effect of long term medication. Identification as a person with HIV commonly leads to harassment from other prisoners and in some cases prison personnel.

ACON is aware of many cases of discrimination in conditions of confinement, which have occurred through breach of confidentiality in gaol. It is often the case that prisoners who have HIV are segregated from other prisoners. This is not done compulsorily, however prisoners in some cases seek segregation for reasons of protection. It has been the experience of NSW prisoners in the past that the protection which segregation offers carries with it denial of access to improvements in security classification.

Experience of discrimination and harassment in the general prison population, and the pressures inherent in segregated accommodation, means that prison life for people with HIV is particularly stressful.

It can be concluded from the foregoing observations that imprisonment confronts a person with HIV with a number of serious threats to continued health, which are unlikely to exist for people who are not HIV positive. It is the opinion of ACON staff whose work has involved direct contact with prisoners that imprisonment is an especially harsh experience for people with HIV.

I strongly urge you to consider the inevitable detriment which imprisonment will occasion to the prisoner's health as a factor in mitigation of punishment.

ACON is aware of several drug rehabilitation services which cater for people with HIV and which have links with specialist AIDS support agencies. ACON is in a position to liaise with rehabilitation services and the Office of Community Corrections to provide an appropriate management plan addressing individual needs. When rehabilitation is linked to AIDS care and support services, an opportunity is given to the offender to make a positive contribution to society despite the burden of a terminal medical prognosis.

I recommend to you the potential benefit to the individual and society of a non-custodial sentencing option.

Yours faithfully,

*Robert Griew
Chief executive Officer
AIDS Council of NSW*

6.4 Checklist of evidence

The following is a suggested check-list of evidentiary matters that may be considered when a client is being sentenced. The list is not meant to be exhaustive.

Medical Information of a general nature:

- What medical information of a general nature will need to be provided to the court?
- Will the medical information best be provided by a medical practitioner, or should the information be provided by an AIDS service provider?
- It is suggested that matters such as general information on HIV/AIDS, T-Cell counts, viral loads and current treatments all be considered.

Medical Information specific to your client:

- Your client's viral load.
- T-cell count.
- Current treatment regime.
- Any side effects your client is experiencing?
- Any specific requirements of the current treatment regime (eg: extra protein)?
- Is the current treatment regime working, or is your client currently trying to find the best combination for their case?
- Does your client rely on any alternative therapies to control their HIV or any treatment side effects?
- What is your client's prognosis?
- What will be the effect on prognosis if the client cannot follow their treatment regime or alternative treatments?
- What is the likely effect of stress on the client's condition?

Prison Life matters:

- What is the best place to get information regarding the possible life in prison of your client? – AIDS Council of New South Wales? Corrective Services?
- Is the draft letter from the AIDS Council of New South Wales included in this kit sufficient?
- Is the AIDS Council able to comment on any of the medical evidence.

Types of Crime considerations:

- Is medical evidence required regarding the medicinal effects of cannabis?
- Is medical evidence required regarding the dosage of cannabis?
- What is the client's evidence regarding the amount of cannabis use?
- Evidence from trial may be available to answer some of these questions.
- If a victim's impact statement is alleging a fear of infection, is it relevant to bring evidence about the actual likelihood of infection?

