A Pragmatic Approach to the Delivery of HIV Related Services to Prisoners

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One of the most interesting issues for those involved in prison health care has been the constant and sometimes deafening demand that, in regard to HIV/AIDS, prisoners are a priority group and should receive special attention and increased services. Needles, condoms, methadone, bleach, testing, education, counselling and conferences are all frequently suggested. This causes wry smiles amongst those who provide the normal range of health services within prisons and face a constant battle to supply basic medical, psychiatric and substance abuse services. We are, for once, inundated by interested parties seeking to provide support, grants, study and comment on our services. Why is this so, when usually opinions are that less rather than more be done for prisoners' health?

The answer seems to be the importance placed on the interface between prisoners and the rest of the community. The health sector and the general public have been lead to believe that prisons are incubators for HIV and will progressively infect the rest of the community. This is not necessarily an irrational belief, although such concern has not been realised as yet in Victoria. Since 1985 only forty-nine known HIV positive prisoners have been admitted into Victoria's prisons, and none has developed AIDS whilst in prison.

HIV policies in prison are not primarily based on concern for individual health, but rather out of fear of contamination of the general public. This point needs to be made because it provides essential background information for understanding some of the health policies suggested for the prevention of HIV infection in prisons. Such an approach is not necessarily a good basis for rational and humane decision making. Fear and stereotyping have been vigorously and successfully opposed by gay groups in the context of HIV policies for the general public.

Compulsory testing, segregation, breaches of confidentiality, and exclusion from particular workplaces have all been rejected as appropriate HIV policies for the general public. Such suggestions are now getting a full re-run in the prison community. To repeat, fear and stereotyping are not a good basis for rational decision making.

I want now to focus on the relationship between corrections and health organisations. It is usually an exercise whereby health services are provided by one group via the medium of another group to the patients. Despite elaborate theories of the competing goals and values of the different organisations - health and corrections - my experience is that the main obstacle to the provision of health services in prisons is the fundamental organisational difficulties that are encountered in prisons.
Prisons as organisations are quite good at providing the few basic and essential services by which they are most readily assessed. These are custody, shelter, food and basic medical services. Other areas that are less fundamental to the organisation's own existence are often frustrated by the exigencies of prison life. Programs for education, employment, pre-release planning, welfare, and psychiatric/psychological and substance abuse services are usually more difficult to organise and more prone to frustration and disintegration. These services demand flexibility of the organisation and a commitment to an individualised and caring model, both of which are luxuries within the prison system.

Prison administration is characterised by:
- inflexible work routines;
- difficulties in communication due to physical isolation of staff and shift work;
- high turnover of both staff and prisoners;
- lack of job definition beyond the provision of the basic services;
- little investment in ongoing training;
- low status and low morale; and
- poor industrial relations but strong industrial organisation.

It is these basic problems that make service provision difficult more often than any conflict of goals or obsession with security. When plans are frustrated in prison I usually counsel a belief in mistakes rather than conspiracies.

If this point is accepted it unfortunately makes one more pessimistic about achieving proper prevention and education strategies than if the problem were one of competing goals or values. This point must be emphasised to those who are unfamiliar with prison administration, so that they are made aware of the real difficulties associated with some of the suggested policies for HIV prevention in prisons.

With the community demanding policies based on fear rather than care and faced with an organisation which struggles to provide anything beyond basic custody and care, what can be done, and what has been done?

Health provision in corrections usually is done utilising one of two models. In the first the corrections department employs its own medical personnel. In the second, the health department or perhaps a large public hospital provides health services to the prison. There are difficulties associated with both models.

Victoria, after a number of years of dissatisfaction about the provision of health services to prisoners took the rather unusual step of forming a Corrections Health Board. This Board provides a method for achieving agreement on policy between the two departments - corrections and health. It was established in 1986 and provides a forum for senior executives from health and corrections not only to discuss issues but also to decide upon policy which will be binding on both departments. Its success relies on the involvement of managers who are sufficiently senior that they can make decisions, not simply recommendations back to their own department.

The Corrections Health Board was established primarily to address the perceived neglect and fragmentation of health services and policies in prison. However, soon after its establishment, HIV issues became one of the very dominant and persistent matters on its agenda.

An interdepartmental approach has given Victoria a good balance between the sometimes conflicting interests in HIV policy in prisons. It provides a forum for full and frank discussion of such issues as confidentiality, testing and segregation. This often means finding a compromise position, but compromise is the art of politics, and AIDS in prisons is
undeniably political. For instance, there has been a constant demand from some areas for needle exchange programs in prisons. Needle exchange programs are to be greatly commended in the community. They are an effective and courageous development for the community, but an unrealistic proposal for prisons. Prison staff cannot be expected either morally or on grounds of safety to accept such a development. It would be anomalous to devote extensive resources to preventing drug trafficking in the prison on the one hand and, on the other, to start distributing needles. Prison staff cannot be expected to keep people in custody for drug offences and then be asked to facilitate drug usage. Prison staff cannot be expected to distribute objects that may well endanger their safety.

Faced with a highly successful health initiative for the general public, but the impossibility of its implementation in the prison system, we opted for making bleach freely available in Victorian prisons for infection control. It is a compromise, but a successful one. Whereas some other jurisdictions have stalled on the issue of infection control amongst IV drug users in prisons, Victoria has proceeded with a policy that is effective and deliverable.

While a policy of freely available bleach has been introduced, ensuring that bleach is always available in practice in every prison is another matter. Generally, it is available, but sometimes prison staff 'forget' to refill the dispensers. This highlights another key factor. Prison staff at all levels must have a commitment to the policies that management adopt, otherwise those policies will be frustrated.

The Corrections Health Board has established a Communicable Diseases Sub-Committee. This is a tripartite body consisting of public health and corrections officials and union representatives. It ensures that all policy recommendations are developed with the benefit of prison staff advice, agreement and ownership. This Sub-Committee, like the Corrections Health Board itself, survives by finding compromise and by ensuring that decisions are made after full and frank discussion from all sides.

The key factor in the establishment in Victoria of a balanced and effective set of procedures for HIV prevention and management has been the intensive AIDS education of a number of key personnel in the prison system. When the first HIV antibody positive prisoners were detected, procedures were inadequate and prisoners were confined to the hospital at Pentridge Prison. Over sixty key managers, union officials, health workers and prison officers were given a six day intensive AIDS course. Innumerable other officers and prisoners were given one to two-day courses. When this was completed re-evaluation of policies commenced. It was not until the appropriate personnel had a full knowledge of the issues that some rationality was injected into decision making. Attendance of large numbers of personnel at extended training requires commitment and cooperation from the corrections side, otherwise it cannot succeed.

Having discussed the linkages between the corrections and health departments and our attempts to involve prison staff at a base grade level - there is one other group that cannot be ignored - prisoners. Prior to the development of proper procedures for HIV management, HIV antibody positive prisoners were confined to the Pentridge Prison hospital. There was little to do there and increasingly these prisoners felt angry and abused. They became abusive and disruptive. If a humane and less isolated management regime had not been developed which supported such prisoners through the trauma of adjusting to being HIV positive then there is no doubt that prisoners would have used their antibody status in assaults against staff.

What does the Corrections Health Board see as the required policies? In brief, they are as follows:

- extensive education of both staff and prisoners, so that they fully understand the virus and maintain a humane attitude;
- extensive training and equipment of staff and prisoners for infection control;
- sound epidemiological information in regard to the prevalence of HIV in prisons;
- proper medical care of prisoners with HIV/AIDS; and
Humane and confidential management of prisoners who are HIV positive and have AIDS related illness.

While complete success has not been achieved in Victoria in relation to each of these matters, substantial progress has been made. It can only be achieved where there is constant discussion and negotiation between health, corrections, and prisoners. Finally, it is important to remember two things. First, that prison officers, prison management and prisoners will not be impressed by policies that emanate from public fear, if such policies are at the expense of their own legitimate interests. Second, that limitations of prison as an organisation be kept in mind when suggesting reforms.