HIV Minimisation Strategies for Queensland Correctional Centres

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In autumn of 1989 a submission was made by the Prisoner & Family Support Association (Queensland), a non-government federation, to the Queensland Department of Health to fund an AIDS education and research program within correctional centres throughout the State. A grant of $29 500 was subsequently made available. Mr Errol Evans was appointed the Project Co-ordinator in August of 1989 by the funded Association with a brief to develop an education and preventive strategy for the containment of HIV infection among Queensland prisoners and to investigate the strengths and deficiencies of existing HIV management practices in the Queensland correctional system. Project STIR (an acronym for Sexually Transmitted Intravenous Risks) was supported by the Queensland Corrective Services Commission. The outcome of this investigation, the STIR Report, was adopted by the Executive Committee of the Association on 8 March, 1990 and submitted to the Ministers for Health and Justice and Corrective Services as well as the Queensland Corrective Services Commission on 12 March, 1990.

The primary aim of the Project was the prevention of HIV infection among prisoners, ex-prisoners, their families and remandees appearing before the courts. The expectation of the community to maintain public health and to be protected from infection coalesced with the expectation of prisoners for access to adequate health care and information on infection from risk behaviours, and formed the fundamental and complementary tenets of the Project. Among the objectives established in the realisation of this Project were:

- that all members of the target group have accurate knowledge about AIDS and its transmission; and
- that those in the target group will adopt safe behaviours.

Program strategies included:

- research into risk behaviours in the target population, current knowledge levels about HIV infection and appropriate educational interventions;

- the development and provision of information based upon the research outcomes; and

- the establishment of behaviour change programs and support.

By early 1990 a two-day inmate peer education and support workshop had been conducted in all Queensland prisons over a six-month period, involving over 150 prisoners, trained as peer educators, and a number of prison staff.

The recommendations of the STIR Report were based upon the feedback and insights into prison culture and risk practices drawn from these workshops. The contents of the Report suggest in part the existence of preconditions for a dramatic increase in HIV infection among inmates in the Queensland correctional system. These preconditions included the significant and increasing frequency of drug dependent behaviour, acknowledged levels of IV drug use and male-to-male/female-to-female situational sexual activity in Queensland prisons, and the fact that significant numbers of HIV antibody positive persons existed within the broader community. It is further suggested from the Report that the prevalence of HIV risk behaviours associated with imprisonment such as situational sex encounters, intravenous drug use and needle sharing will exacerbate infection potential, particularly in the absence of the preventative devices and practices that exist within the broader and `open' community.

Prisons historically have been closed institutions. In Australia they have evolved as places of quasi-militaristic containment and control. People within them have been obliged to be compliant to the rigours of this model and have been constrained by various formal rules, rituals and regulations. In a response to the limitations fostered by such a model, a strong sense of solidarity or camaraderie has developed within the prisoner class. This is particularly evident from the prisoner code and culture that operates within Australian prisons. The informal, yet enforceable, machinations of this code have developed a dynamic of their own. Prisons have become sub-communities as a result of this code with reference points for conduct that are at variance to those which prevail in the broader community.

There are compelling reasons to place Australian prisons under the microscope in these circumstances, particularly with respect to HIV infection. This matter was recognised in the National HIV/AIDS Strategy White Paper published in 1989 which acknowledged the potential for HIV infection in prisons and reported a lack of `information available on the extent of HIV infection in Australian prisons' (1989, p. 51). More significantly, the White Paper also indicated a need for `. . . more information . . . on the nature and level of risk activities within prisons' (p. 51).

The mandatory testing of prisoners in Queensland prisons has, to date, revealed only a small number of people being HIV positive. These prisoners have been administratively segregated from the mainstream prisoner population with the view that such segregation would `contain' and reduce the potential for further infection in the prison environment. In the absence of any serious research into the dynamics of the prison culture, the efficacy of medical interventions and segregation of those identified as HIV positive must be brought into question. There is a real danger if the primary indicator of HIV infection within prisons is taken as being the numerical level of HIV positive persons. Neither the specific community of a prison nor the broader community should be complacent about the seemingly small rate of infection currently evident within the system. The geometric growth implications of transmission of the virus together with the cultural imperative of the prisoner code that appears to legitimise risk behaviours within prisons should be sufficient to justify constant review and evaluation.

These matters are structurally and culturally determined. Factors such as the history of intravenous drug use by prisoners, along with needle and syringe sharing, and issues within the prison drug subculture coupled with the range of sexual transactions, either consensual, coercive or forced, which are apparently legitimised within the prison culture demand further investigation. Whilst mandatory testing will assist in a determination of who is HIV positive within the system, the matter of addressing the level of risk practices and the impact that such practices will have both within the Queensland prison system, and in the wider community remains unexplored.

Furthermore there appears to be a degree of conservatism that militates against the issues being adequately raised on the agenda. The matter of confronting institutional risk behaviours may simply be too challenging for prison administrators and governments,

particularly in the absence of any proactive community concern for intervention. The status quo is maintained. Sooner or later, though, the Pandora's Box of the correctional industry will need to be opened.

In the past twelve months there have been some encouraging developments in the philosophy that directs Queensland prisons. Whilst not directly addressing the issues, proposed structural changes to prisons in the State will indirectly impact on the prevalence of risk behaviour. The logic and methodology of the quasi-military model has been rejected by the Queensland Corrective Services Commission and a model of participatory management involving prisoners has been foreshadowed. This will, in time, contribute to the erosion of the `traditional' prisoner culture, leading to a social normalisation of the environment of the prison. Already, at institutions such as Borallon Correctional Centre, there is a greater awareness developing among prisoners about HIV infection and risk behaviour in response.

The recommendations of the STIR Report are produced below. They were guided by material obtained in workshops attended by prisoners and prison officers, together with program reviews of HIV interventions in the correctional sphere in other jurisdictions. Explanatory material for each of the recommendations is contained in the STIR Report but three particular issues should be detailed here.

Sexual Activity

Corrective services authorities have a clear responsibility to modify sexual behaviours which pose not only a psychological and physical risk to the community but may also present a potential for the violent or coercive transfer of HIV to the public. Case management programs by specialist personnel are essential on both counts. Other control strategies which may be controversial, such as chemical interventions, should be investigated. Program streaming, segregation and individualised risk assessment and management are complementary practices.

Single cell accommodation and individual ablution facilities may lessen the opportunities for non-consensual risk practices. There are indications that culturally sensitive options such as dormitory accommodation may be preferable for some Aboriginal prisoners.

In respect of condom distribution, a different moral criteria appears to have been applied to prisoners than to the general community. However, public health considerations favour the adoption of condom availability and outweigh arguments that condoms may be used as missiles or weapons because of the consequences of HIV infection both to the prison population and the wider community.

Conjugal privilege may modify and diminish institutional sex in prisons. Conjugal privilege should be part of a graduated release or leave program where sexual activity can be recognised, planned, anticipated and managed safely through the provision of education, testing and condoms. It should occur in an environment which is geographically distinct from correctional facilities.

Intravenous Drug Use

IV drug and needle sharing occurs in prison but is difficult to quantify and may vary among populations and settings. Correctional administrators may argue that the provision of bleach and information about cleaning equipment undermine drug rehabilitation efforts or sanction an illegal activity. The counter principle of harm reduction argues that the grave consequences of the spread of HIV necessitate a range of practical options. Since IV drug use cannot be immediately curtailed harm reduction strategies must be employed.

Research

There is little Australian research on risk practices such as anal sex and IV drug use. Research is urgently needed. However, anecdotal evidence from staff and inmates suggest that significant amounts of high-risk practices occur in prison.

Reference

Australia Department of Community Services and Health 1989, *National HIV/AIDS Strategy*, AGPS, Canberra.

Appendix

The STIR Report: HIV Minimisation Strategies for
Queensland Correctional Centres

Report Recommendations

The following recommendations are presented by issue as they relate to the minimisation of the spread of the HIV in Queensland Correctional Centres.

1. The Antibody Test and Screening

1.1 Mandatory testing should continue provided it is complemented by adequate information, pre and post test counselling, training and resources for both inmates and correctional staff.

1.2 Accepted testing guidelines should be strictly adhered to with particular reference to follow-up and pre-discharge tests.

1.3 Inmates should be promptly advised of their test results regardless of outcome.

1.4 Principles of confidentiality of medical information and the security of medical records should be strictly observed.

2. Segregation

2.1 Segregation should continue to be a useful option in containing HIV infection provided that inmates are not doubly penalised by their HIV positive status in terms of discrimination, or unnecessary isolation from programs and social activities.

2.2 The policy and practice of providing single cell accommodation and individual ablution facilities should be continued.

3. Counselling

3.1 Counselling is an important corollary to mandatory testing and inmates should be given access to HIV pre and post test counselling. Counselling should be provided by training program staff or by contract personnel.

4. Education

4.1 Preventative education should be made available to both staff and inmates by regular and ongoing programs. Peer education should be researched, supported and resourced.

4.2 Infection Control Guidelines should be adopted, practised and performance monitored.

4.3 Information and equipment should be readily accessible.

5. Ethnic and Other Groupings

5.1 Specialist programs for groupings such as aboriginal and islander inmates; women; sexually distinct inmates, such as transsexuals; ethnic or culturally different prisoners; and disabled inmates are recommended.

6. Sexual Activity

6.1 Sexual predators should be segregated from vulnerable inmates and surveillance heightened.

6.2 Condoms should be freely made available in Correctional Centres and prior to leave and release. Condoms should be distributed by Correctional Officers, by health service personnel or by community agencies such as the Prisoner & Family Support Association (Queensland).

6.3 Conjugal privileges should be integrated into graduated release programs (where compatible with the rehabilitative and re-integrative goal of the case management plan).

7. Intravenous Drug Use

7.1 Bleach and information regarding decontamination of equipment should be made immediately accessible to inmates.

7.2 HIV preventative interventions should be integrated into existing alcohol and drug programs.

8. Tattooing

8.1 Decontamination of equipment and access to professional tattooists should be seen as options which could be linked to individualised case management plans.

9. Violence and Accidents

9.1 Violence should be minimised through sound managerial and corrective practices which include surveillance and segregation.

9.2 Accidents should be minimised through close supervision, the provision of safety and protective equipment, and workplace training to industry standards.

10. Correctional Officer Education

10.1 Equipment such as resuscitation masks and gloves should be used and correct search procedures adopted.

11. Medical Services

11.1 Medical Services for inmates as they relate to HIV should be of the same importance and quality as those provided in the community.

12. Research

12.1 Research which can give reliable indications of the prevalence and incidence of risk practices should be commenced immediately.

13. Financial and Administrative Support

13.1 HIV programs should receive adequate resources, funding and support from the Commission commensurate with national and state HIV control measures.

14. Infection Control Issues

The following standards should be adopted :

14.1 - barrier precautions (such as gloves) should be used in all situations involving blood or body fluids.

14.2 - lesions and dermatitis should be covered and contact with blood and other substances should be avoided.

14.3 - needle stick and sharp object injuries should be avoided through the use of torches, mirrors, gloves in search procedures.

14.4 - routine hygiene procedures such as regular hand washing with soap and water should be adopted (particularly if there is possible contact).

14.5 - blood and body substance spills should be cleaned with a chlorine based bleach (where possible by the individual concerned).

14.6 - disposable items soiled with potentially infectious materials should be treated as infectious.

14.7 - infectious linen should be stored and transported in leak proof bags.

14.8 - situations where potentially infectious material could enter the eye (e.g. blood spattering) should be avoided and the area should be immediately bathed