THE STIR REPORT

HIV MINIMISATION STRATEGIES FOR QUEENSLAND CORRECTIONAL CENTRES

Clive Begg & Errol Evans

ACRO The Australian Community Safety & Research Organisation Incorporated
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REPORT INDEX

Purpose of the Report

Clive Begg: Melbourne, Victoria; Wednesday November 21, 1990

The purpose of this report is to constructively highlight both strengths and deficiencies in the current management and containment of HIV infection among Queensland correctional inmates, their families and the community.

In correctional facilities in Europe and the United States, HIV infection is significant and on the increase. In Australian prisons, the problem is not of the same order. Needle sharing associated with I.V. drug use and to a lesser extent sexual activity are the main risk factors.

A major objective of Project STIR has been the delivery of AIDS peer education and support programs in all Correctional Centres throughout the state. Over 150 inmates participated in the two (2) day program in eleven (11) centres and provided many important insights into prison culture and risk practices and the impact of these factors upon the AIDS epidemic in Queensland. (Evaluation of program - Appendix A).

Data from this program has been obtained from personal interviews and structured questionnaires. The following recommendations are guided by this source material together with program reviews of HIV interventions in the correctional sphere in other parts of Australia and the world.

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+ 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.

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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.

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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.

Introduction

The fundamental right to access to adequate and timely health care for prisoners is a basic tenet of this report. A major complementary tenet is the right of the general community to maintain public health and protection from infection. Correctional facilities are also required to respond to other principles such as security and protection of the community, correction and rehabilitation, punishment and retribution and the removal of certain rights. Clearly these other principles may conflict with the basic principles of adequate public health care in relation to the transmission of HIV.

Principles such as security, punishment and the removal of some rights condition many existing HIV policies which may be dissonant with overall community HIV preventative initiatives (for example, promotion of condoms, needle and syringe exchange etc.). At the same time, other community initiatives may be less than optimum owing to practical constraints (e.g. impracticality of mandatory mass screening).

The findings of this report are guided by the principles of public health and harm reduction for the community of which prisons form an integral and interactive part. Where recommendations are made they are framed with a view to resolving existing tensions between public health issues and custodial, moral, legal and ethical perspectives which impact upon the containment of the epidemic.

Incubator Thesis

In Australia, the following preconditions exist for a dramatic increase in HIV infection in goals.

- significant numbers of drug users in prison
- acknowledged levels of IV drug use and homosexual activity in prisons
- significant numbers of HIV antibody positive persons in the community

Despite screening and segregation, gaps remain through which HIV infection could enter the correctional

system in Queensland. Such factors include testing and result time delays, the window period for seroconversion, leaves outside the centre, and contaminated contraband.

The incubator thesis holds that the prison environment could facilitate the rapid transmission of the virus through the range and prevalence of high risk behaviours such as unsafe sex, contaminated equipment sharing and violence that takes place in prison. The inmates are considered to be drawn from a population which may have a greater than average pool of infection (e.g. sex workers, I.V.D.U.'s, young people).

Available data suggests a low rate of HIV transmission with prisons in Australia. However, the Australian findings should be interpreted with caution owing to lack of data. (In the most populous state, N.S.W., only a small fraction of the total population has been tested.) In Queensland, at time of writing, there have been no reported transmissions in gaol. Mandatory testing, segregation and the comparatively low level of infection in the community pool from which prisoners are drawn are factors which appear to have constrained transmission. Information, access to counselling, program development, access to condoms and bleach, and case management have been suggested elsewhere as further harm minimisation strategies.

The incubator thesis need not become the reality it is elsewhere in the world provided the full range of preventative measures are adopted in Queensland.

1. The Antibody Test and Screening

There should be a clear distinction between mandatory testing for the general community and compulsory screening in a discrete and high risk environment such as a Correctional Centre.

Imprisonment is almost invariably imposed against a person's will. Much of the everyday regime is imposed upon the inmate, whether it be through overt and formal rules and sanctioned demands or through the "informal" and covert prison code and culture.

Arguments against mandatory testing which may have practical justification in the community at large may lack the same cogency in the prison environment. For example, the notion of infected individuals going underground (i.e. hiding and refusing to co-operate because they fear discrimination; ostracism or quarantine) is not valid or sustainable in the prison context. Inmates cannot hide or become invisible. Discrimination can occur but this is best viewed as separate issues of policy, education and implementation.

Because the test is applied equally and without favour to all inmates, it cannot be selectively or discriminatorily used as a predictor for drug use or homosexuality. The antibody test should be seen as part of the overall strategy of prevention, infection control, and education.

Confidentiality of information and segregation or integration are of course distinct issues and should not be collapsed solely under the question of mandatory testing.

Mandatory testing does not conflict with the principle of prevention. Test results should form part of an integrated intervention which will encourage individuals to reduce the risk of transmission irrespective of the test results being positive or negative. In prisons, mandatory testing should not detract from behavioural and educative interventions.

Knowledge of a positive test result for HIV antibodies may assist clinical management of the individual in addition to minimising the risk of further transmission through behavioural modification and case management.

Mandatory testing may provide useful research and epidemiological insights into the course and

prevalence of the disease in high risk sectors (e.g. I.V.D.U.) of the population from which prisoners are drawn. It may also be of benefit in relation to future medical treatment and with counselling in harm reduction management.

Mandatory testing is a partial acknowledgment of the reality that illegal and high risk activities (e.g. needle sharing and unsafe sex) take place in prison and cannot be policed out of existence. Hence the operating principle in relation to AIDS/HIV should be that persons entering prisons uninfected leave not only uninfected but better informed and prepared for community life.

Neither individuals nor institutions can control all possible situations where transmission can take place (from rapes to consensual activities). Likewise no simple or single strategy (such as testing and/or segregation) will contain the spread of the disease as an exclusive measure because of flaws in testing, the window period or infection from outside through sex on leaves or contaminated equipment.

Accordingly, testing for infection, accommodation, information and education, peer support, case management, and personal risk reduction are all complementary strategies in an integrated policy that will reduce the risk of transmission in prison.

The arguments against mandatory testing usually presented run as follows -

- The primary aim of testing is voluntary behavioural change. People tested by legal compulsion it is argued are unlikely to change their behaviour voluntarily. This argument assumes individuals will not look after their own interests or accept personal responsibility and are personally opposed to mandatory testing. Clearly, this perspective is flawed. Inmates attending workshops overwhelmingly supported their own compulsory testing and strongly endorsed the HIV education program.

- Anonymous epidemiological studies are more reliable and accurate. This is a nonsense objection for a closed institution such as a prison where the test is unavoidable. These anonymous studies serve a research purpose rather than aiding in management or treatment per se which compulsory screening also facilitates.

- The antibody test has predictive limitations. The `window' period or time lag for seroconversion allows for the possibility that a small number of infectious persons will not be identified at first test. In some cases, false results could result through imperfect testing.

- A source of infection could enter a tested prison population lulled into a `false sense of security' through time delays between admission, testing, and results; and contact with outside infected community members (leaves, visits, work releases, contraband).

The latter two objections assume that no important back-up procedures such as counselling, preventative information and resources, and follow-up testing are in place and that these testing problems are also a concern within the general community.

- The fear of detection, harassment and discrimination through lack of confidentiality will drive individuals underground. Although discriminatory reactions are to be deplored, mandatory testing in a total environment does not allow for this conclusion. Prisoners cannot go underground in gaol.

The issues are crystallised around the dichotomous notions of public health (the interest of the collective to protect itself from infection) and individual rights (the interest of the individual in civil liberties and protection from unfair or unequal treatment). A balanced response which is mindful of the negative implications of both extremes is likely to be most effective in HIV prevention in prisons. For practical and some would argue ethical reasons, voluntary testing is more applicable in the general community.

RECOMMENDATIONS :

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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, Accommodation and Confidentiality

Complete segregation will significantly reduce the risk of transmission if HIV status is known through mandatory testing. Flaws in test results, post test seroconversion, and the introduction of infection in the presumed HIV negative population (through leaves etc.) give cause for concern in the mainstream prison population. Sound education, effective management policies, counselling and individual risk reduction programs, availability of preventative resources such as condoms and bleach, will diminish this possibility.

Segregation is not seen as a major issue as long as prisoners are not doubly penalised by their HIV positive status. That is their treatment is not compromised by discrimination, stigmatisation, ostracism, violence, security classification or unnecessary isolation from mainstream social and therapeutic activities.

Confidentiality of medical information and the security of records are important principles inside and outside of the correctional system.

With full segregation in a Special Purpose Unit all staff in the holding facility will know or presume the HIV positive status in prisoners. Confidentiality then becomes a significant issue if information is divulged outside that facility. Relatedly, in a small specialised unit, confidentiality becomes less critical than if information about HIV status is disclosed in a larger integrated setting. Staff may also be selectively deployed and trained.

Discrimination by way of ostracism, real or threatened violence, or unequal treatment may also be more significant in a larger mixed environment. The `need to know' requirement for medical and custodial staff regarding HIV status, can be better restricted in a smaller setting providing that security of records and ethical standards of confidentiality are maintained.

Disclosure of information to spouses, sexual partners or drug equipment sharing associates of a HIV+ prisoner requires the involvement of specifically trained staff who would exercise case related discretion based upon an understanding of the social, environmental, emotional and other risk factors.

It was argued that segregation was likely to be justified on social and environmental rather than medical grounds for asymptomatic seropositive prisoners. Protection from violence, prevention of HIV transmission, and the provision of specialist programs were cited as key factors for opting for partial or complete segregation.

Partial segregation (or partial integration) may be of social or therapeutic benefit in those situations where the risk of transmission or violence is likely to be slight. Mainstream participation in everyday formal and informal correctional activities may provide emotional or rehabilitative benefits to the individual. Decisions regarding involvement should be based upon an assessment of the individual's case needs and the operating environment. With trained staff and sensitive management, segregation per se need not place additional psychological stress or a sense of isolation upon the HIV+ prisoner. The converse should be the organisational objective for the specialised unit.

Streaming into appropriate modules for management, education, and rehabilitation is a well established principle and practice in correctional facilities and segregation for HIV+ prisoners would appear to correspond with this general correctional management strategy. Where HIV+ prisoners require hospitalisation or urgent medical intervention, decisions regarding accommodation can be based upon treatment criteria.

RECOMMENDATIONS :

2.1 Segregation should continue to be a useful option in containing HIV infection provided that inmates are not doubly penalised by their HIV+ 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

Counselling aims at encouraging individuals to be informed, to accept responsibility for behaviours and to modify those behaviours based upon personal risk assessment. It may also serve to provide a more supportive and empathic environment for HIV+ prisoners through improved knowledge while positively influencing peers, family members and friends to be accepting and supportive.

Counselling is an important corollary to mandatory testing for Queensland prisoners. Irrespective of test results, prisoners should be given full access to HIV information and education prior to testing, at a face-to-face level when results are given and upon request or at pre-discharge. Currently, reduction of risk behaviour through education and counselling offers the best strategy for prevention of HIV transmission. Screening without counselling may not ensure the desired behavioural change in the individual at risk. Screening alone may indeed induce a false sense of security in a potentially high risk environment.

Where clinically appropriate, HIV counselling for the individual should be linked or referred to Alcohol and Drug programs or specific treatment regimens.

RECOMMENDATIONS :

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

Preventative education in prisons is currently seen to be limited by a series of factors which include :

- the high turnover and movement rate for prisoners.
- the presence of ill-founded fears, attitudes and misinformation in key players.
- the priority of education activities vis-a-vis competing security and management imperatives.
- cultural factors such as "macho" sexual stereotyping and role assignment of "cats", "hocks", "boys" etc. which may inhibit participation.
- communication difficulties and widespread distrust between inmates and staff.
- inadequate resources.
- negative public perceptions regarding "soft" programs.
- a false "sense of security" because of testing and segregation.
- denial of personal risk.
- high levels of alcohol and drug use and disinhibition regarding high risk practices.
- resistance to the use of condoms.

- ingrained cultural practices (e.g. sharing drug equipment).
- the illegality of many activities may inhibit acknowledgment.

Education programs must effectively and constructively address these factors.

Education should be proactive, comprehensive and widespread. When testing is mandatory so too should be information and counselling. It should be frank, ongoing and repeated in a culturally appropriate language and form. It should be custom developed and relevant to the prison environment. A variety of media (e.g. posters, written material and video) should be included in the presentation which should most appropriately be live. Above all, education programs should be credible and have strong management support. Objectives should be set that are measurable and outcomes monitored and evaluated. Research and compatible policies should complement educational interventions.

RECOMMENDATIONS :

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

Women Prisoners

Available research suggests that a high proportion of women prisoners have a history of IV drug use. A significant number of women have also been engaged in the commercial sex industry. Perinatal, heterosexual and IV drug user transmission are all important vectors for the spread of HIV. It is essential that effective preventative programs are specifically designed and implemented for women prisoners. Because of the relatively small number of female prisoners vis-a-vis male, the accommodation needs of HIV+ women will require special attention as the epidemic invariably spreads.

Aboriginal and Islander Prisoners

Aboriginal and Islander prisoners are over represented in Australian Correctional Centres. There is generally a lower standard of health and greater social dislocation in the communities from which prisoners are drawn. There is higher prevalence of co-factors such as STD's and Hepatitis B. Existing programs and resources may be either inaccessible or culturally inappropriate. Custom designed preventative programs should be provided for aboriginal and islander inmates.

Other Minority Prisoners

Prisoners who have differing cultural backgrounds, religious affiliations, or language barriers should have access to suitable information and counselling.

The physically, intellectually or emotionally disabled should have access to specialised intervention.

Transsexual Prisoners

Prisoners who self-identify (and are assessed) as transsexual should be accommodated in specialised units provided those units are of personal and therapeutic benefit to the individual and contribute to effective management of the correctional system. Sexual orientation should not lead to further penalty in terms of personal treatment or access to programs and activities. Professional consultancy, assessment and management are necessary adjuncts to streaming.

RECOMMENDATIONS :

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

Sexual Offenders

It is a clear responsibility of Correctional Services 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.

Heterosexual and Homosexual Activity

The reality is that sexual activity between inmates occurs, despite the possibility of criminal charges, moral disapproval, disciplinary action or other management strategies designed to minimise such activities. Sex which takes place may be consensual, coercive or forced. Most sexual activity which occurs is consensual or quasi-consensual (e.g. sex in exchange for favours, debts etc.). Despite mandatory testing and segregation, unsafe sexual activity constitutes a substantial health risk both within and outside the correctional environment.

There is a possibility of rapid spread of HIV infection, if a source is introduced (via seroconversion gaps or otherwise) into a presumable uninfected environment. Counselling and education have been stressed as important preventative measures to be adopted in concert with testing and segregation. Sexual practices with potential for HIV transmission may be consciously avoided or modified to reduce possible infection in many instances.

The provision of single cell accommodation and individual ablution facilities may lessen opportunities for non-consensual risk practices. There are indications that culturally sensitive options such as dormitory accommodation may be preferable for some aboriginal prisoners.

Staff should be prepared to actively segregate sexual predators from vulnerable prisoners and afford supervision, support, and protection where necessary.

Consenting homosexual acts between males are illegal in Queensland. These offences are currently subject to considerable public discourse and official review. Many prison administrators make the point that the provision of condoms would appear to condone illegal acts in a correctional environment. In the general community, arguments supporting public health and the minimisation of community harm be containment of the spread of the HIV epidemic have forced public re-appraisal of many moral and legal issues such as homosexuality, needle and syringe availability, prostitution, and drug decriminalisation.

A different moral criteria appears to have been applied to prisoners by virtue of their incarceration. That is, a greater moral sanction is applied to prisoners vis-a-vis other members of the community. If the primary issue for the community is the maximum feasible control over the HIV epidemic then effective counter infection measures should be adopted universally with the caveat that advantages must outweigh disadvantages. The public health argument regarding the spread of HIV would appear to favour the adoption of condom availability as a prophylactic against HIV. Other uses for condoms such as weapons, missiles, or concealment devices in association with legal concern or moral indignation would be outweighed by the consequences of HIV infection. Condom availability has been a cornerstone for

HIV education and prevention programs for almost all target populations. To discriminate against prisoners in this regard may have dire consequences not only prisoners but also the general community.

Conjugal privilege may modify and diminish the total quantity and type of institutional sex taking place within prisons. The reality of conjugal activities are best dealt with by a graduated release or leave program where sexual activity can be recognised, planned and anticipated and managed safely through provision of education, testing and condoms. Conjugal activity should be related to individualised rehabilitation programs and successful goal attainment in a context of progressive normalisation and societal reintegration. The environment for sexual activity should be in line with current community standards and geographically distinct from correctional facilities.

Sex is a powerful commodity in the current correctional culture. Power and dominion are established and imposed through the current organisation and production of prison sexuality. The complex re-patterning of human sexuality in prisons requires urgent research to modify its more dire consequences such as homosexual rape, forced effeminisation, and coercive prostitution.

RECOMMENDATIONS :

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 and 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

Intravenous drug use and the sharing of needles and syringes occurs in Queensland Correctional Centres. The incidence and prevalence of these activities are difficult to quantify and vary among populations and settings.

As in the case of sexual activity, there is a possibility of the rapid spread of infection into a presumably uninfected environment through the introduction of a contaminating source.

Arguments usually presented by prison administrators are similar to those raised in the context of sexual risk behaviour.

Provision of information about bleach and the decontamination of equipment are seen to compromise rehabilitative efforts, to undermine the illegal status of actions, and to sanction or condone drug use.

The counter principle of harm reduction argues that concerns about spread of the disease force a range of practical options. The responses are pragmatic and incremental and range from a "best" of cessation of all drug use, through to modification of means of administration (e.g. a change from injecting to smoking), to provision and exchange of sterile needles and syringes, to supply of bleach and information about decontamination, to control and surveillance (as the least successful response for minimising transmission).

The last response in isolation clearly does not contain the transmission of the virus unless policing can be totally enforced. Of course, this outcome is unattainable and may lead to higher transmission through increased sharing owing to scarcity of equipment.

In the community, past and present Queensland governments have recognised the seriousness of the issue and have improved access to equipment in the general community, introduced exchange and distribution programs, together with interventions such as peer education and changes in legislation.

Since intravenous drug use cannot be immediately curtailed, a series of counter measures incorporating existing drug and alcohol counselling and treatment programs should be introduced in Queensland facilities. At this juncture, information and bleach should be made immediately accessible to prisoners. The future course of the epidemic may force the review of needle exchange and provision of injection equipment (despite legitimate concerns regarding their use as weapons).

RECOMMENDATIONS

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

Tattooing performed by professionals under conditions where infection precautions are taken present no risk of HIV transmission as long as the equipment is sterilised and never shared. Some risk exists in prison because of divergences from the general practice and availability in the community.

Tattooing is a significant anthropological rite in the prison culture and despite prohibition, surveillance, and punishment will not be eliminated in the short term. Access to sterilising agents such as bleach or sterilising equipment would further reduce the low risk of HIV infection. Allowing prisoners to contract professional tattooists is another option which if adopted, should be linked to participation and performance in individual case management plans.

RECOMMENDATIONS :

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 Accident

Correctional facilities may be violent environments. Serious accidents also occur. Accidents and physical violence which allow exposure to blood and other body substances must be minimised and infection control procedures observed by both staff and inmates.

RECOMMENDATIONS :

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

Protection of correctional staff whose work involves risk of exposure to HIV through trauma or infective body fluids is a responsibility of Correctional Services. Occupational risks are involved in body and cell searches, performing emergency medical interventions where there is body fluid present, dealing with assaults, accidents, homicides and suicides, and supervising cleaning and disposal of infectious materials.

The risk of transmission is acknowledged to be low through workplace activities, nevertheless sound infection control procedures should be adopted.

RECOMMENDATIONS :

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

11. The Role of the Correctional Medical Service

The recognition of the independence, integrity, competence and overall importance of medical services is a central factor in delivering adequate health care to a population that has substantial health problems both prior to and during incarceration. For example, intravenous drug users are over represented in the prison population. The medical services have a key role to play not only in the treatment and management of HIV positive prisoners, but in the provision of counselling, education and programming to encourage modification of high risk behaviours.

RECOMMENDATIONS :

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

The literature available reveals a paucity of solid data on risk practices such as anal intercourse and equipment sharing associated with drug use in prisons. Information available is largely sourced from overseas. Findings which relate to the incidence and prevalence of activities must be therefore interpreted with caution. Negligible data is available from Queensland studies despite the importance of sex and drug practices from both management and health perspectives. Anecdotal evidence from both staff and inmates support the contention that significant amounts of high risk practices take place within the correctional environment.

RECOMMENDATIONS :

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

The Commission is in an excellent position to contain the transmission of HIV at the low rate currently represented in Queensland Correctional Centres. A proactive response in areas such as research, counselling and education will produce both immediate and longer term benefits for the community and the Commission. However, preventative measures cannot be initiated without ongoing financial commitment and support.

RECOMMENDATIONS :

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 principle that should be adopted irrespective of the HIV status (presumed or otherwise) of prisoners is the assumption of possible infectivity under all circumstances, hence the need for rigorous and standardised infectional control procedures in all practices.

The infection control procedures for Correctional Officers and inmates are clear and unambiguous.

Routine personal hygiene such as the regular washing of hands with soap and water should be practised.

RECOMMENDATIONS :

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 may 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 substances 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.