



FENCED IN HIV/AIDS in the US Criminal Justice System

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FIGHT AIDS. LOVE LIFE.

More than 60% of the people in prison are now racial and ethnic minorities. For African American males in their thirties, 1 in every 10 is in prison or jail on any given day. The fact that HIV among America's prison population is four times higher than the prevailing rate of HIV in the general population, has a clear impact on racial and ethnic minorities and especially African Americans. Recognizing that over 700,000 former inmates returned to our communities last year alone further raises the urgency to address this crisis. As this report so clearly demonstrates, being HIV positive unquestionably exacerbates the problems faced by men and women who have left prison or jail and are trying to reenter society. This seminal report gives us irrefutable evidence about a growing problem in our society, and why we must do something about it.

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I. Introduction and Background

HIV in U.S. Correctional Facilities

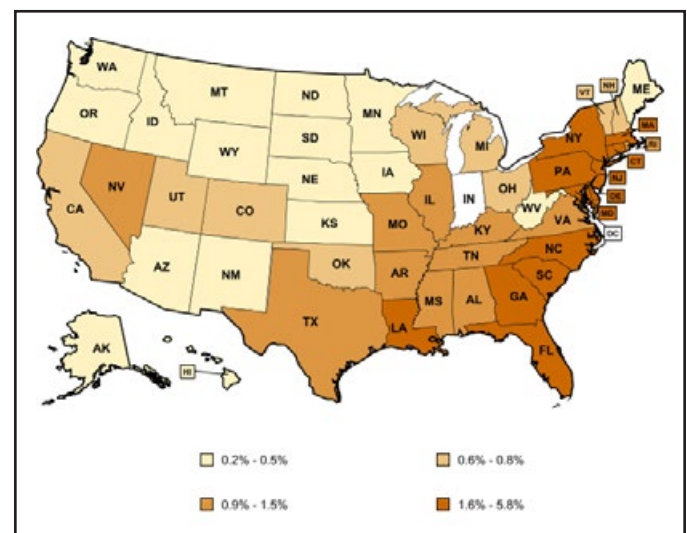
There are currently 2.2 million people in jail or prison in the United States. According to the Bureau of Justice Statistics (BJS), about 1.5% of all inmates in state and federal prisons have HIV or AIDS (21,987 persons).¹ That percentage is four times higher than the prevalence rate of HIV in the general population. The BJS reports that Florida (3,626), New York (3,500), and Texas (2,450) have the largest number of inmates who are HIV-positive.² The BJS also reports that the rate of infection for female inmates (1.9%) is even higher than that of their male counterparts (1.5%).³ The primary routes of transmission are suspected to be unprotected sexual contact and intravenous drug use (IDU)⁴, but precise data on infection and transmission are not available. While numbers remain high for HIV prevalence in prisons, the data may underestimate both HIV prevalence and incidence due to existing stigma and fear. This stigma not only leads to nondisclosure of HIV-positive status, but also places prisoners at an elevated risk of infection.

In addition to HIV, inmates living in U.S. prisons report higher rates of disabling health conditions than the general population. They also have poorer perceptions of their health status and lower usage of primary health services.⁵ Most incarcerated individuals come from populations who are often medically underserved such as black men, intravenous drug users, and individuals with serious health issues related to socioeconomic status and lack of healthcare access. Factors such as drug addiction, poverty, substandard nutrition, poor housing, and homelessness are social determinants that yield increased risk of HIV and other diseases.⁶ Even within the inmate population, health disparities exist along racial and social lines.

The elevated rates of HIV infection found in prisons are not solely a concern for inmates. This public health crisis reaches beyond the confines of prisons, and also reaches the communities to which they return upon completion of time served. In 2009, 729,295 prisoners were released from state and federal prisons and into communities across the country.⁷

Unfortunately, many former inmates find it increasingly difficult to successfully reintegrate

into society. A criminal record can lead to removal of voting rights, minimal employment and housing opportunities, and burdensome financial obligations resulting from incarceration, all of which create barriers to reintegration and increase the likelihood of recidivism. Many states have adopted laws, such as “Three Strikes” laws, which hand down mandatory and extended sentences to persons who have committed a serious offense on three or more occasions, thus adding to the difficulty of reintegration.



While great advancements have been made in identifying methods of transmission, risk factors, and social contexts behind the spread of HIV over the last 30 years of the epidemic, the larger social perception of the epidemic remains fraught with fear, stigma, and anxiety. These issues are exacerbated by structural barriers in prison settings. This includes denial from prison officials of the existence of sexual activity and illicit drug use in prisons.

II. Structural Drivers of HIV in US Correctional Facilities

A complex social environment that compounds the risk of HIV infection for populations who are at increased risk of incarceration underscores the need for evidence-based interventions that minimize risk of HIV infection while incarcerated. In order to reduce HIV risk in jails and prisons, prevention initiatives and structural interventions must remain be prioritized.

Over the past 30 years, the U.S. rate of incarceration has risen to 750 inmates per 100,000 residents, which represents a 500% increase.^{8,9} In 2008, more than 7.3 million people passed through the criminal justice system alone.¹⁰ Of the 1.1 million Americans living with HIV, an estimated 12% passed through the corrections system in 2006 alone.

Furthermore, there are significant racial disparities in rates of incarceration and HIV. The proportion of HIV-positive individuals in the U.S. entering the corrections system was closer to 20% for HIV-positive black and Latino inmates. In 2009, black individuals accounted for 44% of new HIV infections in the U.S., with black men accounting for 70% of new infections among all black people.¹¹ In that same year, 20% of new infections were among Latinos, 79% of which were among men.¹² Intersecting forms of stigma, healthcare inaccessibility, financial stressors, and other factors all combine to drive infection rates highest amongst gay and bisexual men of color (as is demonstrated in Dr. Ron Stall's Syndemic Theory).¹³

According to a study from the Centers for Disease Control and Prevention (CDC) published in 2006, the majority of HIV-positive inmates in Georgia Department of Corrections facilities were infected prior to incarceration. From July 1988 to February 2005, Georgia implemented mandatory testing upon entry into prisons and voluntary testing by request or by clinical indication. Beginning in July 2003, voluntary testing was also offered to inmates on an annual basis. After reporting the results of these tests, it was found that 88 of 856 inmates tested negative upon entry and later tested positive during their incarceration. Of those who were found to be HIV positive in Georgia prisons and jails, 90% were HIV positive upon entry¹⁴. It should be noted that this was one specific study, albeit the most extensive one to date.

This study suggests that despite common misperceptions, incarcerated individuals often contract HIV prior to entering the corrections system, not during a period of incarceration. Although HIV transmission within correctional facilities primarily occurs through high-risk sexual activity or IDU, infections largely occur outside of prison.¹⁵ Furthermore, HIV transmission rates within correctional facilities do not vary significantly based on race, so high-risk activity in prison cannot fully account for the aforementioned racial disparities. The structural factors associated with incarceration and HIV must be examined in order to further understand the intersection between race, incarceration, and HIV. Comparable large scale surveillance programs should be encouraged and funded by the CDC, though future programs should implement testing with voluntary informed consent from prisoners.¹⁶

Drug Policy and Incarceration

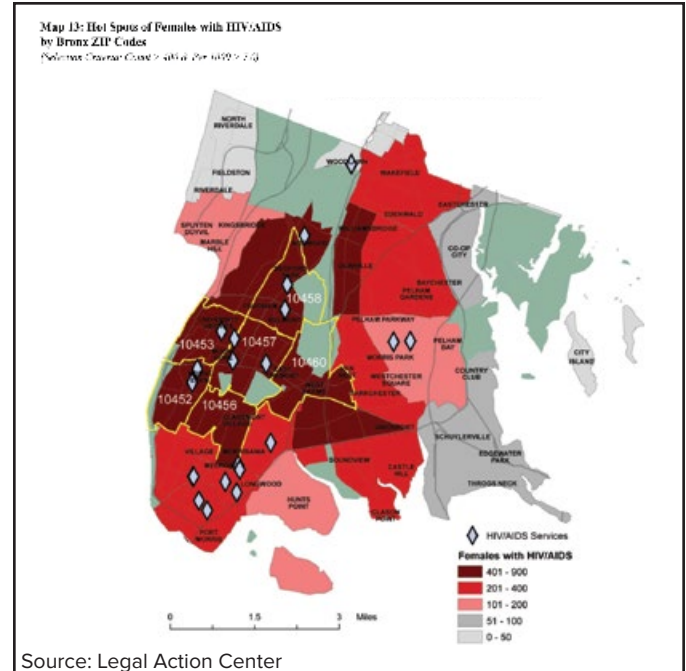
Racial disparities in incarceration have soared since the beginning of the “War on Drugs” in the 1980s, when the federal government launched an effort to combat illegal drug sales through mandatory minimum sentences and foreign military action. Prison admissions for black inmates nearly quadrupled over three years in the mid-1980s, and in 2000 reached more than 26 times the 1983 level.¹⁷ In seven surveyed states in 2000, Human Rights Watch found that 80 – 90% of all convicted drug offenders were black. Nationally, however, the majority of illegal drug users and dealers are white.¹⁸ A wide array of criminal justice policies exacerbate the effects of arrest and incarceration and contribute to observed racial disparities in incarceration: stop-and-frisk¹⁹ practices encourage racial profiling; lack of adequate legal representation at trials disadvantages low-income defendants; racial bias and discrimination in coercive plea bargain tactics adversely impacts minority defendants, and can lead many to plead guilty to crimes they did not commit for fear of mandatory minimum sentences; and penalty enhancements for the sale and use of drugs in certain areas (“drug free zones”) apply more readily in high-density, urban communities.^{20,21} Although not exhaustive, these types of policies promote racial disparities in incarceration and influence how the corrections

system operates as a structural driver of HIV.

Gender and Community Demographics

A thorough analysis of male-to-female ratios provides a quantitative measurement of incarceration’s effects on particular communities. Black men are disproportionately represented in the U.S. corrections system and thus underrepresented in their home communities. A study conducted by Lane et al. compares non-Hispanic white and black sex ratios in Syracuse and evaluates the effects on community level HIV risk factors.

In order to account for the reduced male-to-female sex ratios in Syracuse, this study looked at variables associated with population change, with respect to birth, death, and migration. Incarceration was found to be the most frequent type of non-voluntary migration affecting black men.²² Although there are several conflicting reports, lower male-to-female sex ratios may correlate with concurrent partnerships and diminished female bargaining power.^{23,24} These imbalances lead to constrained social-sexual networks and relationships become harder to secure. Reduced female bargaining power can mean a diminished ability to negotiate condom use, as well as other safe-sex practices or monogamy.²⁵ High rates of recidivism and the way that the U.S. corrections system operates as a structural driver of the epidemic further disrupt



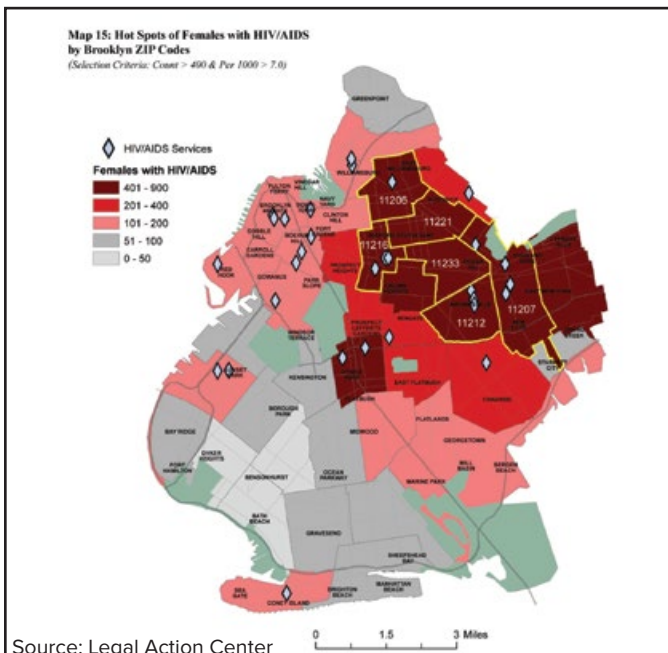
Source: Legal Action Center

community networks, which place formerly incarcerated individuals and their communities at increased risk for HIV infection.

HIV Criminalization

At present, 34 states and two U.S. territories have criminal statutes based on “exposure” to HIV, and prosecutions for “exposure”, nondisclosure, and/or transmission of HIV have occurred in at least 39 states.²⁶ Those convicted have received charges including aggravated assault, attempted murder, and even bioterrorism. In several states, those convicted under HIV-specific statutes have also been forced to register as sex offenders, regardless of whether HIV transmission occurred. In Colorado, a man living with HIV was charged in June 2010 with assault with a “deadly weapon” after allegedly spitting on an electronic monitoring technician. This charge was later dropped to misdemeanor harassment. In a 2008 case in Georgia, an HIV-positive woman was sentenced to eight years in prison and two years’ probation after allegedly failing to disclose her status during unprotected sex. During this trial, two witnesses testified that her partner knew about her HIV status, and she insisted that her partner knew due to a front-page article in a local newspaper that disclosed her status publicly.²⁷

Although these laws were largely created in response to alleged deliberate intent to transmit HIV when little was known about transmission



Source: Legal Action Center

or risk, the laws do not reflect significant advancements that have been made regarding knowledge of exposure and transmission of HIV. Oftentimes, sexual exposure — regardless of whether protection is used or risk is assessed — is punished just as severely as actual transmission. Criminalization of HIV therefore undermines public health initiatives that promote safer-sex practices and may discourage HIV testing and disclosure. Current policies ultimately promote fear and discrimination and further stigmatize people living with HIV. In terms of increasing the rates of HIV in prisons, using these illogical and unethical laws to put HIV-positive individuals in prisons further increases the rate of HIV infection in prisons.

The REPEAL HIV Discrimination Act

The Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act

Current policies ultimately promote fear and discrimination and further stigmatize people living with HIV.

(REPEAL HIV Discrimination Act), introduced by U.S. Representative Barbara Lee (D-CA) in September 2011, addresses HIV criminalization and discrimination in state laws. The bill requires the U.S. Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense to initiate a comprehensive review of all federal and state laws, policies, regulations, and decisions regarding criminal cases of people living with HIV.

Moving forward, the REPEAL HIV Discrimination Act is of great importance, since it encourages

laws that “do not place unique burdens on individuals solely as a result of their HIV status and instead promote public health-oriented, evidence-based, and a medically accurate understanding of the factors surrounding HIV transmission.”²⁸ (A complete list of policy recommendations can be found on page 21)

III. Risk of Contracting HIV in Prison

In addition to the disproportionately large percentage of prisoners being HIV-positive prior to entering

prison, there are many factors putting prisoners at risk of contracting the virus while incarcerated.

High-Risk Sexual Contact:

The frequency of high-risk sexual behavior and sexual assault in jails and prisons is difficult to estimate, yet several reports indicate that male prisoners who have sex with other men (MSM) range from 2% to 65%.²⁹ This wide variation can be partly attributed to non-standardized data collection methods, varying prisoner populations, and issues concerning privacy and stigma. The CDC Georgia study determined that of those reporting consensual sex, only 30% reported using a condom or “other improvised barrier method” (like rubber gloves or plastic wrap). Moreover, only 21% of prisoners who reported exchanging sex for money, food, drugs, and other items used an “improvised barrier method” and none reported using condoms.³⁰ According to the 2007 BJS report on sexual victimization in state and federal prisons, 4.5% of all inmates reported at least one incident of sexual

victimization by other inmates or staff.³¹ However, structural factors such as fear of discrimination, retaliation by the accused, homophobia, and the stigma surrounding same-sex intercourse likely contribute to underestimated frequencies of sexual behavior and assault in the prison system.

Of those who reported being involved in rape, no barrier methods were used.³² The 2006 CDC study subjects were also asked about how best to prevent HIV infection in prisons, and 38% responded that condoms should be made available in correctional facilities. Clearly, access to tools that protect sexual health often presents an obstacle for prisoners.

Prison Rape Elimination Act

Prison rape is another issue that continues to directly contribute to the spread of HIV in prisons and indirectly affect the communities from which they come. Victims of sexual assault who report the offenses face a high probability of retaliation from the accused, leading to further harassment

Personal Perspective: Robert Suttle

I am not a criminal. I am not a sex offender, but the state of Louisiana says that I am.

Louisiana has the highest incarceration rate in the nation. People of color, especially young black males whether they are gay or straight, are at the highest risk of incarceration and at the highest risk of acquiring HIV. Both factors represent a terrible injustice, but when you add HIV criminalization, it becomes an injustice of historic proportions.



A former partner, with whom I had a contentious relationship, filed charges against me for not having initially disclosed my HIV-positive status when we first met. This was not about transmitting HIV – I wasn't accused of that – just about whether or not I had shared my HIV status. I spent my savings to hire a lawyer and ultimately accepted a plea bargain, rather than risk a 10-year sentence. I served six months in prison for a conviction under Louisiana's so called "Intentional Exposure to AIDS Virus" statute. Now I am obligated to register as a sex offender for 15 years.

The reality of life in prison for me, as an HIV-positive gay male, was challenging but I am thankful that I did not suffer any incidents of physical harm or high-risk sexual abuse. But it was practically impossible to maintain medical confidentiality when it came to taking medications publicly or going with other prisoners to the area HIV clinic on the bus. It didn't take a lot for the inmates and staff to know that anyone on that bus either had HIV/AIDS or something relative to it. There were times where I received only a portion of my antiretrovirals or they were not administered in conjunction with meals, as they should have been, which led to unpleasant bouts of stomach sickness.

Some of the most humiliating challenges were when I returned back to my cell after a recreation break or a medical appointment. Every single time I returned to my cell, they ordered me to strip naked, squat and cough in front of prison staff. For the first six weeks, I literally did not leave my cell unless I had no choice. I refused to go outside for the brief periods of recreation allowed because the stripping, squatting, and coughing were so humiliating.

In prison it is a violation to engage in any sexual behavior. If you get caught you'll get written up or lose privileges. But if you have sex in prison and are also HIV-positive, and you don't disclose, it is a crime and you can get prosecuted and have years added to your sentence. There was no privacy when it came to showering or using the toilets, no cubicles or curtains or dividing walls, just a big open room with showers and toilets. Other inmates told me that it was customary for homosexuals to face the wall when showering and always sit when using the toilets. Those who refused to do this, like me, were considered disrespectful.

When I was released from prison about 18 months ago, in January 2011, I needed a new life plan. I was now a convicted felon, a registered sex offender. My career had been in the court system, but they could not hire a convicted felon. My employment options were limited. I knew I had suffered a terrible injustice, although I didn't know it had a name: "HIV Criminalization". As I contemplated rebuilding my life, I remembered this saying: "your misery is your ministry" meaning that which *pains* you, that which causes you *discomfort*, that which has been *burdened upon you* is exactly that which can be *your salvation*, that which can be *your calling*, that which can be the way you become *of service to your fellow man...* and woman.

This lesson has given me the strength to become an advocate to combat stigma, discrimination and criminalization. Today, I am assistant director of The SERO Project and am able to pursue this work full-time. The message, however, isn't about what happened to me. It is about how easily it could happen to any of you. It is about what is happening right now to increasing numbers of men and women with HIV all over this country and all over the world.

The only people who will stop this epidemic of injustice are those of us who understand how insidious and destructive HIV stigma can be. If we do not make this issue a priority, if we do not lead, and if we do not demand change, it will never happen.

and injury. Qualitative data gathered from the Human Rights Watch confirms that sexual assault and rape can often be violent, causing abrasions, and tears to the anus, increasing vulnerability of contracting HIV.³³ For those already living with the virus, the trauma and subsequent stress caused by abuse can increase viral loads and opportunistic infections. In 2007, BJS found that approximately 60,500 state and federal inmates (or 4.5%) had experienced at least one incident of “sexual victimization” by other inmates or staff, with the majority perpetrated by staff.³⁴ This report also identifies specific subgroups—including women, gay and bisexual people, and individuals who had been sexually victimized in the past—as more vulnerable than others to sexual victimization and hence HIV infection.³⁵ Recognizing this, Congress passed the Prison Rape Elimination Act (PREA) of 2003, which established guidelines for preventing and addressing rape in prisons, as well as data collection requirements and grant funding. Through the National Institute of Corrections, PREA provides resources for agencies and localities to fight prison rape and its effects,

and encourages corrections administrators to work with advocates and survivors. Some steps involve providing counseling to survivors, as well as a requirement that all confinement facilities provide post-exposure prophylaxis and optional testing services. It also established a Prison Rape Elimination Commission (PREC), which researched prison rape and released an advisory report to the U.S. Attorney General in 2009.³⁶ (A complete list of policy recommendations can be found on page 21.)

Prison Rape Elimination Commission (PREC)

The PREC advisory report offered a number of recommendations to directly address rape in prisons, which were reviewed by U.S. Attorney General Eric Holder. First, PREC recommended that prisons implement protocols to prevent rape and to respond to it in a disciplinary manner. In addition, all prison staff, volunteers, and inmates should undergo training and education to recognize and respond to sexual violence in prison. The curriculum should include methods to prevent rape, and the message that such violent acts will not be tolerated. PREC also

Prevalence of sexual victimization, by type of accident, inmate sexual history, and orientation, National Inmate Survey, 2008–09

Sexual orientation and history	Prison inmates reporting sexual victimization ^a			Jail inmates reporting sexual victimization ^a		
	Number of inmates ^b	Inmate-on-inmate	Staff sexual misconduct	Number of inmates ^b	Inmate-on-inmate	Staff sexual misconduct
Sexual orientation						
Heterosexual	1,316,000	1.3%	2.5%	706,000	1.1%	1.9%
Bi-sexual, homosexual, or other	114,300	11.2**	6.6**	52,900	7.2**	3.5**
Number of sexual partners						
0–1*	229,800	1.4%	2.4%	121,600	1.20%	1.30%
2–4	181,500	2.3**	2.1	108,800	1.6	1.6
5–10	248,500	2.5**	2.0	141,700	1.5	1.5
11–20	227,600	1.8	2.5	125,200	1.1	1.6
21 or more	509,200	2.2**	3.6**	247,000	1.8**	3.1**
Prior sexual victimization						
Yes	177,000	11.0%**	8.7%**	100,100	7.4%**	6.1%
No*	1,280,400	0.8	2.0	676,900	0.6	1.4

***Comparison Group. **Difference with comparison group is significant at the 95%-confidence level. ^aPercent of inmates reporting one or more incidents of sexual victimization involving another inmate or facility staff in the past 12 months or since admission to the facility, if less than 12 months ^bEstimated number of inmates at midyear 2008 in prisons and jails represented by NIS-2, excluding inmates under age 18. Estimates have been rounded to the nearest 100.”

Source: U.S. Department of Justice

recommended that prisons have standards for investigation of rape claims, which should be followed in all circumstances.

The underlying issues that affect sexual violence were also addressed in the PREC report. It was recommended that medical and mental health staff receive training to recognize cases of sexual assault and to respond to rape cases. PREC strongly discouraged segregating vulnerable inmates from the rest of the prison population, and stated that they should be able to access the same services. The issue of sexual abuse by staff was also addressed, but it was only recommended that opposite-sex staff should not supervise inmates during activities in which they are partially or fully nude. The report failed to address same-sex sexual abuse, which is consistent with a general dearth of prevention messaging for homosexual activity in any federal campaigns. Finally, all facilities should record and report data about rape to BJS to be used in future policy writing.

Many of the recommendations were vague, both in regard to whom they addressed within the prison system and to specific steps that could be taken to follow recommendations. The mandatory trainings to prevent rape do not include any information about sensitivity to sexual or gender differences, despite evidence that these factors often determine which inmates are the targets of sexual violence (as even the report mentions). The staff requirements are particularly lacking, in that cross-gender supervision requirements do not address the specific needs of transgender or gender non-conforming inmates.³⁷

In response to PREC's advisory report, Attorney General Eric Holder released a much weakened set of federal guidelines to respond to prison rape in February 2011. PREC had previously advised that independent auditors monitor correctional facilities, to ensure that they are following proposed standards. However, Holder did not originally adopt any requirement that facilities be monitored by an independent agency. The Attorney General's initial guidelines were also criticized since they maintained cross-gender pat-downs and excluded immigration detention facilities from the newly proposed standards.³⁸ The allowance of cross-gender pat-downs is problematic since it ignores continued

sexual abuse perpetrated by staff.

In May 2012, after a period of public comment and review, Attorney General Holder released final rules that corrected the aforementioned shortcomings of his initial guidelines. His office determined that PREA applied to all federal detention facilities, including those outside the Department of Justice, and that each facility would be audited for compliance every three years. In addition, it banned cross-gender pat-down searches in all women's and juvenile facilities, restricted the use of solitary confinement as protection against abuse, and recognized the specific dangers faced by lesbian, gay, bisexual, transgender, intersex, and gender nonconforming inmates.³⁹ These revisions represent a significant victory for advocates and others who submitted public comment, though implementation of these rules will be a far more significant challenge for years to come.

Intravenous Drug Use

According to the 2004 BJS report on drug use and dependence in state and federal prisons, an estimated 330,000 prisoners were incarcerated for drug law violations and represented 21% of state and 55% of federal inmates. Studies estimate that drug use or dependence among male prisoners ranges from 10% to 48%, and among female prisoners from 30.3% to 60.4%.⁴⁰ Furthermore, sharing needles and other injecting equipment are high risk behaviors that contribute to the spread of HIV in the corrections system, and are among the most efficient modes of HIV and Hepatitis C transmission. Studies estimate that between 10-48% of male prisoners are dependent upon or use injection drugs, and between 56% and 90% of IDUs have been imprisoned. In one study, 25% of prisoners reported using needles to inject drugs, and half of those surveyed reported sharing needles. For those who cease drug use during incarceration, tolerance to certain substances may decrease. Without proper discharge planning and education, an individual may attempt to use these substances upon release in similar amounts to what was used prior to incarceration, often resulting in an overdose. Some facilities, including San Francisco county jails, provide trainings to inmates about how to recognize an overdose and how to respond safely.

IV. Healthcare in Prisons and Jails

The United States Federal Bureau of Prisons (BOP) is responsible for the oversight of health care in federal prisons. This agency provides health care through in-house medical providers, contracted medical providers, and medical providers assigned to BOP by the U.S. Public Health Service.

The fight for proper care and treatment in prisons has been long and difficult and, despite some progress over the years, enormous gaps remain. HIV, tuberculosis and hepatitis are among the most common infectious diseases in U.S. prisons.⁴¹ The CDC reports that up to 41% of inmates have ever been diagnosed with Hepatitis C Virus (HCV) and up to 35% are chronically infected.⁴² In the un-institutionalized population, HCV prevalence is 1-1.5%.⁴³

Disparities in HIV and HCV infection between incarcerated and non-incarcerated populations demonstrate inadequate access to care and treatment. HCV prevalence is also significant because it is linked to HIV. Both infections can be transmitted through unprotected sexual contact and injection drug use. Additionally, HIV-positive individuals are disproportionately affected by viral hepatitis; about one-third of HIV-infected persons are co-infected with hepatitis B virus (HBV) or HCV.⁴⁴

Decades ago, inmates at Attica prison in New York State rioted to demand better health care in August 1971. Soon after, in 1972, the Law Enforcement Assistance Administration of the Department of Justice (DOJ) commissioned a pilot program designed to improve health care in correctional facilities. An American Medical Association (AMA) advisory committee selected six states⁴⁵ to receive funding for at least two years with a \$448,000 annual grant to improve health care in jails and increase awareness of the challenges of doing so.⁴⁶ The AMA later established the National Commission on Correctional Health in 1983. Federal courts also asserted the need for proper care in prison. In *Newman v. Alabama*, a 1972 federal district court found the prison health conditions in Alabama to be a violation of the Eighth Amendment, since they were considered “cruel and unusual

punishment.” Similarly, *Estelle v. Gamble* found in 1976 that since inmates were not able to leave prisons to seek health care, they must receive it while incarcerated.⁴⁷

However the onset of the HIV epidemic, coupled with a political and legislative climate that was hostile toward prisoner health, led to deterioration in health care. Prisoners increasingly faced obstacles to HIV medical care in correctional facilities. In November 1981, the first prisoner in New York State was confirmed to have died from AIDS-related complications. By the early 1990s, two-thirds of all deaths of incarcerated persons in New York were AIDS-related.⁴⁸ Despite this, U.S. Senator Jesse Helms’ (R-NC) and other conservatives’ cries against HIV treatment funding in the late 1980s and

early 1990s made HIV care in prisons a marginally supported cause.⁴⁹ Some 7.4% of inmates in Northeast state prisons were known to be HIV-positive in 1993, a 22% increase from two years prior. Female inmates were significantly more likely to be living with HIV than male inmates.

The number of inmates in state and federal prisons with an AIDS diagnosis increased 124% from 1,682 in 1991 to 3,765 in 1993. AIDS-related deaths in state prisons increased by 46% in the same period.⁵⁰

As the 1990s progressed, the outlook for prison health only worsened. Starting in 1993, “Three Strikes” laws gained popularity across the U.S., eventually being implemented in 23 states and at the federal level. According to the statutes, those convicted of a serious offense on three or more separate occasions received a mandatory and extended period of incarceration. These laws were indicative of recent shifts in public opinion toward widespread fear and misunderstanding of crime. Using this fear, politicians were able to convince the public that increased incarceration meant greater safety, despite the fact that this was never proven and may have led to the opposite result.⁵¹ In line with this rhetoric, the health of prisoners was not prioritized for most people. In 2000, the Federal Prisoner Health Care Copayment Act passed the House of Representatives, which would charge prisoners

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co-payments on any health care they utilized. This bill never became law, but it was indicative of hostile attitudes toward prisoner health.⁵²

Today, the future of HIV care in prisons remains uncertain. Recent increases in use of solitary confinement have made access to medications even more difficult, as prisoners are excluded from regular distribution routines. Many prisons and jails subcontract their health care services out to private companies like Corrections Corporation of America (CCA), Wackenhut Corrections Corporation (WCC), and Cornell Corrections, with varying levels of quality.⁵³

Some companies implement measures such as electronic medical filing to reduce wait times for treatment and other improvements.⁵⁴ However, a 2008 Bureau of Prisons report identified structural problems in prison health, specifically in contracted prisons. According to the report, more than 10% of inmates did not receive most of the required preventive health services. A severe lack of regulation and monitoring on the part of federal officials was also reported.⁵⁵

Many facilities located in rural areas without ready access to an HIV specialist use Telemedicine services, wherein a specialist communicates with inmates through a telephone or online video connection. This technology has greatly increased access to healthcare in rural communities nationwide. However, this system proves highly problematic in prisons, where the confidentiality of the phone or video connection is often unknown to prisoners. Therefore, many prisoners will neglect to inform physicians about their HIV diagnosis or related complications. In order to provide adequate prevention services and HIV care in federal and state prisons, there remains tremendous work to be done.

Immigration Detention Centers

Every year almost 400,000 people are detained for immigration violations and are placed in state prisons, county jails, corporate detention centers, and some facilities run by U.S. Immigration and Customs Enforcement (ICE).⁵⁶ Little is known about the true impact of HIV among detainees or

about medical care for detainees living with HIV. Furthermore, ICE is not mandated to report basic statistics on morbidity and mortality. Existing evidence provides grave cause for concern and suggests that detainees are denied the HIV screening, care and treatment that they need. Immigration detention centers are notorious for poor living conditions. In fact, a 2008 New York Times article identified 66 individuals who died while in immigration custody from 2004 through 2007.⁵⁷ Nine of these detainees died due to HIV-related complications, often because they were denied HIV medication.⁵⁸

Detainee Basic Medical Care Act of 2008

In 2008 Senator Robert Menendez of New Jersey introduced the Detainee Basic Medical Care Act. The Act would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees in custody and for other purposes. This legislation is critical to people living with HIV since current standards, and access to screening and care for HIV, is inadequate. However, there has been no movement on this issue in Congress since then.

A 2008 New York Times article identified 66 individuals who died while in immigration custody from 2004 through 2007. Nine of these detainees died due to HIV-related complications, often because they were denied HIV medication.

Passage of this legislation would ensure that immigrant detainees receive fair and just treatment, including the critical medical care they need. The bill would set mandatory standards for care and require that all deaths be reported to the Justice Department and Congress. (A complete list of policy recommendations can be found on page 21.)

Condom Access

Although the prevalence of high-risk sexual behaviors and sexual assault demonstrate the need for proven HIV prevention methods in correctional facilities, only five county jail systems (New York, Philadelphia, San Francisco, Los Angeles, and Washington, DC) and two state prison systems (Vermont and Mississippi) allow prisoners access to condoms.⁵⁹ This represents less than 1% of all U.S. jails and prisons.⁶⁰ Correct and consistent use of condoms reduces the

risk of sexually transmitted infections (STIs) and HIV transmission and has been shown to be up to 98% effective at preventing pregnancy.⁶¹ Condoms remain the single-most effective prevention intervention and will go a long way towards reducing HIV transmission and other STIs in the corrections system.

The Central Detention Facility of Washington, DC began providing condoms to prisoners in 1993 and each month condoms are provided through public health and AIDS service organizations. Condoms are available during health education classes, voluntary HIV pre- or post-test counseling, or upon request to health care staff. Since condoms were made available in the Washington Central Detention facility, 55% of inmates and 64% of correctional officers support the measure. Only 13% of correctional officers are aware of any problems associated with condom availability, but details about these issues have not been provided. Similarly, no security issues have been reported relating to condom availability and there is no evidence that sexual activity has increased.⁶²

Although a majority supports making condoms available in prisons, 89% of prisoners have not requested them. Also, 65% of those who have received condoms never used them.⁶³ These results suggest that although condoms are available when a prisoner is able to request them, not many condoms are distributed throughout the prison. A possible explanation for this is that prisoners are unwilling to request condoms because this would also be an admission that he or she is engaging in sexual activity. Stigmatization of sexual activity may also discourage those who possess condoms from using them. Distribution policies in other prisons should address these concerns in order to increase condom use.

The successful methods of condom distribution in Canadian federal prisons, for example, can be used as a model for implementation in U.S. jails and prisons. Condoms have been made available in Canadian prisons since 1992.⁶⁴ Like the Washington Detention facility, condoms

were initially only available through health care providers in the prisons. Many inmates reported that they would be more likely to access condoms if they were made available apart from health services. In response, condoms have been made available since 1994 in areas where prisoners are not seen by staff or other inmates.⁶⁵ Condoms are placed in bowls and other containers in sites such as washrooms, shower areas, and libraries. The introduction of condoms in Canadian prisons has met much success and no facility that has made condoms available has reversed the policy.

Efforts to change policies regarding condoms in prisons have met challenges at the state and federal levels. In California, bills that would allow condoms in prisons were passed in 2005 and in 2007, but were vetoed by Governor Schwarzenegger in both instances.⁶⁶ Senator Velmanette Montgomery sponsored a bill (S.230) in the New York State Senate in 2011 which would amend the correction law, requiring

The introduction of condoms in Canadian prisons has met much success and no facility that has made condoms available has reversed the policy.

correctional facilities to distribute condoms in prisons. The bill has yet to come to a vote.⁶⁷ At the federal level, Representative Barbara Lee introduced the Justice Act (H.R. 2704) in 2011, which would permit condoms in federal correctional facilities. The bill has been referred to Committee but at this time, no further action has been taken.⁶⁸

Condom distribution programs also face other challenges upon implementation. In many jails, utilization of these programs is significantly higher in women's facilities than amongst men's facilities due to stigmatization of sex between male partners. Providing condoms through vending machines instead of bowls helps to increase use, and alleviates worries about damage to the condoms. Those who oppose condom distribution argue that since sexual activity is prohibited in prisons, condoms should not be offered. However, it is widely known that sexual activity is common in prisons. Thus, from a public health standpoint, moral judgments about sexual activity must not direct policy. Condoms are an evidence-based prevention tool against HIV and are necessary to protect the health of prisoners.

Drug Treatment and Pharmacological Interventions

In order to combat IDU-related HIV cases, the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended consideration of needle exchange programs, provision of cleaning supplies such as bleach, and drug dependence treatment programs.⁶⁹

Syringe exchange programs (SEPs) and other related structural interventions have been implemented in over 50 prisons in 12 countries in Europe and central Asia, and have found much success.⁷⁰ The first prison-based SEP was implemented in Switzerland in 1992 by prison health care officials. Thereafter, syringes can be exchanged through automatic dispensing units at discreet locations throughout the prison.

Correctional facilities also employ health care personnel in collaboration with participating non-government organizations to conduct syringe exchanges. In

other delivery systems, clean syringes are made available by drug counseling staff.

The documented benefits of prison-based SEPs give further support for the potential use of this structural intervention in the U.S. corrections system. Based on six separate evaluations of prison-based SEPs in Europe, over various time periods spanning up to eleven years, reports of drug use decreased or remained stable over time; reports of syringe sharing declined dramatically; no new cases of HIV, hepatitis B or C were reported; and there were no unintended negative consequences, such as initiation of injection drug use or use of needles as weapons.⁷¹ Furthermore, prison-based SEPs promote access to substance abuse treatment and care. Although syringe exchange is an evidence-based HIV prevention tool, stigma surrounding injection drug use and the concern that prison-based SEPs condone drug use are structural barriers to implementation that perpetuate the spread of HIV within the corrections system. Although overturned in 2009, Congress has since reinstated the ban on federal funding of SEPs in the Labor, Health, and Human Services appropriations bill as part of the FY 2012 appropriations package. This effectively

removes a proven HIV prevention tool, and is a significant setback in the fight against HIV.

Another major benefit of SEP is that it also benefits those using needles for activities other than drug use. In prisons, needles are commonly used for tattooing, as there is a 13-times higher rate of tattooing amongst incarcerated populations, 13% of those surveyed said that safe tattooing should be a priority. In Canada, for instance, Correctional Services of Canada estimated that 45% of inmates acquired a tattoo while in prison. SEPs can provide services that reduce the risk of shared needles during tattooing.

Along with SEPs, opioid substitution therapy is an evidence-based intervention used to treat opioid dependency. Opioid substitution therapies are

available primarily through methadone maintenance therapy (MMT) programs.⁷² In a 2003 survey of medical directors representing prisons from all 50 states, 48% of the respondents

(having jurisdiction over 88% of U.S. prisoners) use MMT.⁷³ Despite its limited availability, MMT has been shown to reduce rates of mortality, drug injection and syringe sharing, HCV infection, HIV-related risk, and recidivism.⁷⁴ As a case example, 27% of MMT subjects tested positive for morphine after four months of follow-up, as compared to 42% of control subjects, in a controlled trial of MMT in an Australian prison system. In addition to a decrease in drug use, the percent of shared syringes for the treated and control groups were 20% and 54% respectively.⁷⁵

Furthermore, studies have also shown that longer periods of MMT are associated with lower rates of recidivism. According to a study conducted by Kate A. Dolan et al., risk of re-incarceration was reduced by 70% during MMT periods of eight months or longer.⁷⁶ Although MMT programs have a positive impact on reducing HIV-related risk and recidivism, their availability remains limited. Promotion and expansion of MMT programs in U.S. prisons and jails is an important harm reduction strategy, since it is a proven structural intervention that reduces drug dependency, HIV risk factors, and the cycle of recidivism.

Prison-based SEPs promote access to substance abuse treatment and care.

HIV Education and Testing

Twenty-two percent of respondents in a 2006 CDC study suggested that HIV education should be provided in prisons. In an editorial note, the CDC echoed that recommendation and cited several successful cases of HIV education, testing and prevention counseling in other correctional systems. The CDC also recommended providing HIV education to corrections staff.⁷⁷

Other than limited knowledge about HIV, specific policies within prisons serve as major obstacles to successful HIV testing. HIV testing strategies vary considerably among correctional facilities and include mandatory, voluntary, and opt-out testing. However, structural barriers largely prevent prisoners from getting tested. Fear of discrimination, lack of confidentiality, and stigmatization of IDU and MSM behaviors hinder access to prevention services and HIV testing and continue to fuel the epidemic in the corrections system.⁷⁸

In order to address these barriers and increase HIV screening, the CDC has recommended routine opt-out HIV testing in all health care settings, including prisons and jails. Under these recommendations, HIV screening is made available as part of the standard medical evaluation and is performed unless the patient declines. The CDC recommendations also include annual testing for persons at high risk for HIV infection, but unfortunately do not require accompanying prevention counseling. They also do not recommend the necessity of specific consent for HIV testing; consent for general medical care is sufficient.⁷⁹

In a study of 298 newly incarcerated inmates in a men's jail in New Haven, Connecticut, routine opt-out testing was offered at three different stages after admittance: immediate (same day), early (next day), or delayed (7 days). The data demonstrated that HIV testing was higher for the early (53%) and immediate (45%) testing groups, compared to the delayed (33%) group.⁸⁰ In another study of a Massachusetts county prison, the voluntary testing rate during the control period was 18%. After transitioning to routine opt-out testing, HIV testing increased to 73.1%.⁸¹ Routine opt-out testing significantly increases HIV testing rates and promotes early detection and access to treatment services.

Part of the success of opt-out testing can be attributed to the near elimination of structural barriers that discourage inmates from testing. Inclusion of voluntary testing as a component of the standard medical evaluation reduces HIV related stigma associated with testing. Strict guidelines in the CDC recommendations concerning confidentiality maintain patient privacy rights and ensure the overall safety of prisoners. Opt-out testing may also reduce racial disparities in testing rates by normalizing and routinizing HIV testing.⁸²

Mandatory HIV testing, on the other hand, is a highly problematic and less effective HIV testing strategy. Upon entering the corrections system, an individual may be ill-equipped to handle a potential diagnosis of HIV. Furthermore, mandatory testing may exacerbate segregation policies for HIV-positive individuals, which continue to exist in Alabama and South Carolina. As part of these policies, HIV-positive individuals are housed separately and are often assigned to maximum security facilities.

In this context, mandatory testing operates as a structural driver of the epidemic in correctional facilities by further stigmatizing HIV-positive individuals. Opt-out testing is therefore a more effective testing strategy that increases and streamlines HIV screening, while targeting structural drivers of the epidemic within the corrections system.

Medical Confidentiality

In an April 2006 study, a University of California San Francisco researcher reported that medical confidentiality in the prison system was "virtually impossible to maintain".⁸³ Medical records, especially the results of HIV tests, could be handled by a number of prison staff members including non-medical personnel. A 1988 California Proposition required physicians in correctional facilities to provide lists of inmates known or suspected to have an HIV infection to custodial staff members. Because prison is a closed community, information travels quickly. Those diagnosed with HIV are often segregated or quarantined, or have been denied visiting privileges or certain work assignments such as kitchen work.⁸⁴

Segregation

Segregation may serve as a measure that dissuades prisoners from getting tested. In the early days of the epidemic, the majority of state and federal prison systems segregated HIV-positive inmates as a method of protecting other inmates from infection.⁸⁵ Over time, policies regarding HIV-positive inmates changed as advances were made in our knowledge of HIV transmission. Currently, integration of HIV-positive inmates is practiced in the majority of states and considered a best practice in correctional health. However, Alabama and South Carolina have maintained segregation policies. Furthermore, they also enforce mandatory HIV testing of all inmates.⁸⁶ If an inmate tests positive, they are immediately

In an April 2006 study, a University of California San Francisco researcher reported that medical confidentiality in the prison system was “virtually impossible to maintain”.

segregated, and most will wear an arm badge or other marker signifying their HIV status to other inmates and personnel.⁸⁷

Segregation policies for HIV-positive prisoners present a number of discriminatory practices and human rights violations. These include: involuntary disclosure of HIV status to family, staff, and other inmates; assignment to higher security prisons where segregated HIV units are housed, and at a greater cost to taxpayers; denial of work-release opportunities, which allow prisoners to earn credits to shorten their sentences; and denial of re-entry opportunities, such as employment, which have been shown to reduce recidivism.⁸⁸

V. Innovative Prevention Efforts

As has been explained at great length, incarcerated individuals are disproportionately affected by HIV. In order to combat the risk of infection, many different harm reduction and educational programs have been implemented. Programs to reduce HIV risk target four critical points in the process: upon entry to prison, throughout incarceration, prior to discharge, and during transition back to society.

Upon entering correctional facilities, interventions can provide inmates with an opportunity to learn their HIV status and can teach about behaviors that may put them at risk for HIV. At San Quentin State Prison in California, peer-led HIV prevention education is a component of orientation to inmates entering the prison each year. The introductory sessions focus on HIV testing, HIV transmission, and the effects of HIV/AIDS on individuals. The sessions are followed by HIV testing, which is provided to all 12,000 new inmates each year.⁸⁹

While incarcerated, interventions must address the reality of prison life: intravenous drug usage and sexual activity. Efforts to reduce transmission through SEPs, as well as access to safer injecting strategies and tools, have been

proven successful. The first SEP in a prison was in Switzerland in 1992, and similar programs have since been implemented across the globe due to their great success in lowering incidence of HIV transmission. In Germany, for example, all seven prisons that introduced SEP saw no seroconversions and strongly reduced rates of needle sharing, with no increase (and sometimes even a decrease) in drug use. In terms of decontamination, prisoners who have access to bleach have been shown to clean syringes prior to use.⁹⁰

Two other possible methods to decrease HIV transmission through drug use include drug-free units (DFUs) and mandatory drug testing programs (MDTs). Prisoners self-selecting to stay in DFUs have substantially lower rates of drug use than other prisoners, though the long-term impact of DFUs has yet to be analyzed. In addition, MDTs may actually slightly *increase* IDU due to the fear that smoked cannabis is more detectable than opioids (resulting in a substitution of cannabis with opioids).⁹¹

Most important, however, is the use of rehabilitation programs to decrease IDU. As many prisoners are incarcerated for IDU, and

inmates have higher rates of IDU history than the general population, rehabilitation programs can dramatically decrease the likelihood of IDU during and after incarceration. Due to limited resources and time constraints of counselors, rehabilitation programs are underutilized as methods to reduce HIV infection rates in American correctional facilities.⁹²

Some individuals are incarcerated due to commercial sex work, while many others have histories of other high-risk sexual activities. Therefore, programs use an individual's time in prison to teach about effective condom use.

Educational programs designed to inform inmates about HIV risk are quite common. The Connecticut Department of Corrections' Addiction and Health Services Unit facilitates a "Beyond Fear" program which seeks to educate inmates about HIV risk, discuss and debunk common myths of HIV testing, anticipate high-risk situations, increase self-efficacy for HIV prevention through role-play, and encourage inmate peer education.⁹³ Florida, New Jersey, and New York also have services in their state prisons that teach about HIV prevention in single or multiple sessions.⁹⁴

One successful example of a pre-release intervention system is Maryland's Prevention Case Management (PCM) program, where groups and individuals are counseled near release in order to promote changes in inmates' risk behavior. PCM has a curriculum taught usually by peer educators with four mandatory modules and three optional modules. The mandatory curriculum includes *Personalizing HIV/AIDS Risk and Risk Reduction*, *Transitioning Into the Community*, *Condoms and Other Devices*, and *Substance Abuse*. Meetings begin 6 months prior to an inmate's release. Through education, PCM has been able to create statistically significant changes in attitude, and behavior related to HIV risk (including effective condom use and safer injection drug use).

Maryland's PCM program is successful in its ability to address a variety of issues that inmates

may face upon release. The program helps facilitate a transition back into society, and could easily be adapted by other states into already existing curricula.

However, the PCM program lacks significant information for inmates living with HIV. Though the vast majority of HIV-positive inmates acquire the virus before entry, many receive their initial HIV diagnosis while in a correctional facility. Thus these individuals have not had experience in managing HIV, and often need guidance as to how to continue treatment after release. Discharge planning programs help inmates find insurance coverage, learn about support systems

In Germany, all seven prisons that introduced SEP saw no seroconversions and strongly reduced rates of needle sharing, with no increase (and sometimes even a decrease) in drug use.

for HIV-positive individuals in their community, find stable housing, and ensure access to continued medical treatment. As of 2002, 78% of jails and 92% of prisons reported providing some degree of pre-release planning for HIV-positive inmates.⁹⁵ Arizona's AIDS Drug

Assistance Program (ADAP) ensures a 30-day supply of ARVs will be held at the prison pharmacy and given to the inmate upon release. New York City's ETHICS (Empowerment Through HIV/AIDS Information, Community, and Services) program helps formerly incarcerated individuals find homes in safe, drug-free environments. For instance, some individuals are given accommodations at local YMCAs until permanent housing is found. Such programs can effectively meet the needs of HIV-positive individuals while keeping them healthy, lowering their viral loads, decreasing transmission rates to partners, and reducing the community viral load.

Women face unique challenges upon reentry that must also be addressed directly. The Women's Prison Association of NYC created the Transitional Services Unit in 1992, which helps formerly incarcerated women navigate state and federal resources for which they may be eligible as either HIV-positive or high-risk individuals. TSU assists women in finding child-care services, transportation to appointments, and referrals for drug rehabilitation programs. A similar program in Rhode Island reduced the percentage of women returning to prison after release from 39% to 17%.⁹⁶

Proven structural interventions can help streamline HIV testing in correctional facilities and reduce certain high-risk behaviors (i.e. unprotected sex, shared needle use) associated with HIV transmission in the corrections system.⁹⁷

The JUSTICE Act

Without uniform prevention, testing, and treatment programs, incarcerated persons living with HIV and/or other STIs can unknowingly infect others. Often left untreated, incarcerated persons with STIs are frequently in the more advanced stages of their disease, and once released can be even more costly for the public health system to treat. One outcome of the lack of a coordinated response to HIV is that among confirmed AIDS cases in prisons, racial minorities account for the majority. Black prisoners are 3.5 times more likely than white inmates, and 2.5 times more likely than Latino inmates, to die from AIDS-related causes.

Advocacy on the Inside

Prisoners at Fishkill Correctional Facility in upstate New York are playing a crucial role in the fight against HIV/AIDS. Prisoners for AIDS Counseling and Education (PACE), a group of advocates and peer educators in the prison system, links inmates to HIV testing, offers discharge planning for those living with HIV and/or Hepatitis C, and holds cancer support groups. PACE also facilitates educational workshops about epidemiology, high risk activity, prevention methods, and smoking cessation, and recruits inmate facilitators to hold educational trainings about HIV for fellow prisoners. These trainings are provided by the Osborne Association and cover the aforementioned topics in addition to nutrition, stress reduction, counseling techniques (including bereavement), domestic violence, hepatitis, substance use and harm reduction, mental health, and LGBT-specific issues. PACE also holds an annual Walk-A-Thon fundraising event where members review information about HIV and compete in outdoor activities. The funds raised are then presented to a non-profit organization in the HIV/AIDS field at a World AIDS Day event. In addition to the Osborne Association, PACE engages in partnerships with other organizations including GMHC to provide updated and additional materials to inmates and to increase awareness outside of prisons.

In August 2011, Representative Barbara Lee (D-CA) introduced H.R. 2704, The Justice for the Unprotected against Sexually Transmitted Infections among the Confined and Exposed (JUSTICE) Act. This legislation would allow prisons to provide condoms to incarcerated individuals. The JUSTICE Act also calls for automatic reinstatement or reenrollment in Medicaid for people who test positive for HIV before reentering communities. This action is of tremendous importance to public health since it would provide a comprehensive response to the spread of sexually transmitted infections in correctional facilities. (A complete list of policy recommendations can be found on page 21.)

Stop AIDS in Prison Act

The Stop AIDS in Prison Act of 2011, led by Representative Maxine Waters (D-CA), addresses comprehensive HIV care and prevention in federal prisons on a structural level. The bill calls upon the Bureau of Prisons to take 11 concrete steps to combat HIV in prison, promote awareness, and improve medical care.⁹⁸ All testing and medical care would be required to be strictly confidential, with penalties for any breach of confidentiality.

The Act would include HIV testing as a medical service provided with consent during intake and within three months prior to release. Testing would also be provided upon request once per year, or following high-risk exposure or upon pregnancy. Prison personnel would be instructed to encourage inmates who might be at high risk for HIV infection to get tested, and would be prohibited from using any request for testing as evidence of misconduct. Those who tested positive for HIV would have the option of “partner notification services.” Inmates would be able to refuse testing at any time, for any reason, without penalty.

Inmates would also be entitled to comprehensive medical care in a timely fashion, with confidential consultations about managing the virus. The care would need to be consistent with standards set by the Department of Health and Human Services, and the Food and Drug Administration’s (FDA) recommended medications would need to be readily available. Upon release, prisons would need to provide information about where to receive treatment and care in the community, as well as 30 days’ worth of medication.

In addition, prisons would need to provide educational opportunities for inmates about modes of HIV transmission. This would involve working with a number of organizations, agencies, and well-informed inmates to provide culturally competent and accessible presentations, written materials and audio-visual resources in multiple languages. Within one year, the Bureau of Prisons would need to report to Congress on its policies to enforce the above provisions. Within two years, and every year after, it would also need to report incidence rates of STIs and IDU.⁹⁹

VI. HIV Post Incarceration

Challenges for HIV-Positive Individuals Upon Release

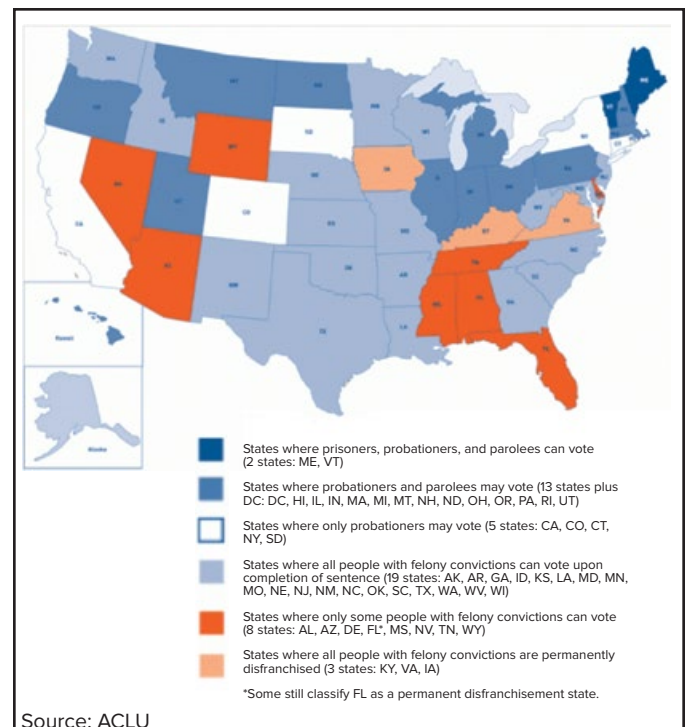
Employment, housing, voting, and even public assistance become increasingly difficult to access following incarceration. In fact, after being convicted of any drug-related offense, students are ineligible for any federal loan, grant, or work assistance for higher education, and all states must abide by this ban.¹⁰⁰ If a person living with HIV is trying to care for themselves following incarceration, they will confront a number of hurdles in doing so. Aside from the fact that it is still legal to deny employment to formerly incarcerated people in most states, or deny voting to those with felony convictions in some states, those living with HIV face other barriers that can threaten their physical health.¹⁰¹

Instability associated with reintegration poses a significant challenge for pre-release planning and continuity of ARV treatment following a period of incarceration. In a study of HIV-infected individuals in British Columbia who were prescribed highly active antiretroviral therapy (HAART) between 1997 and 2001, only 18% of subjects who received their first prescription of HAART while in prison remained fully adherent to their regimen during the first year following release. Alternatively, 48% of those who received their first prescription outside of prison remained adherent.¹⁰² The study also demonstrated that increased time spent in jail was positively associated with HIV suppression. The data indicate that patients are able to adhere to HAART within a structured correctional system but are unable to continue the same level of adherence upon reintegration.

The Stop AIDS in Prison Act was reintroduced in the 112th Congress, and more elected officials need to be alerted to its benefits. The bill effectively streamlines HIV testing while maintaining confidentiality in correctional facilities. Moreover, the legislation will provide the necessary HIV prevention services and treatment in order to improve HIV health care in prisons. (A complete list of policy recommendations can be found on page 21.)

Part of the problem is inadequate pre-release planning and subsequent linkage to patient care following release. The structural barriers and legal ramifications of incarceration regarding housing, education, employment, and economic security also hinder continuity of treatment upon reintegration.

Recidivism and the disruption of community networks not only place communities at increased risk of HIV, but also adversely affect the health management of re-incarcerated individuals. In a study looking at the effect



of re-incarceration on the viral loads and immunological outcomes of prisoners, Stephenson et al., demonstrated that the cycle of recidivism hinders HIV suppression and adversely affects patients' immunological outcomes. Comparing re-incarcerated subjects to incarcerated subjects that remained incarcerated during the entire study, 8 out of 15 re-incarcerated participants and 15 out of 30 incarcerated participants had viral loads of under 400 copies/mL at the beginning of the study. At the end of the study, however, only 3 out of 8 re-incarcerated individuals compared to 14 out of 15 incarcerated subjects maintained this level of viral suppression.¹⁰³ This disproportionate health outcome demonstrates the devastating impact that community disruption and recidivism have on ARV adherence and viral suppression.

Readjustment

Other than just through poor access to medication, newly released prisoners are structurally at a high risk of reincarceration and increased risk of contracting HIV. A 1994 BJS study found that 67.5% of prisoners released were rearrested within three years, and 46.9% were subsequently reconvicted. Overall, 51.8% of prisoners returned to prison within three years.¹⁰⁴ The cycle of incarceration and recidivism only serves to fuel the HIV epidemic by disrupting sexual relationships and ignoring substance use. Ensuring a reliable income and breaking addiction can also help an individual to remain adherent to HIV medications. This will improve overall health and reduce the likelihood of transmission.

Another study conducted among social networks of IDUs in Chicago and Washington, DC found that individuals in communities with higher rates of recidivism were more likely to engage in HIV risk behaviors. Increased movement in and out of the community was associated with higher risk IDU, mainly because of resource availability within IDU networks.¹⁰⁵ Incarceration leads to a high rate of community turnover and the structural barriers associated with incarceration increase the likelihood of recidivism and therefore exacerbate community disruption, which places the communities where prisoners come from at increased risk for HIV.

Housing

Benefits of stable housing

Stable housing represents one of the strongest structural interventions in the fight against HIV. It is a strong predictor of improved health outcomes, increased utilization of health care services, greater adherence to ARVs, and reduced risk behaviors.¹⁰⁶ In a study of health status and medication adherence among homeless and stably housed people living with HIV/AIDS (PLWHA), stably housed respondents were more likely to have higher CD4 counts, lower viral loads, and higher ARV adherence compared to the homeless population. Of stably housed individuals, 48.6% had undetectable viral loads, compared with only 35.3% of homeless individuals. Likewise, only 17.1% of the stably housed population reported having skipped an ARV dose in the past 48 hours, compared with 31.3% of the homeless group.¹⁰⁷ These studies demonstrate that housing security is critical for improved health outcomes for PLWHA and is a strong predictor of medication adherence.

However, for many returning prisoners, access to stable housing is one of the most significant challenges upon re-entry.

Housing and Homelessness

Those with prior felony convictions are ineligible to live in public housing, and those with prior drug and sex offenses are often denied federally subsidized housing.¹⁰⁸ Many applicants who are eligible for subsidized housing return to urban areas with long waiting lists and overcrowded facilities. Often, initiatives to build housing specifically available to formerly incarcerated tenants encounter a “not in my backyard” (NIMBY) attitude from surrounding communities.¹⁰⁹ Moreover, landlords often require background checks from all prospective tenants and deny housing to those with past criminal histories.¹¹⁰ These policies often lead formerly incarcerated individuals into unstable housing situations, such as single room occupancy (SRO) hotels, transitional housing, or homelessness. SROs often have high rates of substance use amongst occupants, including in public areas, which makes recovery from addiction severely difficult. In addition, they are often significantly more expensive than independent housing, even when that housing is heavily subsidized.

Drug felon ban on TANF and Food Stamps

Adopted federal ban	Opted out of federal ban entirely	Opted out of food stamps and modified ban on TANF	Modified ban by requiring treatment	Modified ban by requiring completion of sentence or treatment	Other modifications*
Alabama	Idaho	Illinois	Colorado	Connecticut	Arkansas
Alaska	Maine	Massachusetts	Hawaii		Delaware
Arizona	Michigan		Iowa		Florida
California	New Hampshire		Kentucky		Louisiana
Georgia	New Mexico		Nevada		Maryland
Indiana	New York		South Carolina		Minnesota
Kansas	Ohio		Tennessee		New Jersey
Mississippi	Oklahoma				North Carolina
Missouri	Oregon				Rhode Island
Montana	Pennsylvania**				Washington
Nebraska	Utah				Wisconsin
North Dakota	Vermont				
South Dakota					
Texas					
Virginia					
West Virginia					
Wyoming					

*Limiting ban to distribution or sale offenses or requiring submission to drug testing. **The new statute opting out specifically requires the department to follow pre-existing procedures for referral for assessment and treatment if available and appropriate.

Source: The Legal Action Center

Unstable housing is associated with increased HIV risk behaviors and directly correlates with increased HIV prevalence and incidence rates. A multivariate analysis of HIV-infection among injection drug users in Vancouver, Canada links a lack of secure housing to substance abuse, syringe sharing, lack of MMT enrollment, commercial sex work, inaccessibility of addiction treatment programs, and unprotected intercourse with casual partners.¹¹¹ These correlates of unstable housing place formerly incarcerated individuals and their communities at increased risk of HIV transmission and demonstrate the necessity of securing stable housing.

Economic Insecurity

Individuals with prior convictions also face significant barriers in securing stable employment and establishing economic security. Although data is limited concerning employment and earning potential of formerly incarcerated individuals, a 1979 study of the National Longitudinal Survey of Youth (NLSY79) indicates that employment rates averaged about 60% among young men previously incarcerated and only 45% in formerly incarcerated young black men. These estimates are approximately

20-25% lower compared to young men without prior convictions.¹¹² A 2006 study of low-income fathers found that those with histories of incarceration had an employment rate 6 percentage points lower than those with no such history.¹¹³ In order to control for the direct effect of incarceration on reduced employment opportunities and earning potential, studies often compare employment and earnings both before and after a period of incarceration or compare incarcerated and non-incarcerated populations with similar educational, occupational, and demographic profiles. Studies indicate that earning potential is reduced 10-30% due to a period of incarceration alone.¹¹⁴ A survey conducted in 1996 also indicates that 65% of all employers would refuse to hire an applicant with a criminal record.¹¹⁵ The stigma associated with a prior incarceration creates a series of barriers that place formerly incarcerated individuals at increased risk of economic insecurity when trying to rebuild their lives upon reintegration.

In April 2012, the Equal Employment Opportunity Commission (EEOC) issued updated guidance on employers' use of arrest and conviction records. They found that hiring policies that exclude all applicants with criminal records had disparate

racial impact, and were therefore violating Title VII of the 1964 Civil Rights Act. They instead advised that employers wishing to consider criminal records not include arrests without convictions in their decision, and that they judge applicants on an individual basis considering the “nature of the crime, the time elapsed, and the nature of the job”. Though the EEOC is not a regulatory agency, their guidance referenced social science and case law and can be deferred to by judges in employment discrimination lawsuits.¹¹⁶ This is only an option, however, and many employers continue blanket denial of employment to anyone with a history of incarceration.

In addition to the barriers in securing stable employment, many states impose incarceration-related user-fees on those with prior convictions. Various court costs, costs of prosecution, and mandatory recoupment fees for persons seeking public defenders add up to significant financial obligations that often place formerly incarcerated individuals at increased risk for default on debt repayment. A study published by the Brennan Center for Justice at New York University School of Law found that 13 out of 15 states impose public defender fees for individuals exercising their constitutional right to public counsel. These fees contribute to the economic challenges faced by formerly incarcerated people.¹¹⁷ Furthermore, most states prohibit anyone with certain drug felony convictions from federally funded public assistance and food stamps. Since 2004, nine states have dropped this ban, but many will still confront significant challenges in accessing public assistance with their HIV care.

The lack of economic security following incarceration has a particularly devastating effect on those living with HIV. If these individuals are not able to find adequate financial assistance or gainful employment, they are often forced to choose between housing, transportation, food and other vital necessities. Furthermore, housing and adequate nutrition are both factors that directly correlate with treatment adherence and improved health outcomes.

The long-term consequences of incarceration and its associated barriers ultimately disrupt

community networks and contribute to individual and community level HIV risk factors. Financial insecurity diminishes condom-negotiation ability by disturbing power dynamics in relationships and increasing the likelihood of coercive sex, which directly affects individual risk for HIV.¹¹⁸ Economic insecurity may also force individuals to engage in high-risk behaviors, such as participation in commercial sex work or survival sex work.¹¹⁹ The structural barriers associated with a lack of sufficient wage following a period of incarceration have been shown to increase the likelihood of recidivism, which only further disrupts community networks and contributes to population-wide risk of HIV.¹²⁰

Second Chance Act

The Second Chance Act, signed into law in 2008, addresses the difficulties faced upon re-entry. In 2010, the Act funded 187 programs including education, court projects, mentoring, recovery support, and assistance to formerly incarcerated juveniles and adults in their transition back into communities. These programs address

Most states prohibit anyone with certain drug felony convictions from federally funded public assistance and food stamps.

some of the root causes of HIV transmission for communities affected by incarceration. They set out to decrease the likelihood of recidivism by providing education and vocational training for

better job availability, and addressing substance use and mental illness through counseling.¹²¹ By attempting to stabilize a person’s income and location, as well as making sure their physical and mental needs are addressed, programs can stabilize entire communities.

The Second Chance Act has tremendous potential to reduce new HIV infections in prisons and subsequently in communities disproportionately affected by incarceration. Its potential can only be realized, however, if fully implemented. The Second Chance Act must receive full federal funding in order to be effective in its goals, and 60 Representatives as well as 21 Senators have signed letters this year supporting such funding.¹²² With further education and advocacy, communities can begin to reap the benefits of this necessary piece of legislation. (A complete list of policy recommendations can be found on page 21.)

Personal Perspective: Alan Perez

I was incarcerated in the 1990's after I was arrested for having marijuana. They took me to a local jail and then to central booking, and when I saw the judge, he sentenced me to six months. Out of those six months that I was in Rikers Island, I was afraid. There were a lot of things in the jail system that I didn't like, and that I saw with my own eyes, like the inmates and the COs having sex. And those were kind of like gangs. The inmates were sometimes even like the police, and around some people would say, "Ya'll mines." I've seen the COs take out their stick and whack you if you don't do what you're told. Some of these COs need to have training but I can tell you also that they need to have training on HIV and AIDS in the whole prison system. Get somebody in there to educate those inmates about safe sex. I know in most places they still don't let condoms in.

Then when I was in there, I got sick, and I have diabetes so my sugar went up. I told one of the COs that I needed a doctor and I needed to go to the hospital because my sugar went down, but he refused. I wasn't treated the first time, until the warden came and then he said try to call the ambulance right away because I will be responsible for his death if anything happens to him. So that's what they did. I don't know whether or not I was going to die. They thought I was going to die.

There is no communication between the COs and the inmates, and they don't talk to you as equals. If you give me respect I give you respect but they will not do that. When it would be time to get medication, I wouldn't get all the medications I needed to take, like the ones for high blood pressure and HIV. Also, the doctors didn't know anything about HIV. They need to have HIV specialists in there. My drug regimen changed in prison and I missed doses of my treatment. They also don't talk about treatment on the inside. They used to have a lot of the outside agencies come in but they cut all of that back.

Being incarcerated affected my family very much, especially my mother. She was always crying whenever she would come and see me. She didn't want to bring my brother to prison because she didn't want my brother to see what was going on with me. It was hard for my family. When the families used to come to visit, sometimes they wouldn't let us see the family. I would always have to write to tell them what was going on.

Being in prison has changed my life, you know. Because when I came out, I had no place to go, I had to go house to house to house just to get food and to take a bath and it was even hard for me to get an apartment. When I came out, I went to Roosevelt Hospital and I applied to see a doctor because I was having heart trouble. I couldn't deal with some of the medication because of the side effects that were going on. So, I had to change my medication three times and I had to start all over again. So it was hard. After my release I stayed in an SRO. I didn't like the SRO because there were a lot of people there that would do drugs and I was taking substance abuse counseling. The SRO wasn't that clean.

I have friends who had just come out of jail. And when they come out of jail, the discharged friend, they don't know what they're supposed to do. They only give you \$2 and that's it. They just leave you there. They don't have a plan for housing, for benefits, for anything. I have friends that are on parole and on probation and it's difficult for them to pursue their goals. They're afraid to vote because they once had their rights taken away from them. They can't find housing, they can't find work. Recently my cousin filled out an application, went for the interview, showed his resume, and he was going to get the job. But then they noticed that he had been to prison and they told him no. I have friends that were doing other things like robbery and stealing. I used to talk to them and say, you just came out, why are you going to go back and put yourself in a predicament? There's no freedom in the prison system. But I guess for some of them, that's their home now.

One of the biggest changes that need to happen is much better communication. Also, they should give you the medicine the way they're supposed to. That has to change too. People leaving prison also need a steady home, a steady place to stay and to make sure they have benefits and medical doctors that could check up on them. We need legislative changes in healthcare, treatment, counseling, all that. Just as importantly, once you're imprisoned they take your voting rights away, and while you're on parole you still can't vote. So we just need that back.

VIII. Summary of Policy Recommendations

Community Based Organizations (CBOs)

AIDS service organizations (ASOs) should develop curricula about HIV prevention, care and treatment, including the proper use of prophylactics and how to sterilize needles. Considerable effort should be made to distribute these curricula to surrounding jails and prisons, or when possible, to provide direct training to prisoners and staff. Trainings should always include anti-stigma education and clarification that HIV cannot be transmitted through casual contact. If education inside prisons is not possible, ASOs should attempt to reach individuals upon release through social networking and peer recruiters.

When possible, prisoners should be recruited to become peer educators about HIV epidemiology and prevention. These leaders should also conduct outreach to fellow prisoners about the benefits of HIV testing.

CBOs that work with substance users should develop curricula about overdose prevention and response, including similar distribution efforts to surrounding correctional facilities.

ASOs and other CBOs should offer pre-release training and discharge planning inside jails and prisons or in cooperation with divisions of parole. Inmates should be provided with culturally appropriate, gender specific, and thorough information about options for housing, employment opportunities, access to healthcare, drug treatment programs, childcare resources, transportation assistance, and other support services for those living with HIV.

Prison Administrators, Wardens, and Departments of Corrections

Prisons should avoid the use of solitary confinement under any circumstances, especially of prisoners living with HIV. Solitary confinement can make access to treatment and medications extremely difficult and irregular.

Prisons and jails should never practice regular segregation of HIV-positive or LGBT inmates, unless an inmate specifically requests to be relocated. Family and other visitors should never be informed of an inmate's HIV status without that inmate's consent. HIV-positive inmates

should have access to the same work release and reentry opportunities as other prisoners.

Prisons and jails should implement rigorous protocols to prevent rape, and should educate all inmates and staff about how to report and respond to sexual violence. All claims of sexual assault should be investigated and responded to appropriately, including counseling, medical care, and optional testing for survivors. All incidents of sexual assault should be reported to the Bureau of Justice Statistics. Response to sexual violence should be independently monitored by outside agencies or organizations.

Telemedicine programs should be avoided unless absolutely necessary for medical care. These programs discourage HIV disclosure and/or thorough treatment, and are viewed by many inmates as having dubious confidentiality.

Condoms and other prophylactic devices should be made readily available to inmates without having to request them from medical staff, via vending machines or other dispensaries. Distribution programs should be modeled after those in Canadian prisons.

Sterile syringes should be discreetly available through automatic dispensing units. Syringe exchanges should be operated by independent organizations or drug treatment staff. Exchanges should be modeled after those in Swiss prisons.

Opioid substitution therapy should be readily available to prisoners recovering from substance use. Drug treatment counselors should be on staff in all facilities, and rehabilitation programs should be offered to all prisoners with histories of substance use.

HIV testing should be readily available, optional, consensual, completely confidential, offered at all medical visits, and accompanied by pre- and post-test counseling. Testing should never be mandatory under any circumstances, and diagnostic information should not be shared with any non-medical staff unless absolutely necessary for the prisoner's well-being.

State and Local Governments

States and localities should collect information

about HIV infection rates in prisons and jails, and in communities with high rates of incarceration, to determine whether infection is more common before or during incarceration. All information should be gathered consensually.

States and localities should implement “ban the box” policies, or other policies that discourage indiscriminate background checks. Criminal records should be kept as accurate and current as possible, including erasure of arrests without convictions and expunged charges. Governments should encourage responsible and individual consideration of criminal histories and their relevance to the position being considered.

States and localities should never impose user-fees on any prisoners for court costs, costs of prosecution, recoupment fees for public defenders, or any other expenses. Individuals should have free access to quality public counsel and defense, and governments should make a concerted effort to improve the financial stability of formerly incarcerated persons.

Legislation ***Stop AIDS in Prison Act***

The Stop AIDS in Prison Act of 2011, led by Representative Maxine Waters (D-CA), addresses comprehensive HIV care and prevention in federal prisons on a structural level. The bill calls upon the Bureau of Prisons to take 11 concrete steps to combat HIV in prison, promote awareness, and improve medical care.¹²⁵ All testing and medical care would be required to be strictly confidential, with penalties for any breach of confidentiality.

The Act would include HIV testing as a medical service provided with consent during intake and within three months prior to release. Testing would also be provided upon request once per year, or following high-risk exposure or upon pregnancy. Prison personnel would be instructed to encourage inmates who might be at high risk for HIV infection to get tested, and would be prohibited from using any request for testing as evidence of misconduct. Those who tested positive for HIV would have the option of “partner notification services.” Inmates would be able to refuse testing at any time, for any reason, without penalty.

Inmates would also be entitled to comprehensive

medical care in a timely fashion, with confidential consultations about managing the virus. The care would need to be consistent with standards set by the Department of Health and Human Services, and the Food and Drug Administration’s (FDA) recommended medications would need to be readily available. Upon release, prisons would need to provide information about where to receive treatment and care in the community, as well as 30 days’ worth of medication.

In addition, prisons would need to provide educational opportunities for inmates about modes of HIV transmission. This would involve working with a number of organizations, agencies, and well-informed inmates to provide culturally competent and accessible presentations, written materials and audio-visual resources in multiple languages. Within one year, the Bureau of Prisons would need to report to Congress on its policies to enforce the above provisions. Within two years, and every year after, it would also need to report incidence rates of STIs and IDU.¹²⁶

The Stop AIDS in Prison Act was reintroduced in the 112th Congress, and more elected officials need to be alerted to its benefits. The bill effectively streamlines HIV testing while maintaining confidentiality in correctional facilities. Moreover, the legislation will provide the necessary HIV prevention services and treatment in order to improve HIV health care in prisons.

Detainee Basic Medical Care Act of 2008

In 2008 Senator Robert Menendez of New Jersey introduced the Detainee Basic Medical Care Act. The Act would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees in custody and for other purposes. This legislation is critical to people living with HIV since current standards, and access to screening and care for HIV, is inadequate. However, there has been no movement on this issue in Congress since then.

Passage of this legislation would ensure that immigrant detainees receive fair and just treatment, including the critical medical care they need. The bill would set mandatory standards for care and require that all deaths be reported to the Justice Department and Congress.

The JUSTICE Act

Without uniform prevention, testing, and treatment programs, incarcerated persons living with HIV and/or other STIs can unknowingly infect others. Often left untreated, incarcerated persons with STIs are frequently in the more advanced stages of their disease, and once released can be even more costly for the public health system to treat. One outcome of the lack of a coordinated response to HIV is that among confirmed AIDS cases in prisons, racial minorities account for the majority. Black prisoners are 3.5 times more likely than white inmates, and 2.5 times more likely than Latino inmates, to die from AIDS-related causes.

In August 2011, Representative Barbara Lee (D-CA) introduced H.R. 2704, The Justice for the Unprotected against Sexually Transmitted Infections among the Confined and Exposed (JUSTICE) Act. This legislation would allow prisons to provide condoms to incarcerated individuals. The JUSTICE Act also calls for automatic reinstatement or reenrollment in Medicaid for people who test positive for HIV before reentering communities. This action is of tremendous importance to public health since it would provide a comprehensive response to the spread of sexually transmitted infections in correctional facilities.

The REPEAL HIV Discrimination Act

The Repeal Existing Policies that Encourage and Allow Legal HIV Discrimination Act (REPEAL HIV Discrimination Act), introduced by U.S. Representative Barbara Lee (D-CA) in September 2011, addresses HIV criminalization and discrimination in state laws. The bill requires the U.S. Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense to initiate a comprehensive review of all federal and state laws, policies, regulations, and decisions regarding criminal cases of people living with HIV.

Moving forward, the REPEAL HIV Discrimination Act is of great importance, since it encourages laws that “do not place unique burdens on individuals solely as a result of their HIV status and instead promote public health-oriented, evidence-based, and a medically accurate understanding of the factors surrounding HIV transmission.”¹²⁷

Second Chance Act

The Second Chance Act, signed into law in 2008, addresses the difficulties faced upon re-entry. In 2010, the Act funded 187 programs including education, court projects, mentoring, recovery support, and assistance to formerly incarcerated juveniles and adults in their transition back into communities. These programs address some of the root causes of HIV transmission for communities affected by incarceration. They set out to decrease the likelihood of recidivism by providing education and vocational training for better job availability, and addressing substance use and mental illness through counseling.¹²⁸ By attempting to stabilize a person’s income and location, as well as making sure their physical and mental needs are addressed, programs can stabilize entire communities.

The Second Chance Act has tremendous potential to stop the spread of HIV in prisons and in communities affected by incarceration. Its potential can only be realized, however, if fully implemented. The Second Chance Act requires full federal funding to be effective in its goals, and 60 Representatives as well as 21 Senators have signed letters this year supporting such funding.¹²⁹ With further education and advocacy, communities can begin to reap the benefits of this necessary piece of legislation.

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