HIV Prevention and Care in Incarcerated Populations
Joshua P. Spaete and Josiah D. Rich, MD, MPH

The rate of growth in the incarcerated population of the United States increased by 62 percent between 1990 and 2001.1 This increase has largely been attributed to heightened enforcement and mandated sentencing for drug violations. These politically popular, "tough on crime," policies have had disproportionate effects on Black and Hispanic men and their communities.1 For example, in the 25–29 age group, nearly one in 10 Black men are incarcerated compared to one in 100 White men.2

In 2002, 1.9 percent of all U.S. prison inmates were HIV-positive.3 Confirmed AIDS cases were 3.5 times more prevalent in incarcerated settings than in the U.S. population.3 Women and minorities were disproportionately infected: Hispanic inmates had the highest prevalence, followed by Black inmates, and both groups had a higher prevalence than White inmates.3 Each year, 20 percent to 26 percent of all people with HIV pass through correctional facilities, and more than 150,000 HIV-positive ex-offenders return to their communities.4

Given all of these data, it is clear that prevention and care interventions within the incarcerated population offer an opportunity to reach a large number of people with and at risk for HIV. Further, since so many people with HIV leave prisons annually, public health practice suggests that effective prevention programs in prisons and post-incarceration can benefit society.

HIV Screening in Prisons
While a prisoner’s access to health care is protected under the Eighth amendment of the U.S. Constitution, HIV-related policies and approaches, including screening, risk reduction, treatment, and post-incarceration care vary widely. This is especially true since there is a federal prison system, 50 state prison systems, and thousands of county and municipal jails. Prevention interventions in prisons are underutilized and, when implemented, are more often statements of policy than meaningful practices. While many prisons offer HIV screening, too often the system punishes those who test HIV-positive, discouraging some inmates from testing and negating the benefits—diagnosis and treatment—for those who do test.

Challenges to the implementation of screening programs offer a good perspective on the issues that arise around HIV-related programs in prisons. The stigma associated with having HIV in prison, as well as that associated with homosexuality and injection drug use, presents a barrier to the initial step in HIV prevention: screening. Because of this stigma, many inmates do not volunteer to be tested, do not inquire about HIV education, and fail to report their HIV status.5 The hypermasculine culture within male correctional facilities—created and sustained through violence—establishes a social hierarchy that marginalizes those considered to be less masculine, in particular, male inmates who are perceived to be feminine or who take on a passive sexual role, either through sexual preference or through coercion.6 Inmates who use drugs and are unable to pay off drug-related debts are given the options of forced copulation and marginalization or repeated beatings.6 Additionally, some correctional facilities segregate HIV-positive inmates and offer them fewer program options.4

The medical community, raising well-founded concerns about confidentiality, discrimination, and paternalism, has also resisted mandatory screening. Prison testing programs can compromise confidentiality in a number of ways: explicitly, when inmates are processed in open rooms or, implicitly, when HIV medications are supplied publicly.5

While it is challenging to provide confidential care, it is not impossible. In Rhode
Looking through the bars of the U.S. correctional system is at best disheartening and at worst simply horrifying. There unfolds a struggle to balance the desire to punish criminal offenders with the wish to rehabilitate human beings so they may return to the community. The tension between these priorities seems to be at the crux of a host of confusing policies, but it may also be at the heart of a solution. From California, where the notorious “three-strikes” initiative has swelled the prison population with people convicted of drug violations, to Illinois, where the death penalty stands suspended, voters, legislators, and governors are reconsidering criminal justice and correctional policies and practices.

There are dozens—hundreds—of examples of correctional policies that, based on a tangle of tradition and confused goals, have led to inhuman conditions. The application of the death sentence might be the most egregious of these; the quality of health care within prisons is in the top 10 of the worst aspects. At the same time, however, HIV may be the most compelling platform from which to advocate for the humanity of prisoners, since HIV is perhaps the best argument for health education and care in prisons.

As Joshua Spaete and Josiah Rich suggest in this issue of FOCUS, there is little that compassionate and effective HIV programs require that would sacrifice the reasonable objectives of incarceration. In fact, the main obstacles to these programs are unreasonable and often unstated goals: the desire for prisoners to experience punishment and only punishment, the often unfounded fear that granting prisoners rights will automatically compromise prison authority and control, and the hypermasculine culture of prison life. As Jessica Barclay-Strobel and Robert Espinoza point out, the structured environment of prisons may actually contribute to the success of well-designed HIV treatment and prevention programs.

The failures of the prison system have forced us to challenge our assumptions about criminal justice. The very conditions—moral, financial, practical, and constitutional—that are so disheartening are also the ones that inspire creative approaches. For example, California voters passed an initiative to offer substance abuse treatment rather than prison to people convicted of some first-time drug violations.

Other examples are the programs described in this issue, programs that may represent a template not only for responding creatively to HIV behind bars, but also for responding to the full range of human needs that express themselves in correctional settings. Ultimately, the key to success will be understanding the ways in which prison culture can be reconceived to meet the legitimate goals of society, the concerns of the human beings charged with running prisons, and the needs of the human beings incarcerated in them. The imperative to find an ethical balance will improve not only HIV care, the lives of prisoners, and the functioning of prisons, but also a nation that values freedom and justice.

References

Island, where testing is mandatory for convicted inmates and voluntary for individuals held prior to sentencing, access to records is limited to the medical team and there is no segregation of HIV-positive inmates. Within this context, greater than 90 percent of individuals accept testing with signed consent.4 Between 1989 and 1999, Rhode Island’s testing program identified 33 percent of all seropositive HIV tests within the state.1

This experience illustrates two points. First, testing in correctional facilities serves an important role within the community, enabling early identification of HIV and reducing illness and death through HIV treatment. Second, when properly initiated, it is possible to achieve voluntary compliance rates of greater than 90 percent.1,4 Furthermore, testing can allow for partner notification.1 Additional components necessary for successful screening are counseling, treatment, risk reduction education and interventions, and community linkage.

High HIV prevalence rates, restricted access to risk reduction within most correctional facilities, and the knowledge that injection drug use and unprotected sex occur within prisons all have led to concerns that prisons may serve as amplifying reservoirs for HIV.4 These concerns are not supported by current studies, which have found that while intraprinson transmission of HIV does occur, it is relatively uncommon.4 Further reductions can be achieved through implementation of risk reduction methods such as condom distribution, substance abuse treatment (including methadone maintenance), and needle exchange.

Beneficence versus Control in a Prison Culture

One of the challenges in initiating HIV prevention in prisons is that the concepts of beneficence and nonmaleficence, central to the health care profession, often conflict with the primary focus on custody and security central to the criminal justice system.5 This is illustrated in correctional settings when health care practices such...
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as condom distribution and injection drug treatment are stifled by prison authorities who prioritize the control of a population above the health of an individual. Currently, less than 1 percent of jails and prisons in the United States allow access to condoms and none allows access to sterile needles. A study of a Washington, D.C. jail, which has a condom distribution program, found that support for the program exists both within the inmate population and the correctional officer population and, further, that this program has not led to any major security infractions such as increased fights, rape, or contraband trafficking. Correctional officers who favored the program felt that it would reduce the spread of disease, offer an opportunity for education about correct condom use and HIV, and protect rape survivors. On the other hand, correctional officers and inmates who opposed the program cited moral objections to same-gender relationships and safety concerns; correctional officers also cited conflicting institutional messages when condoms are available but sex is prohibited.

Needle exchange programs are known to be effective at reducing the transmission of bloodborne pathogens, including HIV. It is inevitable that incarcerated injection drug users share materials due to prison policies that prevent access to sterilized syringes. Programs that allow access to sterile syringes have been successfully implemented in Europe without a reported incident of syringes being used as weapons. Why does resistance to risk reduction methods persist in U.S. prisons? Correctional officers cite as major obstacles an absence of moral obligation to provide risk reduction tools to inmates, feelings that society would not approve of access to these risk reduction methods, and a lack of resources. But even if correctional officers support risk reduction approaches, as in the case of the Washington, D.C. condom distribution program, institutions may fail to initiate programs because of societal and financial pressures.

Accommodating the Reality of Prisons

In the current environment of moral judgment and financial and political interests, it is unlikely that condom distribution and needle exchange will be adopted by most prison systems. By shifting the debate from the implementation of programs preventing disease transmission within prisons to prisoner education and community linkage programs, which are better received by prison officials and society, it may be possible to avoid the ideological conflict yet still reduce harm.

Inmate education programs have proven effective motivators towards risk reduction, with a decrease in high risk behavior observed both during and after incarceration. In general, peer-based education programs have support from the prisoners, as well as from the administration and correctional officers. Because these programs are performed in prison but can focus on prevention post-incarceration, they reduce the potential for conflict with prison policy.

Education programs are typically led by professionals from outside of the correctional setting, although peer-based programs are as effective and are preferred by inmates. Additionally, peer educator programs are more cost-effective for correctional facilities, peer educators are either volunteers or compensated but at lower levels than their professional counterparts. Peer leaders are inmates who receive comprehensive training and—through orientation programs and workshops, and informally around the prison—are able to address a variety of topics including HIV transmission, testing, and the impact of HIV disease.

After participation in a peer-led program, 44 percent of inmates volunteered for testing in a facility in which testing was not anonymous and HIV-positive inmates were segregated.

Peer-based education also has the advantage of more naturally reflecting the cultural make-up of the prison population, in terms of a range of factors including race and ethnicity, inmate status, socioeconomic level, and drug use history. By taking into account cultural differences, it may be possible to dispel false beliefs and inform more inmates about HIV. This can further help to reduce post-incarceration transmission of HIV.

Despite indications that prison-based HIV medical care and antiviral treatment can be effective, inmates who are reincarcerated often exhibit signs that treatment is not maintained outside the correctional facility. This suggests the importance of a key component of prisoner education programs, the ability to prepare and link inmates to post-incarceration services. The absence of these linkages limits the impact of even effective prison prevention programs. Further, community-based linkage programs have the potential to provide continuity of treatment, reinforce prevention, and reduce recidivism.

Due to the high level of coordination
needed to initiate and sustain a linkage program, it is not surprising that an evaluation of a series of Centers for Disease Control and Prevention-sponsored programs revealed that ineffective communication among all partners—the enrollee, the correctional facility, community-based organizations, and medical providers—was the most likely inhibitor of collaboration and service delivery. Because each prison and jail is unique, no one approach offers a perfect solution.

In Rhode Island, Project Bridge was established in 1996 as a partnership between the Department of Corrections and The Miriam Hospital, a Brown University teaching hospital, with a primary goal of improving continuity of medical care through social stabilization. The program provides a team of social workers and services for HIV-positive inmates for 18 months after release from prison. Prior to release, each inmate meets with a social worker to assess needs and formulate a discharge plan. As release draws near, the inmate is introduced to an outreach worker who assists in procuring concrete services outside of the facility, linking the inmate to: substance abuse and mental health services; HIV-related and other medical care; and community programs addressing basic survival needs, including housing and nutrition.

The program provides transportation to medical and social service appointments, the case manager accompanies clients to medical appointments, and the outreach worker accompanies clients to social service appointments and locates clients if they miss appointments. In addition, the program institutes case conferences among medical providers, agency representatives, and clients to assess progress and refine treatment plans.

Two similar programs, one designed specifically for women in Rhode Island and another in the Hampden County Correctional Center in Hampden, Massachusetts, have demonstrated reduced recidivism rates among participants when compared to inmates who did not participate in the program. These programs work not only to ensure a continuum of HIV-related care but also to break the cycle of crime that is endemic to the correctional system.

Conclusion

Implicit to a discussion of prisoners and HIV prevention is the moral judgment passed by many members of our society that prison should provide no “perks,” including lifesaving services. This judgment hampers the establishment of HIV prevention programs. For those who hold these beliefs, it is important to remember that nearly all inmates return to their communities, and if it is not compelling enough to protect the health of inmates themselves, it is useful to remember that most of the measures discussed here are aimed at reducing HIV transmission where it is most likely to occur: not in prisons and jails, but within communities. Correctional HIV programs, which incorporate early detection, risk reduction, treatment, education, counseling, and linkage to care in the community, are effective in preventing HIV spread and benefit both inmates and communities.

Cost is also cited as a reason to limit HIV prevention programs. This argument is also short-sighted: HIV antiviral treatment and medical care is less expensive than untreated or inadequately treated HIV. Finally, evidence of efficacy supports a shift in policy toward providing all inmates access to preventive measures. In the meantime, however, improving and expanding HIV education and linkage programs within correctional settings and post-incarceration programs is reasonable and achievable.

Clearinghouse: Prisons and HIV

References


Family Case Management as a Response to HIV Post-Incarceration

Jessica Barclay-Strobel and Robert Espinoza, MPA

Each year, more than 600,000 people return home from U.S. prisons or jails to their families and neighborhoods. With the rate of HIV infection among incarcerated people surpassing that of the general population, HIV prevention and treatment for formerly incarcerated individuals has become more than a prisoners' health issue; it has become a public health issue.¹

The reentry process offers families and service providers an opportunity to address the psychological issues related to HIV among justice-involved people and their families, that is, all the people who are affected by a person's incarceration and release. During this process, family members often lean on each other to ensure that their loved ones are able to access the treatment and services they need to successfully readjust to life post-incarceration.

Because prisons and jails serve as de facto health care providers for many poor Americans, formerly incarcerated individuals are often first tested or treated for HIV in correctional facilities. Even those who are not tested face HIV-related risks in prison and may seroconvert. Upon reentry, individuals with HIV must locate new health care providers and may face the full range of HIV-related complications, including co-occurring health problems, psychological distress and mental illness, substance use, and rejection from family and friends. In addition, without adequate information, resources, or self-confidence, formerly incarcerated HIV-negative people leave jail or prison at high risk of infection. Family Justice, a national nonprofit, draws on the unique strengths of families and neighborhoods to create cost-effective methods for promoting public safety and healthy families. At Family Justice's direct service arm, La Bodega de la Familia, family case management successfully supports justice-involved families residing in New York City's Lower East Side. One in two families affiliated with La Bodega has at least one family member living with HIV.² This article reviews the HIV-related psychological challenges faced by justice-involved families, and how these challenges can be addressed by the Bodega Model through family case management.

The Impact of HIV on Families

Many individuals and families are psychologically ill-prepared for the challenges of reentry. On the one hand, for inmates with HIV, jails and prisons impose a regimented environment that may actually be conducive to HIV treatment. Upon release, access and adherence to such treatment may dwindle in less disciplined spaces.

On the other hand, the highly regulated environment of correctional facilities may not foster personal responsibility or promote the decision-making skills critical to HIV prevention.³ Further, the lack of condoms and bleach kits in most correctional facilities discourages risk-reducing behaviors, which exacerbates the risk of contracting and transmitting HIV for people under justice supervision and for their families. A study of California state prison inmates highlights the need for HIV education for all inmates, regardless of serostatus: 51 percent of study participants reported having sex in the first 12 hours after release and expressed a desire for sex without condoms.⁴ Formerly incarcerated individuals often face the challenge of renewing relation-
ships with partners, children, and other significant people in their lives. The psychological strain that comes with living with HIV, coupled with the persistent stressors of having been incarcerated, create an added burden for both HIV-positive individuals and the families to which they return as both cope with parole, probation, and other forms of justice supervision. Families affiliated with La Bodega have noted that they struggle with fear and stigma regarding HIV, which hampers the quality of support exchanged among family members and leads many people to hide their HIV status from their families. Families have also expressed concerns about inaccurate perceptions, especially among youth, about the low probability of HIV infection and about a general sense of apathy and hopelessness in the face of other pressing concerns such as housing, mental illness, and substance abuse.

To address the interrelated nature of these concerns and challenges, many service providers advocate using a holistic model that manages the web of agencies and family members available to justice-involved families. Because more than one member of a justice-involved family may be living with HIV or may have confronted the risk of acquiring it, the entire family may have developed the ability to support family members in dealing with the stigma, shame, and uncertainty associated with HIV disease.

Family Case Management and Coping

Family Justice’s Bodega Model employs family case management, a strengths-based approach that transforms service delivery by reframing justice supervision work within a family context. Unlike traditional case management, which pairs a case manager with an individual client, family case managers work with and coordinate services for whole families, broadly defined to include friends and their neighbors. Family case management complements HIV prevention and treatment because it focuses on the same relationship networks through which HIV often travels.

Family case management begins by organizing the often disarranged relationships among government, neighborhoods, and families into a network of service provision. This helps families and providers identify existing, but perhaps overlooked, resources and promotes efficient service delivery. At La Bodega, family case managers identify the networks of service providers and family relationships using supportive inquiry, home visits, and two relational tools: the genogram, which identifies generational patterns and family strengths and problems, and the ecomap, which visually depicts the conflicting and supportive relationships among families and organizations. Genograms and ecomaps remind justice-involved loved ones about members in their families and communities who can support them during and after justice supervision. For example, a person who has learned he is HIV-positive after release may find that some of his family members are uncomfortable, confused, and angry about his status, while others are supportive and loving. He may further discover that the supportive family members have strengths and resources to help him define and access the physical and mental health treatment he needs to deal with HIV and avoid re-incarceration. He may discover, for instance, that his godmother has the willpower and time to accompany him to all his appointments. He may also discover that the community has hidden resources; for instance, a local HIV agency that offers career counseling as well as medical services.

Family case management can integrate HIV prevention and treatment with other services, which reinforces behaviors that reduce the risk of HIV transmission. An evaluation of family case management with drug-involved arrestees found that participants reduced HIV-related risk behaviors, decreased recidivism rates, increased retention in substance abuse treatment, and diminished employment problems.5

Conclusion

Practices that tap into the strengths of justice-involved families to manage each other’s health and well-being demonstrate that the impact of HIV can be mitigated. Family case management improves public health by organizing relationships among families, government agencies, and community-based organizations into an efficient, mutually beneficial, and easily navigated network.

Comments and Submissions

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Provider Reports on Post-Incarceration Risk

According to a qualitative study of providers, young men released from incarceration tended to have multiple and “riskier” sex partners, not use condoms, and use drugs in ways that enhance HIV-related risk.

Researchers conducted semi-structured interviews with 97 post-release service providers from 83 different agencies in California, Mississippi, Rhode Island, and Wisconsin. The sample consisted mainly of men (65 percent), and 56 percent of participants were White and 37 percent were African American. Respondents had been employed with their agencies for an average of nine years.

Providers reported that most young men, once released from prison, frequently practiced sexual risk behavior, often in conjunction with substance use. While some men get married or are “selective” about their partners, most men had sex with “riskier” partners: male partners, casual sex partners, those with a history of sexually transmitted disease (STD), and those associated with drug use or sex for money or drugs. Injection drug use did not seem to be a risk, however, because of the widespread use of needle exchange programs. Providers did consider crack cocaine to be a strong correlate of HIV-related sexual behavior, since the drug increases sexual arousal and stimulation and is associated with trading sex for drugs.

Providers identified the following major determinants of risk behavior in this population: drug use, the desire to prove one’s masculinity, the need to “escape,” hopelessness about the future, and lack of proper housing, employment, or financial stability. According to providers, young men tend to “return to their old environ-

HIV-Risk Behavior in Prisons

Half of 80 young men interviewed six months after release from incarceration reported using drugs in prison, which they said were easily obtained, but only 16 percent reported having sex while in prison.

Researchers recruited 80 participants from five minimum- and medium-security state prisons in California, Mississippi, Rhode Island, and Wisconsin. The sample averaged 25 years old and an average of three years of incarceration. Of the sample 54 percent were African American, 29 percent were White, and 10 percent were Latino.

Eighty-six percent of the men were aware of substance use while incarcerated, mentioning most frequently marijuana, alcohol, crack cocaine, and heroin use, and 51 percent reported using themselves. Thirty-six percent of men had direct knowledge of injection drug use, primarily via shared needles. Drugs were described as being easy to obtain from other inmates, prison personnel, and visitors.

Fifty-eight percent of the men had direct knowledge of sexual behaviors in prison. Of these, 96 percent said they were aware of sexual relations between inmates, 32 percent mentioned sexual relations between an inmate and correctional personnel (usually female staff), and 20 percent mentioned relations between an inmate and people outside of the prison.

Of the 12 men who reported having sex while incarcerated, three said they had sex with other male prisoners, four with female prison staff, four with visitors, and one with a female staff person in his community work program. The participants claimed female staff had sexual relations with inmates because they wanted money

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or were threatened or coerced, and that men had sex with other inmates because they were either threatened, needed money, drugs, or favors, or were in jail indefinitely and saw no alternative source of sexual gratification. Most of the men reported that inmates did not use protection while engaging in sexual behavior.

**Community Case Management**


A post-incarceration intensive case management program did not reduce drug use, recidivism, or behaviors that can cause HIV transmission compared to a less intensive approach, according to a large study of young men and women who had been incarcerated in New York.

Over a three-year period, researchers interviewed 1,416 participants, analyzed hair samples for evidence of drug use, and reviewed caseworker records. Participants were randomly assigned to two groups: one group received intensive discharge plans and case management services, including individual counseling, crisis intervention, and referrals; the other group received less intensive discharge plans and no post-release case management services.

According to interviews and hair analysis, participants in the intensive case management group were more likely to be involved with drug treatment programs and experienced a modest reduction in drug use. While there was weak evidence that these participants were less likely to use marijuana, there did not appear to be a reduction in hard drug use, since rates of the social and physical problems associated with drug use—for example, seizures and homelessness—did not change. In addition, according to self-report, there was no systematic reduction in sexual behaviors affecting HIV risk—that is, numbers of sexual partners or amount of unprotected sex—for participants in either group.

It is possible that the study did not result in significant differences because participants in the intensive case management group received only 12 to 14 hours more of post-release contact than participants in the other group, which was less time than the program intended, or that participants from both groups were able to receive supportive community services without assistance from the program.

**Needle Exchange in Prisons**


Prison-based syringe exchange programs are feasible and successful in reducing HIV transmission and the behaviors that lead to HIV, according to a review of the literature and interviews in Switzerland, Germany, and Spain in prisons with fewer than 600 inmates.

As of December 2000, the analysis identified 19 programs discussed in 14 papers, including six program evaluations. The documents and interviews reveal that prison-based syringe exchange programs lead to stable or decreased drug use, a large decrease in needle sharing, a decline in the number of abscesses reported, and improved overall health. Evaluations of programs in Spain report more referrals and better contact with drug programs. Reports did not reveal any unintended negative consequences, for example, the use of needles as weapons or the promotion of drug use.

There were three methods of needle exchange. Programs in Switzerland and Germany used either automatic distribution machines or prison medical staff, that is, doctors or counselors, while programs in Spain distributed kits containing clean works, alcohol swabs, and water.

Staff in all the prisons support the programs. However, staff and inmates in a German prison reported that some inmates were hesitant to utilize the program for fear of revealing their drug use.
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