HIV
C O U N S E L O R
P E R S P E C T I V E S
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LIFE AFTER INCARCERATION

HIV infection is more prevalent in correctional facilities than in society at large, and a steady flow of people in and out of custody contributes to the spread of HIV. Many inmates may not know of their HIV infection status or may be uneducated about HIV and the ways it can be transmitted and progress. This issue of PERSPECTIVES discusses the environment, culture, and challenges former inmates may have experienced during and after incarceration. The Implications for Counseling section examines ways of establishing trust and working with clients who have been incarcerated.

Research Update

Researchers estimate the incidence of AIDS cases to be seven times higher in U.S. correctional facilities than in the general population, and, as of 1995, more than 24,000 inmates were infected with HIV—almost 3 percent of all HIV cases nationally. In California, where HIV disease is not a reportable condition, a 1996 study found that 2.5 percent of new inmates were infected with HIV.

Prisons are generally federal or state facilities designed for convicted felons serving sentences longer than one year, while jails are usually administered by local governments and intended for detaining people awaiting trial and those serving sentences shorter than one year. Some correctional facilities, including federal prisons, screen inmates for HIV. California state prisons offer voluntary HIV testing, but inmates are often informed of their results only if they test positive.

In 1996, there were about 1.46 million incarcerated people in the United States, or about 0.37 percent of the nation’s population. In California, there are currently about 150,000 people incarcerated in state prisons, a 5.7 percent increase from a year ago, and about 100,000 are on parole after being released. Ninety-three percent of the state’s inmates are male, 34 percent are Latino, 31 percent are African American, and 30 percent are White.

Correctional Facilities and Sex

Unprotected sex between inmates is a common occurrence, and it is a major contributor to high HIV infection rates in correctional facilities. Because incarceration restricts the number of ways to satisfy sexual drives, inmates may engage in sexual activities in which they would otherwise not choose to participate.

A correctional facility is a closed system in which there is little opportunity to release and express emotions such as anger, pain, and loss. As a result, sex frequently becomes a coping mechanism. Although incarcerated men may have sex with other men, they often do not identify as gay and may intend to engage only in heterosexual sex upon release.

Sex among male and female inmates may or may not be consensual. Male inmates may use sex to maintain power relationships and hierarchies. Sexual interaction in correctional facilities sometimes takes the form of predatory sex, a
type of rape in which the receptive partner has sex under threat of bodily injury. In male prison culture, the ability to force others to have sex symbolizes power and masculinity, and the receptive partner is considered to be in the “female” role. In addition, while the insertive partner may consider himself to be heterosexual, the receptive partner is considered by others to be homosexual, even if he considers himself to be heterosexual. As a result, receptive partners may be the target of assault, intimidation, and discrimination from other inmates and correctional officers.

Sex also occurs among women in correctional facilities, between inmates as well as with male and female correctional officers. There are anecdotal reports of inmates shunning others—both socially and sexually—who are thought to have HIV, and some inmates claim they are infected with HIV in order to avoid being raped.

Consensual sex between inmates sometimes serves as a way to satisfy a desire for interpersonal contact rather than as a consumption of sexual attraction. It may also be symbolic of membership within and support from a group. In such instances, hierarchies may dictate which partner is insertive, but neither partner describes the sex as rape. Members of such groups often consider themselves to be heterosexual, but, in some cases, an entire group may have a homosexual identity.

Safer sex practices are rare in correctional facilities. Most correctional facilities, including those in California, do not allow inmates to possess condoms. In the United States, 4 percent of state and federal prison systems and 10 percent of city and county jail systems provide and allow the use of condoms within their facilities.

Needle Sharing and Drug Use

Needle sharing—for injection drug use as well as for tattoos—appears to be a more common route for HIV transmission among inmates than unprotected sex.

Upon release from a correctional facility, the psychosocial pressures of returning to society are often overwhelming, and behavior change is especially difficult.

A 1992 study of state correctional systems found that 19 percent of male inmates and 15 percent of female inmates had a history of injection drug use. On average, 10 percent of an injection drug user’s “career” is spent in custody. Drug use is a pervasive problem in correctional facilities, where injection drug using equipment is often available on the “black market.” Correctional institutions in the United States do not distribute clean needles or bleach to inmates. Because injection drug-using equipment is scarce, needle sharing is common among inmates who inject drugs. One study found that more than half of incarcerated injection drug users have shared needles.

In California, 26 percent of inmates in state prisons were convicted of drug-related offenses. Whether they are in or out of custody, many substance users engage in sex to obtain drugs. People who exchange sex for drugs usually have little ability to negotiate safer sex practices.

People charged with drug-related crimes generally receive court-mandated substance abuse counseling or treatment. Most injection drug users, however, are convicted of property crimes—which may be crimes committed to obtain money for drugs—and their underlying addictions are often not addressed by the criminal justice system. For many drug users, this tends to create a cycle of recidivism, or a tendency to return to criminal habits.

Drug treatment programs have
become more prominent in correctional facilities since the late 1980s. These programs often involve therapeutic communities in which inmates are isolated from the rest of the incarcerated population, and the staff typically consists of former substance abusers. Alcoholics Anonymous and other 12-step groups are also active in correctional institutions.

Life Upon Release

Inmates who are released from custody often find the transition between life “behind bars” and life “on the outside” to be complex. Certain community providers, such as parole officers, case managers, and mental health organizations, attempt to help people with this transition. Many inmates, however, are not aware of these services or may see them as institutional programs to be feared or scorned. Although some correctional facilities and parole programs provide and require AIDS education—such as HIV inmate peer education programs—anecdotal reports suggest that many inmates receive little or no education.

Release from custody may involve returning to families, finding housing on one’s own, or becoming homeless. Some people leave correctional facilities to enter work-release programs as part of the conditions of their sentence. Such programs involve partial incarceration in which inmates work for pay outside the correctional institution but spend non-working hours either in custody or in a community-based work release facility, or “halfway house.” This graduated release process may help ease an inmate’s reintegration into a civilian community.

Whether through complete or gradual release from a correctional facility, the psychosocial pressures of returning to society are often overwhelming, and behavior change is especially difficult.

Upon release, people with substance-abusing histories who return to their communities may experience peer pressure and temptations that lead them back to substance use. Even those who received substance abuse treatment in custody face the prospect of returning to substance-abusing behaviors.

Because it is often difficult for former inmates to find employment, they may not have money for basic necessities and may resort to illegal activities such as robbery, drug-dealing, or sex work. People who know no other way than crime to sustain themselves may have difficulty adopting new behavioral patterns.

Former gang members and sex workers may face serious injury or death if they do not rejoin their gangs or pimps. Because of the illegal nature of exchanging sex for money, sex workers routinely get arrested and spend time in correctional facilities. This continuous adversarial relationship with the criminal justice system can further disenfranchise people from beneficial programs, which they may perceive as being part of the “system” that oppresses them.

Some people may want to rejoin former social structures upon release but discover this to be difficult or impossible. After a long period of separation, many former inmates find that their friends and partners have replaced them and families have withdrawn love and support. Without a network of support, a person may feel desperate, worthless, and powerless. In this context, adopting practices that reduce the risk of HIV infection may be a low priority.

If a person is able to reunite with a former partner upon release, one or both may not consider HIV protection to be a serious concern. A couple that has never used condoms in the past will probably find it difficult to change this pattern. A partner who has engaged in risky behavior during the couple’s time apart could unknowingly transmit HIV to the other. In addition, someone who received a positive HIV test result while in custody is likely to have difficulty disclosing the infection to a partner and may avoid doing so.

When a couple makes a concerted

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Although men may have sex with other men in custody, they often do not identify as gay and may intend to engage only in heterosexual sex upon release.
Counselors are likely to see clients with a history of having been incarcerated and should be prepared to provide these clients with appropriate guidance and support.

Building Trust and Accepting Distrust

Because of prejudice and discrimination former inmates often face in society, clients with a history of incarceration may be reluctant to disclose this history in a test counseling session. Clients sometimes acknowledge previous periods of incarceration only after they believe that they will not be harmed for doing so and have decided that it will be beneficial for them. A personal disclosure may take the form of a passing reference to a parole officer or other correctional employee.

Realize that involvement with the law—whether it be time spent in custody, conviction or acquittal in court, or harassment by police—affects the way people view life, including attitudes toward HIV infection and test counselors.

People who have been incarcerated are often suspicious of the “system,” which they may see as something that traps them in a cycle of poverty and incarceration. They may also view counselors as representatives of the system who are out to thwart them and their efforts to live their lives. Counselors who are aware of this dynamic are better equipped to build trust so that clients will feel more comfortable disclosing their incarceration histories. Also recognize that some people who have been incarcerated may have had positive counseling experiences. Test counselors should learn more about these experiences to know which approaches have worked.

Establishing trust with someone who is suspicious can be difficult. Chronic distrust may be the result of a number of factors, such as physical, sexual, and emotional abuse, alcohol and other drug abuse, dysfunctional family systems, and oppressive societal environments. These factors are disproportionately more common in the lives of people who have been incarcerated than in the general population. In addition, abuse—by other inmates, by correctional officers, or by the legal system itself—is a common experience for inmates.

It may take time before a client becomes less suspicious. Acknowledge the complexity of a client’s life, and be receptive to hearing about it. Determine why the client came in for HIV testing and to what extent he or she feels forced to test by authorities or others perceived to be in authoritative posi-

A Counselor’s Perspective

“My clients who have been incarcerated are used to having their thoughts and behaviors invalidated. Validating their decision to come in for HIV testing can be especially meaningful for them.”
A Counselor’s Perspective

“I realize that it may take time for a client who has been incarcerated to trust me. I know I need to be patient, and I accept the possibility that some clients may never trust me.”

How? If not, how does it not? Be both direct about the purpose of the questioning and flexible about how the client chooses to disclose personal information.

Counselors must also be sensitive to the various ways a client might perceive inquiries about his or her experiences with substances. Be prepared to discuss substance use and its possible effects on recidivism. A client who gets high on a regular basis may be likely to miss a parole meeting and become reincarcerated as a result. Such a client may also resort to crime to support his or her substance use. Do not make any assumptions about substance use; rely only on information provided by clients.

One way to learn of a client’s history of substance use is by asking if his or her terms of parole or probation require drug and other tests. In these cases, determine the stage of the client’s recovery, find out what he or she wants to do, and provide appropriate linkage and referrals.

It may be useful to adopt a matter-of-fact approach to a discussion of risk behavior with a recitation of the relevant risks and risk-reduction techniques, including demonstrations of needle cleaning, if it is appropriate to the client’s situation. Do not give “permission” to use drugs; a counselor’s role is to provide clients with the information they need to make informed decisions.
Behavior Change

Programs and services may be of limited value for clients who do not intend to change or at least examine their behavior. Many previously incarcerated people are aware of services available to them, but they may be reluctant to use these services because they often view any official or agency involvement in their lives as interference.

Focus on harm reduction appropriate to the client’s psychosocial situation. In the short time frame of an HIV counseling session, it may be better for the client to examine how certain behaviors affect his or her life than to attempt to make a concrete plan for change. A client is most likely to accept alcohol and other drug referrals, for example, if a counselor presents them as useful resources to explore when the client is ready. Many clients want to reduce HIV infection risks but may not be ready to stop their substance use. It is important not to mirror hopelessness or resentment the client may present; work with the client to identify other possibilities for hope and a sense of peace in his or her life.

To better understand the context and challenges of a client’s situation, be aware of the services former inmates receive. These services may include parole or probation officer visits, mandated drug testing or substance abuse counseling, food stamps, rehabilitation services, and programs to help find work and housing.

It is important to remember that addressing suppressed thoughts and emotions with a counselor may be especially stressful for clients, who may be confronting long-term denial of painful memories such as rape, assault, and other HIV risk activities. Therefore, counselors should carefully choose the way they approach such sensitive topics and recognize that the purpose of discussing such subjects is to determine HIV infection risks. Provide referrals when follow-up support or counseling is needed.

Relationship Dynamics

Clients with a history of incarceration may believe they are not suited or “destined” for positive, mutually respectful relationships—whether they are romantic, platonic, or familial—and will probably not entirely change this view during the course of a brief counseling session. A positive relationship with a counselor, however, may help the client experience a feeling of respect, which can be the first step to a more positive outlook on all relationships, including a client’s relationship with him- or herself.

Clients who return to former sex partners often return to previously established habits in their relationships without bridging the two realities of incarceration and life on the “outside.” Carefully raise the issue of risk, ask if the client has discussed this subject with a current partner, and, if appropriate, explain the possible benefits of such disclosure.

Upon release from custody, people may also discover that their former partners are no longer interested in relationships with them, which may cause disappointment, pain, or possibly relief. Although a client may choose not to reveal these feelings during a counseling session, a counselor may ask how the client is reacting to any changes that have occurred in his or her relationships. Do not force the issue, however, because a client may not be ready for an invasion into such a vulnerable and personal area.

Testing Positive

When asking if a client has been tested for HIV, be sure to learn if he or she received the results, information or counseling, and a risk assessment or disclosure session. The client may be looking for con-
Case Study

Robert, a 29-year-old heterosexual, has just been released from custody and says he wants to “stay clear” of the law. He talks about sex awkwardly. He says that he has a former girlfriend with whom he is trying to “reconnect,” but he is having a difficult time doing so. He says he is “unsure about unsafe sex.”

Counseling Intervention

Reinforce Robert’s decision to take an HIV test and explain the testing procedure. Ask if he has ever tested and, if he has, what he was told during the process and what the results were, if he is aware of them. Let him know that the session will include a discussion of personal information about sex and other behaviors that may involve HIV risks. Tell Robert the session is anonymous or confidential, as appropriate, and clarify the meaning of and reasoning for this. It is not unusual for someone recently released from custody to be suspicious about how information is “really” handled or who will see it.

In these first moments of “framing” and establishing rapport, ask Robert what he means when he says he is “unsure about unsafe sex.” He may mean he is uncertain about what safer sex constitutes or if he wants to practice it. If Robert’s uncertainty relates to a dislike of condoms—a common response for many people—ask him if he has ever tried protected sex and how this has or has not worked for him.

Find out if he had sexual contact in custody. Because he may not view intercourse with inmates as sex, it may be necessary to frame questions about this in different ways. Reflecting a non-judgmental attitude, ask how long it has been since he had unprotected sex or any physical contact that might have put him at risk for HIV and the context in which it occurred. A counselor may decide to make a carefully worded statement about sexual contact in correctional facilities, such as, “Since people in custody sometimes engage in sexual activity or drug use, it is important to ask if you have been at risk through sexual contact or the use of unsafe needles.” Explain both the “window period” of infection and various safer practices. As with all clients, assess Robert’s history of sexually transmitted diseases (STDs), if any.

Ask Robert to expand on his desire to reunite with his former girlfriend. Validate his desire and follow his lead, but do not stray from the counselor’s limited role. If Robert has had unsafe sex with other people and he is hoping to or planning on having sex with his former girlfriend, ask him if she is aware of his risks. From a neutral, “wondering” stance, ask if he thinks she might need to know this. Regardless of the manner in which the counselor presents this question, Robert may take it as a hostile confrontation. Clarify this misunderstanding if it occurs, and explain that this is a common concern for people who have had risks because of the dangers of HIV and other STDs.

If Robert expresses a positive attitude regarding his former girlfriend, use his words when discussing her. For instance, if Robert has said, “I really love her a lot,” begin an explanation of why people contemplate telling partners of their risks with the phrase, “When people really love their partners a lot…” Planting the idea may be the first step in considering disclosure and will be especially significant if he tests positive for HIV after the window period. Listen for any needs for referrals, such as counseling for his desire to reunite with his girlfriend, if this seems problematic. Link him to a referral for which he has the resources and is most likely to access.

Understanding Counselor Feelings

There is a widespread societal perception that people with a history of incarceration are inferior and dangerous, and clients who are accustomed to being oppressed may accept the notion that they are unworthy. Because counselors may have fears or concerns when they discover or suspect that a client has been incarcerated, it is important to be able to distinguish real threats from unfounded fears. Counselors should pay attention to their responses in such situations and promptly discuss these reactions with their peers. While a counselor may understand the relevant facts, he or she may not be able to easily resolve them emotionally.

Visiting a correctional facility may be a valuable way for counselors to assess their preconceptions about people who have been incarcerated. Counselors may also attend a criminal trial to improve their understanding of the justice system, including relationships between judges, attorneys, plaintiffs, and defendants.
Test Yourself

Review Questions

1. How many people are incarcerated in California state prisons? a) 23,000; b) 40,000; c) 150,000; d) 1.46 million.
2. Which of the following is responsible for transmitting HIV in correctional facilities? a) injection drug use; b) unprotected anal sex; c) shared needles used for tattooing; d) all of the above.
3. What percentage of inmates in California are men? a) less than 10 percent; b) 31 percent; c) 68 percent; d) 93 percent.
4. True or False: Arrest and court records indicate that most incarcerated people do not have problems with drugs or alcohol.
5. True or False: Release from a correctional institution does not usually signify the end of a person’s involvement with the criminal justice system.
6. True or False: Men who have sex with men in correctional facilities do not necessarily identify as gay.
7. True or False: Condom use has drastically curtailed HIV transmission in correctional facilities.
8. True or False: Partly because of the challenges of providing basic needs, people often do not consider HIV protection to be a priority upon release from custody.

Discussion Questions

1. Is it appropriate to ask clients if they have a history of being incarcerated, and if so, under which circumstances? If not, why not?
2. Because clients who identify as heterosexual may feel their sexual orientation is being questioned if a counselor asks about their sexual activities while in custody, how can counselors begin such a discussion?
3. Upon learning that a person has a history of incarceration, some counselors may feel fear for their personal safety, regardless of anything else a client says related to this subject. How can counselors assess if they are experiencing such fear and if it is interfering with their counseling?
4. How can counselors assess if the referrals and linkages they offer are resources that are sensitive to the issues of people with histories of incarceration?
5. How can counselors be careful not to exaggerate their understanding of prison culture or “street life?” For counselors who have little understanding of prison culture, when is it appropriate to acknowledge this to clients?
6. Clients whose partners have recently been released from custody may express difficulties in re-establishing relationships and discussing HIV risks. How can counselors effectively respond to these clients?

Answers to Test Yourself

1. c.
2. d.
3. d.
4. False. The majority of incarcerated people have current or past substance abuse related problems.
5. True.
6. True.
7. False. Condom use is rare in correctional facilities, and many prisons and jails, including those in California, do not allow the possession of condoms.
8. True.
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The AIDS Health Project produces periodicals and books that blend research and practice to help front-line mental health and health care providers deliver the highest quality HIV-related counseling and mental health care. For more information about this program, visit http://ucsf-ahp.org/HTML2/services_providers_publications.htm.