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Prisons Sex and Drug Side Effects: A look at HIV transmission, prevention, and treatment behind bars

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INTRODUCTION

Studying the transmission, prevention and treatment of HIV and AIDS in prison is incredibly important. It is reported, "that 2.3 percent of all prison inmates are infected with HIV. The rate of confirmed cases of AIDS in the inmate population is more than six times that of the U.S. [general] population. Approximately one in every three inmate deaths is AIDS-related and AIDS is the leading cause of death among state inmates after 'illness and natural causes.'"[1] Twenty-five percent of all HIV positive people in the United States, at one point make their way through the correctional system. With numbers like these, it is impossible to ignore the problem of HIV and AIDS in correctional facilities in the United States.[2]

Although less than 10 percent of HIV positive inmates contract the virus while incarcerated, the rates of HIV coming in and out of prison and jails systems offer an

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[1] Tischler, Eric. 1997. HIV/AIDS in Prison Population. *Corrections Today*; Dec97, Vol. 59 Issue 7, p24, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=497314&site=ehost-live

[2] Zack, Barry. 2007. HIV Prevention: Behavioral Interventions in Correctional Settings. In *Public Health Behind Bars: From Prisons to Communities*, ed. Tobert Greifinger. New York: Springer Science+Business Media, LLC.

incredible opportunity. This opportunity is the ability to combat the spread of HIV both in corrections and in the general public. "90% of prisoners, representing an estimated 7.5 million prisoners annually, return to the free community at some point. As approximately 51.8% of those individuals are reincarcerated within three years, it is clear that providing effective disease prevention programs to those who are incarcerated would not only help protect them, but would also likely have synergistic impact on HIV rates in out communities."[3] As the Joint United Nations Programme on HIV/AIDS suggests, "prisoners are the community. They come from the community, the return to it. Protection of prisoners is protection of our communities."[4]

This thesis aims to only lightly address the ways intraprison infections occur, namely through male-to-male sexual activity and through the use of intravenous drugs while incarcerated. The main focus of this paper, however is to examine what prisons and jails are doing to stop the spread of HIV in correctional facilities, hopefully in an effort to curb HIV transmissions both behind and outside the gates of prisons and jails. The importance of focusing on the "less scandalous" side of HIV, is incredibly important because scandal and taboo are not what the spread of HIV in prisons is about. HIV in prisons is about prevention and treatment. Focus on what's happening behind bars allows a critique and consequent solutions to furthering the fight against HIV in prison, but also in our communities.

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[3] Zack, 156.

[4] Gido, Rosemary L. 2002, Inmates with HIV/AIDS: A Growing Concern. In *Prison Sex: Practice and Policy*, ed Christopher Hensley. p101. Colorado: Lynne Rienner Publishers, Inc.

CHAPTER 2: Sex Behind Bars

Because the topic of sex in prison is so multi-layered and could be a thesis in and of itself, this chapter will focus on and be broken into three segments, those being: Sexual Assault / Rape, Consensual Sex, and Condom Distribution.

SEXUAL ASSAULT / RAPE

As it stands now, "prison rape may be America's most ignored crime problem."[5] In response to the epidemic proportions of rape occurring in the U.S. prison system, "Senator Edward Kennedy said the following, 'We know that hundreds of thousands of inmates across the nation – not only convicted prisoners, but pretrial detainees… are victims of sexual assault each year. Of the two million prisoners in the United States, it is conservatively estimated that one in ten has been raped.'"[6] "In 2005, there were 2.83 allegations of sexual violence reported to the department of corrections per every 1000 prisoners. More than half of these involved staff." This statistic only takes into consideration those acts that are reported. When taking into consideration sexual assault acts that have not been officially reported, "studies have found that 3-28% of prisoners

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[5] Kunselman, Julie, Richard Tewksbury, Robert W. Dumond, and Doris A. Dumond. 2002, Nonconsensual Sexual Behavior. In *Prison Sex: Practice and Policy*, ed Christopher Hensley. 27 Colorado: Lynne Rienner Publishers, Inc.

[6] Ingley, Stephen J. 2005. First Report on Sexual Violence in Corrections is Released. *American Jails;* Sep/Oct2005, Vol. 19 Issue 4, p7/79, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=18581338&site=ehost-live

are sexually assaulted at least once while inside and that 7-12% of male respondents report being raped an average of nine times while doing time."[7]

It is difficult, with in a prison setting, to find a concrete definition for either sexual assault or rape, as the circumstances surrounding these acts are much different in correctional facilities than in the general public. This gets especially sticky when taking into consideration the different types of sexual misconduct that occur in prisons. By definition, there are three types of sex that occur with in the prison system. These are rape, coercive or exchange sex, and consensual sex. The definition of rape is the most concrete of all three forms of sex, although debate on an exact definition still occurs, for purposes of clarity, this paper will consider rape to be: any unwanted sexual act or "penetration of any orifice against a person's will and with the use of threat or force." Although there is also debate surrounding whether or not coercive or exchange sex is sexual assault, however, again for the sake of clarity it will be considered sexual assault. This type of sex is used as a way to gain protection, money, food, cigarettes, or other material goods. Exchange sex as a trade for protection is known as "hooking up" and is common for newly incarcerated inmates.[8]

As is the case in the general population as well, rape behind bars is quite strictly power play, having little if nothing to do with sex or sexuality. Unlike what is common in the general population, rape and coercive sex behind bars is encompassed by rape culture that create a sort of power/sexual hierarchy. This hierarchy is broken down into the following "scripts" or "patterns":

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[7] Barry, 158
[8] Kunselman, 29.

> "*Kid* or *Punk*: heterosexual and bisexual men who have been 'turned out' or forced to assume a sexually submissive role. *Jocker* or *Stud*: men who have sex with... punks. Since these men only assume the *masculine role* in the sexual encounter, they do not define themselves as homosexual, nor as engaging in a homosexual act. Some of theses *jockers*, however define themselves as bisexual... *Queen* or *Sissy*: homosexual male who adopt stereotyped effeminate mannerisms and play predominantly the submissive sex role. *Homosexual* or *Gay*: men who are more diverse in their sexual activity and who assume both active and passive roles, and who display few if any effeminate mannerisms."[9]

This hierarchy perpetuates "the pursuit of power via sexual violence and the enslavement of weaker prisoners is an integral feature of... prison, where... status and power are based on domination and gratification."[10]

Although it is common assumption that rape is an inmate-on-inmate issue, in a recent report on prison rape (*No Escape: Male Rape in U.S. Prisons*), documentation of "horrific sexual acts upon inmates [not] by other inmates but by correctional custodial staff as well," was brought to the surface. It was also noted that "sexual abuse of prisoners by correctional officials was not even a criminal offence in 14 states."[11] These reports along side others, brought to the forefront an incredible need for the development of "standards for the detection, prevention, and punishment of rape,"[12] bringing about the implementation of the Prison Rape Elimination Act of 2003.

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[9] Knowles, Gordon James. 1999. Male Prison Rape: A Search for Causation and Prevention. *The Howard Journal;* 39 Issue 3, p267-282, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=3254138&site=ehost-live

[10] Knowles p 273-274

[11] Kunselman, 27-28

[12] Beckwith, Curt G., Nick Zaller, and Josiah D. Rich. 2006. Addressing the HIV Epidemic Through Quality Correctional Healthcare. *Criminology & Public Policy*;

The PREA was implemented to work towards eliminating sexual assault in prisons ('prisons' being "interpreted to include prisons, jails, lockups, detention and placement facilities, shelters, and community residences for juvenile and adult offenders"). The mandate applies to all federal, state and local level institutions to "establish standards for the detection, reduction, prevention and punishment of prison rape and provide for the collection and dissemination of information on the incidence of prison rape."[13] The PREA guarantees:

> "The classification and assignment of inmates, using proven standardized instruments and protocols, in a manner that limits the occurrence of prison rap; the investigation and resolution of rape complaints by responsible authorities; the preservation of physical and testimonial evidence; acute-term trauma care for rape victims; referrals for long-term continuity of care for rape victims; educational and medical testing measures for reducing the incidence of transmission of HIV due to prison rape' post-rape prophylactic medical measures for reducing the incidence of transmission of sexual diseases; the training of correctional staff; the timely and comprehensive investigation of staff sexual misconduct involving rape or other sexual assault on inmates' the confidentiality of prison rape complaints and protection of inmates who make complaints; the creation of a system for reporting incidents of prison rape; data collection and reporting on prison rape; and all other matters as may reasonably be related to the detection, prevention, reduction and punishment of prison rape."[14]

Feb2006, Vol. 5 Issue 1, p149-155, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=20583414&site=ehost-live

[13] Maccarone, Robert M. 2007. Community Corrections And The Prison Elimination Act. *Corrections Today*; Oct2007, Vol. 69 Issue 5, p82-85, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=27221075&site=ehost-live

[14] Maccarone, 83.

This act looks to be incredibly helpful in working towards the elimination of prison rape and sexual assault. While it is way too early to tell whether or not this act has made any affect on the prison population, people concerned with sexual assault in corrections are optimistic about results of enacting the PREA in correctional facilities nation-wide.

CONSENSUAL SEX

Study surrounding male sexual behavior in correctional facilities remains sparse. There are very few studies that enter the world of consensual sex; most studies surrounding inmate sexual activity focus on rape or coercive sexual practices. "To date, [only] six studies have been conducted on consensual [sexual] behavior in male correctional facilities with in the United States."[15] The results of two of these studies are explored below.

Although rape and coercive sexual activity is overly common in correctional facilities, even more common is consensual sex and sexual activities between inmates. In study done in 2001, 174 inmates were interviewed from prisons around Oklahoma. From these interviews it was discovered that:

> "Twenty-three percent of the inmates had rubbed their body part against a fellow inmate in a sexual manner or allowed another inmate to rub a body part of theirs against him in a sexual manner. Twenty-four percent had allowed another man to touch their penis or touched another man's penis

[15] Koscheski, Mary; Chrisopher Hensley, Jeremy Wright, and Richard Tewksbury. 2002, Consensual Sexual Behavior. In *Prison Sex: Practice and Policy*, ed Christopher Hensley. pp 111-131 Colorado: Lynne Rienner Publishers, Inc.

> while incarcerated. Twenty-three percent had performed or received oral sex from another inmate while incarcerated. Twenty percent of the inmates admitted to engaging in anal intercourse with another inmate."[16]

A similar case study was done in the Georgia state prison system, however this study was done only with prisoners who had contracted HIV while incarcerated. There were 88 total inmates, 54 of whom reported having had sex with a fellow inmate. Of these 54, 89% reported having sex with a fellow inmate and 72% reported having had consensual sex with another inmates. Rape and exchange sex were also reported. Of 43 inmates who reported having consensual sex, only 30% of these people had used condoms "or other improvised barrier methods" (such as a baggie or saran wrap) at one point or another. With exchange sex, only 21% reported the use of "improvised barrier methods," but none reported using a condom. When the inmates were asked "how to reduce HIV transmission in prison, inmates suggested that condoms be made available in prison."[17]

CONDOM DISTRIBUTION

Condoms are considered to be, aside abstinence, the best way to protect against the spread of HIV and other STDs. Even though "the CDCP has recommended that condoms be made available in correctional settings, ... only two state prison systems (Vermont and Mississippi) and five local jail systems (Philadelphia, Los Angeles, New

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[16] Koscheski, p117.

[17] Taussig, J. 2006. HIV Transmission Among Male Inmates in a State Prison System -- Georgia, 1992-2005. *Morbidity & Mortality Weekly Report,* 2006, Vol. 55 Issue 15, p421-426

York, San Francisco, and Washington, DC) make condoms available to inmates."[18] In these programs, condoms are readily available, not in a one-by-one manner, but rather out in the open so that prisoners are not being observed when they take the condoms.

The debate against condom distribution in prisons is simple. If sex is illegal in all correctional facilities, the distribution of condoms will only work to promote sex and negate any restrictions surrounding sexual activity. It is also believed that condoms may be used to smuggle in contraband of used to throw bodily fluids. "In the systems with condom availability, there have been few if any problems with condoms being used as weapons or for smuggling contraband."[19]

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[18] Bick, Joseph A. 2007. HIV and Viral Hepatitis in Corrections: A Public Health Opportunity. In *Public Health Behind Bars: From Prisons to Communities*, ed. Tobert Greifinger. pp103-126. New York: Springer Science+Business Media, LLC.

[19] Robinette, Penny A, and Billy Long. 1999. Is the Segregation of HIV-Postitive Inmates Ethical?. *The Prison Journal*; 79 Issue 1, p101-118, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=SM186413&site=ehost-live

CHAPTER 3: Intravenous Drugs in Corrections

> "Throughout most of the world, the primary response to problems associated with illicit injection drug use has been to intensify law enforcement efforts. This strategy has contributed to an unprecedented growth in prison populations and growing concerns regarding drug-related harm within prisons. Despite the presence of international laws and guidelines that call for the protection of the health of prisoners, prison authorities have generally been slow to implement activities that have been proven effective in reducing drug-related harms in community settings."

Although drugs are illegal both inside and out of the correctional world, drugs are very readily available in prisons. Because many prisoners enter prison with addictions to injection drugs, prisoners find a way to get drugs into prison.

> "Evidence from the USA indicates that approximately 80% of IDUs [injection drug users] have a history of imprisonment, and a 12-city World Health Organization study of HIV risk behavior among IDUs found that between 60% and 90% of all respondents reported a history of imprisonment since commencing such injection. Available evidence indicates that a substantial proportion of drug users inject drugs while in prison, with 50% or more of drug users from several countries reporting injection while in prison."[20]

[20] Kerr, Thomas, Evan Wood, Glenn Betteridge, Rick Lines, and Ralf Jurgens. 2004. Harm Reduction in Prisons: a 'Rights Based Analysis'. *Critical Public Health*; Dec2004, Vol. 14 Issue 4, p345-360, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=16573320&site=ehost-live

In the case of New York state, "of all the AIDS cases diagnosed in 1999 by the New York State Department of Corrections, 84% were reported to have acquired HIV infection through injection drug use."[21]

Because drugs are difficult to smuggle into prisons, the supplies fluctuate often, forcing the drugs are shared amongst large groups of inmates. As needles are even harder to get into prisons than drugs themselves, there is often only one needle to go around. Because of this difficulty getting new or clean needles, prisoners have been known to "sharpen old syringes and to manufacture syringe substitutes out of hardened plastic and ballpoint pens."[22] This type of drug use has been shown to increase infections, both at the injection site and throughout the body, making the user more prone to HIV infection.

The difficulty of smuggling drugs and needles into prisons does a great deal to curb the use of intravenous drug use in prisons, injection drugs are still a big problem in incarcerated populations. While many drugs and drug related tools do stop at the gates, drug use in correctional facilities is one of the biggest links to HIV transmission behind bars. Injection drug using prisoners are much more likely to contract HIV (due to minimal access to clean needles and high prevalence of HIV in prisons) than the general public. In prisons, "the virus is most commonly transmitted through the needles addicts use to inject drugs." This simple fact shows the importance of the implementation of HIV prevention measures surrounding intravenous drug use in correctional facilities, however,

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[21] Andia, Johnny F., Sherry Deren, Rafaela R. Robles, Sung-Yeon Kang, Hector M. Colon, Denise Oliver-Velez and Ann Finlinson. 2005. Factors Associated With Injection and Noninjection Drug Use During Incarceration Among Puerto Rican Drug Injectors in New York and Puerto Rico. *The Prison Journal*; Sep2005, Vol. 85 Issue 3, p329-342, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=18074524&site=ehost-live

[22] Kerr, 346.

"most strategies for dealing with HIV in prisons focus on a zero-tolerance approach to drug users."[23]

There are three major ways to combat the spread of HIV through intravenous drug use in prisons. These three programs are: Methadone Maintenance, Needle cleaning programs, and needle exchange programs. Outside of prisons, it is estimated that over 980,000 people in the United States are addicted to Heroin or other such opiates.[24] Due to the high exchange of bodily fluids, sharing needles and doing drugs from the same bag or spoon, injection drug users are much more susceptible to contracting HIV. This increases more once that person enters prisons. In this light, a great way to curb the spread of HIV in prisons is to implement drug therapy for addicted inmates in hopes of reducing drug use, and thus, reducing intraprison transmission.

One of the most effective forms of treatment for an addiction to an opiate is Methadone Maintenance Treatment. Methadone is a medication that works to stop the cravings and physical desires for heroin and other opiates. It does so by "block[ing] the euphoric and sedating effects of opiates; reliev[ing] the craving for opiates; ... relieving symptoms associated with withdrawal from opiates; ... not caus[ing] euphoria or intoxication itself, thus allowing a person to work and participate normally in society; and is excreted slowly so I can be taken [only] once a day" The benefits of methadone therapy include: "Reduced or stopped use of injection drugs; reduced risk of overdose and of acquiring or transmitting diseases such as HIV, Hepatitis B or C, bacterial

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[23] Davies, Rachael. 2004. Prison's Second Death Row. *Lancet*; Vol. 364 Issue 9431, p317-318, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=13902892&site=ehost-live

[24] CDC. Department of Health and Human Services. www.cdc.gov/idu

infections, endocarditic, soft tissue infections, thrombophlebitis, tuberculosis, and [various] STDs."[25]

A program such as this would be a great asset to the prison community, however, because treatment can take any where from 12 months to a number of years, this program is not appropriate for all inmates. It is also a not the best option for many inmates, because a great deal of the time, patients may need multiple episodes of treatment over and extended period of time. Although this treatment has been found to be effective in many ways, "it is relatively common for MMT patients to continue using heroin, other drugs such as cocaine or marijuana, and alcohol after admission to treatment."[26] While this isn't an abundant problem, it does call for the need of other prevention programs such as needle cleaning kits or needle exchange programs.

Another program that would greatly assist in combating the spread of HIV through intravenous drug use is a bleach distribution/needle-cleaning program. As a last resort, in the case of not being able to get a clean needle, it is possible to clean a needle with bleach. "The CDC's revised procedure calls for rinsing the [syringe] with clean water [until there is no blood], then with full strength bleach, then with clean water again at least three times, shaking the syringe for thirty seconds during each rinsing."[27] This procedure is incredibly easy to do and even easier to teach. Ideally, little bottles of bleach

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[25] CDC. Department of Health and Human Services. www.cdc.gov/idu
[26] CDC. Department of Health and Human Services. www.cdc.gov/idu
[27] Robinette, Penny A, and Billy Long. 1999. Is the Segregation of HIV-Postitive Inmates Ethical?. *The Prison Journal*; 79 Issue 1, p101-118, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=SM186413&site=ehost-live

with written instructions on how to clean a needle would be made readily available for all inmates.[28]

A bleach distribution program such as this would be cost effective and easy to implement. The cleaning of a syringe is incredibly easy and because bleach is already used as a cleaning supply in prisons, it would take very little to distribute bleach to injection drug users. The implementation of bleach distribution would also work to not promote an increase in drug use, as the number of needles already in prisons would not increase, just simply be safer to use. However, those against bleach distribution argue that "making bleach and information on how to clean injection equipment available may encourage non-users to experiment with injection drug use, and that bleach could be used as a weapon against staff."[29] This however is not what studies have shown to be true. Of all the prison systems in Europe who have implemented a bleach distribution program, none have revoked the program and the number of prisons implementing bleach distribution has grown every year.

"Needle exchange programs [are] generally regarded as the single most important factor in preventing HIV epidemics among injection drug users."[30] "These programmes have been shown to be effective and viable for controlling HIV spread, and do not impede on the safety or effectiveness of drug-prevention policies." They are also incredibly inexpensive to operate, as has been proven by their ongoing use in developing countries such as Moldova and Kyrgyzstan.[31] In addition to being cost effective, NEPs

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[28] Robinette, 113.
[29] Kerr, 349.
[30] Kerr, 350.
[31] Davies, Rachael. 2004. Prison's Second Death Row. *Lancet*; Vol. 364 Issue 9431, p317-318,

are also quite simple and easy to run. Clean needles and depository stations would be readily available through "a number of means including doctors, vending machines, drug counseling services, correctional staff or external staff." For the NEP to function successfully, the prisons have to ensure they hold an adequate supply of clean needles at all times and ensure that they are readily available when needed.[32]

There is, of course, much debate around programs such as these. Those against needle exchange programs argue that "NEPs could promote the use of needles as weapons. However, in surveys on the topic, prisoners consistently emphasize that there are many other things available to them to use as weapons and, more importantly, they see the value of having clean needles available to protect their own health."[33] Another issue is that some feel providing prisoners with clean needles is promoting drug use with in correctional facilities. Because there is no information on this in the United States, we have to look at Europe to examine any truths behind and increase in drug use due to the distribution of clean needles:

> "Switzerland has been distributing sterile injection equipment since 1992. And, as of 2004, NEPs had been introduced in 50 prisons in Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus. These measures have decreased rates of drug use, syringe sharing, and HIV transmission. Needles have not been used as weapons, and there has been no recorded increase in drug use."[34]

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http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=13902892&site=ehost-live

[32] Krebb, 352.
[33] Davies, 317.
[34] Davies, 318.

Although NEPs have shown nothing but positive effects on the population of HIV-positive and negative IDUs, there has still yet to be a needle exchange program here in the United States.

CHAPTER 4: HIV Prevention

The issue of prevention is incredibly multifaceted. Because of this, this chapter will be broken into sections: Testing, HIV Education, and Segregation/Isolation. Not included in this chapter are condom distribution and rape prevention; and needle exchange programs, which are examined in chapters 2 and 3, respectively.

TESTING

HIV testing, mandatory or not, is clearly the best place to start when considering HIV prevention in corrections. As mentioned in previous chapters, the HIV rates in prisons and jails is nearly five times higher than in the general public. That makes correction facilities on the list of high-risk communities – a demographic for which the CDC recommends routine screening and availability to counseling and treatment options (find an article to site this from). It is apparent testing is critically important in correction facilities, but there is much debate over the rights and wrongs of how to go about testing incarcerated persons.

Despite the fact that 16 states are already using mandatory HIV testing in prisons[35], there is still a great deal of debate surrounding mandatory versus routine testing in correctional facilities. After a call for mandatory testing, the debate got heated. While

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[35] Weinstein, Corey. 2003. Mandatory HIV Testing in Prisons. *American Journal of Public Health*; ct2003, Vol. 93 Issue 10, p1617-1617, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=11097164&site=ehost-live

mandatory testing would clearly bring about more positive results, thus allowing more inmates to gain treatment, mandatory testing, infringes on the prisoners' rights as both a prisoner and American citizen.

As it stands now, "The APHA *standards for Health Services in Correctional Institutions* states: 'Mandatory determination of HIV antibody status is only appropriate for prospective donors of blood or other antibodies.'"[36] Activists of prisoners and those working with the APHA argue that "HIV/AIDS in prison must be treated in the same manner as it is treated in the community – which, among other things, precludes the use of mandatory testing."[37]

Many supporters of mandatory testing argue that "in the general population, racial/ethnic minorities are diagnosed late, are the first to present at hospital emergency rooms, have less access to state-of-the-art therapies, and are victimized by systemic discrimination."[38] These same racial/ethnic minorities also disproportionately populate correctional facilities. Those in favor of mandatory testing may well agree that it infringes on some rights of inmates, but argue that the greater evil is not knowing one's status and not being able to receive appropriate health care. Health care that for some inmates may only be accessible while the inmate is incarcerated.

> "All things being equal (which they are not), we agree...
> that free choice is a good thing and that all people would

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[36] Weinstein, 1617.
[37] Weinstein, 1617.
[38] Arriola, Dr. Kimberly R.J. and Dr. Ronald L Braithwaite. 2003. Braithwaite and Arriola Respond. *American Journal of Public Health*; ct2003, Vol. 93 Issue 10, p1617-1617, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=11097164&site=ehost-live

> have the right to make informed health decisions. However, the medical care for HIV-infected inmates in long-term facilities is relatively good, and mandatory HIV testing has the potential to result in treatment and care for individuals who might not otherwise have access to these services. One might argue that the 34 states without mandatory testing are more concerned with the negative financial impact that increased case finding would have on their budgets than with inmates' health."[39]

Routine screening is the option taken by most prison and jail systems. The idea behind this is that HIV testing is available to all inmates, but is not mandatory. There are two types of routine testing available to inmates in the other 36 state prison and jail systems. These two types are opt-in and opt-out testing. With opt-in testing, "HIV testing is routinely offered to all patients but each person must then choose to accept testing."[40] The upside of opt-in testing in the eyes of those who oppose mandatory testing, and the like, is that each individual is actively choosing to take the test. The down side is, because one has to opt-in and actively ask for an HIV test, stigmas surrounding the test are abundant.

With opt-out testing, all inmates are screened for HIV during the routine screening process and only those who actively decline the test are not screened. This form of testing has been shown to increase the number of inmates who accept and HIV tests. Because every prisoner, as far as their peers know, is given the HIV test, it normalizes the process and can breaks down test-related stigmas. This form of testing has

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[39] Arriola, 1617.

[40] Bick, Joseph A. 2007. HIV and Viral Hepatitis in Corrections: A Public Health Opportunity. In *Public Health Behind Bars: From Prisons to Communities*, ed. Tobert Greifinger. p103-126. New York: Springer Science+Business Media, LLC.

been incredibly effective, however, "prisoner advocates suggest that opt-out testing conducted in jail or prison is coercive by nature and akin to mandatory testing."[41]

> "[Opt-in or not,] a recent study with in the California Department of Corrections and Rehabilitation (CDCR) demonstrated that offering routine one-to-one HIV counseling of all incoming inmates doubled the acceptance of voluntary HIV testing. This study also concluded that a significant percentage of high-risk individuals had never previously tested for HIV, and that offering multiple testing modalities (blood, urine, and oral fluid) can increase the number of individuals who choose to test."[42]

One issue surrounding HIV testing, mostly in jails, because of high influx of inmates, some only incarcerated for one or two days, is people coming into jail, being tested, and not receiving the results. With the common HIV blood test, results can take as long as a week. If an inmate is only held for a few days, he may never receive his results, leaving testing completely pointless. The solution to this problem is rapid HIV tests, approved by the FDA in 2003.[43] There are two types of rapid HIV tests currently in use. One of these is a simple cheek swab; the other is a drop of blood from a finger of the inmate. These results are returned in less than 20 minutes.[44] These tests never return false negatives, but can return false positives. If an inmate, or anyone using a rapid HIV test, receives a false positive, it is because he or she has an existing immune deficiency problem. These tests offer an amazing opportunity to help notify and treat HIV positive

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[41] Bick, 107
[42] Bick, 108
[43] Altman, Lawrence K. 2003. Officials Urge a Wider Use of a 20-Minute HIV Test. *New York Times*. February 12.
[44] Altman

people moving through the correctional facility, even if the incarcerated person is only held for a short period of time.

HIV EDUCATION

"Although many prisons offer some form of HIV/AIDS education, [currently,] only 10% of state and federal prisons provide comprehensive HIV/AIDS education and prevention programming, which consists of instructor-led education, peer-led programs, pretest and posttest counseling, and a multi-session prevention counseling."[45] It is likely the reason for so few facilities participating in such an extensive prevention program is cost. A program at the caliber of one with five major components can be incredibly pricey and difficult to have implemented in correctional facilities.

Despite the fact that there seems to be very little adequate education surrounding the spread of HIV in prisons and jails, there is clear need for such programs to be implemented. "Evidence suggests that both HIV related risk behavior and factors known to be related to these risk behaviors can be reduced as a result of intervention."[46] Zack Barry suggests, for the best results in preventing the spread of HIV in corrections, all correctional facilities work to develop and implement HIV education in their specific systems. These programs, should be based on a set of guidelines that take in to

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[45] Krebs, Christopher P. and Melanie Simmons. *Intraprison HIV Transmission: An Assessment of Whether It Occures, How It Occurs, and Who Is at Risk.* 2002
[46] Barry, Zack. *HIV Prevention. Public heath behind bars.*

consideration "four distinct components[:] (1) type of intervention, (2) the timing of the program, (3) the content, and (4) the messenger."[47]

The format or type of education as prevention is incredibly important in how the information given is received. Because there is a great deal of stigma surrounding HIV, especially in amongst inmates and prisoners, it is important to make the way in which education is delivered both comfortable and inviting. It is also incredibly important to make sure that the education surrounding HIV is inclusive and covers a wider range of diseases passed through sexual contact and intravenous drug use. This way the program can speak to a wider audience and is more apt to have a higher number of participants. On the topic of type of education, Barry suggests:

> "Education should be initiated through individual, group or institutional programming. Peer-facilitated, multisession group or individual sessions that are comprehensive and client-centered are most effective. Different learning and literacy capacities should be taken into consideration, as should cultural issues, so that the content and delivery is intellectually appropriate for those receiving it."[48]

The most effective types of interventions happen at the individual level. One-on-one counseling and education is easily geared towards the individual's needs and specifics surrounding the individual's participation in high-risk behaviors. It is important to note, however, that in both group and individual level interventions that it is never assumed that the "recipient engages/does not engage in certain behaviors nor demand that

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[47] Zack, Barry. 2007. HIV Prevention: Behavioral Interventions in Correctional Settings. In *Public Health Behind Bars: From Prisons to Communities*, ed. Tobert Greifinger. 156-173. New York: Springer Science+Business Media, LLC.
[48] Zack, 164.

he or she reveal this behavior to the program staff or to a group. The participant must choose what to reveal to others."[49]

The second point of importance when formatting an HIV prevention education program is the timing with in the inmates' incarceration in which the program is implemented. Because jails have such high turn over, it is important to offer education programs upon entry. This way every inmate is offered prevention education, even if they are only incarcerated for a short period of time. This also allows for HIV prevention information to quickly make its way out in to the community. With in the education occurring directly upon entering, preferably at reception centers, Barry suggests that education include the formalities of risk prevention inside the facilities. This should include things like "institutional/departmental policies about both behavior risks and screening/testing procedures."

More specifically in terms of timing, prevention education should start upon entrance, but should also continue through out the time of incarceration. A prisoner's ability to continue to learn and reinforce ways to prevent HIV through behavioral changes cannot occur after just one session on HIV prevention. It is through ongoing lessons that one may learn best how to avoid infection. It is the hopes of many HIV education advocates that there be education and prevention programs even after incarceration. Through the implementation of programs that work along side community organizations to create a partnership that encourages "entry into a drug treatment

[49] Zack, 167.

program, mental health counseling, access to partner testing and counseling, syringe exchange information, and ongoing support for prevention services."[50]

The importance of having such a long period of education is especially important when taking into consideration the amount of content an inclusive HIV education program has to cover. Because many incoming inmates have never previously had access to HIV prevention education, these classes and workshops have no choice but to start from the very beginning. "At a minimum, efforts must be made to inform the individual of: modes of transmission; risk reduction; the 'window period'; prison/jail and department/jurisdictional specific policies and procedures; counseling and voluntary testing; and available treatment options."[51] These are of course minimums, as there is a great deal more that surrounds the transmission and treatment of HIV and AIDS.

Although this type of basic HIV education does a great deal to inform prisoners, if has shown to do "little to impact behavior," which is why it is important to have a next stage of education which would focus on developing the incarcerated person to develop skills surrounding preventing risky behavior. Such skills include: "Proper use of condoms, strategies for encouraging condom use with partners, understanding and practicing syringe hygiene, increasing awareness of needle exchange programs, and other methods of prevention activities (including not sharing tattooing equipment"[52]

With all the stigmas surrounding HIV and HIV prevention education in prisons, it is of no surprise that programs that use peers can be incredibly effective. It is even more effective, when getting the point across if the peer is HIV positive and can facilitate

[50] Zack, 165.
[51] Zack, 166.
[52] Zack, 167.

discussion in a very personal manner, allowing the inmates put themselves in the same shoes as the instructor as he either has been or is currently incarcerated. Having a peer educator also allows the program to be "culturally tailored [allowing] HIV risk reduction activities [to] be more effective at sensitizing target populations to HIV/AIDS concerns and increasing the likelihood that targeted individuals are tested for HIV and discuss HIV/AIDS with friends,"[53] allowing the information to successfully reach a wide audience.

These programs have not only been found to be beneficial to the attendees of peer led education programs, but also incredibly beneficial to the peer educators themselves. Findings from an peer education program called "Project Wall Talk," a per education program implemented in Texas, show the "effectiveness of the peer education training program in significantly increasing knowledge and self-assessed skills over the nine months between baseline and follow-up in peer educators."[54] This study also showed a great deal of the peer educators were asked outside of the classroom about HIV related information, further showing the advantages of peer education. These same educators were also sharing information with people in their communities outside of the correctional facilities. As far as effectiveness goes, this program proved to increase the number of inmates, both educators and not, who planned to or had already taken an HIV test. The most important findings from this program, as far as prison's are concerned is

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[53] Bick, 109.

[54] Ross, Michael W., Amy Jo Harzke, Deborah P. Scott, Kelly McCann, and Michael Kelley. 2006. Outcomes of Project Wall Talk: An HIV/AIDS Peer Education Program Implemented Within The Texas State Prison System. *AIDS Education & Prevention*; Dec2006, Vol. 18 Issue 6, p504-517, 14p, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=23428364&site=ehost-live

how incredibly cost effective peer led prevention education is,[55] especially when taking into consideration the decrease in HIV transmission and thus necessity for medical treatment while behind bars, as a result of the peer led education.

SEGREGATION/ISOLATION

From the early discovery of the disease well into the present, the isolation and segregation of prisoners has been a form of prevention of the spread of HIV in prison. This form of prevention can be anything from solitary confinement to living in a colony of HIV + people, to having certain activities made unavailable. "In 1985, 42% of prison facilities had segregation programs for HIV-positive and/or AIDS inmates."[56] As of the year 2000, even though "The Federal Bureau of Prisons does not use a segregation policy, generally presuming that HIV- positive inmates can suitably be housed and placed in programs with other inmates unless there is evidence to the contrary,"[57] at least 6 prison systems currently segregate hundreds of HIV+ inmates.[58]

Although completely violating prisoners' first amendment rights to the freedom of religious affiliation and voluntary religious worship as well as "the right to participate in education, vocational training and employment,"[59] in January of 2000, the "Supreme

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[55] Ross,
[56] Robinette, Penny A. and Billy Long. *IS the Segregation of HIV-Positive Inmates Ethical?*. The Prison Journal. 1999
[57] Greenhouse, Linda. *Supreme Court Roundup; Justices Allow Segregation of Inmates With HIV*. New York Times. January 2000.
[58] Robinette, Penny A. and Billy Long. *IS the Segregation of HIV-Positive Inmates Ethical?*. The Prison Journal. 1999
[59] Cripe, Clair A. and Michael G. Pearlman. *Inmate Rights and Responsibilities*. Legal Aspects of Corrections Management. pp. 226-227

Court... [ruled to permit] Alabama prisons to segregate hundreds of HIV-positive inmates and keep them from educational programs and even from religious services where they might mix with other prisoners... [as well as] exclusion from some 70 programs, including job training... and work release."[60]

> "Under the Americans with Disabilities Act of 1990, those who pose a 'direct threat to the health and safety of others' can be excluded from a program. The law defines 'direct threat' as 'a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation' or by modifying existing policies.... The federal Court of Appeals for the 11th Circuit, in an 8-to-3 ruling [April 2000], concluded that the prison system's policy was justified because AIDS is fatal, and 'death itself makes the risk significant.'"[61]

There is, unsurprisingly, still great debate about the ethics surrounding the segregation and isolation of HIV + inmates. Those in favor of mandatory testing and consequent segregation of HIV+ inmates acknowledge that the terms of segregation may impose on certain rights of the prisoners, however they argue that "the concept of rights... must include not only the prisoners but also everyone who comes into contact with those prisoners, from other prisoners to prison employees to family members to the community upon those prisoners' release."[62] These same people argue that it is in the favor of HIV-positive inmates suggesting that this segregation allows the correction facilities to better educate and treat these inmates. They also suggest that through

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[60] Greenhouse, Linda. 2000. Supreme Court Roundup; Justices Allow Segregation of Inmates With H.I.V. *New York Times,* January 19, U.S., online article.
[61] Greenhouse,
[62] Robinette,

segregating these prisoners, the facility is "protect[ing] the HIV-positive inmates from discrimination."[63]

It is also suggested that the segregation and isolation of HIV-positive prisoners is in the interest of the safety of correctional officers who work with such prisoners. Officers argue that:

> "[The] segregation of HIV-positive and AIDS inmates would allow them to act with more caution in performing their duties. Although there has been no reported case of a correctional officer contracting HIV through job-related tasks, there are risks taken daily within this type of employment."[64]

These absurd claims go as far as to suggest that even with a less than 1% chance of an officer being infected doing their given tasks, "it would be ignorance to assume that this case would never happen."

Those in favor of segregation of HIV-positive inmates assert that "it is assumed that the general public would not intentionally and repeatedly act out these high-risk behaviors. The prison community is different from the general population in this manner. It is much more likely that inmates will participate in these behaviors." With out taking into consideration at all that the *vast* majority of HIV-positive prisoners contract HIV through risky behavior as a member of the general public, they conclude that "it is therefore in the best interest of the general population to test each prisoner, segregate all

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[63] Robinette,
[64] Robinette,

HIV-positive inmates and use the average of 2.5 to 3 years of time served to educate and counsel the inmates about their disease – how it affects them and the community."[65]

The argument against HIV-positive prisoner isolation and segregation goes farther than the obvious denial of basic rights concerned with religious freedom, education opportunities and job opportunities and suggests that among losing these rights, segregated HIV-positive inmate inevitably receive inferior health care. It is suggested that "there are two correctional systems, one for seronegative inmates and one for those who are seropositive," and that these two "correctional systems" are intrinsically unequal.[66]

Another argument surrounding segregation comes in to play in concern with preliminary blanket testing. Because of the three to six month window period for antibodies to make an appearance after contracting the virus, blanket testing does not actually catch everyone who is HIV-positive. This would mean some prisoners who are actually HIV-positive may test negative and be placed in the general prison population, negating any rationale that segregation stops the spread of HIV. In the circumstances of having a population who all believe themselves to be negative, "risky behavior may be more likely. Because inmates 'know' that all seropositives are kept in isolation, there must be no danger in engaging in intravenous drug use, or unprotected… anal intercourse."[67]

Because HIV cannot be casually contracted, those opposed to segregation dismiss that there is any risk of infection to guards who are properly performing their duties. Those against HIV-positive segregation measures suggest there are much better ways of

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[65] Robinette,
[66] Robinette,
[67] Robinette,

preventing the spread of HIV in prisons that do not revoke any rights of the prisoners, or further any stigmas surrounding being HIV-positive. These measures are needle exchange programs, needle cleaning kits, and availability of condoms to inmates.[68]

[68] Robinette,

CHAPTER 5: Transitional treatment from behind bars to in communities.

While health care can be less that desirable in prisons and jails, "many incarcerated persons are marginalized from traditional healthcare resources in their communities and incarceration is their window of opportunity to receive care at no cost."[69] For many HIV-positive inmates, prison is their first introduction to current treatments available for HIV-positive persons. "Highly active antiretroviral therapy has remarkably transformed HIV disease into a chronic condition such that when patients completely suppress viral replication, they can expect to live a normal life expectancy."[70] Health care in prisons and jails are already providing this type of healthcare. Through HAART prisoners in some cases have been given and in others, should be given an opportunity to start a regiment that allows them to treat their infection as a chronic disease and not a death sentence, something often not available in their communities. The main issues in corrections, then, start with adequate health care while incarcerated and continue once the prisoner has been released.

A community release plan, to be effective must start at the very beginning. With adequate health care, after being tested the prisoner should undergo a baseline physical and evaluation to determine that person's viral load and CD4 count. Accounting for these

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[69] Beckwith, Curt G., Nick Zaller, and Josiah D. Rich. 2006. Addressing the HIV Epidemic Through Quality Correctional Healthcare. *Criminology & Public Policy*; Feb2006, Vol. 5 Issue 1, p149-155, http://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=20583414&site=ehost-live

[70] Springer, Sandra A and Frederick L. Altice. 2007. Improving the Care for HIV-Infected Prisoners: An Integrated Prison-Release Health Model. In *Public Health Behind Bars: From Prisons to Communities*, ed. Tobert Greifinger. p535-555 New York: Springer Science+Business Media, LLC

numbers then allows the health care provider to determine whether or not to start the patient on anti-retroviral medication.[71] Because of this, "all HIV-infected inmates must be provided access to routine lab work for monitoring treatment, to include determinations of HIV viral load and CD4 counts,"[72] so that if a prisoner's CD4 count does drop, anti-retroviral medication can be administered.

After determining whether or not to place the inmate on an anti-retroviral regiment, the clinician should then administer tests for other conditions that may affect the condition and treatment of HIV-positive inmate, such as other various STDs, tuberculosis, and viral hepatitis. It should also be determined if the inmate has drug addiction or mental illness and be treated appropriately for each illness in conjunction with the anti-retroviral treatment.[73] Whether or not all prisoners have access to this type of treatment has not been noted in any research findings, however, it is commonly believed many correctional facilities do not offer such in depth treatment for their patients. If this type of treatment is available, however the prison or jail can then implement a transitional program for HIV-positive inmates being released, who do not have the means to continue treatment on their own.

A transitional program, to be successful, has to take into consideration 5 distinct areas of focus. The first of these five categories is case management adoption. The idea behind this is that through having one specific person coordinate both medical and psychological care for the recently released inmate. This direct linkage to services provided in the communities allows the inmate, with the help of a case manager, to find

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[71] Springer. 536
[72] Bick. 108. Chapter 8 form good book
[73] Beckwith, 152

necessary services outside of corrections. Of the documented programs around the United States, prison-release programs in general have seen anywhere from 35% - 98% retention rate, meaning 35-90 percent of prisoners, who with out this program would most likely have no access to such help, are able to continue treatment anywhere from 6-18 months after being released.[74] Through case management, newly released prisoners may

The second area of importance is "directly administered antiretroviral therapy" or DAART. A major issue concerning ART (anti-retroviral therapy), post-release, is drop out. Because of obstacles such as homelessness, unemployment, poverty, mental illness, etc., many prisoners who were previously on medication, do not continue with their prescribed medication. Through directly administered ant-retroviral therapy, "an outreach worker [is able to] assist the person in taking medications on a daily or near-daily schedule with the goal of transitioning the person to taking medication on their own." This program works to offer release prisoners encouragement and skills needed to continue medicated regiments on their own, once post-release programs expire.[75]

The third area of focus is with substance abuse treatment. Because substance abuse is so incredibly common in correctional facilities, this aspect of post-release transition is hugely important. Through the use of Methadone or Buprenorphine, post-release programs can continue treatment that has already been enacted during incarceration. Because it can often take multiple treatments over an extended period of time, for methadone monitoring programs to be successful, providing a continuation of these programs, post-release, is beyond important.[76]

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[74] Springer. 536
[75] Springer. 541
[76] Springer. 545

Mental illness, the fourth category, is an underlying issue that cannot be ignored. Drug and substance abuse and other risky behaviors are often linked with mental illness. There are many ways in which post release programs can offer aid for those in need of treatment. The New Jersey Department of Corrections has proposed a program that would break newly released inmates' needs into four categories: Tier 4 through Tier 1. Based on the category in which the inmate placed, the inmate would receive the appropriate care. Tier 4 would classify any prisoners in need of extensive mental health treatment. These inmates, would be provided with 18 months of extensive treatment, 6 months of which would occur prerelease. Tier 1 would classify those inmates who have less need for mental health care, and are only offered 4 weeks of mental health treatment, starting two weeks before release. Tiers 2 and 3 fit respectively between Tiers 4 and 1.[77] This program has yet to be enacted, however has already been proven to be incredibly costly, making it an unlikely fit for most prison systems.

The last important area of concern is reducing postrelease high-risk behavior. Through the continuation of HIV education, programs hope to be able to have an effect on the behaviors of released inmates. Through curbing high-risk behavior, ex-prisoners are much less likely to reenter jail or prison, and help stop the spread of HIV in some of the most at-risk communities.[78] Post release/transitional programs offer an opportunity to continue various treatments, connect to programs that can offer aid with mental health, drug and alcohol addiction issues, and even help change risky behaviors, curbing the spread of HIV in communities.

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[77] Springer. 548
[78] Springer. 550

CONCLUSION

What is most important to take from this work is realizing an incredible opportunity to curb the spread of HIV, both in correctional facilities, but also in high-risk communities, those that are most likely to have members in and out of prisons and jails. If, through routine opt-out testing, quality prevention education, needle exchange programs, condom distribution and transitional programs, we can reduce the number of inmates contracting HIV in prison, and cut down on those contracting the virus in their own communities. And because those same at-risk communities are the ones feeding back into the prison system, we can also cut down the number of incoming HIV-positive people. If we cut down in prison, we cut down in neighborhoods, and the cycle continues until the spread of HIV is occurring at or below the rates of the general public.

Because many people aren't interested in the well being of prisoners, the health, safety, and well being of those who are incarcerated is often left to the wayside. What people don't take into consideration, is that these people are still a part of our communities. Even if they don't actively return to the communities from which they came (although 90%) of them do, they are still human beings and deserve the right to combat the spread of HIV and AIDS. Not providing condoms, needle cleaning kits, or needle exchange programs to inmates is abhorring and embarrassing. We cannot continue to ignore the spread of HIV in our most at-risk areas. By withholding programs we know to to be effective in cutting down the spread of HIV in correctional facilities, we are allowing HIV and AIDS to be acceptable forms of punishment for drug abuse and sexual contact.

It is undeniably important to note that when dealing with the issue of HIV transmission, prevention and treatment with regard to incarceration that race and ethnicity play large roles. If I am able to continue my research further, I would like to explore the racial implication of HIV and AIDS both inside prisons and inside communities that have increasingly high incarceration rates. An undergraduate thesis however is not a long enough study to accurately assess these issues, so I purposely avoided discussion of race or racial implications and stuck with a universal look at HIV behind bars.