

issue brief

“The degree of civilization in a society can be judged by entering its prisons.”

– Fyodor Dostoyevsky

HIV in Correctional Settings: Implications for Prevention and Treatment Policy

The U.S. correctional system is facing critical challenges as the number of incarcerated people continues to grow. At the end of 2006, there were nearly 2.26 million inmates in state, federal, and local correctional facilities, a rate of 751 inmates per 100,000 U.S. residents.¹ This is a record high for the U.S. and is the highest incarceration rate in the world.² For the first time, more than one in every 100 adults in America is now confined in a jail or prison.³ Such high rates of incarceration have far-reaching implications for the health and well-being of families, communities, and society at large. The increasing size of the incarcerated population also has serious cost implications for the healthcare infrastructure, particularly since the cost of medical care in the U.S. is now more than seven times higher than it was in 1980.⁴

HIV/AIDS has a disproportionate impact on incarcerated populations in the U.S., with prevalence among prisoners more than three times higher than the general U.S. population (see Figure 1).⁵ The presence of HIV-infected persons and those at high risk of infection in the correctional system is a critical challenge to both the correctional health system and the public health community. This challenge offers unique opportunities to reach these high-

risk individuals and engage them in HIV prevention, treatment, and care.

The Link Between Correctional Facilities and Communities

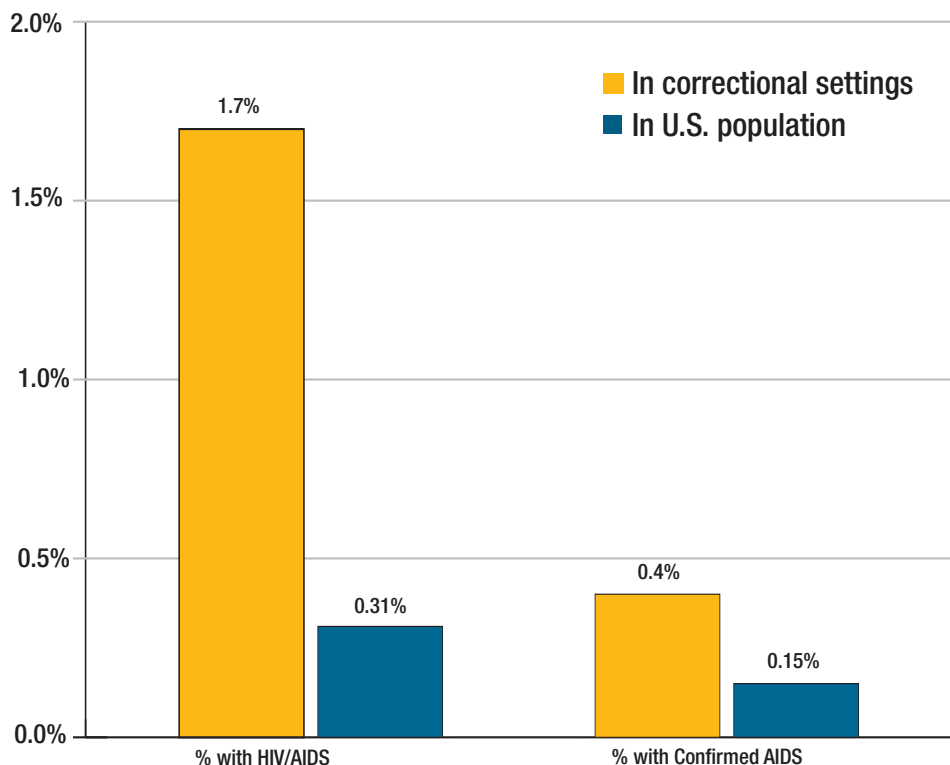
In 2005, more than 7 million people in the U.S. were under some form of correctional supervision, either in institutional correctional facilities (prisons or jails) or in the community (e.g., on probation or parole).⁶ Approximately 3.2 percent of the U.S. population—or one in every 32 adults—were incarcerated, under probation, or on parole at the end of 2005.⁶ Approximately seven percent of all inmates were women.⁷ Communities of color are disproportionately represented in the U.S. correctional system. Approximately 60 percent of inmates in state and federal prisons with sentences of longer than one year are African-American or Latino.⁷ In addition to their over-representation in the correctional system, men and women of color are disproportionately affected by HIV/AIDS (see Figure 2). Although African Americans represent only 13 percent of the total U.S. population, they account for more HIV and AIDS cases and more HIV-related deaths⁸ than any other racial or ethnic group. Latinos, the fastest growing racial or ethnic group in the U.S., are not

far behind. They account for 14 percent of the total U.S. population, but have the second highest HIV prevalence in the nation after African Americans. Women of color are particularly hard hit by the epidemic. They not only represent the majority of American women currently living with HIV, but also account for the majority of new HIV infections and existing AIDS cases among women.⁸

The disproportionate impact of HIV in communities of color and in correctional facilities is exacerbated by a lack of access to adequate health and social services for inmates while incarcerated and upon their return to the community. Since more than 90 percent of inmates are eventually released into the community,⁹ the health profile of returning inmates imposes specific demands on already overburdened community services. Many former inmates do not have the resources to access services that are not part of post-release planning, such as addiction and mental health treatment, psychological support,¹⁰ reproductive healthcare, education and job training, and stable housing.¹¹⁻¹⁵

Inmates' risky behaviors before and during incarceration also have a significant effect on their partners' health. Incarcerated men report engaging in behaviors

Figure 1
Prevalence of HIV/AIDS in State and Federal Prisons and in the U.S. Population in 2005



Sources:

a) HIV/AIDS (State and Federal Prisons): Maruschak LM. *HIV in Prisons, 2005*. Department of Justice. Bureau of Justice Statistics, NCJ 218915. September 2007. Available at: <http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp05.pdf>. b) HIV/AIDS (U.S. Population): CDC. *HIV/AIDS Surveillance Report: Cases of HIV Infection and AIDS in the United States and Dependent Areas, 2005*. Volume 17, Revised June 2007. Available at www.cdc.gov/hiv/topics/surveillance/resources/reports/2005report/pdf/2005SurveillanceReport.pdf.

that elevate their risk for HIV and other sexually transmitted infections (STIs) both before incarceration and after release.¹⁶ These behaviors include injection drug use, needle sharing, and unprotected sex with multiple high-risk partners.¹⁷ Since approximately 50 percent of men who have been incarcerated or have passed through the correctional system consider themselves to be in committed heterosexual relationships and intend to return to their partners upon release from custody,¹⁶ as many as 6.5 million women each year will experience the risk of having a partner who has been incarcerated.¹⁶ Given the disproportionate number of low-income men of color in correctional settings, low-income African-American and Latina women are more likely to have intimate sexual or needle-sharing relationships with recently imprisoned

men.¹⁶ Sexual risk behavior is not limited to those who are HIV negative; one study found that men with HIV who were released from prison had unprotected sexual intercourse within an average of six days of their release, and 31 percent of these men believed it was likely they would infect their primary sexual partner.¹⁸

It should be noted that inmates are not the only ones who engage in risk behaviors. The destructive impact of incarceration on existing partnerships, families, and communities may also facilitate new and varied sexual and social connections that further increase risk of HIV transmission for inmates returning to their communities. For example, individuals whose primary partners are incarcerated for long periods of time may develop other sexual relationships, which may continue even after

the primary partner is released. Similarly, individuals who are released from correctional facilities may want to maintain friendships that were made while incarcerated and, therefore, introduce new members into an existing social or sexual network. The presence of concurrent sexual networks has been found to contribute to elevated rates of HIV infection in communities already affected by high STI rates and other social and health issues.¹⁹ Alcohol and drugs are often a part of the context in which risky sexual practices occur and, in one study of men just released from prison, were associated with risky sexual behavior at one week and at six months after release.²⁰ In addition to sharing drug injection paraphernalia, other risks include engaging in sexual acts to obtain drugs or providing a partner with drugs as a way to obtain sex.

HIV in Correctional Settings

The first report of AIDS in correctional facilities was published in the early 1980s.^{21,22} Currently, all U.S. state correctional facilities have reported inmates with HIV infection, and it is estimated that up to one-fourth of the people living with HIV in the U.S. pass through a correctional facility each year.²³

Although the number of known HIV-positive inmates has been steadily decreasing since 1999, the overall rate of confirmed AIDS cases among the prison population (0.4 percent) at the end of 2005 was close to three times the rate in the general U.S. population (0.15 percent).⁵ Data from federal prisons show that in 2004, HIV infection rates were highest among African-American female inmates (2.6 percent); in both federal and state prisons, females were more likely than males to be HIV positive, and African Americans and Latinos were more likely than whites to be HIV positive.²⁴ State and federal corrections data from 2005 indicate that African-American inmates accounted for two-thirds of the AIDS-related deaths while in custody; moreover, they were nearly 2.5 times more likely than whites

and almost five times more likely than Latinos to die from AIDS.⁵

In addition to higher rates of HIV infection and AIDS, correctional populations also have higher rates of co-morbid conditions that facilitate HIV transmission, such as STIs, substance use, mental health problems, and other infectious diseases such as tuberculosis and hepatitis. Drug-dependent inmates are also more likely than other inmates to report experiences of sexual abuse, housing instability, unemployment, parental substance use, and parental incarceration. One in seven drug-dependent inmates in state prisons reported being homeless in the year before incarceration, which contributes to a lack of access to healthcare.²⁵

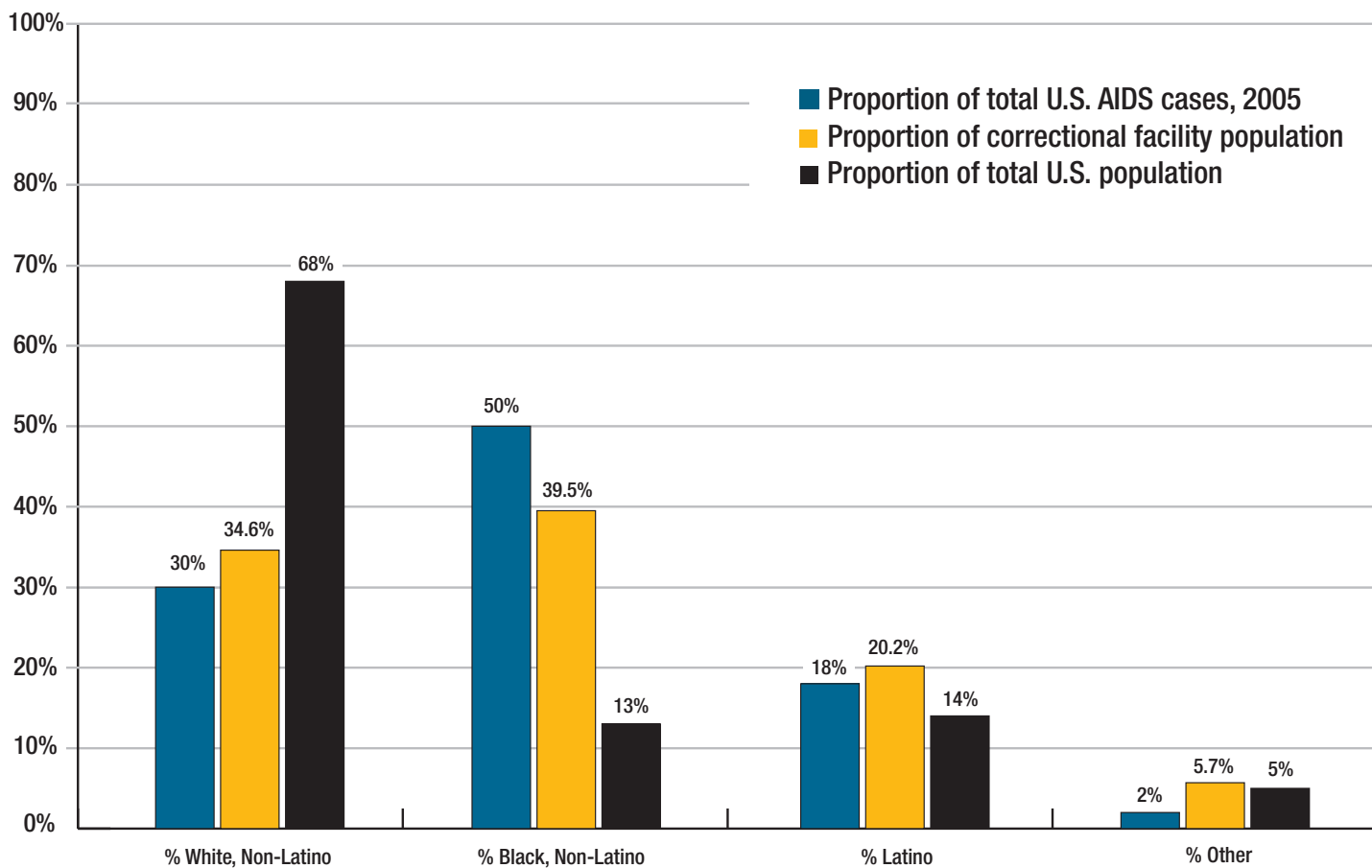
Sexual Behavior

Many individuals are already infected with STIs and other diseases (e.g., hepatitis C) by the time they arrive at a correctional facility. Due in part to participation in sex work, women may be at greater risk of entering prison with STIs.²⁶ Researchers also demonstrated that risky sexual behaviors associated with STI and HIV transmission can occur during incarceration^{27,28} via sexual relations (both consensual and coerced) among inmates as well as between inmates and prison officials (e.g., correctional officers).²⁰ Condom availability is rare except in a few state prisons and county jails. However, even when condoms are available, they are rarely used during consensual sex. In one study, only 30 percent of prisoners reported using condoms or improvised

barrier methods during consensual sex; no barrier methods were used during rape.²⁹

Although some of the sexual activity occurring in prisons may be consensual, the very context of life in correctional facilities is such that true consent may be illusory. Sexual activity may occur as a means of survival (e.g., obtaining goods or protection) or as a result of coercion. It is estimated that 20 percent of male inmates and 25 percent of female inmates face sexual assaults behind bars.^{30,31} While any inmate can become a victim of sexual assault, certain inmates are particularly vulnerable. Nonviolent, first-time offenders are more likely to be victimized, as are gay and transgender detainees and youth held in adult facilities.³² Immigrants are also vulnerable to sexual assault in

Figure 2
Disproportionate Impact of AIDS and Incarceration on Minorities, 2005



Sources:

a) Ethnicity in Corrections: Harrison PM, Beck AJ. *Prisoners in 2005*. Department of Justice, Bureau of Justice Statistics Bulletin, NCJ215092, November 2006, Revised January 2007. Available at: www.ojp.usdoj.gov/bjs/pub/pdf/p05.pdf. b) Ethnicity in AIDS Cases and U.S. Population: CDC HIV/AIDS Surveillance by Race/Ethnicity (through 2005), Powerpoint slides revised June 28 2007. Available at: www.cdc.gov/hiv/topics/surveillance/resources/slides/race-ethnicity/index.htm.

prisons, due in part to fear of deportation, and limited literacy and language skills.³² Such assaults on immigrant prisoners might be prevented by increased monitoring of U.S. Immigration and Customs Enforcement (ICE) detention centers by immigrant advocacy organizations.

Sexual violence in prisons and jails is drastically underreported.

While legal protections exist to protect inmates from guard brutality and violence inflicted by other prisoners, sexual violence in prisons and jails is drastically underreported due to the illicit nature of the activity and the stigma associated with rape and same-sex behavior.³³ Inmates' unwillingness to report their victimization contributes to the failure of prison authorities to react appropriately and to investigate complaints of sexual violence. This limits authorities' ability to prosecute perpetrators or to provide victims with appropriate access to care, including HIV testing, counseling, and post-exposure prophylaxis.³³

Unsterile Injection Equipment

Tattooing is a common practice in correctional settings and is associated with group membership and desire for personal expression. The use of unsterile, makeshift tattooing equipment (including guitar strings, pins, needles, etc.) is a risk factor for transmission of HIV, hepatitis, and other parenterally transmissible infections.³⁴ Not surprisingly, these makeshift instruments are difficult to sterilize reliably,³⁵ thus facilitating the spread of blood-borne infections. Possession and use of illicit substances are forbidden in correctional facilities, but research has found that such substance use prohibitions may be circumvented through the cooperation of correctional personnel.^{20,36} Due to a lack of new and sterile injection equipment, a large proportion of incarcerated drug users

who are using injection drugs share needles or are unable to clean them adequately.³⁷

Mental Health Issues

Mental health issues also contribute to HIV risk behavior. Data from 2005 show that 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates had been clinically diagnosed with mental illness exclusive of substance use or dependence.³⁸ Women were more likely than men to be diagnosed with mental health problems, as were white inmates and those 24 years of age or younger. Compared to other inmates, those with mental health needs were more likely to report having lived in foster homes or institutions while growing up, histories of physical or sexual abuse, family members with histories of substance use and incarceration, and low rates of employment.³⁸ Approximately three-fourths of the state prisoners and jail inmates who had mental health diagnoses also met criteria for substance use or dependence, and more than a third of inmates with mental health diagnoses reported having used drugs at the time of their offense.³⁸ Further, mentally ill inmates are much more likely to suffer physical abuse while incarcerated, earn disciplinary sanctions for breaking prison rules, and to accrue further criminal punishment that lasts throughout their incarceration.³⁹ The use of isolation as a form of discipline can exacerbate mental illness and prompt acts of self-harm.⁴⁰

Improving HIV Services for Incarcerated Populations

The period of incarceration provides a unique window of opportunity to reach both uninfected and HIV-positive inmates with targeted education about and services for HIV prevention, treatment, and care. This position is supported by domestic^{41,42} as well as international^{43,44} authorities on HIV prevention.

Prevention

A fundamental starting point for HIV prevention in any setting is knowledge

of one's HIV status. The Centers for Disease Control and Prevention (CDC) has recommended that correctional institutions routinely offer HIV testing as a component of standard medical evaluation for inmates.^{41,45} While policies for HIV testing vary by jurisdiction and by type of correctional facility,⁴⁶ fewer than half of the state prison systems and few jails routinely provide HIV testing on entry.⁴⁶ For many inmates in correctional facilities that offer or mandate HIV testing, incarceration represents the first real contact with a healthcare system,⁴⁷ and may be the first time they have been offered HIV testing.^{48,49}

Of the institutions that do currently provide HIV testing to inmates, some take the "no news is good news" approach to diagnostic testing and, thus, do not inform or counsel individuals with negative HIV and STI test results.^{49,50} This lack of follow-up for uninfected persons represents an important missed opportunity for prevention counseling that has serious implications. Receiving negative test results can create a critical "teachable moment" for inmates to receive sexual and drug use-related risk reduction education, acquire accurate prevention and care information, and reinforce risk reduction practices. Furthermore, because some inmates who test negative for HIV may actually be in the early stages of infection (before HIV antibodies have developed), it is critical to provide education about the importance of repeat testing.

A major problem with standard HIV testing is the waiting period of two weeks or longer for blood samples to be analyzed and the results returned to the inmate. This issue is particularly relevant for correctional facilities that house inmates for shorter periods of time (such as jails) or that function as transfer facilities for inmates being relocated. In such facilities, waiting two weeks for a test result translates into missed opportunities for inmates to learn their serostatus and receive appropriate counseling and referrals to care. Rapid testing assays that allow the immediate provision of results may be a more viable option in these types of settings.^{51,52}

Aside from the logistical issues, it is important to note that inmates themselves may have valid concerns about getting an HIV test while incarcerated. In addition to the stigma associated with HIV/AIDS, inmates may also be concerned that medical confidentiality will not be maintained. Moreover, inmates may be concerned that testing positive will result in housing segregation, ostracism by or violence from other inmates, and decreased access to medical care and support services.

Despite these issues, offering repeat voluntary counseling and testing within correctional settings can be an important entry point to HIV-related prevention and care services for at-risk and infected inmates.⁵⁰ Because inmates may be psychologically impaired due to substance use or trauma, care must be taken to ensure that they are ready to receive HIV test results and counseling.

To maximize the uptake of HIV testing, correctional facilities should keep inmates' medical information strictly confidential.

Recognizing the benefits of routine testing in correctional institutions, leading public health organizations such as the CDC⁴¹ and the National Commission on Correctional Health Care⁵³ agree that all HIV tests must be conducted with the inmate's consent and that inmates should have the right to opt out of testing. Unfortunately, this agreement is not present in all correctional institutions: in 2003, 19 state prisons and the Federal Bureau of Prisons had mandatory HIV screening

policies for their incoming inmates.⁵⁴ While many prisoners are intellectually capable of giving informed consent, the context of being incarcerated and the omnipresent potential for coercion in correctional settings call into question the degree to which inmates are truly able to give free and informed consent. Routine HIV testing procedures must be undertaken in a fashion that allows inmates to be told of and to exercise their right to refuse testing and other medical care.

Extreme care must be taken to ensure that refusal of testing does not result in adverse consequences or punishment. For example, a study of a pilot program implementing routine HIV testing in District of Columbia jails obtained reports from inmates stating that those refusing HIV testing were placed on "medical hold," that is, confined in a single cell until they complied.⁵⁵ Fortunately, this practice was discontinued as a result of strong negative responses from the local community and the uncertain legal standing of this procedure. Nonetheless, reports such as these imply that routine or "automatic" testing is hardly voluntary given the consequences of refusal. To maximize the uptake of HIV testing, correctional facilities should keep inmates' medical information strictly confidential, and provide linkages and access to specialty care and support services. Correctional care providers in Rhode Island have reported that ensuring these important components of care has resulted in the vast majority of inmates—both positive and negative—accepting HIV testing services.⁵⁶

Peer Education and Other Prevention Services for Inmates

Because incarcerated populations are ethnically, culturally, and educationally diverse, HIV prevention and other health education programs must be designed in a way that effectively reaches diverse populations and addresses special needs. While education about HIV/AIDS preven-

tion and care can and should be delivered by correctional health staff or outside service contractors, research shows that prevention education programs delivered by peer educators are highly effective in establishing the trust and rapport that are needed to discuss sensitive topics related to sexual practices, substance use, and HIV/AIDS.⁵⁷ Because peer educators are often inmates or former inmates, they are more attuned to the realities of life both in the correctional facility and post-release and, thus, may be more successful in providing support and teaching the skills necessary to address the complicated situations that put inmates at risk.⁵⁸ Moreover, peer educators may be able to motivate inmates more effectively to access HIV-related services. For example, one study found that 44 percent of inmates requested HIV testing after participating in a peer-led program, despite the fact that HIV testing in that facility was not anonymous and individuals diagnosed with HIV or AIDS were housed separately.⁵⁹

Harm Reduction and Risks Related to Sexual Behavior and Substance Use

Although sexual and substance use behaviors are not permitted in incarcerated settings, the reality is that such behaviors do occur. Therefore, efforts to reduce the risk of infection from these behaviors would benefit both the incarcerated persons and the communities to which they return. Indeed, researchers and advocates have expressed the need for more harm reduction programs in prisons and jails.⁶⁰

While the use of harm reduction strategies such as condoms and access to sterile injection equipment in correctional facilities is endorsed by the World Health Organization,⁶¹ the vast majority of U.S. prisons and jails specifically prohibit the distribution and possession of these items.⁵⁰ Condoms are currently provided on a limited basis in only two state prison systems (Vermont and Mississippi) and five county jail systems (New York, Philadelphia, San Francisco, Los Angeles, and Washington, D.C.*).²⁴ Contrary to critics' arguments,

* In Washington, D.C., only the public jail has limited condom distribution. The privately run correctional treatment facility bans condoms.

few inmates have used condoms as weapons or to smuggle contraband into correctional facilities^{11,62} and there is no evidence that sexual activity within correctional facilities has increased as an outcome of condom distribution.^{62,63} In fact, in those correctional institutions (both in the U.S. and elsewhere) where a condom availability program exists, there have been no security or custody issues that resulted in the closure of the program.⁶⁴

With regard to substance use, harm reduction measures are relatively new to correctional systems and are often perceived as a threat to their security regulations and traditional abstinence-oriented drug policy.⁶⁵ Currently, no correctional facilities in the U.S. provide sterile injection equipment to inmates. However, harm reduction programs related to injection drug use have been established in more than 50 prisons in eight European countries. Evaluations of such programs in Switzerland, Spain, and Germany found no increase in drug use, dramatic decreases in needle sharing, no new cases of HIV infection or hepatitis, and no reported instances of needles being used as weapons.^{64,65}

Addressing Addiction and Mental Health Issues

Over the past several decades, the number of drug-involved offenders incarcerated in state and federal penitentiaries has increased substantially as a result of more stringent drug-related laws.⁶⁵ These laws, coupled with the inadequate availability of community-based substance use programs, have exacerbated the negative impact of the nation's drug problem on families and communities without addressing the medical and socioeconomic roots of addiction.

Incarceration can provide a unique opportunity to treat inmates with addiction and mental health diagnoses. However, such programs are limited in correctional settings. Estimates from 2004 indicate that, although 53 percent of state and 45.5 percent of federal inmates met diagnostic criteria for drug dependence, only 14.8 percent of state and 17.4 percent of federal inmates received professional

addiction treatment.²⁵ Although such treatment programs can be costly, research has shown that investing in addiction treatment for inmates is cost-effective^{66,67} and can result in substantial reductions in post-release criminal activity, relapse, and recidivism.^{67,68}

Addressing Stigma and Discrimination

Stigmatization of HIV/AIDS remains prevalent in correctional institutions. Individuals who enter with or test positive for HIV may face discrimination and threats from correctional officers and other inmates and can be segregated or denied prison jobs, activities, and visiting privileges.⁵⁵ Some correctional authorities may believe that HIV-positive prisoners need to be isolated for their own safety. Others argue that segregating inmates with HIV is undesirable because it labels them unnecessarily, makes them more vulnerable to assault and discrimination, and may result in disparate treatment and diminished access to services and desirable housing conditions. In some cases, HIV-negative inmates may pressure correctional authorities to house HIV-positive inmates separately. The resulting false sense of security may lead to an increase in high-risk behaviors among a population that incorrectly assumes itself free of HIV infection.¹⁶ As a step toward reinforcing HIV prevention education and minimizing misinformation and stigma, both inmates and correctional staff need comprehensive HIV/AIDS education, including information about the importance of repeat HIV testing for those practicing high-risk behaviors.⁶⁹

Treatment and Care for HIV-Positive Inmates

The implementation of routine testing policies in correctional facilities has important implications for the correctional system's identification and case management of HIV-positive inmates.⁷⁰ Privacy and confidentiality concerns are significant barriers to HIV testing and care-seeking in correctional settings. Given the unique living conditions (and, in many cases, overcrowding) in correctional facilities, maintaining confidentiality of personal and/or medical information can be extremely difficult. While

confidentiality may be breached by other inmates, other breaches of confidentiality may be due to inappropriate behaviors by correctional staff or procedures associated with accessing prison healthcare,⁷¹ by attending pill call or standing in the medication dispensing line,⁵⁶ or simply from having to fill out forms requesting medical attention and the reasons for needing to see a clinician.⁷²

Effective HIV treatment in prisons has led to a 75 percent reduction in AIDS-related mortality.

All inmates in correctional systems have a constitutional right to medical care, including HIV care. Given that about 75 percent of HIV-positive inmates initiate treatment while incarcerated,⁷³ the opportunities for successful viral suppression and overall management of HIV disease can be improved through increased adherence to a well-designed care system. Indeed, effective HIV treatment in prisons has led to a 75 percent reduction in AIDS-related mortality, a decline mirroring that of non-incarcerated populations.^{74,75}

Some have alleged that HIV care and support in the correctional setting lags behind the standards in the community due to cost concerns, lack of adequately trained care providers, and stigmatization of HIV/AIDS.⁶⁹ Privatization of correctional healthcare has imposed further constraints on HIV care delivery.⁷⁶ The increased prevalence of HIV in correctional populations indicates the need for greater attention to HIV/AIDS prevention, case management and care in correctional facilities,⁷⁷ as well as attention to treating the co-morbid conditions (e.g., hepatitis, TB, addiction) that could negatively affect therapeutic outcomes.

One factor contributing to inadequate healthcare for inmates is the lack of coordination and programming within correctional institutions, and between correctional institutions and healthcare providers in the community. Correctional medical providers are not routinely given access to information about the HIV status of individuals under their care.⁵⁰ Certain aspects of incarceration—such as “lock down” periods, punitive detentions, court appearances, and transfers between facilities—also undermine consistent dosing schedules essential to the long-term effectiveness of antiretroviral and other medications. Additionally, some state correctional facilities require inmates to provide “co-payments” for medical services;^{53,72} inmates who cannot pay may be reluctant to seek those services for fear of being rejected.

Correctional administrators in the U.S. are increasingly concerned about the escalating costs of healthcare for “special needs” inmates, such as drug users and those with HIV.⁷⁸ In some cases, correctional staff with no specialized training in HIV, drug or alcohol addiction, or mental illness are the ones obligated to provide care. For example, in 2000, two-thirds of all inmates receiving psychotherapy or medications were in facilities that did not specialize in providing mental health services.⁷⁹ Medical providers have reported missed opportunities for linkages with the public health systems in the community after offenders are released.⁵⁰ In some cases, the lack of coordination is due to confidentiality-related policies pertaining to the sharing of patient information across different agencies.¹² In other cases, poor coordination is due to inadequate staffing levels and insufficient resources for discharge planning.¹² Correctional health and public health authorities should work together to develop cost-effective mechanisms by which HIV-positive and other “special needs” inmates can receive appropriate and consistent treatment and care, both while they are incarcerated and upon release.

Discharge Planning and Other Programs Following Release from Incarceration

Each year, close to 700,000 prisoners are released from state and federal prisons.⁸⁰ Post-release or discharge planning for this population is critical in ensuring continuity of HIV prevention, treatment, and care through linkages and access to necessary medical and psychosocial support services.¹² Even in optimal cases, when inmates receive the care they need during their period of incarceration, the benefits achieved by this treatment are only sustainable if these same services are available and accessible to the inmates when they return to their communities.¹⁴ Discharge planning activities include providing inmates with information about outside resources, prescribing medications at release in sufficient quantity, scheduling and accompanying inmates to appointments with care providers, and assisting with applying for medical and financial assistance.

Offenders with HIV/AIDS have admitted to seeking re-arrest to access medical services in prisons.

Recent data pertaining to the health of ex-offenders underscore the importance of appropriate post-release planning and linkages to care.⁸¹ A study of more than 30,000 newly released prison inmates found that, compared to the general population, former inmates’ risk of death was nearly 13 times higher during their first two weeks out of prison. Over the entire study period of 3.5 years, the adjusted death rate was 3.5 times higher than that of the general population, and the rates for every major cause of death (e.g., drug overdose, liver disease, suicide) were higher. To a large extent, death rates reflected the fact

that the inmate population was poor and uneducated, and over 70 percent of the sample had been diagnosed with drug or alcohol dependence. Without appropriate pre-release planning or other similar support, newly released inmates may not be able to access lifesaving services such as addiction treatment, medical care, and transitional housing.⁸¹

For HIV-positive inmates, one of the greatest impediments to continuity of care is being released from a correctional facility without knowing their HIV status or what their treatment options are.⁷⁰ A study examining the response to antiretroviral treatment in the correctional setting indicated that, when provided with adequate clinical care, inmates have clinical improvements that are comparable to those found in the community.⁸² Without appropriate discharge planning, the benefits of antiretroviral treatment that may have been achieved during incarceration may be lost after returning to the community.⁸² Moreover, applying for federal and state medical assistance can take several months, leaving qualified ex-offenders without access to necessary healthcare and financial support in the critical period after release.¹³ Offenders with HIV/AIDS have admitted to seeking re-arrest to access medical services in prisons, which highlights the crucial need for such services for released offenders.¹⁴

Continuity in HIV treatment and care for ex-inmates is also hampered by lack of access to health insurance. Many ex-offenders do not have private sources of healthcare coverage and must rely on public programs, free clinics, and emergency rooms to receive medical attention.⁸³ Moreover, gaining access to public health insurance can be equally difficult. Although federal regulations do not require termination of inmates’ Medicaid eligibility upon incarceration, a 1999 survey found that all 50 states had policies terminating inmates’ Medicaid coverage upon incarceration.⁸⁴ For those with terminated Medicaid benefits, the process of re-establishing eligibility can take anywhere from 14 to 45 days (and sometimes longer), depending on the state.⁸⁵

The Center for Medicaid and State Operations has encouraged states to suspend rather than terminate inmates' Medicaid benefits during the period of incarceration to ensure that benefits are restored to eligible individuals immediately upon release.⁸⁶ Making reinstatement to Medicaid eligibility a fundamental component of discharge planning would contribute to successful re-entry⁸⁵ and would ensure that ex-offenders have access to essential healthcare services.⁸³

Discharge planning programs focusing on HIV prevention have been found to have significant, positive effects on sexual risk behavior.

Despite these barriers, some correctional systems have tried to reduce the likelihood of ex-offenders falling through the cracks when trying to access care by establishing partnerships with community health providers. These independent efforts enable correctional health facilities to have medical staff who also work in the community, common medical records systems, and well-developed referral and outreach protocols.⁸⁷ Federal funds received under the Ryan White CARE Act (RWCA), as established in Title XXVI of the Public Health Service Act, allow community-based organizations to provide short-term traditional support services, such as linkages to primary care, to HIV-positive inmates prior to release and as part of effective discharge planning.⁸⁸ It is important to note that RWCA funds can be used only where no other services exist, or where these services are not the responsibility of the correctional system.⁸⁸

Some correctional facilities have also tried to address the limitations of the

current system by establishing enhanced discharge planning for inmates. Compared to standard processes, enhanced discharge planning incorporates planning for a variety of inmates' needs, such as healthcare, mental health treatment, treatment of addiction, housing, and employment. Existing discharge planning programs focusing on HIV prevention have been found to have significant, positive effects on sexual risk behavior,^{89,90} while programs focusing on the needs of HIV-positive inmates have been successful in retaining a very challenging population in care and addressing their needs for both HIV medical care and addiction treatment without providing any of these services directly.⁹¹ Addressing these important prevention and healthcare needs in advance of release from incarceration could greatly enhance successful transition to the community.

Removing Social Policy Barriers to Successful Re-Entry

Providing access to adequate health and social services to ex-offenders upon release would address the current gaps in continuity of care for those in need of HIV services. However, the provision of healthcare alone is insufficient to address the complex social and economic issues that contribute to the high prevalence of HIV among corrections populations and minorities. Current policies that make it difficult for ex-offenders to find adequate housing and employment, and to gain access to public assistance, only serve to exacerbate the impact of HIV in these populations, particularly low-income communities of color.

For example, in most states, individuals are released from correctional facilities without the documentation necessary to obtain a state-issued identification card, and many states do not accept prison documentation as valid proof of identity.⁹² Without some sort of government identification, ex-inmates are unable to complete the application processes for a variety of essential medical and health services, such as obtaining Social Security benefits, public or private healthcare coverage, and other public assistance. In addition,

proof of identity is often a necessary requirement for completing job applications, and is absolutely required to cash paychecks or open bank accounts. The simple act of ensuring that all inmates have the appropriate identification documentation upon release may greatly enhance their ability to make a successful transition back to the community.

Lack of identification is not the only barrier to getting a job for former inmates. In fact, very few ex-offenders have jobs waiting for them when they return to their communities and the majority of others face significant barriers to getting employment due to lack of job skills, lack of education, and employers' unwillingness to hire individuals with criminal records.⁹³ Although most corrections facilities offer some type of educational program or vocational training for inmates, there are only a limited number of program slots.^{94,95} This lack of slots is unfortunate given that the existing data indicate that such programs are associated with improved outcomes, including reduced criminal recidivism.^{96,97} Even when such programs are available, however, HIV-positive inmates may not be granted access to them. The Alabama Department of Corrections, for instance, bars HIV-positive state prisoners from participating in community-based programs such as work release.⁹⁸ However, a recent change in the Department of Corrections' policies now allows HIV-positive prisoners to participate in transitional programs involving education and vocational training.⁹⁹

Ensuring that ex-offenders and their families have sufficient social and economic support may help prevent them from participating in illegal activities as a means of support, or engaging in behaviors such as drug use that increase their risk for HIV. In order to support themselves and their families, many ex-offenders turn to public assistance. However, obtaining such support can be problematic. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (which instituted the Temporary Assistance for Needy Families [TANF]

Act; P.L. 104-193) stipulates that persons convicted of a state or federal felony drug conviction are subject to a lifetime ban on eligibility for food stamps and other benefits. While this policy has a direct effect on individual inmates' ability to rebuild their own lives, it also has a substantial impact on inmates' ability to support their children and families. Because formerly incarcerated men have diminished earning capacity (as much as 40 percent less) over the course of their lifetimes, they are unable to provide as much support to the families with whom they live.¹⁰⁰ Hence, a vicious cycle is perpetuated: the communities from which inmates come are places with very few economic resources, and inmates returning to these communities are unable to contribute to the economic stability of the community due to diminished earning potential. The result is diminished family health and well-being, as well as weakened family stability.¹⁰¹

Furthermore, because of the demographic profile of incarcerated persons with felony drug convictions, this policy has a disproportionate impact on African-American and Latina women, as well as African-American men—populations already experiencing significant social and health disparities, including greater risk of HIV infection.⁹³ Revising this policy to reinstate eligibility for benefits to those with felony drug convictions—for example, after some prescribed period of time and after proof of rehabilitation—could have a positive impact on ex-offenders and their families, who are trying to re-establish stable lives in their communities.

Lack of employment, income, and access to public assistance all contribute to housing instability for ex-offenders and their families. Given the links between housing instability and health outcomes (such as HIV risk, mental illness, and addiction), ensuring resources for and linkages to stable housing for newly released individuals is another critical step to successful re-entry. Research has shown that inability to secure stable housing and employment after release from prison may lead drug-involved ex-offenders back to drug dealing and to risks associated with this

lifestyle, including risky sexual behaviors.^{60,102,103}

Federal legislation (such as the Department of Housing and Urban Development's Housing Opportunity Program Extension Act of 1996) restricts or, in some cases, denies access to public housing for many ex-offenders, particularly those convicted of drug-related offenses.^{93,95} While some ex-offenders may try to find housing with family members or friends, such efforts may not always be successful. If family members or friends reside in public housing, accepting an ex-offender into their home may jeopardize their own residential stability due to the exclusion policies applicable to federally subsidized housing.

For inmates with HIV, access to stable housing can be the critical factor in maintaining HIV treatment adherence.

While the lack of affordable housing is a problem for the general population, making efforts to link newly released inmates with affordable, stable housing has been shown to reduce rates of recidivism.^{104,105} For those inmates with HIV or at risk of infection, access to stable housing can be the critical factor in maintaining HIV treatment adherence and risk reduction behaviors, increasing access to medical services, and improving health outcomes.¹⁰⁶⁻¹⁰⁸ Incorporating efforts to secure stable housing as a part of effective discharge planning for soon-to-be-released inmates could help to reduce recidivism and ensure that any health-related gains achieved during incarceration are not reversed once individuals are back in their communities.

Conclusion

As a result of poverty, addiction, and other forms of health and social disenfranchisement in their home communities, inmates in correctional facilities have a uniquely high prevalence of communicable disease, including HIV/AIDS.¹⁰⁹ In some ways, this is not surprising given that, in almost every corner of the world, HIV strikes the communities that are the least economically and politically empowered.¹¹⁰ The disparities observed in America's correctional system reflect some of the problems seen in its healthcare system. A strong commitment from all sectors of society is needed to reduce social and economic disparities in both systems in order to enhance the health and well-being of all Americans, regardless of race or ethnicity.

While it may seem that the goals of the public health and corrections communities are worlds apart, the reality is that both strive to improve the conditions in society that enhance public safety and contribute to overall quality of life. Given the multidimensional impact of HIV/AIDS on individuals and families, the public health and corrections/criminal justice communities should work more collaboratively to address the socioeconomic disparities and environmental factors that put individuals at risk for both HIV infection and incarceration. *Prison health is public health.*¹¹¹ In order to alleviate the devastating impact of HIV/AIDS on communities that are already disproportionately affected by the epidemic, it is imperative to address the individual, social, and environmental factors that predispose members of these communities to both HIV risk and risk of incarceration. It is equally imperative that we take full advantage of the window of opportunity provided by incarceration to give inmates access to the healthcare and social services that could facilitate reductions in morbidity and mortality, successful re-entry, and decreased recidivism. Doing so would not only benefit the health of incarcerated persons, but also their families and communities.

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