National Minority
AIDS Council

Pushing for Progress:

# HIV/AIDS IN PRISONS

JUNE 2002

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NATIONAL MINORITY
AIDS COUNCIL

Pushing for Progress:

# HIV/AIDS IN PRISONS

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JUNE 2002

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# Introduction

## HIV/AIDS in Prisons and Jails — The Disproportionate Impact on Communities of Color

The first report from the Centers for Disease Control and Prevention (CDC) of AIDS among U.S. prisoners was published in 1983.[1] At year-end 1983, there were 424,000 prisoners in state and federal prisons. Fast-forward to year-end 2000, and the number of U.S. prisoners more than tripled to 1,313,000. That massive increase in the prison population — "a wave of building and filling prisons virtually unprecedented in human history"[2] — is absolutely key to understanding the importance of HIV/AIDS in prisons, especially among communities of color.

The disproportionate incarceration of communities of color has been evident since the earliest statistics were kept on race and U.S. prisons — in 1926, African Americans represented 9% of the U.S. population and 21% of prison admissions.[3] In 2000, African Americans represented 13% of the U.S. population and 46% of all U.S. prisoners; Latina/os represented 13% of the U.S. population in 2000 and 16% of U.S. prisoners.[4]

Table 1 shows the official Department of Justice comparative incarceration rates for the United States in 2000.

The proportion of women in U.S. prisons rose from 5.7% in 1990 to 6.6% in 2000; between 1990 and 2000, the number of male prisoners grew by 77%, and the number of female prisoners grew by 108%.[5] As indicated by Table 1, women of color are much more likely to be incarcerated than white women.

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1. CDC. (1983). "Acquired immune deficiency syndrome (AIDS) in prison inmates — New York, New Jersey." *Morbidity and Mortality Weekly Report* 31(52): 700–701.

2. Mauer M. (1999). *Race to Incarcerate*. New York: New Press. p.9.

3. Langan PA. (1991). *Race of Prisoners Admitted to State and Federal Institutions. 1926–86*. Washington, DC: Bureau of Justice Statistics. NCJ 125618. p.5.

4. Beck AJ, Harrison PM. (2001). *Prisoners in 2000*. Washington, DC: Bureau of Justice Statistics. NCJ 188207. p.11. U.S. Census Bureau (2000) *Profile of General Demographic Characteristics for the United States: 2000*. Table DP-1. The National Center on Institutions and Alternatives (NCIA) argued in its 2001 report on race and American criminal justice that whites have been systematically overcounted among U.S. prisoners because of inappropriate statistical classification of Latina/os. When it recalculated national prison statistics to take full account of the Latina/o prisoners who had previously been counted as white, NCIA found that nonwhites accounted for 70% of the growth in U.S. prison populations between 1985 and 1997. (See NCIA [2001] *Masking The Divide: How Officially Reported Prison Statistics Distort the Racial and Ethnic Realities of Prison Growth*. Research and Public Policy Report. Alexandria, VA: NCIA.)

5. Beck AJ, Harrison PM. (2001). *ibid*. p.5.

## TABLE 1.

**Number of Prisoners in State Prisons, Federal Prisons and Local Jails Per 100,000 Residents, Mid-Year 2001.**

| | | | |
|---|---|---|---|
| Black Males: | 4,848 | Black Females: | 380 |
| Hispanic Males: | 1,668 | Hispanic Females: | 119 |
| White Males: | 705 | White Females: | 67 |

***Source:*** *Beck AJ, Karberg JC, Harrison PM. (2002).* Prison and Jail Inmates at Midyear 2001. *Washington, DC: Bureau of Justice Statistics. NCJ 191702. Adapted from Table 15.*

U.S. communities of color are disproportionately incarcerated, and they also bear a disproportionate and growing share of HIV-infection. According to the CDC, African American women and Latinas together make up less than one-quarter of the U.S. female population, but they account for 77% of total AIDS cases reported in U.S. women.[6] The CDC also reports that the number of new AIDS cases per 100,000 U.S. residents in 1999 was 7.6 for whites, 25.6 for Latina/os, and 66.0 for African Americans.[7] Table 2 shows the racial breakdown of known HIV-positive prisoners from 1996 and 1997, the most recent years for which race-specific data are available.

The increasing concentration of HIV/AIDS among communities of color, combined with the mass incarceration of people of color in the United States, create one of the major challenges in the HIV/AIDS epidemic for minority communities in the United States: HIV/AIDS in prisons.

## RESPONDING TO HIV/AIDS IN PRISONS

Among critics and commentators on the issue of HIV/AIDS in prisons, and even among the many governmental or quasi-governmental agencies who have commented on the issue, there is near-universal agreement that prison affords a critical opportunity to provide quality HIV/AIDS-related services to underserved, highly at-risk populations. NMAC concurs with this prevailing wisdom, but feels it is also important to note the gap that exists between this unanimity of expert opinion and the actual practices of U.S. prisons and jails. For example:

- In 1997, the latest year for which data is available, only five percent of U.S. jails and 10 percent of federal and state prisons provided comprehensive HIV/AIDS education and prevention programs.[8]

6. CDC. (2000). *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk.* Atlanta, GA: CDC.

7. CDC. (2000). *HIV/AIDS Among Hispanics in the United States.* Atlanta, GA: CDC.

8. Hammett TM, Harmon P, Maruschak LM. (1999). *1996–1997 Update: HIV/AIDS, STDs and TB in Correctional Facilities. Washington, DC:* National Institute of Justice and CDC. p.27.

## TABLE 2.
### Percentage of Prisoners Who Have Ever Tested Positive for HIV

| | JAIL | STATE PRISON | FEDERAL PRISON |
|---|---|---|---|
| African American Male | 2.5 | 2.7 | 0.8 |
| African American Female | 3.2 | 3.9 | 1.3 |
| Latino Male | 3.5 | 2.4 | 0.7 |
| Latina Female | 1.3 | 4.2 | 0 |
| White Male | 1.3 | 1.4 | 0.3 |
| White Female | 2.1 | 2.3 | 0.3 |

***Source:*** *Hammett TM, Harmon P, Maruschak LM (1999)* 1996–1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities. *Washington, DC: National Institute of Justice and CDC. Adapted from Table 8.*

- Among state and federal prisoners who in 1997 reported using drugs in the month before their offense, only one in seven received drug treatment in prison, and less than one in three received other drug/alcohol abuse services (including self-help and awareness programs).[9]

- While the proportion of prisoners who reported drug involvement rose from 1991 to 1997, the proportion of such prisoners receiving treatment actually declined over the same period.[10]

The issue of HIV/AIDS in prisons is too often thought of by advocates and activists as a quagmire, because of the complex, overlapping problems faced by prisoners living with or at risk for HIV/AIDS. The aim of this position paper is to show that not only is there substantial consensus on what is to be done to address HIV/AIDS in prisons, there is also now significant evaluative and experiential evidence showing what kind of interventions are effective. There is a solid foundation of evidence on which to build a comprehensive national response to HIV/AIDS in prisons. With continued innovation, evaluative research and political will, such a response is within our grasp.

The tasks at hand for advocates and service providers in the fields of HIV/AIDS, public health and corrections are to:

- Use the evaluative and experiential evidence we have from other programs to build new HIV/AIDS in prison interventions

- Evaluate and document the successes and failures of as many interventions as possible to help others learn from current experiences

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9. Mumola CJ. (1999). *Substance Abuse and Treatment, State and Federal Prisoners, 1997*. Special Report. Washington, DC: Bureau of Justice Statistics. NCJ 172871. p.1.

10. Bureau of Justice Statistics. (1999). ibid. p.10.

- Encourage involvement in HIV/AIDS in prisons by a broader spectrum of agencies. Persuade more service providers, funders and advocates that the issue of HIV/AIDS in prisons is within their purview.

The overarching goal for those who care about this issue should be to increase the political and practical feasibility of *progress* in this field. The gap between expert opinion and actual practice must be narrowed. If the past is a prologue, U.S. correctional authorities will not automatically make progress on HIV/AIDS in prisons if there is no pressure to move forward. Despite noteworthy attention to this issue and significant agreement on what must be done to address this issue, and despite evaluation of existing programs that show — in concrete terms — the effectiveness of our prevention and treatment interventions to date, too many elements of the response to HIV/AIDS in prisons are either at a standstill or, as in the case of substance abuse treatment, actually in decline, while the problem continues to worsen.

Advocacy for improving the response to HIV/AIDS in prisons can take place in many different ways and in many different settings. Goals for advocacy include:

- That there are new pilot projects in HIV/AIDS prevention and treatment, as well as the expansion of programs that have been shown to be successful in other jurisdictions

- That correctional facilities receive additional funding specifically for HIV/AIDS prevention and treatment programs

- That counterproductive and discriminatory HIV/AIDS-in-prison policies and practices be abandoned

All of these advocacy goals have local, state and federal components. Every advocate can therefore play a role in closing the gap between what we know are the necessary steps to respond to HIV/AIDS in prisons and the actual response in our nation's correctional facilities.

As the nation's leading agency in the response to HIV/AIDS among communities of color, NMAC recognizes that we have a responsibility to articulate a national agenda for HIV/AIDS in prisons. We hope that our articulation of this agenda helps other agencies and advocates find their own means of contributing to the fight against HIV/AIDS in prisons and jails.

We welcome your comments and suggestions on this position paper, and we look forward to meeting new allies and colleagues in this important work.

# Chapter I
## Health Care

The Department of Health and Human Services (DHHS), in partnership with the Kaiser Family Foundation, has published clinical guidelines for the treatment of HIV since 1997.[11] These regularly updated guidelines reflect the consensus of a broad panel of experts convened monthly by DHHS and Kaiser. They are considered the national standard for HIV/AIDS treatment. Specific federal guidelines have also been issued for the use of antiretroviral drugs in pregnant HIV-positive women,[12] and for the prevention of opportunistic infections in individuals who are HIV positive.[13]

A prisoner is not a fundamentally different kind of patient than any other person living with HIV/AIDS. Nevertheless, a correctional facility is a unique setting in which to provide HIV/AIDS care. While recognizing the exceptional nature of the correctional environment, NMAC recommends that HIV treatment and prophylaxis be administered to patients in correctional facilities in accordance with current federal HIV/AIDS treatment guidelines. Compliance with federal standards has been required by courts in several correctional jurisdictions,[14] and NMAC recommends that all correctional jurisdictions voluntarily bring their health care provision into compliance with federal guidelines.

### HIV SPECIALIST CARE

DHHS HIV/AIDS treatment guidelines recommend, "Where possible the treatment of HIV-infected patients should be directed by a physician with extensive experience in the care of these patients. When this is not possible, it is important to have access to such expertise through consultations."[15]

11. U.S. Department of Health and Human Services and Henry J. Kaiser Family Foundation. (2001). *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents*. Washington DC: DHHS. The latest version of the DHHS guidelines is always available online at www.hivatis.org. Free, printed copies of the latest guidelines can also be ordered by phoning the HIV/AIDS Treatment Information Service at 1-800-448-0440.

12. Public Health Service. (2001). *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States*. Washington, DC: Public Health Service.

13. Public Health Service and Infectious Diseases Society of America. (2001). *2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus*. Washington, DC: Public Health Service.

14. "Judge says prison must obey NIH treatment guidelines." *AIDS Policy & Law*. 14(14):1. August 6, 1999.

15. U.S. Department of Health and Human Services and Henry J. Kaiser Family Foundation. (2001). *ibid*, p.1.

The HIV Medicine Association of the Infectious Diseases Society of America have offered the following guidelines for identifying and recruiting health care professionals with expertise in HIV disease:

> To be an HIV-qualified physician, an individual should be able to show continuous professional development through:
>
> - Clinical management of at least 25 HIV-infected patients within the last year. (Numbers of patients may vary depending upon the concentration of HIV-infected patients in a given community).
>
> - A minimum of 15 hours of HIV-specific Continuing Medical Education (CME), including a minimum of five hours related to antiretroviral therapy per year.
>
> Recently trained infectious diseases (ID) fellows or those recently certified or recertified in infectious diseases should be considered qualified providers of patients with HIV/AIDS. However, given the rapid pace of change in HIV medicine, board certification in infectious diseases and pediatric infectious diseases does not guarantee sufficient knowledge to assure that an ID specialist will remain an expert in HIV disease over time. Therefore, all physicians (including ID and pediatric ID physicians) should meet the experience and education-based criteria outlined above to retain their HIV-qualified status.[16]

In accordance with federal HIV/AIDS treatment guidelines, NMAC recommends that the treatment of HIV-positive prisoners be directed by HIV-qualified physicians. NMAC further recommends that the definition of HIV-qualified physician be determined by the HIV Medical Association of the Infectious Diseases Society of America. Either directly or through close consultation, HIV-qualified physicians should direct all stages of patient care (assessment, monitoring, treatment regimens, end-of-life care).

Baseline and periodic medical examinations, as well as prophylaxis for opportunistic infections, should, at minimum, be conducted in accordance with federal treatment standards. It should be noted that federal standards recommend that all adults living with HIV/AIDS be administered pneumococcal vaccine as soon as possible after HIV infection is diagnosed, to prevent Streptococcus pneumoniae.[17]

Additional corrections-specific guidance may be garnered from current Federal Bureau of Prisons (BOP) Clinical Practice Guidelines for the Management of HIV Infection,[18] which

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16. HIV Medicine Association. (2000). *Qualifications for Physicians Who Care for Patients with HIV Infection*. Alexandria, VA: Infectious Diseases Society of America, HIV Medical Association. Available online at www.idsociety.org.

17. Public Health Service and Infectious Diseases Society of America. (2001). *2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus*. Washington, DC: Public Health Service.

18. Federal Bureau of Prisons. (2001). *Management of HIV Infection*. Clinical Practice Guidelines. Washington, DC: Federal Bureau of Prisons. Available online at www.bop.gov or www.nicic.org.

build corrections-specific clinical guidelines on the foundation of the DHHS HIV/AIDS treatment guidelines. NMAC eagerly awaits the promulgation of corrections-specific standards by CDC.

## HAART

In order to provide care in accordance with DHHS HIV/AIDS treatment guidelines, prison/jail prescription formularies must include all anti-HIV and other associated medications currently approved by the Food and Drug Administration. (For HIV/AIDS medications not currently approved by the Food and Drug Administration, please see "Clinical Trials" section, below).

DHHS HIV/AIDS treatment guidelines note, "Patient education and involvement in therapeutic decisions is important for all medical conditions, but is considered especially critical for HIV infection and its treatment."[19] Because strict adherence to treatment regimens is critical for therapeutic efficacy and the prevention of drug resistance, NMAC concurs with BOP Clinical Practice Guidelines, which note, "Inmate education by clinicians, pharmacy and nursing staff is critical before initiating complicated antiretroviral drug treatment regimens. Counseling should include a discussion of drug side effects, methods for managing side effects, instructions for taking scheduled medications by dose and time and the need to report missed doses."[20]

NMAC also notes that peer education and support programs can effectively foster the involvement and investment of prisoner-patients in their health care. Multifaceted psychosocial support programs, including peer support, can help build or reinforce the constructive doctor-patient relationships needed for effective long-term HIV treatment. Successful peer-based education and support programs are profiled in the National Institute of Justice and CDC's report, 1996–1997 Update: HIV/AIDS, STDs and TB in Correctional Facilities.[21]

HAART must be administered consistently and without interruption. In the correctional environment, this requires close cooperation between health and security staff. Systems must be in place to ensure that prisoners receive HIV medications in a timely and consistent manner, regardless of "lockdowns," transfer between institutions or other circumstances. Pharmacy supply arrangements must ensure that correctional facilities never run short of HIV medications.

All detention facilities, including police cells and jails, must be able to provide for medical necessities 24 hours a day, seven days a week. The prospect of missed doses of HIV medications should be viewed as a medical emergency. An HIV specialist physician should be available for consultation on short notice, and medications should always be available to arrestees within four hours of arrest.

19. U.S. Department of Health and Human Services and Henry J. Kaiser Family Foundation. (2001). *ibid.*

20. Federal Bureau of Prisons. (2001). *ibid.* unpaginated "Procedures" section 6.

21. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid.* pp.33–44.

For medication dispensing within correctional facilities, individual institutions may choose keep-on-person, directly observed therapy, medication lines or other methods: the choice of method should be guided by concerns for consistency of administration and confidentiality. "Pill-call" lines should not violate prisoners' confidentiality, require prisoners to wait outside in inclement weather or conflict with other prison activities (such as yard time or commissary visits). Additional research is needed to better understand the efficacy, advantages and disadvantages of different medication dispensation policies.

Compliance with HIV medications is a complex issue which should be addressed between doctor and patient as a health care issue, not as a disciplinary matter.

## ACUTE CARE

Triage and access to acute care for HIV-positive prisoners should be facilitated by registered nurses or other professional-level health care staff. Access to acute care for HIV-positive prisoners should not be moderated by non-health care professionals, including correctional staff with or without first-aid or first-responder training.

For information about post-exposure prophylaxis (PEP), see HIV Education and Prevention section in chapter 3.

## COINFECTION: TUBERCULOSIS, SEXUALLY TRANSMITTED DISEASES, HEPATITIS

Prisoners with HIV/AIDS are at high risk for coinfection with tuberculosis, sexually transmitted diseases and hepatitis, and coinfection can heighten the danger associated with any of these infections.[22] Although coinfection itself or drug interactions with HIV medications can complicate the treatment of tuberculosis or hepatitis, none of these diseases should be defined as a barrier to treatment for other illnesses.

NMAC recommends that all correctional facilities follow CDC guidance for the screening, prophylaxis and treatment of tuberculosis, hepatitis and sexually transmitted diseases, especially with regard to coinfection with HIV. NMAC recommends that prisoners and correctional staff

22. See, for example, Maddow R, Vernon A, Pozsik CJ. (2001). "TB and the HIV-positive prisoner." *HEPP [HIV Education Prison Project] News*. March 2001: 1, or Paar D. (2001). "Hepatitis B Virus: transmission, prevention, treatment, and HIV co-infection." HEPP [HIV Education Prison Project] News. June/July 2001. p.4.

be vaccinated against hepatitis B. NMAC welcomes the publication of corrections-specific federal standards on the treatment and control of hepatitis (and other infectious diseases), but notes that in the absence of corrections-specific guidance, correctional staff and medical professionals must follow general, non-corrections-specific medical guidance.

## Tuberculosis

According to CDC and the Bureau of Justice Statistics, one out of every 143 Americans was incarcerated in 2000, but incarcerated persons made up one out of every 28 reported cases of tuberculosis that year.[23]

CDC publishes guidelines for the prevention and control of tuberculosis in correctional facilities, as well as guidelines on preventing and treating tuberculosis among individuals who are HIV positive.[24]

## Sexually Transmitted Diseases

Prisoners, especially female prisoners, have been shown to have a higher prevalence of chlamydia, syphilis and gonorrhea than the communities from which they are drawn.[25] One study conducted in 1997 found the incidence of syphilis among repeat female entrants to New York City jails to be more than 1,000 times greater than the rate among women in general in the New York City area.[26]

The treatment of comorbid infections of chlamydia, gonorrhea, herpes simplex, syphilis and other genitoulcerative disease decreases the chances of acquiring and transmitting HIV. CDC has noted that STD screening can be an important component of HIV prevention services and recommends STD screening for persons entering prisons or jails within the first 24 hours.[27]

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23. Beck AJ, Harrison PM. (2001). *Prisoners in 2000*. Washington, DC: Bureau of Justice Statistics. NCJ 188207. CDC. (2001). *Reported Tuberculosis in the United States*, 2000. Atlanta, GA: CDC. Table 23.

24. CDC. (1996). "Prevention and control of tuberculosis in correctional facilities: recommendations of the Advisory Council for the Elimination of Tuberculosis." *MMWR*. 45(No. RR-8):1–28. CDC. (1998). "Prevention and treatment of tuberculosis among patients infected with human immunodeficiency virus: Principles of therapy and revised recommendations." *MMWR*. 47(No. RR-20):1–58. CDC. (2000). "Notice to readers: Updated guidelines for the use of rifabutin or rifampin for the treatment and prevention of tuberculosis among HIV-infected patients taking protease inhibitors or nonnucleoside reverse transcriptase inhibitors." *MMWR*. 49(09):185–9.

25. CDC. (1998). "Assessment of sexually transmitted diseases services in city and county jails — United States, 1997." *MMWR*. 47(21):429–431. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*. Chapter 2.

26. Blank S, Sternberg M, Neylans LL, Rubin SR, Weisfuse IB, St Louis ME. (1999). "Incident syphilis among women with multiple admissions to jail in New York City." *Journal of Infectious Disease*. 180(4):1159-63.

27. CDC. (1998). "HIV prevention through early detection and treatment of other sexually transmitted diseases — United States recommendations of the Advisory Committee for HIV and STD Prevention." *MMWR*. 47(RR12):1–24.

## Hepatitis C

It is estimated that hepatitis C infection among U.S. prisoners is nine to 10 times more prevalent than among non-prisoners; in 1996, people released from prisons and jails represented 29–32% of all people with hepatitis C in the United States.[28]

CDC publishes guidelines on the prevention and treatment of hepatitis C.[29] Additional CDC guidelines for the prevention and treatment of hepatitis C in prisons and jails are anticipated soon.[30]

## Hepatitis B

Approximately 30% of U.S. persons with hepatitis B infection report a history of incarceration.[31] Infection with hepatitis B among correctional populations is thought to be much higher than among the general population,[32] and hepatitis B transmission has been documented in correctional settings.[33]

The Occupational Safety and Health Administration requires that correctional staff who have direct contact with prisoners receive hepatitis B vaccinations.[34] The National Commission on Correctional Health Care advises that prisoners also be vaccinated.[35] It should be noted that hepatitis B vaccination may be less effective in patients who are immune compromised, including those who are HIV-positive — such patients may require boosters or higher doses.[36] Correctional facilities may, through a federal program, be able to receive free hepatitis B vaccinations for prisoners ages 18 or younger.[37] State departments of health may also be able to assist correctional facilities in providing hepatitis B vaccinations to adult prisoners.[38]

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28. Hammett TM, Harmon P, Rhodes W. (1999). "HIV/AIDS and other infectious diseases among correctional inmates: a public health problem and opportunity." National HIV Prevention Conference, Atlanta, GA. August 31, 1999. Abstract #571.

29. CDC. (1998). "Recommendations for prevention and control of hepatitis c virus (HCV) infection and HCV-related chronic disease." *MMWR*. 47(RR19):1–39.

30. De Groot. (2001). "HCV: The correctional conundrum." *HEPP [HIV Education Prison Project] News*. April 2001: 1.

31. CDC. (2001). "Hepatitis B outbreak in a state correctional facility, 2000." *MMWR*. 50(25):531.

32. Spaulding A. (1999). "HCV and HIV in the Correctional Setting." *HEPP [HIV Education Prison Project] News*. July 1999:4. NCCHC. (1997). Management of Hepatitis B Virus in Correctional Facilities. Position Statement. Chicago: NCCHC.

33. Paar D. (2001). ibid. p.1. Bader TF. (1986). "Hepatitis B in prison." *Biomedicine and Pharmacotherapy*. 40:248–251.

34. 29 CFR 1910.1030. Occupational Safety and Health Administration, Department of Labor.

35. NCCHC. (1997). *Management of Hepatitis B Virus in Correctional Facilities*. Position Statement. Chicago: NCCHC. The federal Advisory Committee on Immunization Practices recommends Hepatitis B vaccinations for long term prisoners with histories of hepatitis infection risk factors — see CDC. (1991). "Hepatitis B virus: a comprehensive strategy for eliminating the transmission in the United States through universal childhood vaccination." *MMWR*. 40(RR-13).

36. Spaulding A. (1999). *ibid*. p.4.

37. For information on the "Vaccines for Children" program, Contact the National Immunization Hotline at 1-800-232-2522 or visit the program website at www.cdc.gov/nip/vfc/.

38. Spaulding A. (1999). *ibid*. p.4.

## CONTINUITY OF CARE

Correctional institutions (particularly jails) should establish links from their own health care systems to community health care facilities that serve their patients before and after incarceration. Correctional facility/community health care linkages have been successfully implemented in Rhode Island, the Hampden County Correctional Center in Massachusetts, and several other state and local correctional systems.[39]

All prisoners living with HIV/AIDS should have access to discharge planning services. Comprehensive discharge planning programs include (but are not necessarily limited to) the following areas of service: medical and mental health care, housing, job placement, substance abuse treatment, benefits and counseling. It is expected that the CDC/Health Resources and Services Administration (HRSA) Corrections Demonstration Project will produce new models for discharge planning programs as well as concrete documentation of their effectiveness.

In order to ensure continuity of HIV/AIDS-related medical treatment, patients' medical records must be available to medical staff at every stage of patients' incarceration, during transfers to other institutions and upon transfer to non-correctional health facilities. To facilitate such access without compromising privacy/confidentiality standards, the modernization and computerization of medical records systems should be encouraged.

## HEALTH CARE SCREENING AND MONITORING FOR FEMALE PRISONERS

Initial physical examinations for incarcerated women living with HIV/AIDS should include a pregnancy screening, pelvic exam, Pap smear and STD screening. At the initial encounter with female patients, correctional health care staff should ask specific questions about menstrual history and gynecological symptoms and should identify factors prevalent among incarcerated women that may affect HIV prevention and treatment: history of physical and/or sexual abuse, substance abuse, post-traumatic stress disorder, illiteracy, history of sex work, mood/anxiety disorders or other psychiatric illness.[40]

Because of the high incidence of human papillomavirus (HPV) and other STDs among incarcerated women living with HIV/AIDS, it is recommended that all HIV-positive female prisoners receive Pap smears every six months. Prison health systems may also consider routine baseline colposcopies for women co-infected with HIV and HPV. A colposcopy should always be done when an HIV-positive patient has an abnormal Pap smear.[41]

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39. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid.* pp.77–82.

40. Onorato M. (2001). "HIV Infection Among Incarcerated Women" *HEPP News* May 2001.

41. Goodman A. (2002). "Human Papillomavirus Infections in Incarcerated Women" *HEPP News* January 2002.

Women who are pregnant should be treated and monitored in accordance with federal treatment standards for pregnant women.[42]

## CLINICAL TRIALS

Abuse and exploitation of prisoners in medical research led in the 1970s to blanket restrictions on inmate participation in clinical trials.[43] Early in the HIV/AIDS epidemic, clinical trials were recognized as an important component of medical treatment for HIV/AIDS, which revived interest in prisoners' access to unapproved HIV/AIDS medications and participation in clinical trials. Currently, the Office of Human Research Protections at the Department of Health and Human Services monitors and issues regulations on federally funded clinical trials in prisons.

In general, NMAC recommends that incarceration should not preclude access to experimental therapies for people living with HIV/AIDS. Patients involved in clinical trials before incarceration may in some cases be able to continue participating in trials while incarcerated, especially during short-term incarceration in jails. Prisoners should be encouraged to divulge such participation during intake, and correctional staff should be able to facilitate such arrangements.

In accordance with DHHS guidelines on clinical trials, NMAC recommends that institutional review boards approving research in correctional institutions have a majority of members with no association with the correctional facility (or facilities) involved in the research; in addition, at least one member of the board should be a prisoner or "a prisoner representative with appropriate background and experience to serve in that capacity."[44] NMAC welcomes the anticipated publication of an experts' consensus statement on HIV/AIDS clinical trials in U.S. prisons, following Brown University's conference on the subject in October 1999.

## CO-PAYMENTS

Co-payments for medical services have been instituted in many jail and prison systems as a means of recouping some of the costs associated with prisoner health care and of reducing what is sometimes seen as the over-utilization of correctional health care services. While some co-payment policies exclude chronic care treatment, anecdotal evidence indicates that such exclusions are not always respected in practice.

42. Public Health Service. (2001). *Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States*. Washington, DC: Public Health Service.

43. National Commission for the Protection of Human Subjects. (1978). *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Washington, DC: National Commission for the Protection of Human Subjects.

44. Code of Federal Regulations. Title 45, Part 46.304 a-b. Washington, DC: Department of Health and Human Services, Office of Human Research Protections.

In accordance with the National Commission on Correctional Health Care's (NCCHC) position statement on this issue,[45] NMAC recommends against co-payment policies in any prison or jail setting. Because correctional populations tend to have a high prevalence of serious medical problems, especially infectious diseases, it is unwise and fiscally irresponsible to discourage preventive screening and care by establishing financial barriers to health care.

If a facility must charge co-payments, it is NMAC's recommendation that prisoners with chronic illnesses be exempted altogether. Whether or not it is possible to exempt prisoners with chronic illnesses from medical care co-payments, such policies should be founded on the principle that health care services are available to prisoners regardless of their ability to pay, in accordance with the recommendation of the NCCHC.[46] Fees should be small and reasonably proportional to prisoners' average earnings. Care must not be withheld in the case of inability to pay or previous non-payment. Co-payment policies should be subject to rigorous evaluation and should only be allowed to continue if it can be proven that they do not impede access to care.

## ACCREDITATION

Accreditation by the NCCHC or the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)[47] can be an important measure of the overall structural health of a correctional health system. But because NCCHC and JCAHO standards are not updated frequently enough to contain specific, up-to-date HIV treatment recommendations, accreditation by these organizations cannot substitute for compliance with current federal HIV/AIDS treatment standards.

The Federal Bureau of Prisons clinical practice guidelines on the management of HIV[48] are one model for state and local correctional systems for how to build practical, corrections-specific HIV management policies on the foundation of current DHHS HIV/AIDS treatment standards. NMAC welcomes the anticipated publication by CDC of corrections-specific guidance for implementing DHHS HIV/AIDS treatment standards in correctional settings, but notes that in the absence of corrections-specific standards, U.S. correctional facilities should comply with non-corrections-specific federal treatment standards.

45. National Commission on Correctional Health Care. (1996). *Charging Inmates a Fee for Health Care Services*. Position Statement. Chicago, IL: National Commission on Correctional Health Care. Available online at www.ncchc.org.

46. National Commission on Correctional Health Care. (1996). *ibid*.

47. www.jcaho.org.

48. Federal Bureau of Prisons. (2001). *ibid*.

## HEALTH CARE CONTRACTING

Contracting to a private or public external health care provider does not displace a correctional system's responsibility to ensure appropriate standards of health care. All U.S. prisoners have a constitutionally protected right to health care, and the responsibility for ensuring this right remains with correctional officials, regardless of any decision to contract-out medical care.

Because the main instrument of accountability for health care contractors is the contract entered into with corrections officials, such contracts (or Requests for Proposals — commonly referred to as RFPs) should be drawn up in consultation with state departments of health and with experts in HIV/AIDS and other infectious diseases. Contracts should be open for public comment before bidding and for public perusal thereafter.

# Chapter II

## *Confidentiality and Discrimination*

A person with HIV/AIDS has a right to keep his or her HIV-status confidential. This principle holds as true for prisoners as it does for free citizens. It may be difficult to ensure confidentiality in correctional settings, but it is not impossible. Some simple policy changes can be enough to establish baseline confidentiality protections: clinics and support groups should not be generally announced as HIV-specific; there should not be separate medication dispensing protocols for HIV-positive prisoners; prisoners should not be allowed access to one another's medical records; correctional staff generally do not have a "need to know" the HIV status of prisoners.

### TESTING

Testing for HIV should be voluntary and should be available on a confidential or anonymous basis throughout the period of incarceration. Confidentiality of HIV test results must be ensured. Counseling and testing for U.S. prisoners have been shown to be a cost-effective means of detecting previously undiagnosed infections and preventing new infections.[49]

Anonymous HIV screening (either random or systematic) has important value as an infectious disease surveillance tool, but should not be conflated with patient testing. No results from anonymous HIV screening should ever be traced back to specific individuals.[50]

If a correctional staff member or prisoner may have been exposed to HIV, every effort should be made to ascertain the actual risk of transmission, based on expert consultation. Testing in these cases can be advised, but should not be compelled. Also see "Post-Exposure Prophylaxis" section, in the next chapter.

49. Varghese B, Peterman TA. (2001). "Cost-effectiveness of HIV counseling and testing in U.S. prisons." *Journal of Urban Health* 78:304–312.

50. "Court use of blood sample 'broke confidentiality.'" (2001). *Nature*. 410(6827): 402.

## HOUSING SEGREGATION

Mississippi and Alabama are the only two states that segregate housing for prisoners with HIV; only California segregates prison housing for most prisoners who are HIV-positive and have been diagnosed with AIDS. South Carolina concentrates prisoners with HIV in one prison, but housing within that prison is integrated with prisoners who are not HIV-positive.[51]

The vast majority of U.S. prison systems have found HIV housing segregation to be unnecessary, relying instead on universal precautions, HIV education, and routine classification and security precautions. Segregated housing for HIV-positive prisoners may give staff and prisoners a false sense of freedom from the risk of HIV transmission, because of false negative tests, incomplete testing of correctional populations, and the "window" period of time between infection and the production of antibodies that can be detected on standard HIV-antibody tests.[52] Group housing of HIV-positive prisoners may also pose communicable disease risks, as shown in the 2000 tuberculosis outbreak in the Broad River Men's Correctional Institution in Columbia, South Carolina.[53]

While HIV-positive prisoners should be allowed to remain in segregated housing if that is their preference, NMAC recommends against forced HIV housing segregation.

In addition, any need to geographically concentrate HIV-positive prisoners in order to provide expert medical care must be balanced against respect for confidentiality, patients' access to their families and home communities, and the need to retain distinctions between classification and security levels among HIV-positive prisoners. There is no evidence to suggest that concentrating HIV-positive prisoners geographically necessarily improves their medical care.

## ACCESS TO PROGRAMS

There is no medical justification for denying HIV-positive prisoners access to prison programming, including religious services, education, food service, vocational training and jobs. Excluding HIV-positive prisoners from programs may result in their serving longer sentences, under harsher conditions, with fewer opportunities for rehabilitation and for no reason other than their HIV infection.

51. Hammett TM, Harmon P, Maruschak LM. (1999). ibid. p.63.

52. CDC. (1998). *How long after a possible exposure should I wait to get tested for HIV?* CDC Update. Dated 30 November. Online at www.cdc.gov/hiv/pubs/faq/faq9.htm.

53. CDC. (2000). "Drug-susceptible tuberculosis outbreak in a state correctional facility housing HIV-infected inmates — South Carolina, 1999-2000." *MMWR*. 49(46):1041–4.

Food service is not a special case — there is no medical justification for excluding HIV-positive prisoners from food service.[54] Excluding HIV-positive prisoners from such jobs furthers the misperception that there is a risk of HIV transmission associated with food handling. Misconceptions and prejudices around the issue of HIV transmission should be addressed through HIV education for both prisoners and staff.

## CONFIDENTIALITY AND MEDICATIONS

Medication dispensing procedures have consequences for prisoners' ability to maintain the confidentiality of their HIV-status.[55] Individual institutions may choose keep-on-person, directly observed therapy, medication lines or other methods of medication administration: the choice of method should be guided both by concerns for consistency of administration and confidentiality. As noted above, additional research is needed to better understand the efficacy, advantages, and disadvantages of different medication dispensation policies. As noted above, additional research is needed to better understand the efficacy, advantages and disadvantages of different medication dispensation policies.

## ACCESS TO MEDICAL RECORDS

Prisoners' HIV status should be treated as confidential and should be made known only to medical staff. In accord with the most recent National Institute of Justice/CDC joint report on HIV, tuberculosis and sexually transmitted diseases in correctional facilities,[56] NMAC believes that correctional staff do not generally have a "need-to-know" prisoners' HIV status. Because even prisoners without a positive HIV-test result on file can be HIV-positive, staff and prisoners should be trained to use universal precautions against infectious disease.[57]

Prisoners should be allowed access to their own medical records and should be given the option of releasing their own medical information, including their HIV status, at their own discretion.

50. CDC. (1999). *HIV and Its Transmission*. Atlanta, GA: CDC. p.2. Available online at www.cdc.gov.

51. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*, p.58.

52. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*. p.48.

53. CDC. (1988). "Perspectives in disease prevention and health promotion update: Universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings." *MMWR*. 37(24):377–388.

# Chapter III

## HIV Education and Prevention

### LINKS WITH NON-CORRECTIONAL HIV/AIDS SERVICE PROVIDERS

NMAC recommends that regional AIDS education and training centers, state departments of health and AIDS service organizations reach out to local and state correctional systems to offer HIV education and prevention services to correctional staff as well as prisoners. In particular, NMAC recommends that state departments of health and AIDS education and training centers undertake as part of their responsibilities to facilitate communication and cooperation between correctional systems and local/regional AIDS service organizations. Ryan White CARE Act funds may be available to community-based organizations providing HIV/AIDS-related services to incarcerated populations.

### PRE- AND POST-TEST COUNSELING

As recommended in chapter 1, all HIV testing in the correctional setting should be voluntary and should be available on a confidential or anonymous basis throughout the period of incarceration. All HIV testing should be accompanied by client-centered pre- and post-test counseling, as indicated by CDC guidelines.[58] Again, it should be reiterated that ensuring the confidentiality of HIV test results is a linchpin of correctional HIV/AIDS care.

### STAFF EDUCATION

The level of HIV education among correctional staff is a critical factor affecting the manner in which HIV/AIDS is addressed in correctional settings. Staff education should be given equal weight and priority with the HIV education of prisoners. At minimum, correctional staff should receive HIV education at intake orientation and at least twice-yearly updates. As with prisoners' HIV education, peer-based models of education should be encouraged for correctional staff.

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58. CDC. (1994). *HIV Counseling, Testing and Referral Standards and Guidelines*. Atlanta, GA: CDC.

## PRISONER EDUCATION

In accordance with the most recent National Institute of Justice/CDC joint report on HIV, tuberculosis and sexually transmitted diseases in correctional facilities, NMAC recommends that prisoners receive comprehensive HIV education and prevention services, including "instructor-led education, peer-led programs, pre and post-test counseling and multi-session prevention counseling".[59] HIV education and prevention services can be integrated with general health education curricula, but it is important that all prisoners receive culturally competent prevention and education services.

NMAC believes that peer-led HIV education programs can be both a cost-efficient and effective means of delivering such services. Their demonstrated success in U.S. prisons and jails over the past two decades[60] should encourage their adoption and expansion in more U.S. correctional systems. In addition, peer-based programs can be a critical part of psychosocial support for prisoners living with HIV/AIDS.

## AVAILABILITY OF HIV INFORMATION

In addition to active and ongoing training and education, there should always be culturally competent and multilingual printed HIV education materials freely available to both prisoners and staff. Prisoners and staff should also have access to community-based HIV information phone lines.

## HARM REDUCTION

Harm reduction interventions include, but are not limited to:

- safe sex, safe drug injection and safe tattooing information
- condoms, dental dams and lubricants
- bleach, disinfection materials
- syringe exchange
- safe tattooing materials
- methadone

59. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*, p.27.
60. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*. pp.33–44.

Prison-based HIV harm reduction programs are among the most controversial issues in HIV/AIDS and prisons policy. Indeed, harm reduction programs outside of prisons (especially syringe exchanges) have been among the most controversial HIV policy issues in general. Given the public and political unease surrounding this issue, NMAC recognizes that national leadership on this issue must always be informed by local considerations in the jurisdictions in which policies are implemented.

That said, NMAC also recognizes that international and domestic experiences with harm reduction initiatives in prison have been overwhelmingly positive.

- Several prison systems have successfully introduced syringe distribution or exchange, including Switzerland, Germany and Spain. Such policies have not resulted in adverse incidents involving these materials and have been associated with reported decreases in HIV risk behaviors.[61]

- Condoms are available for use in only seven U.S. jails or prison systems (Vermont, Mississippi, San Francisco, Dallas, Philadelphia, New York City and Los Angeles). Although no adverse consequences have been associated with condoms at any of these sites, Los Angeles is the only U.S. prison or jail system to have developed a new condom distribution policy since the early 1990s.[62]

- None of the many international prison systems that have made bleach available to prisoners (either generally or for the specific purpose of cleaning injecting equipment) has ever rescinded its policy.[63] Ten U.S. prison systems and eight U.S. jail systems reported in 1997 that they had found it feasible to make bleach available to prisoners (though they were not asked if it was made available specifically for cleaning injecting equipment).[64]

NMAC supports the evaluation and dissemination of information about existing harm reduction interventions in correctional facilities, both domestically and abroad. NMAC also recognizes that in contrast to many correctional systems in other countries, the development of U.S. correctional harm reduction is at a relative stand-still. The recent Los Angeles condom policy is a notable — and encouraging — exception. NMAC supports the initiation and evaluation of pilot harm reduction programs in U.S. prisons and jails.

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61. Canadian HIV/AIDS Legal Network and Canadian AIDS Society. (1996). *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society. pp.8–13, 52–66. Canadian HIV/AIDS Legal Network. (2001). *Prevention: Sterile Needles*. Fact Sheet. Montréal: Canadian HIV/AIDS Legal Network. Available online at www.aidslaw.ca.

62. Hammett TM, Harmon P, Maruschak LM. (1999) *ibid*. p.49. Shuster B. (2001). "Sheriff approves handout of condoms to gay inmates." *Los Angeles Times*. November 30.

63. Canadian HIV/AIDS Legal Network. (2001). *Prevention: Bleach*. Fact Sheet. Montréal: Canadian HIV/AIDS Legal Network. Available online at www.aidslaw.ca.

64. Hammett TM, Harmon P, Maruschak LM. (1999). *ibid*, p.49.

## POST-EXPOSURE PROPHYLAXIS (PEP)

State departments of health, teaching hospitals and AIDS education and training centers should ensure that every correctional institution has expert consultation available in case of a possible HIV exposure event. In accordance with CDC guidelines,[65] staff and prisoners who — upon expert consultation — are believed to have had an exposure to HIV that poses a credible risk of infection, should be offered PEP and information about its risks and benefits. Every correctional institution should be trained in PEP protocols, should have PEP-knowledgeable physicians' on-call, and should have appropriate PEP medications on-site or otherwise obtainable within one hour of a potential exposure incident.

65. CDC. (2001). "Updated U.S. public health service guidelines for the management of occupational exposures to HBV, HCV and HIV and recommendations for postexposure prophylaxis." *MMWR.* 50(RR11):1–42.

# Chapter IV

## Substance Abuse and Mental Health

### SUBSTANCE ABUSE

A 1998 analysis by the National Center on Addiction and Substance Abuse at Columbia University found that approximately 80 percent of all U.S. prisoners and jail inmates were "seriously involved" in drugs and alcohol.[66] It is estimated that prisoners are twice as likely to have drug-use histories as non-correctional U.S. populations.[67]

Because intravenous drug use is thought to be the most common source of infection for prisoners living with HIV/AIDS,[68] prison-based substance abuse treatment can be an important element of HIV/AIDS prevention and treatment. Substance abuse treatment for prisoners can not only prevent primary new infections among at-risk populations, it can also reduce secondary new infections among sex partners and drug-injection partners of currently-incarcerated HIV-positive drug-involved persons, reduce an important source of co-morbidity among HIV-positive drug users and reduce recidivism.[69]

The Association of State and Territorial Health Officers (ASTHO) in its 1999 report noted the link between substance abuse and infectious disease among prisoners. The report states that just as prison provides an opportunity to reach populations at high risk for HIV infection who might otherwise not receive HIV/AIDS prevention services, prison also represents an opportunity to provide substance abuse treatment to heavily drug-involved populations who might otherwise not receive such services in the community.[70]

There is a significant gap between the estimated need for substance abuse treatment and the actual availability of such services for U.S. prisoners. According to the Office of National Drug Control Policy, corrections officials estimate that 70% to 85% of prisoners need some form of substance abuse treatment, but a 1997 survey found that only 11% of the prisoner population was receiving such services.[71]

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66. National Center on Addiction and Substance Abuse At Columbia University. (1998). *Behind Bars: Substance Abuse and America's Prison Population*. New York: National Center on Addiction and Substance Abuse.

67. Office of National Drug Control Policy. (2001). *Drug Treatment in the Criminal Justice System*. Fact Sheet. Washington, DC: Executive Office of the President. p.2. Available online at www.whitehousedrugpolicy.gov.

68. Braithwaite RL, Hammett TM, Mayberry RM. (1996). *Prisons and AIDS: A Public Health Challenge*. San Francisco: Jossey-Bass. p.11.

69. National Center on Addiction and Substance Abuse at Columbia University. (1998). *ibid*. pp.129-134.

70. Varghese S, ed. by Fields HF. (1999). *The Link Between Substance Abuse and Infectious Disease in Correctional Settings*. Issue Brief. Washington, DC: ASTHO.

71. Office of National Drug Control Policy. (2001). *ibid*. p.3.

## TABLE 3.
**Prisoners Who Report Receiving Substance Abuse Treatment in Prison, 1997**

| | STATE PRISONERS | FEDERAL PRISONERS |
|---|---|---|
| African Americans | 13.5% | 11.9% |
| Latina/os | 12.5% | 8.2% |
| Whites | 17.0% | 16.0% |

***Source:*** Mumola CJ (1999) ibid. Adapted from Tables 14 and 15.

There are also racial disparities among prisoners who receive substance abuse treatment in prisons. Table 3 shows the percentage of alcohol or drug-involved state and federal prisoners who report receiving treatment for substance abuse while in prison.

NMAC agrees with ASTHO in its recommendation that the chasm between the need and availability of substance abuse treatment must be closed. In addition, we note that there is no justification for racial disparities in the few substance abuse treatment slots that are offered in prisons. NMAC is encouraged by the success of programs that offer alternatives to incarceration for drug-involved offenders and encourages continuing innovation and progress in this field.[72] NMAC encourages states to take advantage of federal technical assistance that may be available for developing integrated substance abuse treatment and diversion programs.[73]

## MENTAL HEALTH

In 1998, 16% of U.S. prisoners were considered to be mentally ill, and 60% of those who were considered to be mentally ill received mental health treatment of some kind in prison or jail.[74] As with substance abuse treatment, there is evidence of racial disparity in mental health treatment in U.S. correctional facilities. In state prisons in 1998, 64.1% of white prisoners considered to be mentally ill were receiving treatment, as compared with 56.4% of African Americans and 59.9% of Latina/os.[75] NMAC concurs with the National Commission on Correctional Health Care in its recommendation that correctional institutions be closely linked with mental health resources in the community and that, where possible, mentally ill offenders be diverted to community treatment facilities.[76] In addition, NMAC recommends that correctional systems seek training for their front-line staff on working with inmates with mental illnesses.

72. Office of National Drug Control Policy. (2001). *ibid*. pp.4–5.

73. “Reducing offender drug use through prison-based treatment.” (2000). *National Institute of Justice Journal*. July: 21–23.

74. Ditton PM. (1999). *Mental Health and Treatment of Inmates and Probationers*. Washington, DC: Bureau of Justice Statistics. NCJ 174463. p.1.

75. Ditton PM. (1999). ibid. p.9.

76. NCCHC. (1992). *Mental Health Services in Correctional Settings*. Position Statement. Chicago, IL: NCCHC.

# Chapter V

## Nutrition and Living Conditions

### NUTRITION

Nutrition is an important component of health maintenance for people living with HIV/AIDS. Prisoners with HIV/AIDS, regardless of their level of immune suppression, should be allowed access to nutritious "medical" diets and to dietary supplements such as vitamins. If HAART regimens require that patients have access to certain types of food, that they fast, that they have extra water or that they have access to refrigeration for their pills, these requirements should be integrated into medication dispensing plans to ensure consistent access.

### SANITATION

Because HIV/AIDS represents a compromise of the immune system, HIV-positive prisoners should live and work in sanitary conditions, in accordance with appropriate local public health and safety regulations.

State departments of health should work with departments of correction to ensure proper sanitation standards are established and maintained in housing and working environments for prisoners with HIV. State and county departments of health should consider establishing inspection protocols for correctional facilities within their jurisdictions.

It is inappropriate for prisoners with HIV to be housed, as a matter of course, in an infirmary or hospital wing, where they will likely be exposed to other prisoners' illnesses and infections.

### AIR QUALITY, VENTILATION, TEMPERATURE

In accordance with public health and safety regulations, living and working quarters for HIV-positive prisoners should maintain adequate ventilation and air quality. In warm and humid climates, their environment should generally include air conditioning in summer months.

Some HAART medications are temperature-sensitive and must be maintained according to manufacturers' instructions.

# Chapter VI

## Compassionate Release and Discharge Planning

### COMPASSIONATE RELEASE

The advent of HAART has caused AIDS-related deaths to decline in U.S. prisons and jails, just as they have in the United States in general.[73] Nevertheless, more than 240 prisoners died of AIDS in U.S. correctional facilities in 1999. NMAC recommends that more correctional systems develop medical furlough and compassionate release policies and that those systems that already have such policies enforce them more readily. There is no reason that terminally ill prisoners should die within prison walls. Although in-prison hospice programs may be necessary when it is not possible to release prisoners, they are no substitute for community-based hospice care.

### DISCHARGE PLANNING

All prisoners with HIV/AIDS should receive discharge planning services, ideally starting six months before release and extending after release through coordination with local AIDS service organizations and other community-based groups. Discharge planning services for prisoners with HIV/AIDS should include services specific to the following priorities:

- health care
- housing
- benefits (including ADAP, VA, Medicaid, Medicare, food stamps, etc.)
- social work/case management
- substance abuse treatment where indicated
- mental health treatment where indicated
- employment and training assistance

NMAC welcomes the evaluation of the seven state discharge planning demonstration project funded by CDC and HRSA.

# Chapter VII
## Conclusion

Prisons are a critical nexus for the HIV/AIDS epidemic, particularly for communities of color. Prisons concentrate people who are among the most affected by HIV/AIDS and the least served by our current responses to the epidemic. The disproportionate incarceration of men and women of color in the United States and the disproportionate impact of HIV/AIDS in communities of color intertwine to create the crisis of HIV/AIDS in prisons.

HIV/AIDS in prisons is a crisis not because it is a new or suddenly worse problem than it was before. Rather, the crisis status of HIV/AIDS in prisons is due to the fact that it has never been addressed effectively. Since the earliest days of the HIV/AIDS epidemic, people passing through the prison systems are among the most at-risk populations for infection in this country. Some departments of corrections are among the largest providers of health care to people living with HIV/AIDS in the United States.

No one argues that prisons and jails are the ideal agencies for providing the complex, cutting-edge, integrated services needed to serve highly infected and at-risk populations. But AIDS advocates and service agencies must play the hand we have been dealt. The fact is that the people who most desperately need HIV/AIDS services and health care in the US are in prisons and jails, and the U.S. HIV/AIDS epidemic cannot be curtailed if prisoners are ignored.

Corrections may sometimes seem like an unwelcoming place for HIV/AIDS advocacy and collaboration, but it is critical that we find ways to do this work.

- If you are an AIDS service provider looking for a way to target your services to the individuals who most need them, you often need look no further than your local correctional facilities.

- If you are a policy-maker or advocate looking for ways to make a concrete difference in the lives of underserved, needy populations, you often need look no further than the policies and regulations affecting your local correctional facilities.

- If you are a person living with HIV/AIDS who wants to make contact with others living with this disease who are in need of support, information and comfort, you often need to look no further than your local correctional facilities.

NMAC will continue to take a leading role in articulating a national advocacy agenda for HIV/AIDS in prisons. But it is local efforts that will actually alleviate this crisis. We look forward to meeting new allies and colleagues in this important work.

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