Incarcerated People and HIV/AIDS

The Incarcerated Population in the United States

Over the last three decades, the number of inmates in State and Federal prisons in the United States has skyrocketed: from less than 200,000 in 1970 to 1,254,600 by 1999. Local jails house another 606,000 people, and in addition to those who are incarcerated, 5 million people are either on probation or parole. Thus, the United States has one of the highest rates of incarceration in the world: 682 inmates per 100,000 citizens, second only to Russia's rate of 685.¹

The dramatic increase in the number of incarcerated people has, in part, been fueled by the American "war on drugs." In 1984, 29 percent of the population in Federal prisons were drug offenders. From 1984 to 1998, the Federal incarcerated population more than tripled and, in 1998, nearly 60 percent were drug offenders.²

The incarcerated population is primarily male—94 percent in 1999—and the majority are people of color: African American (48 percent) and Latino (19 percent). Incarcerated people often come from poor backgrounds, and tend to be less educated than the general population: in 1991, 32 percent of jail inmates who had been free for at least one year prior to their arrest had annual incomes of under $5,000; 65 percent of State prison inmates had not completed high school.³

There is a "revolving door" into incarceration in the United States, with thousands of inmates rotating in and out of jails and prisons each year. Although recent data on recidivism are not available, a study estimated that of the 108,580 persons released from prisons in 11 States in 1983, 62.5 percent were rearrested for a felony or serious misdemeanor within 3 years, 46.8 percent were reconvicted, and 41.4 percent returned to prison or jail.³

Incarcerated populations suffer from myriad diseases and health problems. In particular, tuberculosis, HIV/AIDS, and other sexually transmitted diseases such as syphilis, gonorrhea, hepatitis, and chlamydia are far more prevalent among incarcerated persons than the general U.S. population.⁴ Many of today's inmates are involved with drugs; some reports estimate that two-thirds of those entering State and Federal penitentiaries have histories of substance abuse.⁵

In addition, criminal offenders also suffer from a high incidence of mental health problems. According to recent estimates from the Substance Abuse and Mental Health Services Administration, 7 percent of all prison inmates have serious mental illnesses, and 12.5 percent have significant psychiatric problems requiring intermittent care.

Providing adequate health care to the incarcerated population is rife with challenges. Despite the fact that inmates are the only Americans with a guaranteed right to health care, there is a long history of inadequate and substandard care for this population.

While correctional institutions are obligated to provide health care to inmates, security and detainment remain their foremost concerns. The concern for security

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Health Problems of the Incarcerated

58,000 current inmates are HIV positive.
Of all AIDS cases in America, 17 percent have spent time in the U.S. correctional system.
Of people with tuberculosis, 35 percent have been incarcerated.
Of people with hepatitis C, 30 percent have been incarcerated.
Of people with hepatitis B, 15 percent have been incarcerated.

Source: Abt Associates Research funded by National Commission on Correctional Health Care; HIV/AIDS data collected by Bureau of Justice Statistics

HIV-positive State and Federal Prison Inmates, 1996

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Percent of Custody Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>17,551</td>
<td>2.2%</td>
</tr>
<tr>
<td>1992</td>
<td>20,851</td>
<td>2.5%</td>
</tr>
<tr>
<td>1993</td>
<td>21,475</td>
<td>2.4%</td>
</tr>
<tr>
<td>1994</td>
<td>22,747</td>
<td>2.4%</td>
</tr>
<tr>
<td>1995</td>
<td>24,256</td>
<td>2.3%</td>
</tr>
<tr>
<td>1996</td>
<td>24,881</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

Source: Bureau of Justice Statistics, National Prisoner Statistics

Incarcerated People with HIV

According to the "1996-1997 Update: HIV/AIDS, STDs, and TB in Correctional Facilities," 2.5 percent of all State and Federal prison inmates were infected with HIV, or 24,881 people (947 Federal and 23,934 State) at year-end 1996. Recent estimates indicate that the number is now 56,000.

In 1996, New York housed more than one-third of all inmates known to be HIV positive; Florida had the next largest number. More than one-half of the State prison inmates known to be HIV positive were found in the Northeast, where 7.5 percent of the prison population were HIV positive (2.0 percent were HIV positive in the South, 1.1 percent in the Midwest, and 0.8 percent in the West.)

A 1999 study found that, of the 220,000 persons in the United States reported with AIDS from January 1994 through December 1996, 9,370—or 4 percent—were incarcerated at the time of diagnosis. Compared with the overall population of PWAs at the time of the study, more of the incarcerated population were male (89 percent versus 81 percent), African American (58 percent versus 40 percent), and younger at the time of diagnosis (median age of 35 versus 37). Not surprisingly, more of the incarcerated persons contracted HIV through injection drug use than the general population—61 percent versus 27 percent, and more were men who had sex with men who inject drugs (9 percent versus 5 percent).

Harm Reduction in Correctional Settings

High-risk behavior for HIV transmission occurs in correctional settings, but the HIV transmission rate during incarceration is not known. However, a 1994 study that examined a group of Florida prisoners who had been continuously incarcerated from 1977 through 1991 indicated that HIV transmission among inmates occurs at high rates. Of a 556-prisoner sample, 87 were tested for HIV in 1991; 18 prisoners—or 21 percent of those tested—were found to be HIV positive, or 3.2 percent of the entire sample. Given the length of their incarceration prior to testing, it is highly improbable that they contracted HIV outside of the correctional setting.

The risk reduction education that would include recommendations on condom use during sex and the use of bleach to clean injection equipment is not generally being provided in the prison or jail setting. The majority of U.S. correctional facilities prohibit condoms, and most are reluctant to provide bleach for the specific purpose of cleaning needles, although they are finding increasing acceptance in other places such as Europe and Canada.

In terms of HIV testing, a 1999 survey conducted by the trade journal Corrections Compendium found that 20 of the responding U.S. systems test inmates at intake. Thirty-six test if it is requested by the inmate, and 29 will test if requested by a physician. Testing can also be done if court ordered or if the inmate is exposed to bodily fluids. New Jersey, South Dakota, and Wisconsin will also test if requested by a physician, but only with the inmate's consent. Mississippi, South Carolina, Nevada, and Texas segregate infected inmates; four other jurisdictions will do so if the inmate's behavior warrants such action.

Within correctional systems, HIV/STD education and prevention programs are becoming increasingly common, including instructor-led education and, in some cases, peer-led programs. Evidence suggests that peer-education programs are particularly effective in reaching inmates with practical information on HIV and STD prevention; such programs are credible to inmates, as well as cost effective.

Few inmates have had contact with the health care system prior to their incarceration, and the corrections setting provides a pivotal opportunity to fill this void. For example, the Hampden County Correctional Facility in Massachusetts has linked with four community health
Availability of Condoms and Bleach in Jails and Prisons, 1997

<table>
<thead>
<tr>
<th>Policy</th>
<th>Jail systems (n = 51)</th>
<th>Prison systems (n = 41)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make condoms available</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Make bleach available</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Source: NIJ/CDC Survey

HIV/STD Education and Prevention Programs in Adult Correctional Facilities, 1997

<table>
<thead>
<tr>
<th>Programs</th>
<th>State/Federal facilities (n=1486)</th>
<th>City/county facilities (n=152)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor-led education</td>
<td>61%</td>
<td>66%</td>
</tr>
<tr>
<td>Peer-led programs</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Pre-posttest counseling</td>
<td>86%</td>
<td>84%</td>
</tr>
<tr>
<td>Multi-session prevention counseling</td>
<td>31%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: NIJ/CDC Survey

Challenges in the Provision of Care

Adherence
Adherence is an especially significant challenge for incarcerated individuals living with HIV/AIDS. Correctional health care providers often must supervise the dispensing of medication for every dosing. Following specific dietary requirements may be difficult because inmates do not have access to food storage facilities; they may not even have access to an appropriate diet. Additionally, tools for improving adherence, like pill boxes, may not be available in a prison setting. Ultimately, security and containment are of the highest priority in prisons and jails, and the case-specific approach that is necessary for supporting adherence often is not the norm.

Training
For a variety of reasons, prison health care providers have difficulty keeping abreast of the most current advances in HIV treatment. Many lack the caseloads necessary for generating a wide base of experience. Others are isolated from urban centers where HIV is most common, leaving them cut off from providers who are knowledgeable about complex HIV standards of care. Prison health care providers also often operate with scarce resources, so securing funds and time for participating in educational activities is difficult.

Emory University School of Medicine, with funding from the Special Projects of National Significance Program in HRSA’s HIV/AIDS Bureau, has developed and evaluated programs that mitigate some of these problems through training. (See "SPNS Case Studies" on page 4 for a description of the program.)

HRSA’s AIDS Education and Training Centers have also responded to the training needs of prison personnel through special initiatives. Telemedicine and the Internet, in particular, are improving access to up-to-date treatment information for these clinicians.

Costs
HIV/AIDS care in prisons is expensive: based on voluntary reporting through a 1998 survey, the San Francisco-based Correctional HIV Consortium estimates the average cost of housing and security for an AIDS-diagnosed Federal inmate to be nearly $106,000 a year, compared with $38,500 for the average inmate. (Because of huge variances, calculating accurate costs for State and local prison costs is not possible.) The Consortium estimates that an HIV-positive Federal inmate’s housing and security costs are more than $80,000.

In the context of high treatment costs, some in the prison health care field express concern about the provision of prison health care services by outside vendors or contractors, who receive set amounts of funding to provide services in a specific institution or locale. Contractors may regard early identification and treatment of persons with HIV infection as a financial liability, which may serve as a disincentive to identify and treat such inmates.

Discharge Planning
Case management and discharge planning services are critical if inmates are to receive appropriate HIV care and treatment after release. Many will rely on providers funded through the CARE Act, and these providers must be prepared to meet the needs for a comprehensive array of services. Discharged inmates with HIV need immediate access to health care services. Prisoners are often released
Hampden County Correctional Center

Through relationships with community partners, the Hampden County Correctional Center in Ludlow, MA, provides high-quality medical care to inmates, and assures continuing health care after inmates are released from jail. The results of their program hold great promise for replication by other correctional systems.

This facility has contracted for medical services with the four non-profit neighborhood health centers in greater Springfield. Each center provides physicians and case managers, who work both at their center and at the jail. When an inmate is diagnosed, he is matched with a physician and case manager at the health center nearest his home, in anticipation of his eventual release.

All inmates in this facility are seen by a medical professional and receive a physical exam and comprehensive medical and diagnostic assessment. Eligible inmates without health insurance are enrolled in Medicaid, which is activated after their release.

This program follows the basic public health model of care: early detection, early treatment, prevention, education, and continuity of care. The program has made a considerable difference in terms of health and quality-of-life—the vast majority of inmates keep medical appointments after being released, and the recidivism rate among the facility’s inmates is much lower than the national average. Although every corrections system has unique characteristics, the Hampden County Correctional Center model is instructive for other institutions that seek to develop partnerships based on a public health model.

Contact information: Thomas Conklin, M.D., Director of Health Services, 627 Randall Road, Ludlow, MA 01056, (413) 547-8000, x2344, tom.conklin@sdh.state.ma.us

Emory University School of Medicine:
HIV Training for Georgia’s Correctional Health Care Providers

Helping prison health care providers stay abreast of the most current advances in HIV treatment is a significant challenge. In Georgia, Emory University School of Medicine is helping to fill the training void, with promising results that can be replicated elsewhere.

From 1994-1999, Emory, home of the Southeast AIDS Education and Training Center, provided training to Georgia Department of Corrections personnel on a variety of topics related to HIV/AIDS. The training took place in two settings: large, off-site statewide HIV training workshops that covered a wide range of subject matter, open to any employee of the corrections department; and within eight prison sites, where interactive clinical teaching was provided by a preceptor.
The project's goals were:

1. Increase the capacity of correctional health providers to deliver appropriate, comprehensive care to inmates with HIV/AIDS through the provision of training and education;

2. Design two distinct models for correctional health worker training in order to compare their impact and outcome; and

3. Evaluate the effectiveness and replicability of different models of correctional HIV training and education.

In addition to the two training models, the HIV knowledge base among correctional providers was assessed, and an HIV curriculum for corrections was developed. Results have been disseminated to the professional community. The program has also focused on the need to educate caregivers about the particular problems inmates face as they transition back into their communities.

Contact information: Jackie Zalum, Project Director, 735 Gatewood Road, NE, Atlanta, GA 30322-4950, (404) 727-2927, jzalum@emory.edu

The Fortune Society, ETHICS 3 Program

Even for those inmates who receive good care while in a jail or prison, continuity of care once they are released is a significant obstacle. The Empowerment Through

HIV/AIDS Information, Community and Services (ETHICS) 3 program at The Fortune Society in New York City helps provide continuity of care for HIV-positive ex-offenders, and does so with a family model.

The Fortune Society serves incarcerated people and ex-offenders with a "holistic" approach, offering a wide range of health, support, and social services. The majority of ETHICS 3 clients make initial contact with Fortune Society staff while they are still incarcerated, and are then linked with medical care and support services upon their release.

The program links clients and families with an integrated system of care that is sensitive and responsive to the needs of people with HIV/AIDS; health care providers work closely with case managers, who help stabilize ex-offenders' lives.

Program staff have found that substance abuse figures prominently among many of their HIV-infected clients, making substance abuse treatment a high priority in their discharge plans. Without it, clients relapse, making it difficult for them to adhere to medication regimes. In addition, homelessness, risk of relapse, transition from incarceration, and isolation are issues that staff must address as they help clients make the transition back to their communities.

Contact information: Althea Brooks, Project Director, 39 W 19th Street, New York, NY 10011, (212) 206-7070, althea@fortunesociety.org

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**A Request for Help, with Gratitude**

Peer education increasingly is common in correctional facilities. These "inmate-to-inmate" programs are effective in disseminating practical information on HIV and STD prevention. This recent request to HRSA for training materials came from an incarcerated peer educator in New York State.

I am writing your organization in the hope that you may help to provide me with your manual, "Heart of Training." I am currently incarcerated at Mid-State Correctional Facility, and am an HIV/AIDS Peer Educator. I am confident that your training manual will be very useful and beneficial to my peers and myself, in our struggle to educate the inmate population at this facility about the dangers of this deadly disease. Inmates as well as the general public are very fortunate to have organizations such as yours, with such an abundance of information that can help in the prevention of contracting this awful disease, and learning how to cope with the disease itself.

I would like to ask you at this time, if it is at all possible, to have the packet that I am requesting, addressed with a Legal/Privileged mail stamp. This will insure that the packet is received in a confidential manner.

I would like to thank you and all involved, on behalf of my peers and myself, for sharing your manual and your valuable time. We look forward to receiving your manual and applying it to our HIV/AIDS Awareness Seminars.
<table>
<thead>
<tr>
<th>Grantee</th>
<th>Project summary</th>
<th>Population/providers served</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emory University School of Medicine: HIV Training for Georgia’s Correctional Health Care Providers Atlanta</td>
<td>Trains prison health care personnel in delivery of comprehensive HIV/AIDS care</td>
<td>Correctional health care providers</td>
<td>Education and training in HIV/AIDS care</td>
</tr>
<tr>
<td>The Fortune Society: Empowerment Through HIV Information, Community and Services (ETHICS) 3 NYC</td>
<td>Provides medical and case management services to HIV-positive ex-offenders and their families</td>
<td>Ex-offenders and their family members</td>
<td>Primary medical care, discharge planning, case management, social support</td>
</tr>
<tr>
<td>University of Washington: Tri-County Collaboration: HIV/AIDS, Mental Health, Substance Abuse and Corrections Seattle</td>
<td>Integrates health care delivery to persons with multiple issues that include HIV, mental illness, chemical dependency, and a history of incarceration</td>
<td>Offenders, ex-offenders, the mentally ill, substance abusers; service providers</td>
<td>Primary medical care to clients; education and training to providers</td>
</tr>
<tr>
<td>Volunteers of America: Guiding Responsive Action for Corrections at End-of-Life (GRACE) Project In Jail Orleans Parish, LA, Alameda County, CA</td>
<td>Provides end-of-life care to terminally ill incarcerated people with AIDS</td>
<td>Incarcerated people with HIV/AIDS, ex-offenders with HIV/AIDS</td>
<td>Health care, palliative care, case management</td>
</tr>
<tr>
<td>The Miriam Hospital: Project Bridge Providence, RI</td>
<td>Promotes primary care utilization among inmates being released and to clients exiting drug detoxification programs</td>
<td>HIV-positive inmates upon release, HIV-positive clients exiting drug detox programs</td>
<td>Primary medical care, case management, outreach, social support, community outreach</td>
</tr>
<tr>
<td>Health Care for the Homeless: Diamond Project Baltimore</td>
<td>Augments existing services to provide access to primary care, support services, and housing</td>
<td>HIV-positive homeless people who are mentally ill and/or are substance abusers</td>
<td>Primary medical care, case management, substance abuse and mental health services, health education, social services assistance</td>
</tr>
<tr>
<td>Montefiore Medical Center Bronx, NY</td>
<td>Developing guidelines for providing palliative care to inmates with HIV/AIDS</td>
<td>Correctional health care providers</td>
<td>Will recommend appropriate palliative care services for the incarcerated population</td>
</tr>
<tr>
<td>Rollins School of Public Health of Emory University Atlanta</td>
<td>Implements the activities of the Evaluation and Program Support Center for projects dealing with HIV/AIDS among the incarcerated</td>
<td>Correctional facilities and state health departments that serve HIV-infected people, both incarcerated and released</td>
<td>Evaluates State-initiated programs; provides evaluation training and technical assistance for State grantees</td>
</tr>
<tr>
<td>Lutheran Social Services San Francisco</td>
<td>Combines stable shelter with on-site services to improve health and well-being of chronically homeless people (many who have histories of incarceration)</td>
<td>HIV-positive homeless adults who are substance abusers and/or mentally ill</td>
<td>Transitional housing; integrated services</td>
</tr>
<tr>
<td>Hampden County Correctional Center Ludlow, MA</td>
<td>Through partnership with local community health centers, provides health care to inmates, both in jail and post-release</td>
<td>Incarcerated people, post-release inmates</td>
<td>Complete medical and diagnostic care, based on public health model; uninsured enrolled in Medicaid for post-release</td>
</tr>
<tr>
<td>Cock County Children’s Hospital Chicago</td>
<td>Increases number of youth receiving both HIV counseling/testing and comprehensive medical/mental health services; testing used to reduce risky behaviors among youth; starting to conduct screenings in juvenile detention center</td>
<td>12- to 19-year-olds, both those in school and dropouts</td>
<td>HIV educational sessions (including counseling and testing) within community adolescent service agencies</td>
</tr>
</tbody>
</table>
Policy Development: CARE Act Funds Transitional Services

HRSA/HAB has recently conducted a study with the Federal Bureau of Prisons regarding the needs of persons living with HIV in corrections who are soon to be released. Results of the project and the experience of grantee's are informing the development of a formal policy that will clarify how CARE Act funds can be used to support transitional services for incarcerated persons.

The study focused on gaps in services faced by Federal inmates reentering the community. CARE Act funds cannot be used to provide services covered by other resources, but the study considered to what extent they can be used to provide transition services not available from other sources. The study concentrated on Federal inmates with HIV disease entering a community-based halfway house setting, but findings are applicable to inmates released from State, county, and local prisons and jails.

The study revealed that corrections staff often assist HIV-positive individuals who are about to be discharged. For example, a physician may make clinic appointments and establish community contacts for the inmate. Some case managers and social workers assist inmates with linkages to medical and social services. However, recently released inmates did not always enter the halfway house program with a 30-day supply of medications. Moreover, halfway house staff were often unaware of the HIV status of residents.

Authors of the study made the following recommendations:

Make release planning for inmates with HIV disease the primary responsibility of the unit management case manager with assistance from the medical staff.

Adjust current Bureau of Prisons policy to allow for more than a 30-day supply of medications.

Create appropriate linkages with the community, to begin during the release planning process. For example, CARE Act-funded programs in a community could link with release planners at Federal prisons.

Allow inmates to apply for Medicare and Medicaid while in Federal custody.

Create a community resource manual.

Increase prevention education and training for both staff and inmates.

Increase support for case managers at halfway houses.
HRSA Debuts First Clinical Care Guide on Women and HIV/AIDS

HRSA debuted an important new publication, *A Guide to the Clinical Care of Women with HIV*, at the XIII International AIDS Conference in Durban, South Africa.

More than 15,000 copies of the 400-page guide were given away during the Conference – 8,000 on the first day.

Edited by Jean Anderson, M.D., Johns Hopkins School of Medicine, the book includes 14 chapters written by women care providers on a range of topics, including primary medical care and prevention, HIV and reproduction, gynecologic problems, psychiatric issues, substance abuse, adolescents, and palliative and end-of-life care. The guide also includes an extensive list of resources.

The Women’s Guide is available online at www.hrsa.gov/hab. Single copies may be ordered from the HRSA Information Center by calling 1-800-275-4772.

This is a preliminary edition, and the HIV/AIDS Bureau invites your comments. Please send them to:

E-mail: womencare@hrsa.gov
Fax: "WomenCare" at 301-443-0791
Mail: WomenCare
HRSA/HAB
5600 Fishers Lane, Room 11A-33
Rockville, MD 20857

When the conference completed its work a final bill will be created. The bill and the conference report will then be sent to both Houses and, after passage, to the President for signature. It is unlikely that this process will be completed before mid-September.

Generally, key stakeholders in both the House and the Senate have given their respective bills strong support. However, certain provisions that are of concern are likely to be the focus of much discussion during the House-Senate conference. The House bill includes language on several issues not included in the Senate’s, for example: partner notification, perinatal transmission, data and evaluation, and activities with the CDC. Other provisions in the House bill expand representation of affected communities on planning bodies and favor using HIV surveillance data (not reported AIDS cases) as a basis for planning and funding. Finally, the hold harmless provisions for Title I EMAs differ between the two bills and will need to be resolved.

The bills are largely similar in the areas of planning, bringing people who are HIV-positive into care, services to women, quality management, and capacity building.

**To order publications, call: 1-888-ASK-HRSA**

**REMINDER!**

"Highlights from the XIII International AIDS Conference"
Satellite Videoconference
September 7, 2000
1:00 - 3:00 PM EDT
To register as a downlink site or for more information, visit http://www.tech-res-incl.com/hrsabroadcast

**HRSA Care ACTION**

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Please forward comments, letters and questions to:

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or by E-mail to: konelll@hrsa.gov

Downloadable Documents Available on the Web

HRSA’s Web site (www.hrsa.gov/hab) now has technical assistance documents for downloading. Items can be found under "Tools to Help CARE Act Programs TA Publications." Among the additions: Needs Assessment Guide; Outcomes Evaluation TA Guide; PLWH Sourcebook; Title I, II, and III Manuals; Evaluation Monographs; and National TA Call Reports.