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Opportunities for Action: Legislative and policy interventions to address HIV and prison health

Healthcare in prisons: A structural overview

The United States Federal Bureau of Prisons (BOP) is responsible for the oversight of health care in federal prisons. This agency provides health care through in-house medical providers, contracted medical providers, and medical providers assigned to BOP by the U.S. Public Health Service.

Healthcare and HIV in prisons: A fight for care and treatment

The fight for proper care and treatment in prisons has been long and difficult and despite some progress over the years, enormous gaps remain. HIV, tuberculosis and Hepatitis are among the most common infectious diseases in U.S. prisons.[1] According to the Bureau of Justice Statistics (BJS), about 1.5% of all inmates in state and federal prisons have HIV or AIDS.[2] This is 4 times the prevalence rate of HIV in the general population. The U.S. Centers for Disease Control and Prevention (CDC) also reports that up to 41% of inmates have ever been infected with Hepatitis C Virus (HCV) and up to 35% are chronically infected.[3] In the un-institutionalized population, HCV prevalence is 1-1.5%.[4] Disparities in HIV and HCV infection between incarcerated and non-incarcerated populations demonstrate inadequate access to care and treatment. HCV prevalence is also significant because it is linked to HIV. Both infections can be transmitted through unprotected sexual contact and injection drug use. Additionally, HIV-positive individuals are disproportionately affected by viral hepatitis; about one-third of HIV-infected persons are co-infected with hepatitis B virus (HBV) or HCV.[5]

Prison health before HIV

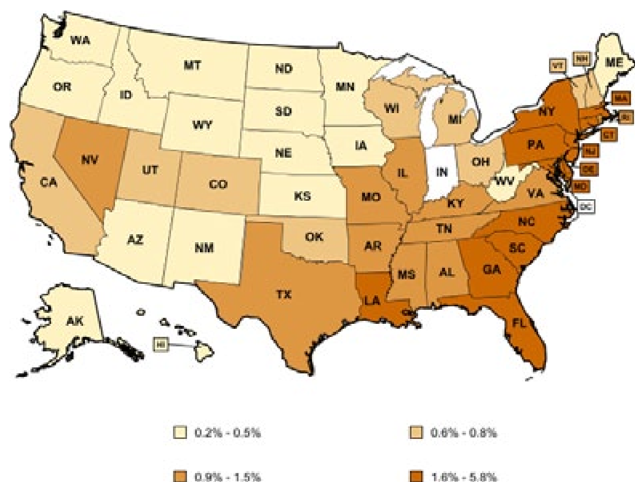
Decades ago, inmates at Attica prison in New York State rioted to demand better health care in August 1971. Soon after, in 1972, the Law Enforcement Assistance Administration of the Department of Justice (DOJ) commissioned a pilot program designed to improve health care in correctional facilities. An American Medical Association (AMA) advisory committee selected six states to receive funding for at least 2 years with a $448,000 annual grant to improve health care in jails and increase awareness of the challenges of doing so.[6] The six states were Georgia, Indiana, Maryland, Michigan, Washington, and Wisconsin. The AMA later established the National Commission on Correctional Health in 1983. Federal courts also asserted the need for proper care in prison. In Newman v. Alabama, a 1972 federal district court found the prison health conditions in Alabama to be a violation of the Eighth Amendment, since they were considered "cruel and unusual punishment." Similarly, Estelle v. Gamble found in 1976 that since inmates were not able to leave prisons to seek health care, they must receive it while incarcerated.[7]

HIV enters the landscape

However the onset of the HIV epidemic, coupled with a political and legislative climate that was hostile toward prisoner health, led to deterioration in health care. Prisoners increasingly faced obstacles to HIV medical care in correctional facilities. In November 1981, the first prisoner in New York was confirmed to have died from AIDS-related complications. By the early 1990s, two-thirds of all deaths of incarcerated persons in New York were AIDS-related.[8] Despite this, Jesse Helms' and other conservatives' cries against HIV treatment funding in the late 1980s and early 1990s made HIV care in prisons a marginally supported cause.[9] Some 7.4% of inmates in Northeast state prisons were known to be HIV-positive in 1993, a 22% increase from two years prior. Female inmates were significantly more likely to be living with HIV than male inmates. The number of inmates in state and federal prisons with an AIDS diagnosis increased 124% from 1,682 in 1991 to 3,765 in 1993. AIDS-related deaths in state prisons increased by 46% in the same period.[10]

As the 1900s progressed, the outlook for prison health only worsened. Starting in 1993, "three strikes" laws gained popularity across the U.S., eventually being implemented in 23 states and at the federal level. According to the statutes, those convicted of a serious offense on three or more separate occasions received a mandatory and extended period of incarceration. These laws were indicative of recent shifts in public opinion toward widespread fear and misunderstanding of crime. Using this fear, politicians were able to convince the public that increased incarceration meant greater safety, despite the fact that this was never proven (and may have proven just the opposite).[12] In line with this rhetoric, the health of prisoners was not a priority for most people. In 2000, the Federal Prisoner Health Care Copayment Act passed the House of

Inmates in Custody of State or Federal Prison Authorities with HIV or AIDS, 2008[11]



Representatives, which would charge prisoners co-payments on any health care they utilized. This bill never became law, but it was indicative of hostile attitudes toward prisoner health.[13]

Today, the future of HIV care in prisons remains uncertain. Many prisons subcontract their health care services out to private companies like Corrections Corporation of America (CCA), Wackenhut Corrections Corporation (WCC), and Cornell Corrections, with varying levels of quality.[14] Some companies implement measures such as electronic medical filing to reduce wait times for treatment and other improvements.[15] However, a 2008 Bureau of Prisons report identified structural problems in prison health, specifically in contracted prisons. According to the report, more than 10% of inmates did not receive the required health service for half of the preventive health services that were tested. A severe lack of regulation and monitoring on the part of federal officials was also reported.[16]

In order to provide adequate prevention services and HIV care in federal and state prisons, there remains tremendous work to be done. The following are some of the legislative measures that could improve access to care and treatment for people living with HIV in correctional facilities.

Second Chance Act

A 1994 BJS study found that 67.5% of prisoners released were rearrested within three years, and 46.9% were subsequently reconvicted. Overall, 51.8% of prisoners returned to prison within three years.[17] The cycle of incarceration and recidivism only serves to fuel the HIV epidemic by disrupting sexual relationships and ignoring substance use. Ensuring a reliable income and breaking addiction can also help an individual remain adherent to HIV medications. This will improve overall health and reduce the likelihood of transmission.

The Second Chance Act, signed into law in 2008, addresses the difficulties faced upon re-entry. In 2010, the Act funded 187 programs including education, court projects, mentoring, recovery support, and assistance to formerly incarcerated juveniles and adults in their transition back into communities. These programs address some of the root causes of HIV transmission for communities affected by incarceration. They set out to decrease the likelihood of recidivism by providing education and vocational training for better job availability, and addressing substance use and mental illness through counseling.[18] By attempting to stabilize a person's income and location, as well as making sure their physical and mental needs are addressed, programs can stabilize entire communities.

The Second Chance Act has tremendous potential to stop the spread of HIV in prisons and in communities affected by incarceration. Its potential can only be realized, however, if fully implemented. The Second Chance Act requires full federal funding to be effective in its goals, and 60 Representatives as well as 21 Senators have signed letters this year supporting such funding.[19] With further education and advocacy, communities can begin to reap the benefits of this necessary piece of legislation.

Prison Rape Elimination Act

Prison rape is another issue that exacerbates the spread of HIV in prisons and in communities affected by incarceration. In 2007, the Bureau of Justice Statistics (BJS) found that approximately 60,500 state and federal inmates (or 4.5%) had experienced at least one incident of "sexual victimization" by other inmates or staff, with the majority perpetrated by staff.[20] Recognizing this, Congress passed the Prison Rape Elimination Act (PREA) of 2003, which established guidelines for preventing and addressing rape in prisons, as well as data collection requirements and grant funding. Through the National Institute of Corrections, PREA provides resources for agencies and localities to fight prison rape. It also established a Prison Rape Elimination Commission (PREC), which researched prison rape and released an advisory report to the U.S. Attorney General in 2009.[21]

Prison Rape Elimination Commission (PREC)

The PREC advisory report offered a number of recommendations to directly address rape in prisons, which were reviewed by Attorney General Eric Holder. First, PREC recommended that prisons implement protocols to prevent rape and to respond to it in

a disciplinary manner. In addition, all prison staff, volunteers, and inmates should undergo training and education to recognize and respond to sexual violence in prison. This education should include ways in which rape can be prevented, and the message that such acts will not be tolerated. PREC also recommended that prisons have standards for investigation of rape claims, which should be followed in all circumstances.

The underlying issues that affect sexual violence were also addressed in the PREC report. It was recommended that medical and mental health staff receive training to recognize cases of sexual assault and to respond to rape cases. PREC strongly discouraged segregating vulnerable inmates from the rest of the prison population, and stated that they should be able to access the same services. The issue of sexual abuse by staff was also addressed, but it was only recommended that opposite-sex staff should not supervise inmates during activities in which they are partially or fully nude. The report failed to address same-sex sexual abuse. Finally, all facilities should record and report data about rape to BJS to be used in future policy writing.

This report was not without its faults. Many of the recommendations were vague, both in regard to whom they addressed within the prison system, and in regard to specific steps that could be taken to follow recommendations. The mandatory trainings to prevent rape do not include any information about sensitivity to sexual or gender differences, which tend to determine which inmates are the target of sexual violence (as even the report mentions). The staff requirements are particularly lacking, in that cross-gender supervision requirements do not address the specific needs of transgender or gender non-conforming inmates.[22]

In response to PREC's advisory report, Attorney General Eric Holder released a much weakened set of federal guidelines to respond to prison rape in January 2011. PREC had previously advised that independent auditors monitor correctional facilities, to ensure that they are following proposed standards. However, Holder has not adopted any requirement that facilities be monitored by an independent agency.[23] It is essential that this requirement stands in order to ensure that PREC's standards are being enforced and correctional facilities are adhering to these policies.

The Attorney General's guidelines have also been criticized since they maintain cross-gender pat-downs and exclude immigration detention facilities from the newly proposed standards.[24] The allowance of cross-gender pat-downs is problematic since it ignores continued sexual abuse perpetrated by staff.

As of the date of this report's publication, the Attorney General's finalized guidelines have yet to be released. The significant delay in the Attorney General's release of proposed and finalized guidelines has presented numerous challenges in moving forward with combating prison rape. Furthermore, it remains to be seen if the standards will adequately protect prisoners from sexual assault.

Stop AIDS in Prison Act

The Stop AIDS in Prison Act of 2011, led by Congresswoman Maxine Waters, addresses comprehensive HIV care and prevention in federal prisons on a structural level. The bill calls upon the Bureau of Prisons to take 11 concrete steps to combat HIV in prison, promote awareness, and improve medical care.[25] All testing and medical care would be required to be strictly confidential, with penalties for any breach of confidentiality.

The Act would include HIV testing as a medical service provided with consent during intake and within three months prior to release. Testing would also be provided upon request once per year, or following high-risk exposure or upon pregnancy. Prison personnel would be instructed to encourage high-risk inmates to be tested, and would be prohibited from using a request for testing as evidence of misconduct. Those who tested positive for HIV would have the option of "partner notification services." Inmates would be able to refuse testing at any time, for any reason, without penalty.

Inmates would also be entitled to comprehensive medical care in a timely fashion, with confidential consultations about managing the virus. The care would need to be consistent with standards set by the Department of Health and Human Services, and the Food and Drug Administration's (FDA) recommended medications would need to be readily available. Upon release, prisons would need to provide information about where to receive treatment and care in the community, as well as 30 days' worth of medication.

In addition, prisons would need to provide educational opportunities for inmates about transmission. This would involve working with a number of organizations, agencies, and well-informed inmates about how to provide culturally competent and accessible presentations, written materials and audio-visual resources in multiple languages. Within one year, the Bureau of Prisons would need to report to Congress on its policies to enforce the above provisions. Within two years, and every year after, it would also need to report incidence rates of sexually transmitted infections and intravenous drug use.[26]

The Stop AIDS in Prison Act was reintroduced in the 112th Congress, and more elected officials need to be alerted to its benefits. The bill effectively streamlines HIV testing while maintaining confidentiality in correctional facilities. Moreover, the legislation will provide the necessary HIV prevention services and treatment in order to improve HIV health care in prisons.

Detainee Basic Medical Care Act of 2008

In 2008 Senator Robert Mendez of New Jersey introduced the Detainee Basic Medical Care Act. However, there has been no movement on this issue in Congress since then. The Act would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees in custody and for other purposes. This legislation is critical to people living with HIV since current standards, and access to screening and care for HIV, is inadequate.

Every year almost 400,000 people are detained for immigration violations and are placed in state prisons, county jails, corporate detention centers, and some facilities run by U.S. Immigration and Customs Enforcement (ICE).[27] Little is known about the true impact of HIV among detainees or about medical care for detainees living with HIV. Furthermore, ICE is not mandated to report basic statistics on morbidity and mortality. Existing evidence provides grave cause for concern and suggests that detainees are denied the HIV screening and care they need. Immigration detention centers are notorious for poor living conditions. In fact, a 2008 *New York Times* article identified 66 individuals who died while in immigration custody from 2004 through 2007.[28] Nine of these detainees died due to HIV-related complications, often because they were denied HIV medication.[29]

Passage of this legislation would ensure that immigrant detainees receive fair and just treatment, including the critical medical care they need. The bill would set mandatory standards for care and require that all deaths be reported to the Justice Department and Congress.

The JUSTICE Act

Without uniform prevention, testing, and treatment programs, incarcerated persons living with HIV or other sexually transmitted infections can unknowingly infect others. Often left untreated, incarcerated persons with STIs are frequently in the more advanced stages of their disease, and once released can be even more costly for the public health system to treat. One outcome of the lack of a coordinated response to HIV is that among confirmed AIDS cases in prisons, minorities account for the majority, with African-Americans 3.5 times more likely than Whites, and 2.5 times more likely than Hispanics to die from AIDS-related causes.

In August 2011 Congresswoman Barbara Lee (D-CA) introduced H.R. 2704, The Justice for the Unprotected against Sexually Transmitted Infections among the Confined and Exposed (JUSTICE) Act. This legislation would allow prisons to provide condoms to incarcerated individuals. The JUSTICE Act also calls for automatic reinstatement or reenrollment in Medicaid for people who test positive for HIV before reentering communities. This action is of tremendous importance to public health since it would provide a comprehensive response to the spread of sexually transmitted infections in correctional facilities.

The REPEAL HIV Discrimination Act

The REPEAL HIV Discrimination Act, introduced by Congresswoman Barbara Lee in September 2011, addresses HIV criminalization and discrimination in state laws. The bill requires the Attorney General, the Secretary of Health and Human Services, and the Secretary of Defense to initiate a comprehensive review of all federal and state laws, policies, regulations, and decisions regarding criminal cases of people living with HIV.

At present, 34 states and 2 U.S. territories have criminal statutes based on “exposure” to HIV, and prosecutions for “exposure”, nondisclosure, and/or transmission of HIV have occurred in at least 39 states.[30] Those convicted have received charges including aggravated assault, attempted murder, and even bioterrorism. In several states, those convicted under HIV-specific statutes have also been forced to register as sex offenders, regardless of whether HIV transmission occurred. In Colorado, a man living with HIV was charged with assault with a “deadly weapon” after allegedly spitting on an electronic monitoring technician. This charge was later dropped to misdemeanor harassment. In Georgia, an HIV-positive woman was sentenced to eight years in prison and two years’ probation after allegedly failing to disclose her status during unprotected sex. During this trial, two witnesses testified that her partner knew about her HIV status, and she insisted that her partner knew due to a front-page article in a local newspaper that disclosed her status publicly.[31]

Although these laws were largely created in response to alleged deliberate intent to transmit HIV when little was known about transmission or risk, the laws do not reflect significant advancements that have been made regarding knowledge of exposure and transmission

of HIV. Oftentimes, sexual exposure — regardless of whether protection is used or risk is assessed — is punished just as severely as actual transmission. Criminalization of HIV therefore undermines public health initiatives that promote safer-sex practices and may discourage HIV testing and disclosure. Current policies ultimately promote fear and discrimination and further stigmatize people living with HIV.

Moving forward, the REPEAL HIV Discrimination Act is of great importance, since it encourages laws that "do not place unique burdens on individuals solely as a result of their HIV status and instead promote public health-oriented, evidence-based, and a medically accurate understanding of the factors surrounding HIV transmission."[32]

Personal Perspective

The Action Center is the client advocacy arm of the Public Policy department at GMHC. In Action Center meetings, members discuss and implement advocacy efforts pertaining to HIV-positive women, housing for people living with HIV, and other topics that are part of their everyday lives. On April 6, 2011, the Action Center organized a trip to Washington, D.C. to lobby federal legislators on several key issues. After being incarcerated, one Action Center member expressed the need for better HIV care and prevention in prisons in a letter to members of Congress as part of an Action Center lobbying day.

According to this Action Center member, who will be referred to as V.F. and whose full name will be kept confidential, sexual activity is very much a reality in correctional facilities, especially amongst same-sex inmates. V.F. was incarcerated between 2008 – 2009 at several correctional facilities in New York State, and witnessed similar realities at all the aforementioned facilities. Corrections officers cannot watch all inmates at every moment, and sex is very common. V.F. points out that HIV infection amongst female inmates is a growing problem, and women who enter the prison system may or may not know their serostatus or if they are carrying other sexually transmitted infections (STIs). They also may or may not be educated on how to prevent transmission of STIs, but even if they are, the structure of the prison system is one that discourages safer sex behaviors. Due to a lack of confidentiality from medical staff and corrections officers, most inmates are fearful of discussing their serostatus with staff or mentioning the need for condoms and dental dams.

V.F. recounts that in one case, two female inmates were sexual partners and their relationship was widely known among other inmates. One woman was known to be living with HIV, and was thought to have transmitted it to her partner. When the partner asked to be seen by medical staff for a yeast infection, other inmates began telling her and the staff that she had been infected with HIV. This information spread quickly throughout the facility, and confidentiality was completely absent.

Those living with HIV or other infections often do not disclose to partners due to the stigma, ridicule, and sometimes physical backlash that can be the result of a known infection. In addition to the barriers of stigma, confidential HIV testing is often unavailable in prisons. Inmates are reluctant to seek out testing for fear of numerous consequences if their status is revealed to others.

HIV treatment is often difficult to access, even when a prisoner's regimen is already determined. V.F. waited two weeks for access to medication, a period in which the immune system could be severely weakened by a gap in treatment. V.F. tried calling family members, offices of elected officials and prison investigators to seek help in accessing treatment. V.F.'s physician finally had to call the facility stating that she had the authority to determine her patient's proper medical care, and after she demanded it, the medication was made available.

V.F. also found that coercive sex and rape were common in these facilities, and increased the difficulty of navigating safer sex. Many male corrections officers would provide female inmates with goods in exchange for sexual favors, or would verbally harass inmates. When V.F. was the victim of such harassment in a work release program and asked the officer why he was doing this, he replied, "because I can." Other inmates advised V.F. not to report the harassment, despite other inmates having similar experiences, because of the risk that officers would delay release dates.

Conclusion

The proposed measures outlined in this brief provide a clear perspective on some of the legislative measures that could be taken to improve access to care and treatment for people living with HIV in correctional facilities. Prior and subsequent reports will continue to address the behavioral, institutional, and structural contexts of HIV in prisons. These reports can be accessed at GMHC.org.

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