

## HIV Prevention and Care for Incarcerated Populations

In the United States today, approximately two million people are incarcerated or on parole. Incarcerated populations are five times as likely to be living with AIDS and eight to ten times as likely to be HIV positive compared with the general population. Providing HIV prevention and care services to incarcerated populations may prevent new infections and keep people already living with HIV/AIDS healthy.

Community-based organizations (CBOs) are well positioned to provide HIV prevention and care services to incarcerated populations. In light of the fact that CBOs may provide services to ex-offenders after their release, it makes sense for CBOs to consider developing relationships with incarcerated populations prior to their release. Since 20% of people living with AIDS and 13-19 % of people living with HIV in the general population have been incarcerated at some time, incarcerated populations and their visitors are a viable audience for CBOs to reach with HIV prevention and care services.

The following are recommendations for CBOs seeking to become involved in meeting the needs of incarcerated populations. The recommendations summarize *Bringing Communities Together*, a forum AIDS Action convened on February 26-27, 2001, in cooperation with the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

### ▶ **ACKNOWLEDGE THAT CORRECTIONAL FACILITIES HAVE DIFFERENT PRIORITIES THAN CBOs**

In order to initiate and foster productive relationships, CBOs must recognize the ideological differences between themselves and correctional institutions and make an effort to bridge this divide. The primary responsibility of correctional institutions is to ensure public safety. CBOs can present themselves as a resource that can improve the health of incarcerated populations while maintaining the institution's security. By conducting a community needs assessment, CBOs can identify that there are HIV-related services that are not currently provided in the correctional facility. The needs assessment process enables CBOs to be viewed as a resource for needed services that the institution may not be able to provide as a result of financial or other considerations. For example, jails often do not make discharge planning available to inmates. A CBO case manager can facilitate referrals for inmates living with HIV/AIDS to receive medical care, housing, and supportive services upon release.

### ▶ **ENGAGE CORRECTIONAL STAFF**

Correctional staffs can make or break a CBO's access to incarcerated populations. Superintendents and sheriffs have the discretion to determine who is allowed into prisons and jails to provide services. Creating and maintaining open dialogue between all parties, while acknowledging the diverse perspectives of corrections and CBOs, can foster productive working relationships. Once a CBO has made that connection, correctional officers within the institution still have the authority to prevent CBO staff from conducting private meetings with inmates or even entering a facility on any given day. To ensure that inmates receive appropriate HIV information and care, CBOs need to maintain good relations with corrections staff. Delivering the promised services is essential to creating a trusting relationship with the correctional facility and its inhabitants.

### ▶ **PROVIDE SERVICES TO THE COMMUNITY BY TARGETING THOSE VISITING THE INCARCERATED POPULATION**

Family members and friends visiting incarcerated populations present an opportunity for CBOs to provide HIV prevention and care services. For example, CBOs or local health departments can provide HIV education, counseling and testing, and referrals during visiting hours. As a result of the disproportionately high rates of HIV/AIDS in incarcerated populations, the sexual partners of inmates and ex-offenders may be at particularly high risk of HIV transmission. CBOs can develop and implement HIV prevention programs to meet the needs of this population, particularly around negotiating safer sex and education about the risk of HIV infection during incarceration.

**▶ DEVELOP A CONTINUUM OF HIV PREVENTION AND CARE SERVICES FOR INCARCERATED POPULATIONS**

To the extent possible, CBOs should offer HIV prevention and care services to inmates from the time of initial orientation to a facility until the ex-offender is connected to services following release. The development of long-term relationships between CBO staff and inmates will promote consistent, coordinated care for incarcerated populations and encourage positive behavior change through stable relationships with care providers. HIV care programs should provide access to health care and medication for discharged inmates until alternative medical relationships can be established. CBOs should assist correctional health care providers in developing linkages with physicians, clinics, and pharmacies who will provide health care and support services to ex-offenders. CBOs may also accompany discharged inmates from the correctional facility to available housing to assist in the transition to life outside the correctional facility.

**▶ PROMOTE ACCESS TO VOLUNTARY HIV TESTING AND COUNSELING FOR INCARCERATED POPULATIONS**

Upon request, voluntary HIV testing and pre- and post-test counseling should be available to all incarcerated populations at no cost to the inmate. Ideally, rapid testing should be used to ensure that individuals receive their results prior to being discharged or transferred from a facility. Inmates are more likely to request HIV testing if they receive HIV education and counseling from CBOs or CBO-sponsored peer outreach programs. Institutions can encourage HIV testing through the provision of HIV education and counseling to all new inmates. CBOs can assist corrections by providing HIV related information during orientation sessions in correctional facilities and through ongoing HIV education and information sessions.

**▶ PROVIDE HIV PREVENTION AND EDUCATION IN AN EMPOWERING AND CULTURALLY COMPETENT MANNER**

Incarcerated populations are similar to other at-risk populations in their reluctance to participate in HIV prevention programs; however, due to their confinement, they may be more available to HIV prevention programs. Providing HIV education in the context of health improvement and empowerment may be more successful in appealing to incarcerated populations. For example, women's health programs have the potential to attract more clients than an HIV prevention program and therefore reach a greater audience. HIV education programs that incorporate the physical, emotional, and spiritual needs of program participants are most likely to be successful.

Due to the diversity found among incarcerated populations (e.g., ethnicity, language, gender, age, and length of prison stay), CBOs should design programs that effectively reach diverse audiences but also address the special concerns of incarceration. For example, because having sex in prison/jails is forbidden, CBOs may not be able to discuss condom usage to prevent HIV transmission inside the facility. Some CBOs who are involved with correctional facilities opt to hire ex-offenders and inmate-peer educators to provide HIV education and outreach, as these individuals have a greater understanding of the incarcerated population subculture.

**▶ IMPLEMENT DISCHARGE PLANNING PROGRAMS**

The more support offered to an ex-offender, the more likely he or she is to follow up with a first visit to a medical provider and to minimize risky behaviors. Individuals discharged late at night or on holidays to locations where drug dealers are available, such as bus stations in major cities, are at immediate risk for reverting to behaviors that may increase the risk of HIV transmission. CBO staff and peer educators can minimize these risks by meeting released inmates at the discharge location during daytime hours. CBOs should work with correctional institutions to develop policies where inmates living with HIV/AIDS are only released during reasonable hours.

Upon discharge, ex-offenders living with HIV/AIDS should have access to sufficient medication until their next medical appointment. Sometimes inmates are released with only one pill or a seven-day supply. CBOs can address these issues by completing applications for Medicaid and ADAP during a prisoner's final six months before release. Additionally, CBOs with relationships with pharmacists and medical providers can supply HIV medications until appropriate health care services can be accessed.

**▶ TAKE ADVANTAGE OF INCARCERATED POPULATIONS' ACCESS TO HEALTH CARE SERVICES AND ADVOCATE FOR THE BEST SERVICE AVAILABLE**

Incarcerated populations are the only Americans with a constitutional right to health care. Local prisons, jails, and correctional facilities have an invaluable opportunity to provide primary care, including voluntary HIV testing and care as well as other medical screenings. Access to medical treatment is of vital concern as many of these individuals may have traditionally experienced limited access to health care. All inmates should be medically stabilized and encouraged to improve their health and minimize risky behaviors by correctional health care providers and CBOs.

**▶ USE RYAN WHITE CARE ACT FUNDING TO DEVELOP PROGRAMS FOR INCARCERATED POPULATIONS**

The Ryan White Care Act is an important resource for CBOs who wish to provide HIV prevention and/or care to incarcerated populations. Three Title I cities and three Title II emerging communities receive funding as a result of the high rates of HIV incarcerated populations in those localities. Ryan White capacity building grants are available to support CBOs that work with incarcerated persons in order to assure a direct and immediate link to HIV services upon release.