Jails and prisons house populations with high HIV prevalence and high risk of transmission in a closed, "single-payer" health care system—a system in which medical care is constitutionally mandated and "directly observed therapy" is actually possible—yet HIV treatment in most U.S. prisons and jails lags behind treatment provided in the broader community. This article examines the challenges to providing adequate medical care to HIV positive prisoners and discusses new models of prisoner health care that can improve HIV treatment in U.S. prisons and jails.

HIV TREATMENT IN U.S.JAILS AND PRISONS

Mary Sylla, JD, MPH

The Eighth Amendment

Ironically, while medical care in jails and prisons is generally poor, prisoners are the only U.S. citizens with a constitutional right to medical care. The Eighth Amendment to the Constitution prohibits "cruel and unusual punishment" of prisoners, and the Supreme Court ruled in 1976 that "deliberate indifference to serious medical needs of prisoners" violates the amendment.

"Deliberate indifference" has been interpreted differently by various court cases in recent years. For example, in a 1997 case in New York State, the court ruled that a week-long hiatus from antiretroviral medication (during a prisoner's transfer to another facility) did not constitute deliberate indifference. In contrast, in the 2000 case of *Sullivan v. County of Pierce*, the Ninth Circuit Court ruled that medical providers had shown deliberate indifference when they refused to provide a protease inhibitor, which the jail's pharmacy did not stock, to an HIV positive prisoner whose usual antiretroviral regimen was interrupted by his arrest and imprisonment; the court stated that the treatment the patient received in jail was "far from the medical norm."

However, while health care is a prisoner's constitutional right, today there are no mandated guidelines or standards for correctional medical care. The American Correctional Association, the American Public Health Association, and the National Commission on Correctional Healthcare offer voluntary guidelines for correctional health care generally and HIV care in particular, but there is little incentive for correctional entities to comply with voluntary standards when the legal standard of deliberate indifference is much lower.

HIV and the Prison Explosion—Double Trouble

Nationally, the prisoner population is growing. Over the past 25 years, the number of prisoners in U.S. correctional facilities has increased by 400%. As a result, jails and prisons are overcrowded, and correctional staff—including medical staff—are in many cases faced with a near-impossible job: providing services on a limited budget to an ever-increasing population. This situation has particularly dire consequences for HIV positive prisoners.

And the number of U.S. prisoners living with HIV is alarmingly high—estimated at five to ten times that of the general population. As recently reported by the federal government, the rate of AIDS cases is three and a half times as great. Why does HIV appear to disproportionately affect prisoners?

In 1988, then-President Reagan signed the Anti-Drug Abuse Act, which created mandatory minimum sentences for drug-related crimes and allocated millions of dollars to the construction of new prisons. As a result, a conviction for selling five grams of crack cocaine suddenly meant a mandatory sentence of five years in prison. Today, as increasing numbers of people are sent to jail or prison for non-violent crimes, including drug-related offences and sex work, more and more prisoners are likely to have engaged in behaviors—such as needle sharing and unprotected sex—that put them at high risk for HIV infection.

In addition, the same risky behaviors occur inside. Although prohibited by state laws, sex and substance use do happen in correctional facilities—and they happen in the absence of condoms and sterile syringes, both of which are considered contraband in most U.S. jails and prisons. Although the majority of prison systems throughout Europe and Canada now permit condom distribution, only a handful of cities, counties, and states in the U.S. allow prisoners access to condoms. On October 15, 2007, California Governor Arnold Schwarzenegger vetoed the latest "prison condom bill" to hit his desk (although this time, he directed the California Department of Corrections and Rehabilitation [CDCR] to determine the "risk and viability of such a program" by establishing a pilot condom-distribution program in one state prison).

The high HIV prevalence among people entering jails and prisons and the high risk of HIV transmission inside contribute to the alarming numbers of prisoners living with HIV. Given the explosion of this high-prevalence population and the increasing complexity of medical treatment for HIV, it is not entirely surprising that medical care for HIV positive prisoners is inadequate.

Who Provides Prisoner Health Care?

Correctional facilities are legally required to provide medical care, but how they go about it varies by jurisdiction. The National Commission on Correctional Health Care recommends that the custody and medical services of a prison or jail belong to separate entities, with distinct departments and reporting structures—that is, the same person who is primarily responsible for keeping you locked up should not also be responsible for compassionately caring for your medical needs.

However, in many prisons and jails, the incarcerating authority directly manages prisoner medical services: doctors report to wardens in prisons and captains in jails. One exception is the San Francisco County jail system, in which the San Francisco Department of Public Health is responsible for medical services. A similar arrangement has been suggested in Los Angeles County, but may prove prohibitively expensive: the L.A. County Department of Public Health has projected costs three times greater than what the Sheriff's Department currently spends on prisoner health services.

Exploding prisoner populations and increasingly complex medical care—including pricy combination antiretroviral regimens—mean that prisoner health care costs are continually

rising. Most states have turned to for-profit managed-care companies to provide some portion of their prisoner health care services. Two major corporations, Prison Health Services and Correctional Medical Services, provide prisoner medical services in 43 states and account for 25% of dollars spent on prisoner health care.

While of obvious appeal to jail and prison administrators with little or no background in managing medical services systems and personnel, the delegation of prisoner medical care services raises serious concerns. For any business to make a profit, money earned must exceed money spent, and in correctional settings the aim of controlling costs becomes a risk analysis based on the ability of prisoners to bring and win constitutional claims for violation of their Eighth Amendment rights. Some managed care companies even advertise such "risk management" benefits as "reduced client liability and exposure to inmate lawsuits" as part of their services.

This focus on avoiding the costs of legal challenges ignores the humanitarian and public health functions that prisoner health care can and should serve. And the risk analysis is inevitably weighted in favor of the corporations: poor, undereducated, and/or physically or mentally ill prisoners face huge barriers to successfully engaging in constitutional litigation to secure their rights to medical care.

Obstacles to Adequate HIV Medical Care for Prisoners

Providing medical care in a correctional environment is admittedly challenging. Joseph Bick, MD, Chief Medical Officer at the California Medical Facility in Vacaville, notes that many clinicians in correctional settings must work without such basic equipment as sinks and exam tables. Others must rely on old-fashioned paper charts rather than electronic medical records and have little or no access to computers or other efficient tools for managing appointments and tracking patients' medical histories. Correctional medical service providers are often isolated both geographically and professionally, which limits their access to continuing medical education, information about new HIV drugs and treatment regimens, and HIV specialists for consultation. Isolation also contributes to professional burnout.

Recruiting health care professionals to work in correctional facilities is another challenge. The pay is often lower than in community settings; for example, prior to a court-ordered intervention a year ago, the CDCR paid nurses 20% to 40% less than they would earn in the private sector, and supervisory nurses receive less than half the salary of private-sector nurses with comparable responsibilities. Combined with the challenging work environment and nurse shortages throughout the country, it is difficult to understand why any nurse would take a prison job! Indeed, at some California institutions, as many as 80% of the registered nurse positions were vacant in late 2006, leaving few medical staff to deliver countless pills throughout the day to patients on combination antiretroviral therapy.

In addition, medical professionals who do get recruited are not always the cream of the crop. While some are truly dedicated health care providers who struggle to maintain adequate standards of care, CDCR clinicians in many cases have had privileges revoked from hospitals, and approximately 20% have some disciplinary record or a malpractice settlement.

Finally, the security measures inherent to jails and prisons are themselves an obstacle to continual, competent care. Medical needs are often screened by nurses who walk through rows of cells or address large dorms of prisoners in a non-confidential "sick call" procedure, leaving HIV positive prisoners open to discrimination from other prisoners. Missed or delayed medications are frequent consequences of court hearings or being sent to administrative segregation, and secure transfers to and from facilities—including medical clinics—are time consuming and fraught with potential for delayed treatment, missed medications, and, hence, the development of drug resistance.

All of these difficulties threaten the health of HIV positive prisoners on complex antiretroviral regimens, in addition to limiting the number of patients who can realistically expect to see a correctional medical service provider and the quality and quantity of time prisoners can spend with a nurse or clinician.

Correctional medical providers themselves recognize the deficiencies in the HIV care provided in jails and prisons. Kathleen Bernard of Brown University and colleagues conducted a survey of correctional medical service providers attending the 2005 National Commission on Correctional Healthcare Conference, and they report some alarming statistics. For example, 38% of correctional care providers surveyed said that an HIV specialist is never available to see patients at the facility where they work, and only 65% of correctional medical providers reported that viral load testing is available for monitoring disease progression. By these commonly accepted standards of HIV medicine, the care provided by the correctional facilities surveyed is woefully inadequate.

Controversy and Change

In some places, attempts to provide quality medical care have created other problems and controversy; segregation of HIV positive prisoners, mandatory testing, and challenges to continuity of care during incarceration demonstrate the complexity of providing HIV care in a "lock down" environment, and how, as HIV treatment changes, prisoner health care needs to change as well.

Segregation vs Clustering for Care

Segregating HIV positive prisoners was, for many years, seen as a way to improve treatment and prevent trans-

mission to prisoners who were HIV negative. (Ironically, while this practice acknowledged that high-risk behavior occurs between prisoners, condoms were and are still considered contraband in most U.S. facilities.) Of course, this arrangement worked only in prison systems with mandatory HIV testing; in facilities which segregated but did not require testing, the segregation itself served as a disincentive to be tested or voluntarily disclose HIV status.

For nearly 20 years, the Alabama Department of Corrections' segregation policy denied HIV positive prisoners access to rehabilitative programs. Repeated lawsuits and appeals filed by the American Civil Liberties Union failed; the courts ruled that any risk of HIV transmission posed a significant threat to the general prison population and warranted segregated housing and exclusion from educational and vocational training. Not until 2004, following years of advocacy, legal challenges, and an investigation by the Alabama Governor's HIV Commission for Children, Youth and Adults, was the segregation policy reversed. Similarly, Mississippi re-integrated its rehabilitative programs in 2001, after providing comprehensive HIV/AIDS education to prison staff and prisoners.

In California, the controversy over segregation first played out in a unit of the California Institution for Men in Chino. In the late 1980s, a unit called "Del Norte" was designated for HIV positive prisoners to provide palliative care, effectively serving as a hospice for the ill and dying. Special social services were also provided, and the unit served a valuable purpose for the population.

The Del Norte unit was still in use in 2000, however, despite vast improvements in HIV medical care and the consequent improvements in the health of HIV positive prisoners. Prisoners segregated into Del Norte continued to be excluded from the vocational and educational opportunities available to the general prison population. Because participating in work and school in prison reduces a prisoner's sentence, HIV positive prisoners in Del Norte were serving longer sentences than they would have otherwise. Thanks to advocacy by the Center for Health Justice and the San Quentin–based Prison Law Office, the institution was desegregated in late 2002. HIV positive prisoners are now housed with others based on medical needs and security level, not simply HIV status.

At the California Medical Facility in Vacaville, HIV positive prisoners are similarly "clustered for care" based on medical need. Because the entire facility is for prisoners with special medical needs, educational and work opportunities are not categorically limited there. And given the dearth of high-quality HIV medical service providers in the prison system as a whole, it makes sense to house HIV positive prisoners where the medical staff is best able to provide competent treatment. Largely because of the care provided by Chief Medical Officer Joseph Bick, this facility is recognized as one of the nation's best medical units for HIV positive prisoners.

Mandatory HIV Testing

Of course, early diagnosis is key to effective treatment, and in most correctional facilities this public health intervention opportunity is missed. Given that the measured prevalence of HIV among prisoners is higher than the Centers for Disease Control and Prevention's "high prevalence" definition of 1%, and that the U.S. Preventive Services Task Force recommends routine testing for high-prevalence populations, the wisdom of encouraging testing in jails and prisons is obvious. However, the stigma associated with HIV is an even bigger problem in jails and prisons than in the broader community, because confidentiality is almost non-existent.

In the U.S., 19 state prison systems and the federal prison system have some form of mandatory HIV testing in place (in the federal prison system, it is reserved for cases of suspected transmission). Nationally, legislators are proposing bills to increase testing in state and federal prisons. In April 2007, Representative Maxine Waters (D-CA) introduced a bill that would require testing of federal prisoners upon entry and exit, with an "opt-out" provision (although it is debatable whether prisoners, confined in an environment characterized by lack of choice, will be consistently able to exercise their right to opt out of testing). The bill was passed by the House of Representatives on September, 25, 2007; it now awaits a Senate sponsor.

HIV testing of prisoners is likely to remain a high-profile issue, and testing may become highly federally subsidized: in his State of the Union address in January 2006, President Bush proposed to direct approximately $20 million to programs for prisoner testing, offering assistance to state and local jurisdictions to encourage increased testing of prisoners. Response to this issue will be an interesting gauge of the HIV advocacy community's commitment to voluntary testing.

Continuity of Care

HIV medical care, particularly medication adherence, often falls apart when an individual is arrested and enters the correctional system. Police stations and detention centers may be unable to provide antiretroviral medications, and people entering jail are often, for many reasons, unable or unwilling to communicate their HIV status and medical needs. An arrest or transfer to a new facility always carries the risk of a disruption in medical care—a grave danger in particular for individuals taking HAART, for whom a treatment interruption may mean the development of drug-resistant HIV and the threat of decreased drug potency or the loss of entire antiretroviral classes as treatment options.

Some innovative attempts to remedy this situation have been successful. In Los Angeles County, for example, Sheriff's Department stations now

allow recent arrestees to have their antiretrovirals brought to the station, and if the drugs can be confirmed as HIV medication (by comparing them to an illustrated pharmaceutical chart), detainees are allowed to take them.

Transitional services organizations help to ensure continuity of care for individuals exiting the prison system. These programs, such as the Transitional Case Management Program (TCMP), help former prisoners find medical treatment and other supportive services before the limited supply of HIV medications they received upon release from prison runs out.

Conclusion: Prisoner Health is Public Health

Isolated elements of better prisoner health care systems offer hope, but to truly provide the community standard of care to HIV positive prisoners, we need to bring community medical service providers into our prisons and jails.

This approach has been tried, and with success. In Hampden County, Massachusetts, doctors, nurses, and case managers are brought into the county jail to treat prisoners—a model for providing HIV medical services that has improved care and also resulted in a cost savings to the community. The Sheriff and Chief Medical Officer view the period of incarceration as a public health intervention opportunity and recognize that diagnosing and treating HIV positive prisoners protects public health and reduces costs to the community down the line. Continuity of care is emphasized and made far easier by the fact that the community medical service providers who care for former prisoners are the same people who treated them in jail. Discharge planning programs assist prisoners in accessing government benefits and social services on the outside, further supporting improved medical outcomes.

A variation on this model is partnering an academic medical center with a correctional system. In Rhode Island, Brown University Medical School provides care to all of the state's prisoners. Likewise, the University of Texas provides medical care to HIV positive prisoners in the state's correctional system. An obvious advantage of this arrangement is that prisoner medical care is provided by clinicians with access to the latest research on HIV treatment. These clinicians also rotate through the prison system and work in community settings as well, thereby avoiding the burnout so often experienced by some geographically and professionally isolated prison doctors.

Other developing models would serve the same goal. In California, where prisons are increasingly located in rural areas and the Central Valley, cash-strapped rural medical systems are beginning to explore joint projects with the CDCR. The exciting potential for a win-win-win-win exists, with benefits for rural and correctional health care systems, prisoners, and the community.

These models recognize—as must any long-term strategy for improving HIV care for prisoners—that in a nation where we incarcerate increasingly greater numbers of people for less serious offenses, and where many repeatedly cycle in and out of corrections, it is unwise and short sighted to think of prisoners as a population separate from the community. Indeed, it is estimated that one quarter of people living with HIV in the U.S. have been in jail or prison at some time. The truth is that poor prisoner health care—including inadequate HIV treatment—affects everyone, and our best strategy is to treat prisoner health as public health.

Mary Sylla, JD, MPH, is the founder and Director of Policy & Advocacy for the Center for Health Justice. She has worked on HIV and incarceration issues for the past 10 years, and now leads the organization's research and policy work and heads its Northern California operations.

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If you were incarcerated, would you take an HIV test?

Mary Sylla posed this question to a panel of national experts at a public forum, "Preventing HIV in Prisons and Jails"—and the answers might surprise you! The forum, in which panelists and audience members grappled with the challenges—both practical and political—of preventing HIV among incarcerated people, was part of the San Francisco AIDS Foundation's HIVision series. To view a webcast of this forum, hear a recording, read a transcript, or learn about past and future HIVision events, visit ***www.sfaf.org/hivision/prisons.html.***