

Just punishment? HIV infection and AIDS in correctional facilities

Men and women incarcerated in correctional facilities make up one of the highest risk population groups for HIV infection and AIDS. Consequently, correctional staff (health care providers, counsellors, teachers and correctional officers), because of their contact with these offenders, are also at risk.⁽²⁾

Various strategies have been implemented in an effort to prevent and control HIV infection and AIDS among offenders. However, debate continues on the necessity for and effectiveness of any or all of these strategies. In fact, some government officials and correctional administrators insist that "there is no problem," that HIV infection in correctional facilities "has been blown out of proportion, and that "if the situation is so bad, how come we don't have more offenders with AIDS in correctional facilities?" Unfortunately, still others seem to feel that offenders deserve whatever problems they encounter.⁽³⁾

This article briefly discusses the main strategies that have been proposed or implemented in an effort to prevent and control the spread of HIV infection and AIDS among incarcerated offenders in North America and evaluates the effectiveness of these strategies. Such an evaluation is vital to community corrections because the large majority of incarcerated offenders will eventually be returned to the community. The problem Cases of AIDS have been reported in correctional facilities throughout western Europe and North America since the early 1980s. In fact, HIV-positive rates reported for offenders are extremely high compared with those reported for the general population.⁽⁴⁾

It is now increasingly being recognized that correctional facilities have one of the highest concentrations of people at risk of, or living with, HIV infection or AIDS.⁽⁵⁾ AIDS is currently the leading cause of death among offenders in many correctional jurisdictions,⁽⁶⁾ and this number continues to rise.⁽⁷⁾ It is predicted that AIDS will be the leading cause of offender death in North America by the year 2000.⁽⁸⁾

Why?

The increasing and exceedingly high HIV-positive rates among offenders (compared with the general population) are primarily the result of their involvement in high-risk behaviours, such as anal intercourse, sharing needles, tattooing and body piercing (for ear, nose, navel and nipple rings). For various reasons, offenders generally engage in more of these high-risk behaviours than do people in the general population and engage in them more frequently.⁽⁹⁾ The risk is then compounded because offenders are confined with other offenders, who are themselves at greater risk.

In an attempt to begin dealing with this increasingly serious problem, several correctional facilities have implemented a number of specific strategies. The following is a discussion of five principal strategies that have been recommended or implemented in an effort to deal with the escalating incidence of HIV infection and AIDS in correctional facilities. Giving condoms to offenders A significant amount of homosexual activity occurs among male offenders in correctional facilities.⁽¹⁰⁾ Anal intercourse is commonly recognized as the highest risk sexual behaviour related to the transmission of HIV infection, therefore several AIDS prevention programs have recommended giving condoms to offenders in an attempt to decrease the risk of HIV transmission.⁽¹¹⁾ However, there are a number of problems with the

effectiveness of condoms in preventing the transmission of HIV infection. Condoms often fail because of breakage, leakage or slippage during sexual intercourse.⁽¹²⁾

The actual use of condoms also presents problems in the correctional setting. It is highly unlikely that anal intercourse, which is part of the social psychology of male dominance within correctional facilities (gang rape or forcing a physically weaker or new inmate to be a "punk" or "girl" for a stronger inmate or group of inmates),⁽¹³⁾ would be accompanied by the use of a condom.⁽¹⁴⁾ Use of a condom might be construed as a sign either of weakness (such as a fear of AIDS) or of undue concern for the punk." Therefore, for both of these reasons, supplying condoms to incarcerated offenders is not recommended as an effective strategy for the prevention of HIV infection. Providing sterile injection equipment Provision of sterile injection equipment has been widely used in communities throughout Europe, and needle/syringe exchange programs have been implemented in several high-risk community settings across Canada and the United States (including Edmonton, Montreal and New York) with some preliminary promising results.⁽¹⁵⁾ However, needle/ syringe exchange programs have also been strongly opposed, and their overall effectiveness has been seriously questioned.⁽¹⁶⁾

Intravenous drug use is a routine practice among offenders in many correctional facilities.⁽¹⁷⁾ Therefore, serious thought should be given to implementing research-based programs aimed at decreasing intravenous drug use in correctional facilities and to the possible interim provision of sterile needles and syringes for offenders who inject drugs.

However, until there are adequate safeguards to prevent offenders from using needles as a source of barter or weapons, needle exchange programs within correctional facilities are not recommended. In the interim, appropriate educational, detoxification and treatment programs are necessary and should be made available to incarcerated offenders who would like to discontinue their intravenous drug use. Availability and continuity of these programs should be ensured both within correctional facilities and in the community. Universal precautions The application of universal precautions means treating all offenders as if they were HIV positive and taking appropriate safeguards (such as the use of gloves when there may be contact with another person's body fluids) to prevent the accidental transmission of the virus to correctional staff. However, even universal precautions cannot provide 100% protection against HIV infection. For example, a person can become infected from accidental or deliberate injuries with an HIV-infected needle.⁽¹⁸⁾ Mandatory HIV testing As a minimum standard, there should be mandatory HIV testing of every sentenced offender upon incarceration in a correctional facility. Offenders should be retested after three months (to ensure that the first test was an accurate reflection of HIV infection status) and whenever there is a specific reason to suggest that the offender's HIV status may have changed (such as physical symptoms or evidence that a previous sexual or needle-sharing partner has become HIV positive). The newly incarcerated offenders would have to be segregated during the initial three months of incarceration to ensure that they don't engage in any high-risk activity (which could infect others or themselves).

Now that safe and reliable saliva tests for HIV are available, the discomfort and slight risk associated with obtaining blood samples for HIV testing have been entirely eliminated.⁽¹⁹⁾ Segregation of HIV-infected offenders Segregation from the general inmate population (or medical quarantine) of HIV-

positive offenders has been used in several correctional facilities in the United States and Canada (segregation may also include the termination of conjugal visits to prevent the possible spread of HIV infection to and from the community).⁽²⁰⁾

However, segregation significantly affects fundamental human rights and must, therefore, only be undertaken, even in correctional facilities, after careful consideration of the rights of the individual offender and the potential risks and benefits to others.

Even then, who should be segregated? Any offender testing HIV positive? Any offender with AIDS? Only offenders testing HIV positive, or with AIDS, who are "irresponsible" in their behaviour, posing a significant threat of transmitting HIV to others?

In addition to concerns about human rights, segregation also raises questions about the allocation of institutional space, staff and financial resources.

Having stated these concerns, we emphasize that segregation of HIV-infected offenders, while considered drastic by some,⁽²¹⁾ is the policy that offers the best chance of controlling HIV infection in correctional facilities. Segregation is absolutely necessary if the spread of HIV among offenders in correctional facilities or to families, friends and other community contacts is to be controlled.

Segregation best serves HIV-infected offenders by placing them in a facility that recognizes and can better meet their physical and psychological needs. It best serves non-infected offenders by protecting them from HIV infection during their incarceration. It best serves correctional staff by limiting the number of staff who have direct contact with HIV-infected offenders to those who are aware of the risk and who have the education and training necessary to take appropriate precautions. Finally, segregation best serves the community by helping to prevent the spread of HIV among offenders before they are paroled or released. Recommendations Our recommended approach to preventing the spread of HIV and AIDS in correctional facilities involves the following:

- the provision of appropriate educational programming on the nature, transmission and prevention of HIV infection and AIDS for incarcerated offenders, their families and community contacts, and correctional staff;
- mandatory HIV saliva testing for all sentenced offenders upon incarceration; and
- the use of appropriate forms of segregation to protect both incarcerated offenders and correctional staff from infection by HIV-positive offenders.

Although far from a definitive solution to the problem of HIV infection and AIDS in correctional facilities, implementation of these measures would be a good starting point.

To ignore the problem of HIV infection and AIDS within Canadian correctional facilities would be negligent and inhumane. Lack of immediate and adequate attention to this very real and significant threat will result in unjust punishment for many offenders incarcerated in correctional facilities, their families, friends, other community contacts, and a significant number of correctional staff.

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- (1) Substance Abusology Research Unit, University of Alberta, 500 University Extension Centre, 8303-112th Street, Edmonton, Alberta T6G 2T4.
- (2) L. Pagliaro and A. Pagliaro, "Sentenced to Death? HIV Infection and AIDS in Prisons - Current and Future Concerns," *Canadian Journal of Criminology*, 34 (1992): 201-214.) See also L. Pagliaro, "The Straight Dope: Focus on Prisons," *Psynopsis*, 13 (1991): 8.
- (3) Pagliaro and Pagliaro, "Sentenced to Death? HIV Infection and AIDS in Prisons - Current and Future Concerns." See also Pagliaro, "The Straight Dope: Focus on Prisons."
- (4) L. Coates, "Coming to Grips with Substance Abuse in the Federal Prison System," *CCSA Action*, 2 (1991): 6-9. See also A. Falkenrodt, G. Schwartz, M. North, et al., "Explorations biologiques et recherches de deficits immunitaires chez les connerus de sang en milieu carceral," *Revue française de transfusion et immuno-hematologie*, 27 (1984): 525-529. And see M. Goldsmith, "Inescapable Problem: Aids in Prison [News]," *Journal of the American Medical Association*, 258 (1987): 3215. And see G. Wormser, F. Duncanson, L. Krupp, et al., "Acquired Immune Deficiency Syndrome (AIDS) in Prison Inmates - New York, New Jersey," *Morbidity and Mortality Weekly Report*, 31 (1983): 700-701.
- (5) R. Shore, "HIV/AIDS on the Inside," *Canadian AIDS News: The New Facts of Life*, 5 (1992): 7-16. See also Pagliaro, "The Straight Dope: Focus on Prisons."
- (6) D. Morse, B. Truman, J. Mikl, et al., "The Epidemiology of AIDS Among New York State Prison Inmates," abstract, *International Conference on AIDS*, 5 (1989): 761.
- (7) T. Brewer and I. Derrickson, "AIDS in Prison: A Review of Epidemiology and Preventive Policy," *AIDS*, 6 (1992): 623-628.
- (8) L. Pagliaro, "The Straight Dope on HIV Infection and AIDS in Prisons," Alberta Solicitor General Provincial Corrections Conference, Edmonton, Alberta, May 1991. See also Pagliaro and Pagliaro, "Sentenced to Death? HIV Infection and AIDS in Prisons - Current and Future Concerns." And see Pagliaro, "The Straight Dope: Focus on Prisons."
- (9) Pagliaro, "The Straight Dope on HIV Infection and AIDS in Prisons." See also A. Pagliaro, L. Pagliaro, P. Thauberger, et al., "Knowledge, Behaviors, and Risk Perceptions of Intravenous Drug Users in Relation to HIV Infection and AIDS: The PIARG Projects," *Advances in Medical Psychotherapy*, 6 (1993): 1-28.
- (10) P. Nacci and T. Kane, "The Incidence of Sex and Sexual Aggression in Federal Prisons," *Federal Probation*, 47 (1983): 31-36. See also W. Wooden and J. Parker, *Men Behind Bars: Sexual Exploitation in Prison* (New York: Plenum, 1982).
- (11) J. Greig, *AIDS: What Every Responsible Canadian Should Know* (Ottawa: Canadian Public Health Association, 1987). See also A. McMillan, "HIV in Prisons: Action, Research, and Condoms Needed," *British Medical Journal*, 297 (1988): 873-874.) And see D. McCaskill and M. Thrasher, *Joint Committee on Aboriginal AIDS Education and Prevention: Final Report on AIDS and Aboriginal Prison Populations* (Indian River, ON: Thrasher Consultants, 1993).
- (12) M. Fischl, "Prevention of Transmission of AIDS During Sexual Intercourse," *AIDS: Etiology, Diagnosis, Treatment, and Prevention* (2nd ed.), V. DeVita, S. Heilman and S. Rosenberg, eds. (Philadelphia: J.B. Lippincott, 1988). See also L. Pagliaro and A. Pagliaro, *Results of the PIARG Major Study*, in press.

- (13)N. Chonco, "Sexual Assaults Among Male Inmates: A Descriptive Study," *The Prison Journal*, 69 (1989): 72-82. See also H. Eigenberg, "Male Rape: An Empirical Examination of Correctional Officers' Attitudes Toward Rape in Prison," *The Prison Journal*, 69 (1989): 39-56. And see N. Smith and M. Batiuk, "Sexual victimization and Inmate Social Interaction," *The Prison Journal*, 69 (1989): 29-38.
- (14)R. Jurgens, *HIV/AIDS in Prisons: A Working Paper of the Expert Committee on AIDS and Prisons* (Appendix 1) (Ottawa: Correctional Service of Canada, 1993).
- (15)K. Fournis, "Montreal AIDS/IV-Use Hot Spot," *The Journal*, 1 (April 1991).
- (16)Pagliaro, Pagliaro, Thauberg, et al., "Knowledge, Behaviors, and Risk Perceptions of Intravenous Drug Users in Relation to HIV Infection and AIDS: The PIARG Projects."
- (17)S. Gore and A. Bird, "No Escape: HIV Transmission in Jail," *British Medical Journal*, 307 (1993): 147-148. See also M. Gaughwin, R. Douglas, C. Liew, et al., "HIV Prevalence and Risk Behaviours for HIV Transmission in South Australian Prisons," *AIDS*, 5 (1991): 845-851. And see A. Bird, S. Gore, S. Burns, et al., "Study of Infection with HIV and Related Risk Factors in Young Offenders' Institution," *British Medical Journal*, 307 (1993): 228-231.
- (18)L. Michaelson, "N.Y. Shouldn't Contest a Court's Decision for a Nurse with AIDS," *RN*, 55 (November 1992): 8. See also P. Jones, "HIV Transmission by Stabbing Despite Zidovudine Prophylaxis," *The Lancet*, 338 (1991): 884.
- (19)R. van den Akker, I. Van den Hoek, W. Van den Akker, et al., "Detection of HIV Antibodies in Saliva as a Tool for Epidemiological Studies," *AIDS*, 6 (1992): 953-957.
- (20)C. Clements, "AIDS and Offender Classification: Implication for Management of HIV-Positive prisoners," *The Prison Journal*, 69 (1989): 19-28. See also The Canadian Press, "Inmate on Hunger Strike over Segregation for HIV," *The Edmonton Journal*, July 19, 1992.
- (21)E. Jurgens, *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons* (Ottawa: Correctional Service of Canada, 1994). See also McCaskill and Thrasher, *Joint Committee on Aboriginal AIDS Education and Prevention: Final Report on AIDS and Aboriginal Prison Populations*.