HIV In Correctional Settings: Implications for Prevention and Treatment Policy
amFAR
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MONICA RUIZ, PhD, MPH: —today's briefing on HIV in correctional systems, before we begin I'd like to thank Congresswoman Barbara Lee for her advocacy and her leadership on HIV/AIDS issues and particularly for her focus on communities of color and correctional systems. I would also like to thank Christos Psentas, the legislative director in Congresswoman Lee's office, for helping us with for arrangements for today and I'd like to invite him up right now to say a few words of welcome on behalf of Representative Lee.

CHRISTOS PSENTAS: Hello. Good afternoon. I just want to thank you all for being here and thank amFAR for putting on the event. Congresswoman Lee was unable to join us, she is actually on her way back to D.C. for the starter session.

But I did want to take the time and just say that this is an important issue for our office and for the congresswoman. It's something that she would like to address if we can in this session of congress and if not plan for next year taking a very aggressive and active approach to dealing with HIV and frankly other STIs in correctional facilities throughout the country.

We have legislation, which you may or may not be aware of, HR178, the justice act, to help really revamp our approach to sexually transmitted infections in correctional institutions. First of all, we encourage the provision of

condoms in federal prisons and we encourage states to take steps to do the same. But we also require the development of a five year strategy and plan to reduce the spread of STIs in all correctional facilities throughout state, federal and territorial settings.

So we hope you will take a look at the bill and consider supporting it and lending your organization or your members name to the bill. So I just want to thank again our panelists and Monica and Elijah for putting this together. Thanks.

MONICA RUIZ, PhD, MPH: Thank you so much, Christos. We are very glad to have you with us today and for your and Mrs. Lee's attention on these very critical issues. I would also like to thank the Kaiser Family Foundation for webcasting this briefing. I can tell you that you have the face of many of our colleagues that are not able to be here today to attend in person.

This is the second of amFAR's AIDS 2020 emerging issues briefing series. The purpose of the briefing series is to raise the awareness of policy makers, advocates, the media and the general public about critical issues that must be addressed if we are to make substantial progress in ending the AIDS epidemic. In conjunction with today's briefing, we are releasing amfAR's latest issue brief "HIV in Correctional

Systems: Implications for Prevention and Treatment Policy." Copies of this document and the summery of recommendations which are just inside are available on the table outside of this room and they will also be available on our website, www.amfar.org.

The U.S. Correctional System is facing critical challenges as the number of incarcerated people continues to grow. At the end of 2006 there were nearly 2.26 million inmates in state, federal and local correctional facilities a rate of 751 inmates per 100,000 U.S. residents. This is a record high for the U.S. and the highest incarceration rate in the world.

These numbers were updated when a recent P-report found that for the first time in history more than one in every 100 adults in America is now confined in jail or prison. Communities of color are disproportionately represented in the correctional system, dated from the Bureau of Justice statistics show that approximately 60-percent of inmates in state and federal prisons with sentences of longer than one year are African American or Latino.

HIV AIDS has had a disproportion impact on incarcerated populations in the U.S. Currently all U.S. state correctional facilities have reported inmates with HIV infection and it is estimated that up to one fourth of the people living with HIV

in the U.S. pass through a correctional facility each year. At present the HIV AIDS prevalence among prisoners is over three times higher than that of the general U.S. population.

In additional to their overrepresentation in the correctional system, men and women of color are disproportionately affected by HIV and AIDS. Although African Americans represent only 13-percent of the total U.S. population, they count for more AIDS and HIV cases and more HIV related deaths than any other racial or ethnic group. Latinos, the fastest growing racial and ethnic group in the United States, are not far behind. They account for 14-percent of the total U.S. population but have the second highest HIV prevalence in the nation after African Americans.

Data from federal prisons show that in 2004 HIV infection rates were highest among African American female inmates. In both federal and state prisons, females were more likely than males to be HIV positive and African Americans and Latinos were more likely than whites to be HIV positive.

In addition to high rates of HIV infection and AIDS, correctional populations also have higher rates of comorbid conditions that facilitate HIV transmission, such as sexually transmitted infections, substance use, mental health problems, and other infectious diseases such as tuberculosis and hepatitis. The disproportionate impact of HIV in communities

of color and in correctional facilities is exacerbated by a lack of access to adequate health and social services for inmates while incarcerated and upon their return to the community.

Since more than 90-percent of inmates are eventually released into the community, the health profiles of those inmates impose specific demands on an already overburdened community services. Many former inmates do not have the resources to access services that are not part of post release planning, such as addiction and mental health treatment, psychological support, reproductive health care, education and job training, and stable housing.

The presence of at risk and HIV infected persons in the correctional system is a critical challenge to both the correctional health system and to the public health community. This challenge offers unique opportunities to reach these high risk individuals and engage them in HIV prevention, treatment, and care. It also offers opportunities to break the vicious cycle of HIV's impact on inmates as well as on the communities from which they come and to which they return.

With that as background, I would like to introduce our most esteemed panel of experts, Mr. Barry Zack, Mr. Harold Atkins, Dr. Jody Rich, and Ms. Darla Bardeen. We are especially thankful to Darla for filling in at the last minute

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for Ms. Malike Saada Saar, who unfortunately is sick today. Their bio sketches are printed on the handouts that are placed outside so you can read them at your leisure.

Our first speaker is Mr. Barry Zack who will be talking about HIV prevention in correctional systems and what works in these settings. In the interest of making sure that all of our speakers have time for their presentations, we ask that you hold your questions for any of our speakers until the end of the session at which point we will have a Q&A.

BARRY ZACK, MPH: Thank you Monica. I am honored to be here and I want to thank Monica, amfAR for making HIV in correctional settings a priority, an issue my colleagues and I have been working on for many years. I think in Monica's introduction, you are probably going to be hearing a theme today about while the focus is HIV, there are all these other issues that we need to be speaking to, issues of mental health, substance use, housing, etc, and I think there will be a consistent theme as we talk about what is working in HIV and some of the primary issues, some of them working, some of them not working, in HIV in the correction system.

Let me start off by really speaking to this by stating that our nation's prisons and jails have been forced to confront the breakdown of our community health and social service system. What we are not confronting in a free

community will eventually find itself as an issue in the criminal justice system.

HIV is but one of these issues. If we do not confront homelessness and the lack of mental health beds, then it's just a matter of time before the correctional system gets involved. There is a strong association between mental health and substance use. There is a strong association between housing and taking care of yourself. We need to prioritize prevention. It works. It really does work.

I mean it's amazing to me, I mean just as far as the prevention works but where is the prevention on the policy continuum? What we need is the political will that will support evidence based prevention practices. What we need is a commitment to a policies and practice based on the reality of life, what really is, not just what one may hope to be.

As it relates to HIV, we can and we must reduce HIV incidence rates. We must increase voluntary testing rates. We must increase access to care and treatment. We must improve and in some places create a whole system of re-entry for people, re-entry treatment and prevention services for people leaving the correctional system instead getting back into the free community.

So how can we reduce the incidence of HIV in the correctional setting? I have been asked to speak on HIV

prevention, what works, and I am happy to say that the evidence is quite robust and overwhelming. Education works. Education behavioral interventions work. They reduce risk behaviors. The Centers for Disease Control and Prevention recently published the first HIV, STD and hepatitis intervention developed specifically for the correctional setting that is project START.

That was a multi-site, multi-year intervention. I am happy to say it will probably be rolled out in July ‘09 and through the DEBI process if you are familiar with that and that document, to lower rates of sexual risk among young men in the study compared to a control group. The bottom line is it works.

Access to condoms work. Condoms are effective. They prevent HIV transmission. The World Health Organization and UN-AIDS have recommended for more than a decade that condoms be made available to people who are incarcerated. The United States is but one of few industrialized countries that do not make this a priority. I can speak in California because both in Los Angeles and San Francisco county jails impress implementation of condom availability programs are indeed taking place.

And the California Department of Corrections and Rehabilitation is about to pilot a condom availability program.

Access to syringe exchange, or access to sterile syringes, the evidence is overwhelming how this harm reduction method reduces infection rates. There is really no question about its impact in reducing incidence. We need to be discussing how to make this work. We need to be discussing our public health values and how we apply those values into the correctional setting.

Counseling and testing works when someone learns of their HIV status, their behavior changes. If they test negative, we need to support efforts so they stay negative. If they test positive, we need to provide comprehensive prevention and treatment services that will start on the inside and continue upon release.

Treatments works. Treatment is prevention and that's treatment for HIV that is treatment for STDs that is treatment for mental illness that is treatment for substance abuse, all these treatments are indeed HIV prevention. Discharge planning and proactive linkages to care works. It is HIV prevention. And you know getting people into safe and affordable housing is an effective intervention. Housing is prevention, it works.

Those work on the outside and they work on the inside and what I mean by works is that science has shown these to be effective that these interventions are evidence based and

prevention, prevention is cost effective. Incarceration is expensive on the whole, not cost effective.

These interventions not only improve public health and public safety but the data show there is no evidence. I want to repeat this. There is no evidence that these prevention and treatment activities disrupt the day to day security priorities in the correctional setting.

There are too many people incarcerated in the United States. The highest rate in the world, and the burden of disease among people who are incarcerated is indeed many times greater than the free community but people on the inside today, people on the inside today were outside not too long ago. They are not bring a new disease from inside outside when they get out but are far more likely to have brought it in from the outside. We incarcerate far too many people who are inside as a result of their health status, of their illness, and prison and jail is not the place for them. The health status of those incarcerated which we hear so much about is an outrageous statement on the lack of the medical care system in the free community.

I would like to make one other point about the burden of disease among people inside. Men in prison have been blamed for increasing rates of HIV and STD infection, primarily the cause, increase, blamed for the increased rates among African

American women. This increases stigma and discrimination and results when policy makers look to mass testing of people in jail and prison as an answer. This issue is much bigger than further stigmatization and people in prison.

A recent editorial articulated how imprisonment does indeed impact HIV and STD rates in the community and as a result how imprisonment changes community male female ratios and it's that that impacts sexual concurrent partnerships within the community. That is an important point, again, because a lot of people think that people on the inside are getting on the inside and bringing it out and that is not the case.

It is not from people getting HIV on the inside and bringing it out. We know it works. Prevention works. Treatment works that is substance abuse treatment that is mental health treatment that is STD treatment and that is HIV treatment. Discharge planning works, housing works. What works as a comprehensive continuum of prevention and care that is not disease specific but person specific, looking at the whole person, their health, their family, and their community? What we've learned is that the more comprehensive we are, the more effective we are.

HIV prevention is not just about HIV. This is so much bigger than HIV itself. When I say we need to be

comprehensive, I mean we need to look at everything from the lack of community health system to sentencing reform. We need to be looking at eduction to housing to employment. All of these are effective HIV intervention strategies. No one can do it alone.

We cannot expect corrections to tackle these major health issues on their own and we cannot expect public health to take on these safety and custody issues. We have to work together to collaborate, and as someone who has been doing this for over 20 years I contest that it's not easy but it is doable. It is feasible and the world of public health and the world of corrections have different cultures and different priorities and that needs to bring us together, not keep us apart. We have to partner well and we can do it together and make prevention work. I applaud amfAR for speaking to this issue and making this a priority. Thank you. [Applause]

MONICA RUIZ, PhD, MPH: Thank you so much. Our second speaker is Mr. Harold Atkins who was an HIV care educator in San Quentin State Prison in California. He will be giving us an insider perspective about the need for prevention and education for inmates.

HAROLD ATKINS: Good afternoon. So, I want to talk from a different perspective. Unlike Barry, I want to talk

from being behind the bars and having to deal with this issue head on.

As my bio said, I was the first non infected HIV peer educator in San Quentin State Prison and I'll tell you there were a lot of concerns about me at my age, at the time I was 18 years old, going in and becoming a peer educator, first was stigma, right, they said Harold just by being associated with the peers people will think you are questioning your sexuality, people will probably question the fact whether you're HIV positive or not, but you know I was up to the challenge. I said you know what? It's necessary. I wanted to go in and learn this work more so than teach it and I'll tell you why. At the time, I had just heard that my aunt and my cousin had just tested HIV positive and I come from a very small and fragile community of East Palo Alto, California where I never understood how that 2x2 miles.

I understood all the behaviors that were going on in there and the type of behaviors that you'll find in East Palo Alto are some of the same issues you will find in any big city in the United States as far as drug use, you know, the sex trade, violence, you name it, and coming from there I never looked at the public health impact of those behaviors in that little city.

When I was on the way to San Quentin I didn't think about the public health concerns inside of San Quentin, either. I thought about who was going to be there, who would I know, how safe would it be, and what the program would look like, but when I first got there they did two things. They booked us and then they sent us to what was called HIV orientation.

When I went to HIV orientation, I had my own stigmas. I was saying okay I do not fit the criteria of what HIV is, and if you ask me what criteria was that back then for me, we would point straight to San Francisco because we were told San Francisco and Los Angeles and nowhere in between.

Well, when I went to that HIV orientation I was told how the virus was spread, you know, ways to live inside a prison and not contract HIV regarding tattooing, you know, drug use, even the sex inside a prison, and I didn't understand how that was going to apply to me. I kind of fell asleep on them.

I remember that saying this isn't for me, this is for someone else, but when I woke up they were asking that question, do you want to take the HIV test? And I was like no I do not want to take the HIV test. Why? Because I was scared and I didn't understand what that test meant and why would I wait until I come to prison to take that HIV test? I went to West Block, which is the reception center for new arriving inmates and I asked myself why didn't I take that test, right?

When I went to get my physical, the doctor, she asked me, she said Mr. Atkins do you want to take the HIV antibodies test? I said yeah.

This is where I learned what behaviors would spread the virus versus safer behaviors. It wasn't until I took that test that I walked around saying I am not at risk at all. I left that testing room knowing that I was at risk for HIV and I remember when they came back to give me my results which was two weeks later they said Mr. Atkins you are negative and walked away.

No questions and I'll tell you I do not know if it was because I was 18 but to me positive was something good, negative was something bad, so when they told me I was negative I thought I had AIDS, right, I was thinking oh my God now not only am I in prison but I've got to call my mom and tell her that I also have AIDS, right, it wasn't until a few hours later that my cellie, he actually told me what the difference was between being HIV negative versus positive. All of these things I learned inside of San Quentin State Prison.

After that, I kind of understood that I needed to learn more about this virus, but I was more worried about treatment because of my aunt and my cousin so I was trying to learn treatment. I remember walking down and asking the people at center force at the time that was Barry Zack, you know, I need

to learn about treatment. He said why do not you come to this, what was it, at 36 hour pre education class, and I was like oh my God, and I'll tell you it was only because I had time literally [laughter] that I wound up going to this class and the class changed my life.

I'll tell you through that class I became the first non infected HIV peer educator. I learned through that class how important this information was to my community but I also learned in that class not only statistics about the prisons but I learned that my city, East Palo Alto, was in a state of emergency based on HIV infections.

I lived there my whole life and nobody ever told me that HIV even existed in my city, because the stigma I heard, all the people who passed away died of cancer, so when I learned this information on the inside it was then my job as a 19 year old to come in and educate all the new arriving inmates.

I want to tell you the power of peer education. Before I came to the classes I believe 20-percent of the class actually opted to take the HIV test after the pre-test counseling. After I started doing it and the face of AIDS had changed to look more like myself, 80-percent of the people coming through the class actually opted to take the HIV test whereas only 20-percent refused.

After they would take the test, we actually increased the program by having myself go in and talk to them after they came back positive, the people who came back positive, and offer resources in their community. Barriers, well I was in San Quentin. People in San Quentin were coming from as far as San Diego.

I wasn't equipped with the information in the community from San Diego to tell them when you get out of here and you go back home, you can connect to these resources so that was one of the biggest barriers. However, we did catch people in pre-release classes before they left the prison and this is where we would talk about getting retested, talking about that window period and getting people to understand that just because you tested negative when you walked in here doesn't mean you are going to be negative when you leave here.

What I was able to do with that information actually changed my life and it changed a lot in my community. East Palo Alto now has services for people with HIV. I am the one providing those services. I work for the AIDS community research consortium. I am the health education coordinator. My job is to teach people who have HIV or hepatitis C through a comprehensive system of education and the program is called HIV Living Now and Hepatitis C Living Now.

We teach people how to live with the virus and how not to spread the virus onto other people as well as how to adhere to their treatment. But it's not enough. It's not enough because when I first started in this work, prevention looked like, you know, you would identify high risk behavior, go in and offer prevention strategies before someone got the virus. Now it seems like we are focusing more on secondary prevention and I tell people all the time if you come to my office it's too late.

Once you get to my office it's too late so that I try to do now is through my volunteer work I coach football and I chose to work with seven year olds and I follow that team all the way until they are 15 years old and they go to high school and then I come back down with the seven year olds which I am doing again this year and people say well why do you stay with the kids? Because I am not only teaching them football, I am teaching them life.

And one of the most important things that I do with these kids is HIV prevention. And I do not do it in the sense of me standing up, having them sit down and I draw T-cells on the board or what not, I do it in the place that they are most comfortable, on the football field, during practice; they know we can ask coach questions because he knows about hepatitis C.

If you see a kid get cut in my practice you'll see that the kids already know. They back up and they say coach, such and such is bleeding. These kids are learning vital information to keep themselves safe at an early age so they never make it to my office. These kids will probably never see the inside of a prison. The most at risk populations in the community go to our prisons and in those prisons they can either continue the behavior until they come home and outside of that they do not have many other opportunities.

All I am asking is that we give this population other opportunities, and opportunity to learn prevention, an opportunity to come back to their communities and be assets to their communities in the way I am as well as looking at family, children that will come after that, but if they do not have the information and I'll tell you people walk around telling me, Harold why do you do this work?

Everybody knows about HIV. Everybody understands prevention. Everybody understands safer sex, and I tell them not everybody because if I hadn't have met Barry Zack or Center Force when I first got to prison I wouldn't know this information either so I'll tell you I really want you to look at prevention on the inside as something that is vital to the community because 95-percent of the people on the inside will be coming home someday, and HIV is to incarcerated communities

what Katrina was to New Orleans, the only thing is we still have a chance to respond. Thank you. [Applause]

MONICA RUIZ, PhD, MPH: Thank you so much. Our third speaker is Dr. Jody Rich, who will be discussing treatment of HIV positive inmates and continuity of care post release.

JOSIAH RICH, MD, MPH: Thank you all for coming. And really thanks to Monica and amfAR for putting together this issue brief and I am going to talk for a few minutes but if you remember nothing else that I say, read this issue brief. This is really, it sums up a lot of information and really hits home some important issues.

So, I am an infectious disease specialist and I first saw a patient with HIV in 1985, diagnosed him with AIDS, and have been taking care of patients with HIV ever since. And for the last 14 years I have been located in Providence, Rhode Island. We have a single correctional facility which is a prison and a jail, almost 4,000 inmates, and almost 20,000 cycling in and out each year, and I provide Tuesday mornings.

I should have been there this morning but every other Tuesday morning I've been going down there and taking care of inmates and then we also have the largest HIV care program at the Miriam Hospital where I work and so I have the luxury of both seeing inmates, people while they are incarcerated, and following up on the outside and seeing them back and forth, and

to me this unique perspective has clarified a few things but first of all the connection between addiction and incarceration.

If somebody gets out and they pick up again, they are generally not going to follow up in the hospital clinic. They are generally going to follow up back at the intake center and if they get out and they do not pick up drugs then generally I see them back in the clinic, so to me that makes me think well wait a minute, these people are not fundamentally criminals. They have a disease of addiction, and that direct correlation is crystal clear.

I've taken care of hundreds and hundreds of patients both on the inside and the outside and cycling in and out and I am going to try and sort of distill that experience down to the next few minutes and give you my impressions but when I started thinking about what I wanted to tell you all here, to me the issue is much bigger than HIV. We have a systemic problem with incarceration. We are incarceration happy and we are becoming a nation of jailers.

Now there is a story about a guy who is walking along a river and he looks in the river and sees there is a baby in the river, floating down, so he jumps in and he rescues the baby and takes care of the baby. The baby is fine. And then a little while later another baby comes floating down the river.

He says oh my God and he jumps in and he rescues that one and then this keeps going on for some time and finally he says you know I think I am going to take a walk upriver and see who's up there throwing the babies in.

And I feel like I have been pulling these babies out of the river but why are they going in? Why do they keep getting re-incarcerated? What is going on? What is this system? And if you look at the numbers and Rhode Island mirrors the rest of the country, we are locking up more and more people.

Who are these people and what are they getting locked up for? For me as a health care professional it's a health care issue. There are really two diseases and these two diseases are the disease of addiction and the disease of mental illness and if these diseases are untreated people tend to do things that end up with them being incarcerated. So if you treat the disease of addiction, if you treat the disease of mental illness, they tend to not get incarcerated.

Now along with getting people at risk for incarceration, those people are also at risk for HIV and you heard Monica say one in four people with HIV in this country, one in four every year passes through a correctional system, one in four every year, so if you want to address HIV in your community and if you are not looking at what's going on in the correctional population, you are missing one in four of the

people with HIV. As Barry mentioned prevention is the same issue and Harold as well, the highest risk people in our communities go through corrections so if you want to make an impact with prevention, or treatment that is the place to do it efficiently.

I think ultimately HIV can help to show us, to lead us away from this path that we've strayed away from and people, some people I believe need to be incarcerated. I think that to keep our community safe there are some people that need to be incarcerated but the people that I see that I care for on the inside and the outside and get to know and get to understand what they face in life and what they have faced in life, it's crystal clear to me the vast majority of them have no need to be incarcerated.

They get incarcerated and everything gets worse. Their addiction gets worse, not that they are using on the inside although they sometimes do but when they get out, they've lost their housing, they cannot get a job, they have done nothing about their addiction, they've generally not picked up any useful skills, and even if we tell these people okay you do the right thing, you just get a job, just stay away from drugs and live the American dream, the American dream is never going to happen to most of these people. They have no chance.

They are lucky if they can get a job at Burger King flipping burgers for $5 an hour and that's not going to pay their rent. That is not going to pay anything. They cannot raise a family. They cannot do anything and so we scratch our heads and wonder gee, why did they go back to using drugs? Drugs are an escape. Drugs appear to be an easy way to make some fast money.

So, the other very important issue brought up in his brief is the whole racial disparity issue. I mean this is crazy, what we are doing is crazy. We are locking up and it's true for HIV as well as the incarcerated population, we are locking up huge numbers of African American men, we are warehousing them in correctional facilities and we are wondering gee, why are these inner cities not thriving? What is going on here?

Well if you take one out of three men out of a community that is one out of three families that do not have a father figure that do not have someone that can keep an eye on the neighborhood that cannot keep things safe, so it's no wonder and to me this is, you know, there is a concern about governments getting too big and we are spending too much money, this is big government. This is big government in the worst sense of the word and this is what we become. We are a nation of jailers.

So how does HIV fit into that and how can we benefit from the experience and our knowledge of HIV? Well, so we already know this population has a higher prevalence of HIV and is at higher risk for HIV and they are coming through. Now, these one in four people, a lot of them do not know they have HIV, do not even know they are at risk for HIV.

And so I think in addition to the tremendous prevention opportunities there are three things we can do and one is to diagnose them so to diagnose people you need to get them to agree to get tested, to go from a 20-percent to an 80-percent that's phenomenal that's great. But people should, if they are at risk they should get tested so thinking about ways to optimally do that, now looking at the case of Rhode Island, in 1989 Rhode Island passed a law mandating HIV testing for sentenced prisoners.

But as I mentioned it's both a prison and a jail so they've got the health care, correctional health care providers there and they've got this stream of people coming through and they cannot sort out who is a prisoner and who is in the prison and who is in the jail.

So they implemented a policy of routine testing and yes technically you can opt out if you really have to, but in general this is like the routine, you go here you get your finger, you go there and you get the HIV test, you go there you

get your TB test, and it just happens and over 90-percent of the people passing through corrections since 1989 in Rhode Island have been tested.

Now through that testing process, we have diagnosed one in three people in the entire state with HIV so that's a phenomenal slice of the pie, one in three diagnosed and it's also I should note the largest HIV testing program in the state. Now those people get diagnosed and so the first part is to diagnose people.

The second part is to get them appropriate treatment and so we have done that. The Department of Corrections has brought in Brown University faculty members to provide HIV care and we have developed a model program of HIV care on the inside and the inmates have benefitted tremendously. But it's not just the care on the inside, the third component and perhaps among the most critical is linkage to care on the outside.

Now in our, one of the best government programs is the Ryan White Care Act that has created a network of care providers and resources to divide care for people with HIV around the country but if you look there is very little interaction between Ryan White Care Providers in the community and HIV care in corrections and so there is a missed opportunity for linkage into care when people get out.

This is an opportunity to really offset some of the racial disparities. People who get diagnosed are much more likely to be from minority communities to be incarcerated, much more likely to be from minority communities to have HIV while they are incarcerated. We can link them up to care on the outside, then they are less likely to suffer the adverse health consequences of having HIV and in fact less likely to spread HIV.

So in Rhode Island we had a Ryan White funded spins program to link people up to care after release and incarceration and this has been a model program and if we look over the last ten years in Rhode Island, the rates of HIV among people with drug use have dramatically declined and that, if somebody comes and gets incarcerated and doesn't know they have HIV and goes out the door and doesn't know they have HIV, they are going to infect their wives, they are going to infect their drug using partners and they are not even going to know about it.

If they get tested and they get put into treatment and they get linked up to care on the outside that's not a guarantee that they are not going to go out and relapse but it certainly gives them a much better chance to protect not only that individual but the people around them and so I think that is what we really need to do.

And finally I want to echo the sentiments of the last two speakers with prevention and prevention is a critical opportunity, not only the secondary prevention I was mentioning about getting people who are positive into care on the outside but primary prevention and that means education that means STD screening, STD treatment, and the like, so I think with that I thank you for your attention. [Applause]

MONICA RUIZ, PhD, MPH: Thank you. Our final speaker is Ms. Darla Bardeen who will be discussing the challenges in meeting the needs of women, ex-offenders, and their families.

DARLA BARDEEN: Good afternoon. I am going to be talking to you about our addicted moms who are incarcerated and an effective substance abuse treatment known as “Family Treatment” which effectively deals with mental health issues, addiction, and also offers health services such as HIV and AIDS prevention and treatment.

Part of my work is with the D.C. jail, the women there. I help co-lead a written and spoken and express word workshop for the Life Line Program. I also travel throughout the U.S. and I assist in leading a two day leadership and advocacy training for moms in recovery. Most of these women have suffered the removal of their children and have been incarcerated.

I am going to start off by sharing a story that is pretty representative of the women that we're talking about, the women who have been incarcerated. We are going to call her Stephanie for the purposes of this story. She is the mother of four children. She grew up in an alcoholic home and began being sexually molested at the age of five by her uncle.

At the age of 12 she began using alcohol and marijuana to cope with the trauma in her life. When alcohol and marijuana no longer worked for her, she turned to crack cocaine to self medicate. Quickly she became addicted and knew right away that she needed help. She sought help and spent two years going in and out of seven to 30 day drug detox programs. None of these programs addressed her needs as a mother and none of the programs addressed the underlying reasons why she started using in the first place.

During this time, Stephanie's three children were taken from her and she spiraled further down into her addiction. She was then incarcerated. After she was released from jail, by the grace of God she was able to enter the one family based treatment program in her city. Over eight months, this program provided her with an individual therapist that helped her to deal with her core issues of sexual trauma.

She also received substance abuse counseling and HIV AIDS prevention classes, parenting classes and vocational

training, just to name a few of the services. This family program also helped her to reunite with her three children over two years. The children also received therapeutic services from this program.

Stephanie struggles financially to provide a safe place for her children to grow up because she is not eligible for TANF or housing assistance due to her drug felony conviction. It is only because of the supports that Stephanie received in the family treatment program at re-entry that she was able to stabilize her family and get her children back. And it was only because of the vocational help and training that she received at the program that she is able to sustain her family to this day.

It does not need to be so hard for women like Stephanie. Stephanie is a good mother who is clean and sober and who only wants to raise her children in a different and safer environment than she was raised. Today, she is proud to be a mother that her children can depend on and look up to.

Presently in the United States, non violent offenders who are mothers to minor children are the fastest growing prison population. Most of these mothers behind bars are untreated addicts. The pathway to addiction for women is distinct and most women who suffer from the disease of addiction were first victims of physical and sexual violence.

These women self medicate to their trauma with drugs and alcohol. These mothers, who in other contexts society would profess an obligation to support and protect, these mothers suffer the loss of their children because of their incarceration and lack of access to health and healing as a whole family.

Women suffer when they lose their children. Children suffer when they are not with their mothers, either temporarily or permanently. These women want to be good mothers. They want to raise their children with health and dignity. Our mothers are denied these inherent rights because they are placed in prison for the disease of addiction and our children are temporarily or permanently taken from their families. This denies women the right to care for their children and to remain whole as a family.

When mothers are released from prison, they often have little support to help them. Many mothers that I have spoken to have been released to the streets in the middle of the night with a few dollars in their pocket and no where to go. So they go back to doing what it is they know, which is abusing drugs.

Communities shun addicted moms. Their families are often full of brokenness and severe dysfunction. These families are not eligible for TANF and housing assistance because of drug felony convictions, even mothers who have

children to care for. These families who are denied necessary support suffer and our communities suffer as a result.

For a mom to regain custody of her children who has been incarcerated, she has to meet a number of standards to show that her children can live in a safe, stable and healthy environment and housing is key and these women who often have little vocational abilities find it very difficult getting employment where they can actually have the number of bedrooms that they need to get their children back from children and youth services.

What we need is more access to comprehensive family based treatment programs where all of these services and programs are provided. What we also need are moms to be able to get the TANF and housing benefits that they need so that children can be raised in healthy, safe and stable families. Thank you. [Applause]

MONICA RUIZ, PhD, MPH: Thank you. At this time I'd like to open up the floor for questions from the audience for any of our speakers. The gentleman right here in front.

DR. KEITH CRAWFORD: Good evening everyone. I am Dr. Keith Crawford from Howard University College of Medicine. The first question I have is for Mr. Atkins, the program, the peer program that you have in the prisons, could you tell me a little bit about how that functions and how receptive inmates

are to getting prevention information, how stigma may interfere with them receiving that information, and just what some of the nuts and bolts of how that type of a program would operate?

HAROLD ATKINS: The program, every inmate entering San Quentin would have, after being booked, would have to go through HIV orientation. There was no resistance on the part of the inmates because believe it or not, inmates do not want to get HIV either, you know, and they want to be educated around the issue, it's just how e educate them and we made it culturally relevant to that population in more than one way.

We all know that there is a racial game being played on the inside so of course the peers had to really represent the population on the inside both culturally and ethically, so we had African American, Caucasian, someone who spoke Spanish, you know, across the board, as peer educators, and as groups came in, there was a team effort to educate the population so everybody would sort of relate to one of the peer educators. I do not know if this was the information that you wanted?

DR. KEITH CRAWFORD: Was there an ongoing aspect of the program after they had that initial one on one orientation?

HAROLD ATKINS: So after that one on one orientation, whether they were like a maximum security inmate that was going to be in the cell or in the dorm living, by opening up the peer educators to people like myself who were not HIV positive, you

had people now in the cell blocks who were trying to do this work on the one on one with people every single day.

And what happened was inmates would come to the cell and say, Harold, this is what, you know, I just got a tattoo and this is what happened, should I be tested? Am I at risk doing this? Or I got stuck with this or this is some of the behavior I engaged in but I do not want anybody to know and you said it would all be confidential, what is my risk or what is my next step? And I think that opens it up to where people could have access to someone who understood prevention 24 hours a day.

DR. KEITH CRAWFORD: So you all are identified as a resource for the inmates and they come to you all, what about confidentiality?

HAROLD ATKINS: That was a part of our training, yeah, confidentiality and remember we had a pay number through Center Force to do this work so we were paid employees pretty much of Center Force to do this work and that was the incentive to get involved as well.

And I think by going up to talk to people after they tested positive and then catching people at the pre-release classes which are classes that were mandatory for people who were I believe 14 days from release, we were going and reeducate them, we said okay we gave you all the information on

how to life in this prison, you know, and not contract the HIV virus.

Well let me give you some more information complete with prevention strategies because remember on the inside we couldn't say go to the condom distribution or go to the needle exchange because that didn't exist on the inside so there were other, there was a different set of rules per say or the information was different for the people who were on the inside and that were going to be there for awhile as opposed to the people who were leaving in 14 days and we would tell them in the community you have different, you know, access to better prevention strategies.

DR. KEITH CRAWFORD: One last question, since you are the only non HIV infected peer educator, do you feel that affected your advocacy in terms of communicating and challenges and some of the issues related to living healthy and prevention, those types of things?

HAROLD ATKINS: Not really because I think I was an asset to a different part of the population. There were many people who said I want to talk to you about prevention because it obviously is working in your life whereas talking to someone who is HIV positive, you know, where is the credibility from a prevention standpoint? Not to mention most people who wanted to talk to me were people who were young like me, people who

engaged in a lot of the behaviors that I engaged in both outside and inside the prison regarding HIV risk factors so I think once again it came down to being the actual peer of that community.

Now my counterparts and my colleagues who were HIV positive played a major role within that population as far as talking about adherence to medication, actually convincing some people to tell the department that they were HIV positive because a lot of people came in, wouldn't tell the department they were positive because they didn't want to live in special housing so they would actually convince them in that way and sometimes through harm reduction practices we saw people actually share their meds, you know, share their meds with people who were positive that didn't want to tell the department they were there but knew what they were taking or what they were supposed to take.

DR. KEITH CRAWFORD: That could be kind of dangerous.

HAROLD ATKINS: Definitely, it could be.

JASON KENNEDY: My name is Jason Kennedy. I am the state policy coordinator with the AIDS Institute and first I would like to thank Monica and amfAR for hosting this important briefing today and my question for the panel is we've heard a lot about what in your experience has been successful aids, I am not talking about HIV AIDS but what have been successful

aids in curbing the HIV AIDS epidemic within the correctional systems and my question to the panel is what are some of the barriers that we are currently facing that need to be overcome in order to successfully implement those various ideas and programs that you all have suggested and put forth today?

Are we looking at lack, a cultural issue within the premises and I think Mr. Atkins you were saying it's not necessarily the case, are we looking at policies that need to be tweaked a little bit either legislatively or through regulations? What is preventing us from doing this? Are we seeing a lack of medical providers who want to get involved in the correctional settings? What barriers do we need to overcome? Thank you.

JOSIAH RICH, MD, MPH: That's an excellent question and it actually crosses with the previous question in that correctional facilities there are 100's of them across the country and they are each an own little fiftum run by the warden and so this program, having peer educators, is wonderful and has really helped a lot of people but in my own correctional facility the warden and the director are very opposed to peer education programs.

They feel it gives too much power to the inmates that can be used to undermine their primary mission of safety, something I clearly disagree with, but it runs the whole gamut

so in terms of other policies, obviously if the direct control that our senators and congressmen have is over the federal bureau of prisons and there is state, county and local facilities as well where a lot of work can be done but I think there are things that can be done to encourage implementation of HIV testing, encourage the CDC for example, the NIH to get involved in this issue, encourage Ryan White funded providers to reach out to their local correctional facilities and get involved.

HAROLD ATKINS: To pick it back on that answer, I would say also people from say the Bay area in California can be sent to as far as San Diego to do their time and I think in the federal prison system it's even further than that so when you look at opportunities for prevention, if you go to San Quentin you get prevention.

If you go to Donovan you do not get the prevention so opening up the opportunity if we are going to call it a system, for every inmate or person in the community to have access to the same prevention education and I think that would be something that we could do because right now it's almost like luck of the draw and if you are a lower security inmate you will have more access to prevention whereas if you are a higher security inmate you probably have none and sometimes it doesn't

even come down to that, it comes down to where you are sent to do your time.

BARRY ZACK, MPH: As we all spoke about some of the issues from family violence to housing, I think something on a national level that can be addressed is what does, how is HUD dealing with recently released inmates? What about housing and transitional case management? How about the Centers for Disease Control, what is their, what are they doing about correctional health? I mean, they are actually doing something. What is NIH's portfolio in correctional health care, in the national research agenda? So from as a policy maker, there are quite a few things to question the leadership, the administration about what is working, what are they doing, what is working and to paraphrase about going upstream.

The bottom line is if we still, I mean look I've been doing correctional, I've been doing for 20+ years, but this is way down stream, you know, the fact is this is where people end up. If we want to start talking about primary, secondary, tertiary prevention, we have got to go upstream and start dealing with why are so many people in prison? Why is it that there are people who go to prison to get health care?

I know people who are getting better care and treatment inside than they do outside. There is data to support that when you look at viral loads, if you look at for HIV, look at

hepatitis adherence, you look at vaccinations that it is actually in the criminal justice system where there are people getting care and treatment and attention.

Why? Because actually the Supreme Court said they've got to provide it. And you know free people do not have a constitutional right to health care. People inside a prison or jail do. So I think we do have to go upstream and we do have to deal with some of these issues.

DARLA BARDEEN: I just wanted to speak I had mentioned earlier the importance of alternative incarceration, especially for our mothers who are first victims of sexual and physical violence and second addicts.

What they need is effective substance abuse treatment that is family focused because the children have suffered as well and this is also prevention and it is in these family treatment programs that they get the whole family gets good health services, they get excellent HIV and AIDS prevention and treatment.

And there are only, it only represents five of the overall treatment available and often with limited spots for alternative sentencing so I think we really need to focus on keeping these mothers and keeping these women out of jail and putting them in appropriate treatment that will benefit not only them but their entire family and communities.

MONICA RUIZ, PhD, MPH: Thank you. Any other questions from the audience? Please.

LOLA JILASHO: Good afternoon. My name is Lola Jilasho [misspelled?] and I work as an epidemiologist for the D.C. Department of Health and I have a question for Dr. Rich, at least in part, and I would like to talk about your first of all your level of pre-test counseling that is provided and could you also discuss what kind of test the HIV test that you provide in prison, and what is the level of recidivism in your prison, your jail population, just your jail population and yeah I think that's it.

JOSIAH RICH, MD, MPH: So again, I would refer you and all of you to this document and it really outlines a lot of what Barry's work has done about the ideal way to do pre-test counseling and informed consent and I would say that our system is not perfect and yet this is a situation where the perfect is the enemy of the good that if we had, the system has worked in terms of a public health intervention, probably been one of the biggest public health interventions with HIV in our state, does everybody get a complete pre-test counseling?

Do they really know what they are doing to our people coerced, you know, the answer is it's not perfect. Some people are probably coerced. Some people do not really understand

what they are getting tested, I think the public health impact speaks for itself.

Our recidivism rates are same as the rest of the country, in fact we are the smallest state and yet we are looking at incarceration rates going up and why is this? Why do we have to follow the national trend? Well it's a whole series of laws. There is the war on drugs with mandatory minimums and long paroles and probation and it's a very sticky system.

It's like fly paper, once you step on it and you try to get out, you put your other foot down, you just cannot get out so even when we see people that stop using drugs, they often will cycle back in and out and in and out for some period of time before they finally break free and it, to me it is a tremendous waste of resources that could be used to help. I do not know if that answered all your questions.

MONICA RUIZ, PhD, MPH: Another question for our panel?

JACKIE WALKER: Jackie Walker from the ACLU National Prison Project, Barry made a really good comment earlier about we have seen this rash of legislation both on the state level, even on the federal level in terms of seeing African American and Latino men as vectors of disease and infecting women in their communities, can you talk a little bit more about ways to

counter this and sort of like more appropriate responses to this?

BARRY ZACH, MPH: Good question, Jackie. I think an appropriate response is when we hear about it is not to be silent so that when word gets out and people start pointing their fingers at the incarcerated African American man as being responsible for the increased rates amongst women in the community we need to say you know what? That is not true. There is no data to support this.

We need to look at this more clearly. There was actually an article, editorial in the *Washington Post* out of, as a result of some data that was, we were just talking about this that really showed how this, it really changes the male female ratio in the community and that is what is happening. You are taking African American men out of the community and now you are leaving a whole different, basically a sexual network or drug using network that is impacting so that impacts the transmission rates.

I think it is really important that we speak out as with anything when we hear issues of racism and sexism that we cannot be silent and sadly there is an enormous amount of blame and finger pointing going on to African American men as a result of a lot of other reasons why they are doing time that may not have anything to do with criminal behavior, but they

are doing time and people are looking for another reason, another scapegoat, so one I think foremost we need to speak out.

Two, we need to be looking better at the data. What is this impact so we have some good data that shows concurrent relationships and its impact on modes of transmission, on networking, and that we need to look at that more. We need to understand that better. I think foremost it's too easy, we have written this off as oh it's gay white men, oh it's African American ex-offenders, oh it's this, oh it's that, and it's so much more complex than this and I think it's our duty for those of us who are in this field is that when the issue comes up that we do not remain silent.

ADISA GRIFFIN: Hi I am Adisa Griffin with the National Minority AIDS Counsel, I would actually want to ask a question that touches on a couple of things that both Harold and Dr. Rich spoke to in terms of the variability of programs available to inmates across institutions, both within states and in the federal system, Dr. Rich touched on the power and the critical position of wardens in terms of determining what happens within in a prison related to HIV and a cross ration.

My question is as an example there is a state that NMAC has worked with where they have taken great measures to standardize or to make the programs that are available in one

prison available throughout their network by networking with the wardens themselves and their representatives that they are sending to these meetings to make sure that if one prison is doing something that works that the other prisons know about it.

On a national level or even in the statewide level, do you know of any other efforts to really touch on or connect with these very key people in this tapestry of HIV and incarceration?

JOSIAH RICH, MD, MPH: We are very fortunate. Director of Corrections in Rhode Island is very forward thinking and understands the critical role of health and public health that correctional institutions play. He I think, he has been there maybe six years or so and that has made him the I think second or third most senior director of state correctional facility in the nation.

It is a tough job and certainly in Rhode Island they have the unions on one side and you have the politics on the other side and there is a lot of turnover. On the other hand, and he clearly has insight and as an example he says well you know when somebody is a rapist or a murderer and they get locked up in my facility that is generally a good thing that there is one less rapist or murderer out in the community and

yet when a drug dealer or drug user gets incarcerated that is a job opportunity in the community.

That is not addressing the problem and so for a director of corrections to say that, he clearly has a lot of insight. And he, you know, he is really working on trying to educate other directors on this issue and he gets a lot of positive feedback when he speaks around the country and hears of things that are going on with HIV care and treatment in Rhode Island he gets positive feedback so it's a synergistic issue.

He had a confirmation hearing and the union showed up and said he's terrible and myself and other health care providers showed up and said well he is really doing a great job and that is the kind of benefit he can get from working with health care providers in the community and so I think that is a strategy is to educate the wardens and directors on how to get more alliances and work together for, because of the supreme court decision that said that to not provide adequate, comparable health care that you can get in the community is cruel and unusual punishment and therefore not allowed.

Health care, correctional facilities have become defacto health care institutions, that is part of their mission in addition to public safety, and so understanding this really opens a lot of possibilities.

That said, I think there has probably been almost no health care improvements in corrections, funded by corrections that have occurred without legal action or threat of legal action but nevertheless the system does work in a lot of ways in terms of providing health care.

BARRY ZACK, MPH: Let me say also when, a lot of times when we talk about HIV and peer education we talk about street outreach, we talk about inmate peer education, there is peer education amongst wardens. There is peer education amongst correctional officers. Peer education need not be limited to one group. Peer education is effective.

When we started peer education at San Quentin it was with two goals, one to increase the perception of risk and really the second was to change social norms and peer education is excellent at doing those and if we can get wardens, there are some excellent achieved directors of departments of corrections, there are excellent wardens, superintendents around the country that are really behind health efforts and if they can become our peer educators, if they can become the leaders in their field that will be a good thing.

HAROLD ATKINS: That was sort of in the short was going to be my answer as well. We have an epidemic, really it's a pandemic, but we have this epidemic that we are dealing with in the prison system as well as in the community, the HIV and

STIs, we have to create this epidemic, to face this epidemic, one of education, prevention, and compassion and empathy for people who are positive or at high risk.

And the biggest issue in California is the CCPLA, the correctional officers union is the second most powerful union in our whole state. While we had a director of corrections that we worked with directly at Center Force that actually came and got me off of a bus when a captain wanted to send me to another prison just because he could, she said no he is going to stay here.

He is going to do HIV prevention in this prison. That was as an associate warden. Then when she was made the director, there was so much red tape that she is no longer the director of corrections anymore so it's hard to hold them accountable if they have the most powerful union in the state but I do think is it possible? Yeah. I think if we have to get them to understand how important the job is and that it doesn't end at HIV prevention because I learned HIV prevention and the trade all at the same time.

Now I am working and having, I've never been back to prison since. I went one time and I've never gone back to prison. I've been home nine years taking care of my own family, taking care of my own community so by investing in me that actually, it looks good on their part as well.

MONICA RUIZ, PhD, MPH: Thank you. Do we have anymore questions for our panel? Okay then I will like to thank you all for being here today.

Please join me once again in thanking Congresswoman Lee's office for their assistance with the spree thing and our four panelists who took the time to share their expertise with us today.

I would also like to draw your attention if you are interested in other correctional issues and prison litigation reform there is a briefing, a hearing at 4:30 in Rayburn. These sheets with the location, all the information, are outside on the table. So if you are interested, please go and get one and one of our testimonies is being presented by Deborah Golden who is right here with us today and who was a reviewer of this document as was Adisa Griffin and others in this room.

I would like to thank you all for being here and please have a good afternoon. [Applause]

[END RECORDING]