Administrative Management of HIV in Correctional Institutions

This position statement does not address the medical management of HIV. The National Commission on Correctional Health Care board of directors endorses the concept that medical management of HIV in correctional settings should parallel that offered in the community. Medical management guidance is available from the U.S. Department of Health and Human Services (http://AIDSinfo.nih.gov).

Introduction

In The Health Status of Soon-to-Be-Released Inmates report (National Commission on Correctional Health Care, 2002), it was estimated that the prevalence of HIV infection among jail and prison populations was markedly higher than of the general public. Confirmed cases of AIDS among state and federal prisoners are 2.5 times higher than in the general population. One in seven persons living with HIV in the United States is processed through the criminal justice system each year (Centers for Disease Control and Prevention [CDC], 2014). Yet few prisons or jails in the United States offer opt-out HIV testing and few have comprehensive programs to provide critical services that link HIV-positive inmates to care after their release. Thus, jails and prisons have an opportunity to impact HIV detection, transmission, and care.

NCCHC believes that correctional administrators have an important role in HIV education, testing, and management. The quality and length of life for seropositive inmates is affected by administrative decisions regarding screening and detection, access to quality medical treatment, mental health support, housing, and funding. The public health of our communities also is influenced by administrative decisions regarding discharge planning. For example, poor care coordination and/or failure to enroll in relevant health insurance can result in interruptions in antiretroviral therapy (ART) that foment resistant viral mutations.

HIV Screening and HIV Detection

The CDC states: “HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening). Persons at high risk for HIV infection should be screened for HIV at least annually. HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.” The CDC further states: “In correctional settings, CDC recommends that HIV screening be provided upon entry into prison and before release and that voluntary HIV testing be offered periodically during incarceration. Testing has both individual and public health benefits, given the importance of getting early HIV care and the increased risk of HIV transmission among persons who do not know they have HIV.” The administrator should know and adhere to applicable state law with regard to informed consent (CDC, 2006). However, a correctional health care survey published in 2014 showed that only 19% of prison systems and 35% of jails provide opt-out HIV testing recommended by the CDC.

The CDC recommendations underscore the move toward opt-out testing for HIV, where all individuals are tested as part of a routine physical exam unless they specifically opt out. Such routine testing greatly increases the likelihood of detection, which should lead to earlier patient treatment and a reduction in the spread of the disease. Inmates should be informed of opt-out options and administrators should ensure that immediate counseling and linkage to HIV care, including with a provider trained in ART, is available for inmates testing positive.

Consistent with CDC guidelines, NCCHC recommends that all pregnant women be tested for HIV and, if infected, given antiretroviral treatment to prevent transmission to the infant. Correctional administrators should make HIV education to women a priority and encourage them to be tested for HIV, especially if they are pregnant.
**Housing Issues**

Housing for HIV-positive inmates should be appropriate for their age, gender, and custody class. NCCHC opposes routine segregated housing for these inmates. HIV-positive inmates, like any other inmate, may require a higher level of care that may not be available at all institutions. This is a clinical judgment based on the acuity of care required for the patient. Patients should not be medically isolated solely because of their HIV status.

**Programs**

HIV-positive inmates and those with AIDS who otherwise meet eligibility criteria for special correctional programs (e.g., education, work, parole, or medical reprieve) should be given the same consideration as other inmates.

**Access to Quality Medical Treatment**

The community standard for HIV care is to have access to HIV specialists who are knowledgeable about HIV management, including assessment of HIV resistance and selection of ART. The correctional administrator is responsible for assuring continuity of care upon arrival and discharge. Various quality improvement studies can be performed to ensure that HIV-infected patients receive quality services. These studies could include timeliness of referrals made and kept, patient adherence to antiretroviral therapy, and the number of patients seen in the HIV chronic disease clinic. The administrator’s role in assuring continuity of care, one of the greatest challenges to HIV care in jails and prisons, cannot be overstated. Treatment interruption can foster ART resistance. Viral resistance can preclude further treatment options for the remainder of the inmate’s life. Viral resistance can spread through communities through sexual contact, needle sharing, or perinatally. Thus, access to continuous quality medical treatment is critical during and following release.

**Pharmacy**

Successful HIV therapy requires that there be no interruption in antiviral medications. This necessary continuity can be assured by establishing mechanisms to make all ARTs continuously available to infected patients immediately upon arrival as well as during transport and upon release. All ART and related drugs to treat and/or prevent opportunistic infections should be on the formulary. All intake facilities should have a system to assure continuity of HIV medications and should maintain adequate supplies of all approved antiviral medications, as well as drugs used for PCP, MAC, and CMV treatment and prophylaxis, so that newly admitted inmates will be able to continue their treatments without interruption. Jails and prisons should establish automatic renewal systems for these medications to prevent predictable interruptions in care.

**Mental Health Support**

As many as one in three people with HIV suffers from depression. If not treated, depression can increase the risk for suicide. There is also a high incidence of anxiety disorders among people with HIV. Correctional administrators need to ensure that sufficient mental health services are available to inmates with HIV. In addition, mental health services can be useful in HIV prevention efforts. It is well-documented that high-risk behaviors contribute to the spread of HIV, and many of these behaviors are associated with loneliness, depression, low self-esteem, sexual compulsivity, sexual abuse, marginalization, lack of power, and oppression. Consequently, mental health specialists should be involved in HIV prevention programs.
Education of HIV-Positive Inmates

Clinical outcomes are greatly improved when the patient is informed and motivated. Correctional administrators can foster successful HIV care and services by ensuring that HIV-positive inmates receive effective education. Information should be designed to take into account the common characteristics or lifestyles that put inmates at risk for noncompliance with HIV treatment. Staffing levels should be appropriate to ensure provision of education and support of continuity of care.

Ongoing Prevention Services

Successful strategies to prevent HIV exposure include peer education, discharge planning, transitional case management, and harm reduction techniques. It has been shown that trained inmate peer educators can effectively provide HIV education and orientation sessions in the inmate population. Health staff and peer educators should use educational materials written in the diverse languages found in jails and prisons. The materials should be written for low reading levels and a lower socioeconomic group. Correctional administrators can support the training and maintenance of peer educators.

Correctional administrators should assist in the provision of adequately trained staff and the development of case management programs for HIV-positive inmates. Case managers may conduct adherence checks of medications, follow up with patients not keeping HIV clinic appointments, and provide inmate education/counseling and referrals as appropriate.

Harm reduction techniques such as condom distribution and counseling have been used successfully in incarcerated populations (May & Williams, 2002). California is slated to introduce condoms to its 34 state prisons over the next 5 years. While NCCHC clearly does not condone illegal activity by inmates, sexual contact does occur in incarcerated populations. The use of effective and proven public health strategies to reduce the risk of contagion is our primary concern. NCCHC recommends that correctional administrators implement harm reduction strategies including condom distribution and counseling. Counseling should address the risk of reinfection with other, potentially more resistant or virulent, strains of HIV.

Confidentiality

One of the most difficult tasks facing correctional staff is to maintain confidentiality of medical information, such as tests, diagnoses, and treatments. Correctional administrators can promote confidentiality by creating a supportive environment that reminds staff to exercise caution and diligence in maintaining confidentiality. Administrators should ensure that custody staff receive regular training to not discuss observed or overheard medical care, and to reinforce health staff training by insisting that patient information is not discussed within earshot of other inmates or officers and that ART medications not be dispensed in recognizable containers or times. Administrators also should ensure that medical records are secured at all times.

Infection Control

Correctional administrators should provide infection control training for staff. They should ensure implementation and enforcement of universal precautions policies, such as sterilizing equipment for each patient, preventing exposure during surgical procedures, and wearing masks and gowns when appropriate. Combining universal precautions with harm reduction strategies is the most effective way to address the infection control issues of HIV in correctional facilities. Current procedures for postexposure prophylaxis should be effectively implemented.
Discharge Planning

Discharge planning for soon-to-be-released inmates is important for all inmates and even more critical for HIV-positive inmates. Yet, less than one in five prisons and jails follows the CDC’s guidelines for helping inmates transition back into the community. This includes services such as making an appointment with a community health care provider, assisting with enrollment in an entitlement program such as Medicaid, and providing a copy of the medical record and an adequate supply of HIV medications. HIV-positive inmates need to receive education on their condition, prevention of transmission, and availability of services in the locality where they intend to reside.

Facilities need to make arrangements to ensure no interruption in ART. All inmates exiting while on ART should be scheduled for follow-up with an HIV provider in their area of intended residence, and they should receive detailed, printed contact information, including directions. They also should be given a supply of their HIV medications sufficient to last until they have an appointment with the community HIV provider. Optimally, health staff should contact the community HIV clinic to enhance linkage for the soon-to-be-released HIV-positive inmate and provide condoms. Some community clinics will interview the inmate prior to release and thus improve the chances of a successful transition.

Linkages With Community Resources

The Ryan White CARE Act has played a significant role in funding HIV care and ART medications for uninsured people living with HIV in the United States. In some localities, patient assistance programs (PAPs) funded by pharmaceutical companies have complemented Ryan White services. Correctional administrators should understand the availability of PAPs in the communities where inmates will reside after release, with the aim to better prepare exiting inmates to seek and to receive aftercare.

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References


