HIV
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HIV AND INCARCERATION

HIV infection is much more prevalent in correctional facilities than in the American population as a whole. This issue of PERSPECTIVES *examines some of the reasons for high HIV prevalence among incarcerated individuals, the impact of incarceration on HIV risk for their partners, and prevention interventions to reduce these risks. It also suggests ways to establish trust and work with formerly incarcerated clients.*

Research Update

More than 7.3 million Americans are under some form of correctional supervision (including incarceration in prisons and jails, and on probation and parole), almost five times the number who lived under such supervision in 1980. According to the Bureau of Justice Statistics, the prevalence of AIDS among people in prison in the United States is almost triple that of the U.S. population as a whole. While only 0.6 percent of all Americans are living with HIV, 1.6 percent of male inmates and 2.4 percent of female inmates are HIV-positive.[1] As of 2006, there were 21,980 HIV-positive people in prison in the United States.[1]

Clearly, incarceration is associated with a greater likelihood of HIV infection. In fact, one study estimates that in a given year, one quarter of Americans with HIV pass through a correctional facility.[2] It not clear, however, that most HIV transmission in this population occurs during incarceration. For example, a 2006 Centers for Disease Control and Prevention (CDC) study of 68 HIV-positive inmates in the Georgia state prison system found that 90 percent had been infected prior to their current incarceration.[3] Since many individuals experience multiple incarcerations, being HIV-positive prior to the current incarceration does not prove they became infected outside the correctional setting. Despite this, and the fact that the study was small, the Georgia findings do lend support to the theory that a large proportion of people are infected while living in the community. Whether individuals are infected with HIV while incarcerated or while living in the community, it is critical to create quality HIV care services in correctional settings.

Since most inmates eventually return to their communities, it is also important to implement interventions both inside and outside of prisons that prepare inmates for a successful life after incarceration. This Research Update explores some of the factors that place these individuals and their partners at risk for HIV, including contextual factors that may facilitate both HIV infection and incarceration. It also examines the use of HIV testing and other prevention interventions to help reduce HIV incidence among incarcerated and formerly incarcerated people and their partners.

Sex, Consent, and Corrections

It is hard to know how much sex takes place in U.S. prisons, because sexual contact between inmates and between inmates and correctional officers is a punishable crime in many jurisdictions.[3,4] Further, one 1996 study found that male inmates were more reluctant to discuss sex in prison than were female inmates,[5] possibly because of the hypermasculine prison culture that particularly stigmatizes male homosexuality, and which especially stigmatizes the receptive partners in anal sex.[6] Studies

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published between 1982 and 2002 have estimated that anywhere between 2 percent and 65 percent of inmates of U.S. correctional systems have had same-sex sexual contact while incarcerated.[7]

It is also difficult to know how much of the sex that occurs in prison is consensual. As it does in the outside world, sex in prison serves several functions: a way to express emotions, intimacy, and relationship; a means to cope with boredom, loneliness, and pain; a way to obtain protection, support, and goods; and a violent expression of power and domination through rape.

Unquestionably, both coerced sex and rape occur in prison, with severe physical and emotional consequences. Yet some researchers have suggested that while the media often focuses on sexual assault in prison, consensual sex is likely more common than rape. In the 2006 Georgia study, 73 percent of inmates who reported same-sex sexual contact in prison stated that it was consensual, while 22 percent characterized it as "exchange sex" (goods or services were traded for sex) and 12 percent characterized it as rape. These researchers found that even among men who reported consensual sex, some of the reasons given included the need for food, money, drugs, cigarettes, or personal protection, and they suggest that "consent" in prison occurs on a continuum from truly consensual, non-exchange sex through exchange sex to coerced sex and rape. Both consensual and coerced sex also occur between inmates and correctional officers, often in exchange for goods, services, or privileges[5] —although the Prison Rape Elimination Act defines all sexual contact between inmates and staff as nonconsensual and illegal.[3]

The fact that sex in prison is often illegal also thwarts HIV prevention measures. Only Vermont and Mississippi state prisons allow condom distribution, as do urban jail systems in San Francisco, New York, Philadelphia, Los Angeles, and Washington, D.C.[4] Even when condoms are made available, they may be tightly regulated. In the Los Angeles County Jail, staff from the Center for Health Justice distribute one condom per week per inmate, by request, only to a segregated group of gay-identified male prisoners. Correctional concerns about condom distribution include the fear that making condoms available would condone an illegal activity (sex in prison) or that condoms might be used to hold and hide items such as drugs.[4] Inmates sometimes create their own safer sex tools, for example, by cutting off the fingers of latex gloves to use as condoms and using hand lotion for lubrication.[5] Sex is often hidden and hurried, however, making it difficult to take HIV prevention measures.

San Francisco's jail system, which has allowed some condom distribution since 1989, recently tested a new approach: distributing condoms via vending machines, allowing more privacy and more access to a greater number of condoms. While more than five times as many inmates received condoms under the new program as under the old program, discipline problems did not increase, and prisoners did not report increased sexual activity.[8] Solano State Prison, also in California, is currently the site of a one-year pilot program in which condoms are distributed by machine at no cost.[9]

Needle Sharing, HIV, and Hepatitis C

Substance use is part of most incarcerated people's life experience: In 1998, 80 percent of people in U.S. prisons reported histories of addiction.[10] In part due to mandatory drug-sentencing laws, 53 percent of federal prisoners in 2007 and 20 percent of state prisoners in 2005 were serving time for drug offenses.[11] More than half of state prisoners in 2004 reported symptoms of drug abuse and dependence. Injection drug use experience in particular is also common: As far back as the mid-1980s, researchers studying hepatitis among inmates in New Mexico, Wisconsin, and Tennessee found that 25 percent to 40 percent of men entering prison had histories of injection drug use.[12]

> Recent research underscores the connections between mental illness, incarceration, and HIV and hepatitis infection.

The custodial environment makes it more difficult for inmates to inject drugs as frequently as they would in the community, but it also increases the HIV risk involved in injecting drugs. Yet, in one 1998 Canadian study, 39 percent of injection drug users continued to inject while in prison, and 82 percent shared injection syringes.[13] Incarcerated people are more likely to share injection equipment and not to sterilize it between users, because clean injection equipment and bleach are considered contraband.[4,5] Since HIV prevalence is higher in the prison system than outside it, prisoners who share needles inside are at increased risk for acquiring or transmitting HIV. In response to these problems, several European prisons distribute clean syringes, and have noted few problems and improved prisoner health: reduced incidence of abscess, and no newly identified HIV, hepatitis B, or hepatitis C infections.[4] No U.S. prisons provide syringes, and only a few provide bleach to clean injection equipment. Methadone maintenance (which substitutes the legal prescription drug methadone for opiates such as heroin) is only rarely available in prisons.[4]

Tattooing using shared tattoo needles is also commonplace,[4] although no documented cases of HIV transmission through tattooing have been reported.[3] Researchers are currently investigating the extent to which shared tattoo needles are responsible for the transmission of another blood-borne virus: hepatitis C.

Blood-to-blood contact that may result in HIV transmission presents a far greater risk of hepatitis C (HCV) transmission. Hepatitis C is easier to transmit through blood contact than HIV, and this risk is further magnified by the fact that HCV prevalence among prisoners is estimated at 15 percent to 40 percent,[14] compared with a 1.6 percent prevalence in the entire U.S. population.[15] One 2005 study of 469 prisoners entering California state correctional facilities found an HCV prevalence of 34 percent overall and 66 percent among inmates with a history of injection drug use.[16]

Co-infection with HIV and HCV in correctional settings is so common that some researchers have estimated that 100,000 HIV/HCV-infected people are released from prison each year—half the total number of co-infected people in the United States.[14] Co-infection with HIV hastens the damage hepatitis C does to the body. For all these reasons, the CDC has recommended that prisons be a key site for HCV screening and treatment. In correctional settings, however, HCV testing is much less common than HIV testing: While 49 states have at least one prison that conducts HCV testing, only 10 states offer routine HCV testing in all facilities.[17]

HIV Testing in Prisons

Strategies for HIV testing in correctional settings vary across correctional systems and across the country.[18] In 2006, 21 states reported testing all inmates for HIV upon admission or during custody.[1] As of 2006, no large city or county jail systems had made HIV testing mandatory.[18]

Forty state prison systems and the federal system test inmates who have been involved in incidents that may have exposed an inmate to HIV.[1] Federal prisons and 47 state prison systems offer HIV testing in prisons when an inmate requests testing or when an inmate becomes ill and HIV is suspected.[18]

While testing is a key aspect of HIV prevention, voluntary testing in correctional settings presents special challenges. There is little confidentiality in the custodial environment, and inmates may reasonably be concerned about discrimination or being segregated from other prisoners should their HIV-positive status become known.[7] Six states, including California, house at least some of their HIV-positive inmates in separate facilities in order to provide more intensive medical care.

The Larger Context

There is considerable overlap between the populations of incarcerated people in the United States and those most at risk for HIV. Poor people, Black people, people who use substances, and people with mental illness are all disproportionately represented among both the HIV-positive and incarcerated populations. Incarcerated people are also more likely to become homeless, and this risk is especially high for those who have a history of mental disability or illness.[19,20]

Researchers are increasingly examining the relationship between incarceration and HIV disease. Among the areas of interest that have emerged are mental health disparities, systemic factors that undermine the quality of life after release from prison, and the impact of incarceration on inmates' partners.

Mental Health Disparities. Recent research underscores the connections between mental illness, incarceration, and HIV and hepatitis infection. In 2008, University of Texas researchers published the results of a three-year study of the medical records of more than 370,000 Texas Department of Criminal Justice inmates (Texas has one of the largest prison systems in the country). The investigators found that inmates diagnosed with HIV alone, co-infected with HIV and HCV, and co-infected with HIV and hepatitis B (HBV) had higher rates of major depression, bipolar disorder, schizophrenia, schizoaffective disorder, nonschizophrenic psychotic disorder, and any type of psychiatric disorder. Inmates with HIV/HCV co-infection had higher rates of psychiatric disorders than those with HIV alone.[21] Further, a 2009 retrospective study, also by the University of Texas, found that inmates suffering from major psychiatric disorders had substantially increased risks of multiple incarcerations over the six-year study period.[22]

Social Marginalization after Release. Incarcerated people are usually from poor, disadvantaged communities, communities to which they return upon release.[20] At the same time, many rights and services are closed to people who have been released from incarceration (sometimes called "releasees"). Although rules vary tremendously between states, convicted felons in most states cannot vote. They are also often ineligible for welfare assistance,[23] federal housing or housing subsidies, and federally financed student loans, and may either be ineligible for or simply passed over for employment.[20,24]

These destabilizing effects may contribute not only to recidivism, but also to vulnerability to HIV infection. For example, people who lack basic necessities such as food, shelter, and social support may also find it difficult to make HIV prevention a priority. For former inmates who have used sub-

stances, difficulties obtaining housing or employment may increase the likelihood that they will return to using drugs or to trading sex for drugs, behaviors that can increase HIV risk.

The time immediately following release from prison can be an especially vulnerable one. A recent four-year study of more than 30,000 Washington State Department of Corrections releasees reported that during the first two weeks after release, the risk of death among former inmates was 13 times that of other state residents, with a significant risk of death from drug overdose.[25] Clearly, a comprehensive array of health and mental health services are critically needed to address these vulnerabilities—including the vulnerability to HIV infection.

One such program is Project START, an evidence-based intervention designed to reduce HIV, STD, and hepatitis transmission among male and female releasees. The program uses an individual-level, multi-session intervention that begins prior to release to educate clients about HIV risk and improve their risk reduction skills and create a plan to meet other needs such as housing, employment, financial stability, sobriety or substance-related harm reduction, mental health treatment, legal advice, and reincarceration prevention. Post-release sessions include review and update of clients' needs, goals, and risk reduction and transitional plans.[26]

Concerns of Partners of Incarcerated People. Ninety-three percent of prison inmates are male, most identify as heterosexual, and 50 percent report a regular female sexual partner to whom they plan to return on release.[11,27] Since having a sexual partner who has been incarcerated is associated with heightened rates of HIV and other sexually transmitted infections,[28] and since there is evidence that releasees, like other groups of people, are less likely to use condoms with regular sexual partners than with one-time or occasional partners,[29] women whose partners are or have been incarcerated are a population particularly in need of HIV prevention services.

According to research by the University of California, San Francisco, female partners of male inmates may engage in unprotected sex or needle sharing because they underestimate their HIV risk from their partners or because they want to re-establish closeness after forced separation. The experience of isolation, relationship pressures, and interaction with the custodial system all can leave women with a diminished sense of self-efficacy that can prevent them from successfully negotiating safer behaviors.[28]

Conclusion

Incarceration and life after release present multiple social, psychological, and economic hardships to both inmates and their partners. Within this context, the challenge of remaining HIV-negative or preventing HIV transmission is particularly difficult. Effective HIV prevention interventions must acknowledge the real risks of HIV transmission both inside and outside correctional facilities, address the psychosocial needs of former inmates, and use a combination of strategies to empower inmates and their partners to protect their health.

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Implications for Counseling

Involvement with the correctional system affects how people view life, including their attitudes toward HIV infection and HIV test counselors. In some cases, clients and counselors may find it difficult to build rapport quickly in the brief counseling session. This may happen for many reasons, for example, because the client's past experiences of stigma make trusting the counselor difficult, the client perceives the counselor as the representative of an oppressive system, or the counselor's assumptions and judgments about the client create barriers to connection.

Formerly incarcerated people have often experienced multiple layers of stigma related to race, economic or educational status, or sexual orientation, in addition to their incarceration history. Understanding the stigma and other challenges that formerly incarcerated people may have experienced (both inside and outside of correctional facilities) can help counselors understand how these individuals view and prioritize the risk of contracting HIV and how they may react to the dynamics of the counseling session.

Start Where the Client Is

As with any client, it is useful for the counselor to ask formerly incarcerated clients about what brings them in to test, their HIV knowledge, and their prior testing experiences and results. Because the goal of the custodial system (maintaining rules and order) is different from that of the public health system (preventing disease), the experience of testing may have been quite different for the client in a correctional facility.

In the correctional environment, for example, there is little privacy or confidentiality. As a result, some clients may have difficulty trusting that the experience of HIV testing outside of these settings will be truly confidential. These clients may choose not to reveal personal information for fear of negative consequences. Clarifying the ways that the session at a counseling and testing site is different from those the client has previously experienced may be helpful.

Examine Assumptions and Judgments

Some counselors experience fears and concerns about working with people who have been incarcerated, and it is important for counselors to try to distinguish between real threats and unfounded fears in these cases.[6] Some counselors also bring assumptions or judgments to the session—judgments that could be related to the crime for which the person was incarcerated or to the notion that, as a former inmate, this person will be incapable of reducing his or her risk for HIV.

It is important for counselors to examine these beliefs and feelings, and to discuss them with peers and supervisors, so that these feelings do not get in the way of counseling and further disempower the client. A

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respectful, non-judgmental encounter allows clients to receive the services to which they are entitled, and is a small step toward helping clients feel more powerful and connected, which can help reduce their HIV risk.

Talking about Risk

Clients may be reluctant to disclose that they have been incarcerated or that they engaged in HIV risk behaviors while incarcerated. Clients may not only feel shame about certain sexual or drug-related behaviors, they may also have experienced (or seen others experience) punishment—from prison authorities or other inmates—for these behaviors.

When clients disclose sexual activity during incarceration, it is helpful for counselors to avoid assumptions and remember that sex can be consensual, used in exchange for goods or services, coerced, or forced. Similarly, same-sex sexual activity, even if consensual, may or may not be related to the way that the client identifies his or her sexual orientation—as gay, straight, or bisexual.

While it is important to help clients understand which past behaviors may have put them at risk for HIV transmission, it is even more critical for clients to consider how they can reduce the risk of acquiring or transmitting HIV in the future. As with any client, it is useful to ask formerly incarcerated clients questions such as "Do you have a regular partner?" "How much are you and your partner able to share about each other's sexual (or drug use) history?" "What kinds of conversations have you had (or would you like to have) about avoiding HIV?"

"Third-personing" can introduce information and normalize certain experiences without directly confronting the client about a specific experience. For example, a counselor might say, "Often it's hard for people to talk with their partners about their experiences in prison," or "Some of my straight clients have gotten together with other guys."

Prioritizing HIV Risk Reduction

Even clients who are knowledgeable about HIV prevention may not translate that knowledge into behavior change if they feel personally disempowered, if they view HIV risk behavior as a way to maintain a sense of security and connection, or if they are more concerned with meeting other needs than with reducing HIV risk.

A Counselor's Perspective

"The greatest challenge for me in counseling formerly incarcerated people is to help them feel powerful about their ability to reduce their risk for HIV. Often the entire prison experience has left them feeling so powerless."

The custodial environment typically offers inmates few choices in their day-to-day lives, encouraging a sense of powerlessness rather than one of personal responsibility. The transition back to the pace, demands, and decisions required by the "real" world can be overwhelming.[30] Affirm the step the client has taken by testing, avoid inundating the client with information, and help the client to see HIV risk reduction in terms of small, manageable steps, rather than a laundry list of requirements.

Understand that incarceration "cuts people off" from much of the rest of the world, and that sexual activity and substance use are ways that many people use to feel connected or to deal with painful feelings of loneliness, isolation, or frustration. Further, people who have been incarcerated and their partners may feel impatient to "get on with life" by re-establishing intimacy, and sex without condoms is one way that many couples do this. A counselor might acknowledge this reality by saying, "I can hear how much you missed your girlfriend. Sometimes people tell me that they can't wait to 'make up for lost time,' but they want to make sure that they are protecting their partners too. What are some ways that you two could get close without worrying about HIV until the window period is over for both of you?"

Given all the other challenges that formerly incarcerated people must cope with, HIV prevention may not be at the top of their priority list. The challenge for counselors is to affirm the importance of HIV risk reduction while acknowledging the complex content of clients' lives. Among the other priorities that compete for client energy and attention are surviving day-to-day, finding housing, working, obtaining food and money, reuniting with family, and obtaining drugs or substance abuse treatment. Offering referrals to meet some of these needs can build rapport in the session, while at the same time helping the client stabilize his or her life in ways that can also reduce HIV risk.

Making Key Referrals

A working knowledge of the key referrals for formerly incarcerated people is a must. Some of these critical referrals include those for housing, benefits assistance, employment services, substance abuse services, and medical care. It is also especially

Case Study

Darryl is a 38-year-old heterosexually identified man with a long history of injection drug use who has come in for an HIV test. During the session, Darryl reveals to his test counselor, Aaron, that he was released from prison on parole about six months ago after serving two years. He also says that he has been diagnosed with hepatitis C, and that he's been reunited with his longtime girlfriend, Denise.

"You asked me why I'm here," Darryl says. "The truth is that I slipped. I got loaded right after I got out with some of my old running buddies. I know it was weak, but a lot of things were hitting me at once." He pauses a moment and then adds, "Fortunately, Denise is a patient woman—we're going to get married soon. I wanted to get checked out for her too."

Aaron smiles. "Congratulations on getting engaged." He continues, "A lot of guys say that it just feels like the world is spinning too fast when they get out, and it's easy to fall back into old habits. So you're mostly concerned about having shared injection needles about six months ago, is that right?"

Darryl nods in agreement. "Yeah. It was real hectic with my housing situation, and the pressure was getting to me. Since then I've been staying with friends, but nobody wants to hire me and I'm running out of couches to sleep on."

Aaron nods. "OK, let's step back for a second and get the picture of what's been happening. You just got out, you're in a relationship with your fiancée that's important to you, you're having trouble finding work and a place to live. I can see how that might be overwhelming. On top of all that, you're dealing with hepatitis C."

"Uh-huh," Darryl says. "I didn't like being on the inside, but sometimes it can be really harsh out here too."

"In the middle of all these big changes it makes sense that you might feel pulled toward things that feel good, like heroin," Aaron remarks.

"I just want to get away from everything sometimes," Darryl responds.

"That's a lot for one person to handle on his own," Aaron agrees. "One resource that has been helpful to some of my clients who have been incarcerated is Friends Outside—they can help with food, job counseling, and a lot of the re-entry process. I'll give you their contact information at the end of the session if you'd like it."

"That sounds good," Darryl says. "Can they help me get back on methadone?"

"I know they have some substance use treatment resources, and I can also give you the contact information for the methadone clinic," Aaron replies. "But first, let's talk a little more about what brought you in here: You don't want to get HIV and you also want to protect Denise's health…."

helpful if the test counselor is knowledgeable about specific local services for formerly incarcerated people that can help the client make the transition back to community life. At the same time, counselors and clients may experience frustration because of the lack of adequate resources to assist incarcerated and formerly incarcerated people and their partners.

Because of the lack of autonomy they experienced during incarceration, former inmates may especially benefit from prevention and case management services that help them make good choices. Ongoing HIV prevention services such as Comprehensive Risk Counseling Services may be helpful in supporting clients in reducing HIV risk behavior over time. Formerly incarcerated individuals who are newly diagnosed HIV-positive may need more help than other clients in getting connected to a health care provider, especially if they have been recently released.

Counselors should take extra care to troubleshoot referrals for recently released individuals. Many of these clients may be confused about how certain systems work. For example, public transportation schedules, routes, and farecards may have changed since the last time the client used them. Clients may also feel impatient, frustrated, or have trouble dealing with bureaucracies.[30]

When counselors can help clients manage their expectations and think through what the client will need to successfully use the referral, the chances that the client will actually benefit increase. It is also helpful for counselors to track how other service providers treat formerly incarcerated people, so that counselors can make referrals to agencies that are most likely to welcome and serve these clients.

Test Yourself

Review Questions

1. True or False: The prevalence of AIDS among people in prison in the United States is five times that for the U.S. population as a whole.

2. The prison environment may increase the risk of HIV transmission for injection drug users for several reasons. Which of the following is not one of those reasons? a) The prevalence of HIV in prison settings is higher than outside them; b) Incarcerated people are more likely to share injection equipment than people outside prison; c) Incarcerated people tend to inject drugs more frequently than people outside prison; d) Incarcerated people are less likely to sterilize injection equipment than people outside prison.

3. True or False: HIV prevalence is higher among female inmates in the United States than among male inmates.

4. Women may engage in unprotected sex or needle sharing with their formerly incarcerated partners for a number of reasons. Which of the following was a reason highlighted in this Research Update? a) Women want to re-establish closeness in the relationship; b) Women feel a sense of guilt and shame about the partner's incarceration; c) Women are physically coerced by their partners; d) None of the above.

5. True or False: Few state prison systems offer routine hepatitis C screening.

6. It is difficult to implement safer sex measures in prison because: a) sexual contact is illegal in prisons; b) most sex in prison is nonconsensual so there is no chance to use protection; c) despite massive education efforts, incarcerated people are reluctant to use condoms; d) condoms are prohibitively expensive.

Discussion Questions

1. What do you think are the most serious challenges to HIV prevention for formerly incarcerated people and their partners? As a test counselor, how would you help clients respond to these challenges?

2. What kinds of assumptions might a counselor make about a formerly incarcerated client that could get in the way of HIV prevention counseling?

3. How would you talk with a client about his or her HIV risk behavior while incarcerated?

4. What do you find to be the most important referrals for clients who have been recently released from correctional settings?

Answers to Review Questions

1. False. The prevalence of AIDS among people in prison is roughly three times that of the entire U.S. population.

2. c.

3. True.

4. a.

5. True.

6. a.

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals.

Each issue explores a single topic. A ***Research Update*** reviews recent research related to the topic. ***Implications for Counseling*** applies the research to the counseling session. Also included are a ***Case Study*** and two sets of questions for review and discussion.

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Editor: Robert Marks
Clinical Editor: Michelle Cataldo, LCSW
Author: Michelle Cataldo, LCSW
Case Study: Michelle Cataldo, LCSW, Bryan Kutner
Clinical Advisor: George Harrison, MD
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Production: Carrel Crawford, Lisa Roth, Lawrence Sanfilippo, Beth Wrightson, LCSW
Circulation: Stephen Scott

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Executive Director:
James W. Dilley, MD

Manager of Publications and Training:
Robert Marks

Designers: Saul Rosenfield, Lisa Roth

Contact Us:

Michelle Cataldo, LCSW
UCSF AIDS Health Project, Box 0884
San Francisco, CA 94143-0884
415-476-2626
e-mail: michelle.cataldo@ucsf.edu