Breaking Into New York's Correctional Facilities

November 10, 2014 By Demetrius Thomas

Getting into New York's correctional facilities has been one of my primary tasks since I began working at GMHC in September 2013. The urgency of this task was felt even during my interview process; it was a central component and the most difficult deliverable for GMHC's Prison HIV/AIDS Prevention Project. Before my arrival, little progress had been made, and on September 30, 2014, GMHC's grant from the Ford Foundation, which funded the project, was scheduled to end. It was designed with two primary objectives: (1) improve prevention and health care services for persons incarcerated living with or at risk of contracting HIV, and (2) ensure that individuals living with HIV are connected to services upon their release.

I was not surprised that, after several attempts, GMHC was unable to gain access to New York's correctional facilities. As an attorney familiar with the process, I witnessed bureaucratic blockades that non-correctional, community-based organizations like GMHC experience when trying to access facilities.

What I was most surprised by was the pervasive mentality among New York's correctional leadership that there are no problems in HIV/AIDS health and transitional care services in their facilities. This mindset is the biggest barrier to access to care and reducing new HIV infections. Until correctional leadership and key stakeholders change this insidious mindset, New York Department of Corrections and Community Supervision's (DOCCS) role to help end the HIV/AIDS epidemic will never be realized. Furthermore, inadequate HIV/AIDS health care in facilities and the lack of comprehensive transitional services upon release is in direct opposition to New York Governor Andrew Cuomo's recently announced plan to end the HIV/AIDS epidemic by 2020 in New York State (NYS).

The notion that New York correctional facilities don't need to improve care for people living with or at risk for HIV/AIDS is in stark opposition to the findings of numerous reports, which concluded that health and transitional care services fall well below the standard of care received and required by the general public. I've heard advocates refer to New York's correctional facilities as "reservoirs" of concentrated HIV/AIDS prevalence. In early 2014, a DOCCS subcommittee, which included the NYS Departments of Health and Mental Hygiene's AIDS Institute, submitted recommendations to the State's AIDS Advisory Council on the delivery of HIV/AIDS healthcare in prisons. Among the

recommendations are: (1) enhanced HIV testing, (2) improved and increased comprehensive HIV services, and (3) better monitoring and oversight.

Testimonies of those who have been incarcerated in New York further demonstrate the urgency for intervention. TJ is 59 years old and has spent the majority of his life, 33 years, incarcerated. A former IV drug user, TJ turned to crime to support his substance use; he was only 14 years old when he started using. Instead of being offered an alternative to incarceration to address his addiction, TJ, like so many, was forced into a cycle in the correctional system. At only 22 years old, he served his first federal sentence. Throughout his time in the system, he was incarcerated in at least 12 facilities, and the majority were maximum security. TJ entered the correctional system reading at a fourth grade level and performing at a third grade math level. Yet, while incarcerated, he was on track to receive his bachelors of arts degree. However, college programs in correctional facilities were cut, and he was forced to settle for an honors association of arts degree. He also earned nearly 50 New York State Department of Health certifications in areas including: substance abuse; lesbian, gay, bisexual and transgender (LGBT) cultural competency; Hepatitis C and HIV/AIDS peer educational trainings; and anger and violence resolution. TJ's resolve and educational achievements suggest that he was a better candidate for alternative drug treatment programs than jail or prison.

While TJ was able to accomplish most of his educational goals within New York's correctional system, he was not able to access basic HIV/AIDS health care services. In 1984, TJ stopped using intravenous (IV) drugs for fear that he would contract HIV. It was too late. In 1985, as a result of IV drug use, TJ was diagnosed with HIV while in prison. Like so many others, he was afraid to seek HIV treatment for fear of being stigmatized or discriminated against. This led to an AIDS diagnosis in 2007. TJ refused to seek treatment for the last 13 of his 15-year sentence because he was afraid others would learn his status. He witnessed how people whose status had been discovered were mistreated; warm embraces were replaced with cold head nods as greetings.

Demetrius Thomas

The most egregious mistreatment came from correctional staff, especially in upstate New York. The lack of patient confidentiality while incarcerated exacerbates people's fears of others learning their status. For example, before seeing a doctor individuals are required to complete a public sick call list, which includes the purpose for the appointment. In doctors' offices, rooms are marked with "HIV/AIDS Specialist." To receive medication refills, one must complete a sick call form that requires the name of the medication. Additionally, sick call forms and medication are often distributed by peers in facilities.

Even when people are brave enough to take their medication, distribution is often a problem. TJ often went days without his HIV medications because they weren't available and needed to be ordered. Even when medications arrive, individuals often aren't notified. As a result, TJ went days without medication. TJ also said that there are no staff to track whether a person is taking or even receiving medication. Because they are often self-administered, it is each individual's responsibility to save food for medications that must be taken with food, a big problem if meals are served on a different schedule.

Sex and drug use are common in correctional facilities. Unfortunately, those incarcerated in New York, and in the majority of facilities across the country, engage in these activities without the benefit of condoms or clean syringes, as their distribution is against the law. TJ says that sex without condoms occurs about 90% of the time. He recalled an incident where someone killed his lover after learning that he had contracted HIV, a murder that possibly could have been avoided if proper treatment and condoms were available. In rare instances, TJ recalled people creating makeshift condoms with latex gloves or balloons. He also said that sharing needles for IV drug use is rampant and described a process called "fishing," where persons housed in different cells, or even floors, share needles to get high.

HIV/AIDS education and prevention training is almost as scarce as condoms and syringes. TJ says there is no mandatory HIV/AIDS education and prevention education in facilities. Instead, persons entering facilities receive a rules and regulation booklet, which includes a short paragraph that summarizes only statistics on those living with HIV/AIDS in facilities. The booklet may also include information on where to get additional education on HIV/AIDS and prevention, which often requires signing up on a public list. Based on his expert advice as a certified HIV/AIDS peer education trainer, TJ believes that lack of education and sensitivity training is the greatest cause of HIV/AIDS stigma by both correctional staff and those incarcerated.

Unfortunately, TJ's story is not unique. It's echoed by attendees of GMHC's Releasing Health Working Group, a member-led group comprised of many people formerly incarcerated in New York and living with HIV/AIDS. This group advocates for these issues, as well as criminal justice reform and prisoners' rights.

While, there is much work to be done, DOCCS deserves recognition for some improvements. It has expanded its voluntary HIV-testing program, improved testing and treatment of tuberculosis, and opened regional medical units for people with chronic illnesses, including those living with HIV/AIDS. It also partnered with the New York State AIDS Institute to create the Criminal Justice Initiative (CJI) and Positive Pathways (PP). The CJI funds community-based agencies to provide priority services to those with HIV/AIDS. PP identifies people who have recently seroconverted or who have not disclosed to and/or are not in treatment with DOCCS medical in order to enroll them in its community care component. This ensures linkage to care upon release and for six months post-release. These accomplishments are not easy, especially given continuously shrinking budgets and the inherent conflict of providing quality health care in institutions with strict security procedures.

In addition, DOCCS should not have the sole responsibility for improving delivery of HIV/AIDS health care and transitional services in correctional facilities. Elected officials and lawmakers must create policies that improve and secure funding in correctional facilities and focus on the needs of those in the criminal justice system. Correctional and/or DOCCS contracted organizations should not have a monopoly on providing health care and traditional services in correctional facilities; these organizations and DOCCS should be open to working with other community-based organizations to expand and improve services.

More foundations, government entities, and private funders need to invest in these policy and bureaucratic changes. Funders need to invest in the long term, not just while an issue is "hot." Thus, organizations seeking to do the work will feel less pressure to create unrealistic and unmanageable deliverables for fear of not having their proposals accepted, or fear that their grant will be withdrawn or not re-funded if a deliverable hasn't been met.

Foremost, New York's correctional leadership and staff must change their belief that HIV/AIDS health and transitional care services in facilities are fine. The term "institutionalized" is often used to describe a

person incarcerated who has begun to accept prison thinking as that of the greater society. It seems that the term also describes correctional leadership and staff. Reports and personal testimonies make clear that HIV/AIDS health and transitional services need improvement.

In June 2014, New York Governor Andrew Cuomo announced a plan to end the HIV/AIDS epidemic by 2020. While his plan includes ensuring those released from correctional facilities are linked to proper HIV/AIDS health care and services in the community, it does not address improving prevention and health care services for persons while incarcerated, where many receive HIV/AIDS medical treatment for the first time. Proper medical treatment can suppress a person's viral load and prevent transmission up to 96%. Approximately 30,000 individuals are released per year from New York's correctional facilities, and many return to communities that are disproportionately affected by HIV/AIDS. Proper treatment while incarcerated and access to services upon release will decrease and help lower the communities' viral load.

New York's correctional system can play a vital role in ending the HIV/AIDS epidemic, but not unless we change the way we view those who are or have been incarcerated and who are living with HIV/AIDS. Everyone deserves the right to live with human dignity, which includes access to quality health care in correctional facilities. We must understand that the implications of HIV/AIDS health care and transitional services for those incarcerated extend well beyond the confines of correctional walls and affect the public health of all New Yorkers. Until these changes occur, the positive effect New York's correctional system can have on ending the epidemic will never be realized. Until Governor Cuomo and New York's correctional system provide adequate health care services for persons incarcerated with or at high risk of contracting HIV and improve transitional services upon release, his plan to end the HIV/AIDS epidemic in New York will be an unrealized vision.

Ultimately, GMHC sought to partner with the correctional organization Osborne Association to put New York's correctional facilities on track to: (1) identify those with HIV; (2) implement HIV testing that is universal, routine, available upon request; (3) provide HIV prevention education that follows national, community standards of care and that provides programs with adequate training, services, and resources; (4) ensure that healthcare and support services meet the same standards of care received and required by the general public; and (5) offer transitional care services that identify and link at-risk and HIV-positive individuals to the most effective, community-based program(s).

At the time this article was sent to publication, we were still awaiting approval of our entry applications from DOCCS…

To read the issue as a PDF, click here.

© 2026 Smart + Strong All Rights Reserved.
http://beta.docker.poz.com/article/sero-zero-correctional-facilities-26417-1548