Society’s Disposable People: HIV Serostatus, Sexual Orientation, and Incarcerated

Victoria L. Harris, MD, MPH1

The United States incarcerates more people per capita than any other country in the world that keeps records of such events. The point prevalence midyear 1999 (1.9 million adults) only represents those incarcerated in county jails, state prisons and federal institutions. It does not include those on parole, work release, and mandated community supervision or home electronic detention. From July 1, 1998 to June 30, 1999, the number of inmates in prison rose by 3.8%. During the same time period, there was a 9.6% increase in federal prisoners, and jail detainees rose by 2.3%. Two-thirds of incarcerated adults are in state prisons and federal institutions (1.2 million) (1, 2).

While the absolute numbers of incarcerated adults continues to climb (1–3), mental illness among those incarcerated has increased disproportionately (4–6). The reported decrement of HIV seroprevalence in state and federal prisons from 2.3% (1996) to 2.2% (1997) is hardly cause for celebration (7). HIV in prisons remains over five times that of the national community prevalence (7–9).

There is clear and convincing evidence that correctional facilities have become collection and containment centers for both mental illness and HIV (7–12). Schizophrenia and major affective disorders among male jail detainees were found to be 2–3 times higher than general population rates (10). In a study of 95 male prison inmates over the age of 50, the one month prevalence rate of a depressive disorder was 35%; for anxiety disorders 4% and for a simple phobia, 30% (11). In a study of 1272 female jail detainees, over 80% of the sample met criteria for one or more lifetime psychiatric disorders (12).

The man was sitting on a wooden bench sobbing. His hands obscured his face and he was hunched over in a defensive posture that suggested oblivion to the environment. It was so unusual—sometimes on rounds on the psychiatric unit I see and hear soft crying, and sometimes in the outpatient clinic people need Kleenex to wipe their eyes. But to see loud crying with sobbing in the central jail corridor—something unusual was going on.

The psychological evaluator who was nervously thumbing through a medical record seemed relieved that I had come out of the office to see what was happening. He pulled me aside and told me that a deck officer had referred Tom because of the crying. He had learned that Tom was indeed on psychiatric medications and was HIV seropositive.

“And he is probably gay” I added to myself. Tom was clearly agitated. Both legs bounced up and down on the floor and his hands went from his face to wringing and back to his face. The sobbing continued and I could see tears streaming down his face. He looked young—somewhere in his late 20s I guessed, neat (expensive) hair cut, no scars or tattoos on his pale white arms and face, no earring holes visible, no nicotine stains, and severely bitten fingernails on both hands. He seems a little pudgy, but with a swollen face from crying, only arms and face not covered by clothing and the baggy jail uniform, I knew I could easily be wrong. I noted Tom wore the red uniforms (surgical scrubs)—it meant he had, at the very least, been accused of a serious (felony) crime that could result in going to prison.

1Department of Psychiatry and Behavioral Sciences, University of Washington, 901 Boren, Suite #1100 Seattle, Washington 98104; e-mail: vharris@u.washington.edu.

2In the United States jails are pretrial facilities and hold both those accused of minor (misdemeanor) and major (felony) crimes awaiting trial. In addition, they serve as detention facilities for those who have been found guilty or plead guilty to a misdemeanor crime and were sentenced to (usually) “a year less a day.” Prisons are facilities for those who were found guilty or plead guilty to a felony and were sentenced to more than a year of incarceration. Federal Institutions hold those who were found guilty or plead guilty to a federal crime.
I turned my body so the officer in the central control could see me clearly and raised both arms up to my ears. Both flexor and extensor surfaces of my wrists and forearms were shown with a quick pronation/ supination movement. All so the officer could see I had (literally) “nothing up my sleeves” that I would pass along to Tom. The movement took a fraction of a second and was acknowledged. Both the officer and I acted from well-practiced behavior all because I planned to touch Tom. I sat next to him on that hard wooden bench with my hand on his back and introduced myself as: “Dr. Harris. Dr. Victoria Harris.” Tom responded immediately by calming his feet. He allowed me to lead him to a private clinic office (actually a converted solitary cell) one floor below.

Possible reasons for the concentration of the mentally ill in the correctional facilities have been discussed previously (4, 10–12). In summary, it has been well documented that communities in general believe that the police are more appropriate to deal with aberrant behavior as opposed to any (if present) mental health crisis outreach team (4, 13). As a society we believe that if you are not guilty of something you don’t end up in jail, so there is no harm in calling the police. The deinstitutionalization movement of the mentally ill from state facilities to the community in the 1950s was supported with good intentions. However, policies and legislation were implemented without sufficient community stability such as housing, health and mental health care, and vocational training programs (4, 10). Finally, federal legislation mandating prison sentences for drug charges such as possession of crack cocaine have all combined to increase the likelihood of a mentally ill individual ending up in jail (4, 10, 12). HIV seropositive individuals are concentrated in county jails as a direct result of community instability, the sex-trade industry (prostitution, which is a misdemeanor offense) and virtually all jurisdictions, and IVDU (7–9, 14, 15).

Peers-reviewed articles combining the issues of mental illness and HIV serostatus in the context of correctional health exist primarily in the form of program outcomes (16–20). Although the integrated programs clearly show beneficial results for program participants in terms of rearrest and (some) markers of community stability, there are no epidemiological summaries. That is, how common is mental illness among incarcerated HIV seropositive individuals? What is the most likely psychiatric diagnosis? Answers to these questions could have a profound impact on provider knowledge, resource planning, and treatment planning for individuals.

Although epidemiological studies on incarcerated HIV seropositive mentally ill adults are not available, the professional literature is replete with information concerning the treatment of mental illness in the context specific context of HIV/AIDS (21–24). However, the information and expertise is clearly beyond the current capabilities of most correctional health and mental health providers. Easy access to the web and a medical reference database are essential to maintain a current knowledge base. In addition, time and resources devoted to ensuring continuing medical education is required to maintain knowledge of current practice standards. Yet, correctional providers are subject to overwhelming clinical burden of relatively unhealthy people.

Tom was an unplanned appointment that took about an hour and a half, during a 4-h clinic that already had nine new HIV seropositive people scheduled. Thankfully, two people had already been released, and one was in court. The clinic was manageable, but I was concerned about Tom.

He told me immediately that he had been accused of attempted murder of his boyfriend. They had been living together for 4 months in a relationship marked by domestic violence and alcohol abuse, if not outright alcohol dependence. In a nonstop, pressured manner, Tom told me the story of the night of the (alleged) crime. But I couldn’t follow it. He wasn’t crying anymore, but was not telling the story in a chronological manner … and I hadn’t said a word yet. I let Tom continue. Listened for details I wanted to remember, noted where his psychomotor movements became more or less agitated, and waited. Eventually all that Tom told me was repetitive—and with that I interrupted.

Eventually I learned that Tom had been incarcerated for about 6 weeks. Tom was in his late 30s. He had been on an antidepressant through his community internal medicine doctor. By phone consultation between the community provider and one of the other jail psychiatrists, Tom had been placed on: Stavudine (D4T) 40 mg BID, Epivir (3TC) 150 mg BID, Indinavir 800 mg TID, Albuterol puffer ii PRN, and Paxil 20 mg QAM. His last CD4 count and viral load were done 4 months prior to incarceration and were 480 and unavailable, respectively. He had been seen several times by a medical provider at the jail, had somehow missed his 14 day physical exam and was waiting to be called to the clinic for a rash on his hands.

It took the majority of our time to get that little information from Tom. Every question I asked somehow referred to his boyfriend (Doug). He would leave from the tangent and pursue a response that was entirely concerned with Doug.

Eventually I learned that Doug had been incarcerated for about 6 weeks. Doug was in his late 30s. He had been on an antidepressant through his community internal medicine doctor. By phone consultation between the community provider and one of the other jail psychiatrists, Doug had been placed on: Stavudine (D4T) 40 mg BID, Epivir (3TC) 150 mg BID, Indinavir 800 mg TID, Albuterol puffer ii PRN, and Paxil 20 mg QAM. His last CD4 count and viral load were done 4 months prior to incarceration and were 480 and unavailable, respectively. He had been seen several times by a medical provider at the jail, had somehow missed his 14 day physical exam and was waiting to be called to the clinic for a rash on his hands.

The psychiatric signs and symptoms were confusing and did not fit into a nice DSM-IV diagnosis.