

Community-Based Alternative Sentencing for HIV-Positive Women in the Criminal Justice System

Cynthia Chandler† with Gwen Patton* and Jenny Job**

True horror stories of the HIV/AIDS incarcerated women are many and painful. There are very few like myself who will write, speak out, and act up. . .¹

In many important respects women in prison are the most vulnerable people in our country. The assault on the rights of women prisoners points to the systemic assault on democratic possibility in this country. To stand up for the rights of women in prison is to challenge racism and poverty and resist becoming an incarcerated society. To stand up for the rights of women in prison is to defend the possibility of a democratic future in this country.²

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1. Joann Walker, *A Woman's View: The Worst Day of My Life!*, THE CAL. PRISONER (Prisoners' Rights Union, Sacramento, Cal.), Spring 1994, at 4. Joann Walker (June 1, 1950 - July 13, 1994) was an HIV-infected prisoner activist who was awarded compassionate release from the Central California Women's Facility in Chowchilla, California just two months before she died.
2. Nina Siegal, *An Interview with Angela Davis*, Ms., Sept./Oct. 1998, at 73, 73 [hereinafter Siegal, *Interview*] (quoting Angela Davis, Professor at the University of California, Santa Cruz, activist, author, and former political prisoner).

I. INTRODUCTION

The United States has the highest incarceration rate in the world,³ with women comprising the fastest growing prison and jail⁴ population in the United States.⁵ The vast majority of incarcerated women were convicted of non-violent crimes.⁶ As HIV infection has reached epidemic proportions in United States prisons and jails, many women prisoners are HIV-positive.⁷ Women currently incarcerated in the United States suffer disproportionately higher rates of HIV infection than male prisoners.⁸ Recent public health research shows a correlation between disenfranchised societal status and increased HIV risk,⁹ and criminological literature points to a correlation between disenfranchised status and the risk of incarceration.¹⁰ Reflecting these correlations, incarcerated women and HIV-positive women share many of the same demographic characteristics.¹¹ Both are overwhelmingly women of color struggling with poverty and addiction¹² and with histories of sexual abuse¹³ and other victimization.

3. See Alexander C. Lichtenstein & Michael A. Kroll, *The Fortress Economy: The Economic Role of the U.S. Prison System*, in CRIMINAL INJUSTICE: CONFRONTING THE PRISON CRISIS 16, 17 (Elihu Rosenblatt ed., 1996).
4. The primary distinctions between prisons and jails include the government entity overseeing the facility and the status of the people incarcerated in the facility. Prisons are run either by the states or the federal government to incarcerate persons convicted of felonies, which are crimes punishable by a term of one year or more. Jails are usually run by city or county governments and are usually used to incarcerate persons either awaiting trial; convicted of misdemeanors, which are crimes punishable by a term of incarceration not to exceed one year; or convicted of felonies, but sentenced to short jail terms. In this article, I refer to people incarcerated in either type of institution as prisoners.
5. See Anne S. De Groot et al., *Barriers to Care of HIV-Infected Inmates: A Public Health Concern*, AIDS READER, May/June 1996, at 78, 81 [hereinafter De Groot et al., *Barriers to Care*] (relating that between 1980 and 1993 the female prisoner population rose by approximately 313%); Nina Siegal, *Women in Prison: The Number of Women Serving Time Behind Bars has Increased Dramatically. Is this Equality?*, Ms., Sept./Oct. 1998, at 64, 65 [hereinafter Siegal, *Women in Prison*] (relating that the number of women in prison in the United States grew by 6% in 1997).
6. See Siegal, *Women in Prison*, supra note 5, at 68 (relating that only 8% of women in federal prisons and 32% of women in state prisons were convicted of violent crimes).
7. See De Groot et al., *Barriers to Care*, supra note 5, at 79 (reporting that the rate of HIV infection among prisoners is 10 to 100 times higher than the rate in the general population).
8. See *id.* at 81 (relating that the rate of HIV infection is higher among women in almost all of the correctional systems surveyed); PETER M. BRIEN & CAROLINE WOLF HARLOW, U.S. DEPARTMENT OF JUSTICE, *HIV IN PRISONS AND JAILS*, 1993 1 (1995) (relating that 4.2% of women prisoners reported testing HIV-positive as compared to 2.5% of men prisoners).
9. See THE GLOBAL AIDS POLICY COALITION, *TOWARDS A NEW HEALTH STRATEGY FOR AIDS: A REPORT OF THE GLOBAL AIDS POLICY COALITION* 4-6 (1993) (arguing that a significant risk factor for HIV infection is belonging to a group in a culture that is marginalized and disenfranchised); Sally Zierler & Nancy Krieger, *Reframing Women's Risk: Social Inequalities and HIV Infection*, 18 ANN. REV. PUB. HEALTH 401 (1997) (arguing that social inequalities are strongly related to HIV infection among women in the United States).
10. See Sabina Virgo, *The Criminalization of Poverty*, in CRIMINAL INJUSTICE, supra note 3, at 47 (describing the links between incarceration and poverty, race, and gender).
11. See Brenda V. Smith & Cynthia Dailard, *Female Prisoners and AIDS: On the Margins of Public Health and Social Justice*, 9 AIDS & PUB. POL'Y J. 78, 78-79 (1994); see also Zierler & Krieger, supra note 9, at 410-11.
12. See Smith & Dailard, supra note 11, at 78-79 (arguing that racism, poverty, and drug use put women at increased risk both of contracting HIV and of incarceration).

Despite the alarming number of women prisoners affected by HIV/AIDS, federal and state departments of corrections lack a comprehensive strategy for providing HIV treatment or education.¹⁴ There is a growing gulf between the medical care offered in prisons and in the outside community.¹⁵ While medical care is generally substandard for all prisoners, women face additional barriers to care, reflecting the lower value society places on caring for low-income women.¹⁶ Alarming, many women prisoners die prematurely of AIDS.¹⁷

Despite the suffering endured by HIV-positive women caught in the criminal justice system, an effective community response to their situation is generally lacking. Most criminal court staff remain unaware of, or unable to allocate resources to address, their specific needs. Prosecutors, judges, and defense counsel are often unaware of the consequences of incarceration on HIV-infected women's life expectancies and therefore fail to consider these consequences in plea negotiations and sentencing. Often defense counsel does not broach the subject of health concerns with clients.¹⁸ Similarly, although the HIV service community has recently given increased attention to the needs of HIV-infected women, virtually no HIV/AIDS service agencies are prepared to assist this population in inter-

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13. See Debi Cuccinelli & Anne S. De Groot, *Put Her in a Cage: Childhood Sexual Abuse, Incarceration, and HIV Infection*, in *THE GENDER POLITICS OF HIV/AIDS IN WOMEN: PERSPECTIVES ON THE PANDEMIC IN THE UNITED STATES* 221, 225-26 (Nancy Goldstein & Jennifer L. Manlowe eds., 1997) (arguing that a history of sexual abuse increases women's vulnerability to HIV and to incarceration); Anne S. De Groot et al., *A Standard of HIV Care for Incarcerated Women: North-eastern United States' Experiences*, 5 *J. CORRECTIONAL HEALTH CARE* 139, 162-63 (1998) [hereinafter De Groot et al., *A Standard of HIV Care*] (arguing that both incarcerated women and HIV-positive women are likely to have experienced sexual abuse).
 14. See Nina Siegal, *Infected - and Ignored: Despite Their High Rate of HIV and AIDS, Women in State Prisons Are Denied Care*, *S.F. BAY GUARDIAN*, Feb. 19, 1997, at 19 [hereinafter Siegal, *Infected and Ignored*]. Standards of care for HIV-positive prisoners have been proposed but none have been uniformly adopted. For an example of recent proposed standards of care for HIV-positive women prisoners, see generally De Groot et al., *A Standard of HIV Care*, *supra* note 13.
 15. See Smith & Dailard, *supra* note 11, at 80; Andrew A. Skolnick, *Critics Denounce Staffing Jails and Prisons with Physicians Convicted of Misconduct*, 280 *J. AM. MED. ASS'N* 1391, 1391 (1998) (reporting on the allegedly substandard and negligent health care provided to prisoners as a result of lenient licensing practices allowing doctors to practice medicine in prisons when they are not allowed to practice in outside communities); Siegal, *Infected and Ignored*, *supra* note 14, at 19 (reporting the inadequate medical care provided to HIV-positive women prisoners).
 16. See Smith & Dailard, *supra* note 11, at 79, 79, 80; Crystal Mason, *Comments by Crystal Mason: HIV-Positive Women in Prison*, 9 *BERKELEY WOMEN'S L.J.* 149, 150 (1994) (discussing the inadequate health care HIV-positive women prisoners receive); see also Siegal, *Women in Prison*, *supra* note 5, at 69-70 (relating that women prisoners receive substandard gynecological and prenatal care).
 17. See Judy Greenspan, *Struggle for Compassion: The Fight for Quality Care for Women with AIDS at Central California Women's Facility*, 6 *YALE J.L. & FEMINISM* 383, 385-86 (1994) (citing specific examples of HIV-positive women prisoners who did not receive necessary medical care despite their requests, leading to their deaths); see also Siegal, *Infected and Ignored*, *supra* note 14, at 19 (stating that HIV and AIDS health complications often go untreated until they become life-threatening).
 18. These observations are based on my experiences representing HIV-positive women in alternative sentencing interventions.

facing with, and transitioning out of, the criminal justice system.¹⁹ Their intervention could positively affect case dispositions by educating the court about the unique needs of HIV-positive women. Without such intervention, their clients all too often are destined to flow in and out of jail and prison.

There is a pragmatic need to work within the setting of current prison conditions to reduce the harms occurring to HIV-positive prisoners. This article is a collaborative effort toward decreasing the potential suffering of HIV-positive women facing criminal charges. It develops a model for community-based alternative sentencing intervention, that offers, in lieu of incarceration, community-based programming designed to address the personal, medical, and security needs of an individual. As the Founder and Director of Women's Positive Legal Action Network, a non-profit project providing legal services and community education around the special needs of HIV-positive women caught in the criminal justice system, I asked Gwen Patton and Jenny Job to share their experiences as formerly incarcerated HIV-positive women affected by alternative sentencing. Their stories reveal the particular vulnerability of women to both HIV infection and incarceration because of poverty, abuse, and discrimination. Their stories, and this article, speak out against the abuses of HIV-infected women in prison and demonstrate how positive community-based solutions and interventions can reduce the detrimental impact of HIV and incarceration on women. These solutions strengthen HIV-positive women's community ties, therefore increasing their ability to succeed in their communities, while also pragmatically helping them escape the grim realities of incarceration.

II. WOMEN, HIV, AND INCARCERATION: A STATE OF EMERGENCY

A. Gwen's Story

I was always told that I was the first African-American woman to test positive for HIV in the California prison system. I know the truth about what it's like to be a woman living with HIV and trying to survive the prison system.

I was from a pretty much broken-up home. I was always told that my dad supposedly left my mom when I was a two month old fetus in my

19. These observations are also based on my experiences representing HIV-positive women in alternative sentencing interventions. See generally, Jeffrey Selbin & Mark Del Monte, *A Waiting Room of Their Own: The Family Care Network as a Model for Providing Gender-Specific Legal Services to Women with HIV*, 5 DUKE J. GENDER L. & POL'Y 103, 116-19 (1998) (discussing generally the obstacles to providing HIV-positive women with legal services).

mom. My great-grandmother really raised me, but I lived with my mom. I was badly abused by my mother's boyfriend who claimed to be my father, but I knew he wasn't. He would hit me, putting his knee on my chest and beating me in the head. I was a very much a problem child—always in trouble, jails, institutions, and facing death through life on the streets. I left home when I was thirteen years old.

My first love was my daughter's father. He started out a real sweetheart. But that was too good to be true, and he turned out to be a real dog. He abused me awfully—physically and mentally beating me. When I left home at thirteen, I had been pregnant with his child. But he beat me so badly I lost the baby.

My boyfriend introduced me to drugs. I didn't even know how to inject myself. Oh, but he did! I once found a condom full of heroin. We tried some, and we were strung out to the bone. We became addicted and our drug use led to my crimes. My boyfriend would act as my pimp and offer me to men. Then sometimes he would rob them. I was in and out of jail, taking the rap for his robberies. He wouldn't even visit me in jail. That hurt me a lot.

My boyfriend and I had a daughter when I was fifteen years old. The violence in our relationship continued and got worse. On February 2, 1972, when my daughter was almost three years old, I finally left my boyfriend after a really bad beating—my whole face was swollen. I gathered up my daughter and snuck out of the house. He was so high he didn't notice. No one believed I would leave, but I did. But he was still in my life because he was my daughter's father. I was never free of him; we're linked through our child.

In 1986, I was sentenced to my longest and last prison term of seven years after, once again, being railroaded by my old man—as usual they wanted me to snitch and I wouldn't. When I was sentenced, I was expected to do my time. I didn't know I'd be expected to fight for my life.

When I got to prison, they were offering to give anyone who had used intravenous drugs a free HIV test. I, not knowing the repercussions I would face for taking the test, said, "I do, I do." That was the most horrible thing that I could have ever done in my life.

I was working at my job site in the kitchen at the prison when they came to tell me the results. They treated me like I had the black plague. These male cops came up to me, immediately isolated me, kicked me in the butt while handcuffing me and accused me of knowing that I had the virus. I was trying to figure out what I did, why these men were kicking me. And I was so embarrassed, not only in front of the women I worked with, but I was also in front of the whole cafeteria line of women. I was being embarrassed in front of the whole system. These men just kept kicking me, calling me an "AIDS infected bitch". That's how I found out I had the virus. I didn't even know the difference between having HIV and

having AIDS. I thought I was going to die. No one told me anything. There was no counseling.

The cops took me handcuffed from the cafeteria and threw me in a small infirmary. They wouldn't allow me to pack my things. I was flown to the California Institution for Women where I joined eleven women who had entered prison with the prison system knowing they had HIV. We were segregated from the main population. We were scared stiff. There was no medical attention. The staff treated us really unprofessionally.

Soon after I got there, the girl in my cell with me got really sick. One night she started screaming for oxygen. She had a heart condition and HIV, and she was kicking from heroin. The guard came to the door and told her to shut up. But she was having even more trouble breathing, and she begged for help. Later, the guard threw a bag in the room and told her to "blow in this bitch." She kept screaming for help. I tried to help her through the night. Finally, I fell asleep. When I woke in the morning, she was dead.

The next morning, my mother died. I was denied permission to go to my mother's funeral. I think they didn't want me to tell anyone about how they were treating us. They would threaten me, saying, "you better not tell how we done you or we'll take your date. We'll put a shank or something in your cell, anything we have to do, and we'll take your date."²⁰

We had to do something after my cellmate died, so we started to write the closest AIDS foundation and the media for help. Most of the letters disappeared, taken by staff. But thank God a friendly correctional officer felt so sorry for us that she mailed some letters for us. Then the media took the right action and got into the prison.²¹ They interviewed us on TV and in the newspaper, and they interviewed outside doctors who said if only my cellmate had been given oxygen she would not have died.

20. They were threatening to create false disciplinary charges against Gwen by placing a weapon or contraband in her room in order to have her good time credits taken away, which would delay her release, or to have her face new criminal charges, which would force her to serve more prison time.

21. Such media intervention and public access to information on prison conditions would not be possible today. In 1995, California's Governor Pete Wilson and the state Youth and Adult Correctional Agency placed a temporary media ban on prisons by barring news organizations from personal interviews with state prisoners. See Michael Taylor, *State Inmates Barred From Media Interviews*, S.F. CHRON., Dec. 25, 1995, at A1 (providing a history of the California media ban on prisons). This media ban has since been sustained through its codification as CAL. CODE REGS. tit. 15, § 3261.5(a)(2) (1998), which provides that prisoners "may not participate in specific-person face-to-face interviews." Prisoners may participate in "random face-to-face interviews." See CAL. CODE REGS. tit. 15, § 3261.5(a) (1998). However, "[s]uch interviews shall be conducted as stipulated by the institution head, including restricting the time, place and duration of interviews." *Id.* Access to terminally ill prisoners is further curtailed by CAL. CODE REGS. tit. 15, § 3261.6(b) (1998) which provides that random interviews of terminally ill patients shall be "closely monitored," and CAL. CODE REGS. tit. 15, § 3261.6(c) (1998) which provides that "no more than two visits per calendar month to a unit housing seriously or terminally ill inmates shall be allowed."

They even showed pictures in the paper of how we had our food thrown in under the door so the correctional officers didn't have to touch us, and how we had to cook any extra food we had on irons. I thank God that we did what we did so that we could open up what was happening. I hope that things are under control there now, but I hear that conditions are really pretty much the same.

I knew I would never go back to prison. I was not going to die there like that girl in my cell. I have worked hard to become a success on the outside. It wasn't easy. When I got out, I was homeless, sick, and alone in the world. I had to rebuild everything in my life—find a place to live, reconnect with my family, find things to do to be useful, and learn about my health. I've done that and I know that I am truly blessed. I feel really strongly about helping make sure other people get what they need to make them a success on the outside too. I am learning to become an HIV peer educator. I volunteer as a fashion coordinator for an organization called Women Organized to Respond to Life-threatening Diseases (W.O.R.L.D.) where I help women get clothes for themselves and their families. I do outreach work, trying to get folks on the streets to test for HIV and Hepatitis B and C, and I distribute food at a food bank. Anything to give back. I try to make a positive difference in my community.

It's important to keep HIV-positive people out of prison because there is no compassion for individuals with HIV in prison. There is no real medical care. There is no education and you may be segregated. That takes one's hopes and willingness to live with the virus away. We're only human.

I met Cynthia Chandler while I was working to keep a family friend out of prison. My friend had begun using drugs again. She was in danger of violating her probation. I knew she needed a treatment program and with that she could be a good person, wife, and mother. She needed help, and I knew she would not get that in prison. Also, I did not want her family ripped apart by her losing custody of her daughter. I worked at keeping the family together while my friend was held in jail before her hearing, helping my friend's husband care for their daughter—even taking their daughter into my own home for a while. Cynthia helped educate the judge and attorneys about HIV and what happens to women with HIV in prison. She found my friend a long-term treatment program, and organized community members and doctors who knew my friend to write letters on my friend's behalf. Our work together helped save a family and gave my friend a new lease on life. I don't know if she knew so many people loved her. Knowing people care in your community and knowing how to get services and benefits gives you an incentive to do well by yourself and to stay out of jail. Now Cynthia and I are working together to continue helping others.

I am not ashamed of my HIV. I think it is important for me to let the world know what is happening so that people can make a difference. I speak the truth because I know that the truth has power. And people need to have the courage to step up and do what is needed. I know that if we help, and show women that there is a reason to fight for themselves, they will succeed.

B. Women and Incarceration

While the stories of Gwen and her friend exemplify many of the trends that make women vulnerable both to HIV and incarceration, their stories have dramatically positive outcomes in comparison to the typical experiences of HIV-positive women facing incarceration. Gwen and her friend are just two examples of the many women increasingly drawn into the criminal justice system. Women are currently the fastest growing prison population.²² While women make up under 7% of the incarcerated population in the United States,²³ the number of women in prisons has more than tripled since 1980, nearly double the rate of increase among male prisoners.²⁴ As of 1994, there were 113,282 incarcerated women in the United States,²⁵ and the number of women prisoners continues to grow disparately. In 1997 alone, the number of women prisoners increased by 6%, while the number of male prisoners increased by 4.7%.²⁶

The increase in the women's prison population does not reflect an increase in violent crimes;²⁷ rather it is directly tied to the "war on drugs",²⁸ the impoverishment of women of color,²⁹ and the abuse of women generally.³⁰ The vast majority of women prisoners, 92% in federal prison and 68% in state prisons, are serving time for non-violent property or drug offenses,³¹ and many are incarcerated for their first criminal

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22. See De Groot et al., *Barriers to Care*, *supra* note 5, at 81; Siegal, *Women in Prison*, *supra* note 5, at 65.
 23. See Siegal, *Women in Prison*, *supra* note 5, at 68 (reporting that women make up only 6.4% of the total United States prison population).
 24. See De Groot et al., *Barriers to Care*, *supra* note 5, at 81; Siegal, *Women in Prison*, *supra* note 5, at 65.
 25. See *Women in Society: Statistics on the Conditions of Women*, in *CRIMINAL INJUSTICE*, *supra* note 3, at 130, 132.
 26. See Siegal, *Women in Prison*, *supra* note 5, at 65.
 27. See *id.* at 68 (relating that women are imprisoned more frequently for drug and property offenses); Nancy Kurshan, *Behind the Walls: The History and Current Reality of Women's Imprisonment*, in *CRIMINAL INJUSTICE*, *supra* note 3, at 136, 150 (reporting that the number of violent crimes committed by women have remained constant or declined despite the increased number of women prisoners).
 28. See Zierler & Krieger, *supra* note 9, at 405, 410 (describing the activities and history of the political "war on drugs" and its impact on the incarceration and HIV epidemics among American women); Siegal, *Women in Prison*, *supra* note 5, at 65 (asserting that mandatory drug sentencing laws are the main reason for the accelerated rate of female incarceration).
 29. See *infra* notes 37-45 and accompanying text.
 30. See *infra* notes 46-48 and accompanying text.
 31. See Siegal, *Women in Prison*, *supra* note 5, at 68.

offense.³² In the mid to late 1980s, the federal government and most states passed new mandatory sentencing laws for drug offenses.³³ While these sentencing laws were ostensibly aimed at drug "kingpins", they are more likely to be applied to small-time drug offenders.³⁴ They are also more likely to be applied to women,³⁵ frequently as tools to induce women to give information to the police regarding others' criminal conduct.³⁶

With the significant increase in incarceration of women over the past decade, the women prisoner population has increasingly become disproportionately comprised of women of color from impoverished communities.³⁷ Although women of color comprise only 21% of the female population in the United States,³⁸ they comprise over 60% of the female state prison population.³⁹ Moreover, over 50% of women in state prisons were unemployed prior to their incarceration.⁴⁰ In my work, my clients are regularly women of color, and the vast majority come from backgrounds of poverty.

The increased incarceration of women is directly linked to an increased intolerance for and outcasting of poor communities of color.⁴¹ A particular emphasis is placed on impoverished women of color: "illegal activity [and increased incarceration] is different for men and women because crime is 'distinctively gendered' . . . Drug offenses and other non-violent crimes that women commit are often linked to persistent poverty and biased law enforcement practices in low income communities of color."⁴² Lack of opportunities and choice drive poor women into illegal economies of drugs, sex work, or theft in order to support themselves and their families.⁴³ Because of the heightened police surveillance and criminalization of poor communities, these women are more likely to be arrested for engaging in these activities and then punished through

32. See *id.* at 66 (citing that 62% of women in federal prison are incarcerated for their first offense).

33. See *id.* at 65-66; Zierler & Krieger, *supra* note 9, at 410.

34. See Siegal, *Women in Prison*, *supra* note 5, at 66.

35. See *id.*

36. See *id.* (providing the example of Hamedah Hasan, a woman "whose story is like that of many women in prison today," who was offered a "deal" from the prosecutors in charge of her case in exchange for information about a drug ring); see also *id.* at 67 (noting that many incarcerated women are imprisoned on drug conspiracy charges).

37. See Kurshan, *supra* note 27, at 151.

38. See Smith & Dailard, *supra* note 11, at 79.

39. See TRACY L. SNELL & DANIELLE C. MORTON, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: WOMEN IN PRISON, A SURVEY OF STATE PRISON INMATES, 1991 2 (1994) (reporting that 46% of women in state prison are Black non-Hispanic and 14.2% are Hispanic).

40. See *id.* (reporting that 53% of women in state prisons were unemployed at the time of arrest).

41. See Kurshan, *supra* note 27, at 152 (relating that studies indicate that women of color are "over-arrested, over-indicted, under-defended, and over-sentenced" when compared to white women).

42. Siegal, *Women in Prison*, *supra* note 5, at 68 (quoting Beth E. Richie, Associate Professor of Criminal Justice and Women's Studies at University of Illinois at Chicago).

43. See *id.* (citing Angela Davis).

incarceration.⁴⁴ For women with addictions, their addictions may be caused by the helplessness created by their disenfranchised social position.⁴⁵

Sadly, in addition to new drug policies, poverty, and racism, women's incarceration is also frequently linked to experiences of sexual and physical abuse,⁴⁶ often at the hands of the people they love.⁴⁷ I have yet to have a single client deny a history of abuse. Of the few women who are incarcerated for violent offenses, the vast majority are incarcerated for defensive or retaliatory crimes against abusive partners.⁴⁸ Tragically, all too often women's own victimization leads directly to their entanglement in the criminal justice system.

The increased incarceration of women has had a tremendous impact not only on the women themselves, but on their families and communities as well. Approximately 80% of all women currently in prison are mothers;⁴⁹ most of my clients, like Gwen and her friend, are mothers. Over 100,000 children nationwide have mothers in jail or prison.⁵⁰ A mother's incarceration has a devastating impact on her children and family since the vast majority of incarcerated mothers were the primary caregivers for their children prior to their imprisonment.⁵¹ The devastation of incarceration is often second to a woman's grief over her children's separation not only from herself but frequently from their other siblings as well, resulting in destruction of the family unit. As a result, some of the first questions I pose to a new client facing criminal charges are: "Do you have children?"; "Are they safe; where they are now?"; and "How can I help make sure there is someone to care for them if the worst happens and you are incarcerated?"

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44. See Siegal, *Interview*, *supra* note 2, at 73; Kurshan, *supra* note 27, at 151-52 (discussing generally that women of color face a different set of dynamics than do white women with respect to arrest and incarceration).
 45. See Zierler & Krieger, *supra* note 9, at 417 (arguing that women of color may turn to self-medication in response to constant racism and denial of dignity); Cuccinelli & De Groot, *supra* note 13, at 225 (relating that women may develop drug addictions in an attempt to block out memories of sexual abuse).
 46. See SNELL & MORTON, *supra* note 39, at 5 (citing that approximately 34% of female prisoners reported being physically abused and 34% reported being sexually abused); De Groot et al., *Barriers to Care*, *supra* note 5, at 85 (reporting that an estimated 75% of incarcerated women have experienced forced sexual intercourse as a child or as an adult).
 47. See SNELL & MORTON, *supra* note 39, at 6 (citing that approximately 50% of female prisoners who reported abuse indicated that it had been "at the hands of an intimate").
 48. See Kurshan, *supra* note 27, at 153 (discussing that women who commit homicide have often killed a male partner in self-defense as a response to his abuse); Siegal, *Women in Prison*, *supra* note 5, at 68 (quoting Thea R. Dubow, a founding member and vice-chair of the National Network for Women in Prison).
 49. See Siegal, *Women in Prison*, *supra* note 5, at 66; Kurshan, *supra* note 27, at 155 (reporting that 80% of women entering state prisons are mothers).
 50. See Siegal, *Women in Prison*, *supra* note 5, at 71.
 51. See Siegal, *Women in Prison*, *supra* note 5, at 70; Kurshan, *supra* note 27, at 155 (reporting that women in prison who are mothers were frequently the primary source of economic and financial support for their children prior to their incarceration).

Ironically, poor women's status as mothers may increase their risk of incarceration. The societal shift in the United States toward increased incarceration and the "war on drugs" was accompanied by an increased intolerance for social welfare. This intolerance resulted in the 1996 federal welfare reform act.⁵² This Act contains several provisions which punish people caught in the criminal justice system and will have a disparate impact on women prisoners attempting to avoid further incarceration. These provisions include: a) rendering those convicted of a drug-related felony, regardless of their health, ineligible for federal welfare benefits⁵³ and b) rendering those found to be in violation of any parole or probation condition ineligible for food stamps,⁵⁴ need-based social security disability income,⁵⁵ and public housing assistance.⁵⁶ These welfare reform provisions will increase the desperation and suffering of many HIV-positive women prisoners with histories of drug addiction who are attempting to transition back into their communities. Given that approximately 80% of women prisoners are mothers,⁵⁷ and that many are serving prison terms for drug-related offenses,⁵⁸ these welfare reforms will have a devastating impact on women prisoners with children who are trying to reunify and support their families. Taking entitlements away from these women will only serve to further disenfranchise them, heighten their desperation, and greatly increase their risk of their further incarceration and thus the destruction of their families.

C. HIV Infection and Women Prisoners

In addition to facing an increased risk of incarceration, poor women have extremely limited access to preventative health care in the United States.⁵⁹ As a result, it is not surprising that women entering prison have a high incidence of serious health concerns, including HIV/AIDS.⁶⁰ Although there are difficulties in accurately determining the rate of HIV infection

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52. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193, 110 Stat. 2105 (1996) (codified primarily in scattered provisions of 42 U.S.C.).
53. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 115, 21 U.S.C. § 862a (1996); see generally Cynthia Godsoe, *The Ban on Welfare for Felony Drug Offenders: Giving a New Meaning to "Life Sentence,"* 13 BERKELEY WOMEN'S L.J. 257, 259-63 (describing the likely impact of the law on women and on society).
54. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 821, 7 U.S.C. § 2015(k)(2) (1996).
55. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 202, 42 U.S.C. § 1382(e)(5)(B) (1996).
56. See Personal Responsibility and Work Opportunity Reconciliation Act of 1996 § 903, 42 U.S.C. § 1437d(l)(2) (1996).
57. See *supra* note 49.
58. See *supra* notes 28, 31-36 and accompanying text.
59. See Smith & Dailard, *supra* note 11, at 79-80 (describing the factors that limit low-income women's access to health care).
60. See *id.* (reporting that an increasing number of women are entering prison with serious health problems); see also Siegal, *Women in Prison*, *supra* note 5, at 69.

or AIDS cases among incarcerated women,⁶¹ the rate of HIV infection is known to be significantly higher in prison than in the general population.⁶² Furthermore, the rate of HIV infection for women prisoners is higher than for male prisoners, with a U.S. Department of Justice study reporting that, as of 1993, 4.2% of female prisoners were HIV-positive, as compared to 2.5% of male prisoners.⁶³ Yet, despite the disproportionately high HIV rates found in numerous studies, my experience, and that of experts in this field, has been that these numbers drastically underestimate the prevalence of HIV in prisons.⁶⁴

The high incidence of HIV among women in prison can be explained by several factors, many of which are the same factors that put these women at risk of being incarcerated: being of color, intravenous drug use, histories of sexual and physical abuse, and poverty. The disproportionate representation of women of color in prison, combined with the disproportionate impact of HIV on women of color, inherently leads to a high prevalence of HIV among incarcerated women. A U.S. Department of Justice study revealed that, as of 1991, women of color in prison were disproportionately infected, with an estimated 6.8% of Latina/Hispanic women and 3.5% of African-American women testing positive for HIV, as compared to 1.9% of white women prisoners.⁶⁵

Incarcerated women, even more than incarcerated men, are frequently struggling with substance abuse issues, particularly intravenous drug use, a significant risk factor for HIV infection.⁶⁶ In addition to the

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61. See De Groot et al., *Barriers to Care*, *supra* note 5, at 79-81, 82-83. HIV infection rates are particularly difficult to determine because laws and practices concerning HIV-antibody testing of prisoners vary from state to state. Some state correctional facilities conduct mandatory testing of all prisoners; others test a voluntary sample; others test a select group, such as known injection drug users or those arrested for sex-related offenses. In some jurisdictions, incarcerated persons are tested only when medically necessary; that is, when the individual is showing clinical indications of her or his infection, such as a lowered T-cell count, opportunistic infections, a positive tuberculosis test, or active tuberculosis.
 62. See *id.* at 79 (reporting that the rate of HIV infection among prisoners is 10 to 100 times higher than the rate in the general population).
 63. See BRIEN & HARLOW, *supra* note 8, at 1. However, it must be emphasized that the HIV rates documented in this study are inherently low as the study counts as HIV-positive only those prisoners whose HIV-status was known to prison officials. Procedures for testing prisoners for HIV vary from jurisdiction to jurisdiction, with the vast majority only testing selected populations.
 64. See De Groot et al., *Barriers to Care*, *supra* note 5, at 81, 82-83 (elaborating on the factors contributing to such underreporting: testing prisoners for HIV only upon entering prison and therefore failing to detect later HIV infection rates; corrections departments' fear of reporting high figures when unable to address the needs of this population; prisoners' unwillingness to disclose their HIV status or to test for HIV while incarcerated because of fears of discrimination, retaliation, and lack of confidentiality).
 65. See SNELL & MORTON, *supra* note 39, at 9.
 66. See Smith & Dailard, *supra* note 11, at 79 (reporting that not only do female prisoners have a consistently higher rate of drug use than male prisoners, but also that female prisoners are more likely than male prisoners to have used more serious drugs and to be injection drug users); De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 142 (reporting that drug usage, including but not limited to intravenous drug use, increases risk of HIV-infection, that women are more likely than men to be serving time for drug offenses, that women often test positive for drug use

risks directly associated with drug usage, addiction combined with poverty increases women's chances of having to engage in survival sex—prostitution in exchange for food or shelter—or sex in exchange for drugs.⁶⁷ While recent studies have shown that sex work does not generally increase HIV susceptibility,⁶⁸ the desperation of women forced to engage in these particular forms of sex work may increase their risk of HIV infection by undermining their ability to negotiate safer sex practices with clients and intimate partners.⁶⁹ Thus, drug addiction and poverty, and the forms of sex work which stem from them, increase women's vulnerability to contracting HIV.

Incarcerated women's high rate of sexual and physical abuse also heightens their risk of HIV infection. This increased risk results not only from the physical act of sexual abuse itself, but also because the experience of physical and sexual abuse impacts women's future behavior.⁷⁰ Abuse survivors may be particularly susceptible to future abusive relationships,⁷¹ within which they may lack the bargaining power necessary to insist that their partners protect them by using a condom during intercourse.⁷² Abuse survivors may also develop harmful drug addictions attempting to self-medicate to forget or to recover from the assault.⁷³

Linked to all of these risk factors are conditions of disempowerment created through poverty, racism, and sexism that heighten the susceptibility of incarcerated women, particularly incarcerated women of color, to HIV infection.⁷⁴ Dr. Jonathan Mann, Chairman of the Global AIDS Policy Coalition, has stated that the greatest risk factor for HIV infection is belonging to a marginalized and disenfranchised cultural group because socie-

upon arrest, and that women exhibit a higher prevalence than men of cocaine use, which is a significant risk factor for HIV infection).

67. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 142 (reporting that many incarcerated women have traded sex for drugs); Cuccinelli & De Groot, *supra* note 13, at 225-26 (relating that women who have been sexually abused are particularly vulnerable to HIV infection because they may exchange sex for love, drugs, or money).
68. See Judith B. Cohen & Priscilla Alexander, *Female Sex Workers: Scapegoats in the AIDS Epidemic*, in *WOMEN AT RISK: ISSUES IN THE PRIMARY PREVENTION OF AIDS 195* (Ann O'Leary & Loretta Sweet Jemmott eds., 1995) (presenting a literature review of studies finding that the HIV infection rate for women sex workers is comparable to or lower than that of women in their same communities who are not sex workers and who have other similar HIV risk factors, such as a history of intravenous drug use).
69. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 142; Cuccinelli & De Groot, *supra* note 13, at 225-226 (discussing that it is rare for women who exchange sex for money to be empowered to reduce HIV risk exposure, particularly in their personal sexual relationships).
70. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 143 (describing the relationship between sexual abuse and potential exposure to HIV, including substance use, sex work, and unprotected sex among non-incarcerated and incarcerated women).
71. See Cuccinelli & De Groot, *supra* note 13, at 225.
72. See *id.* at 225-226.
73. See *id.* at 225.
74. See De Groot et al., *Barriers to Care*, *supra* note 5, at 81; Zierler & Krieger, *supra* note 9, at 401 (arguing that social inequalities are the major risk factor for HIV infection among women in the United States).

tal discrimination undermines and interferes with education, prevention, and care.⁷⁵ The current situation in the United States strongly reflects this trend as impoverished women of color who face the additional disenfranchisement of incarceration are at a significantly heightened risk of HIV infection.

D. Conditions of Confinement and Barriers to Care

Women prisoners living with HIV have many of the same needs as those living outside the prison setting. These include access to high quality health care, including new and experimental treatments, and supportive services and counseling. Prisoners must have access to drugs which can enhance their quality and/or length of life. They must be allowed access to peer education and prevention programs. Individuals living with HIV deserve uniform quality care regardless of their gender, race, or incarcerated status. In addition, prisoners have other distinct and critical needs. They must be protected from discrimination and harassment in the prison setting. Such discrimination and harassment occurs by violating the confidentiality of prisoners regarding their HIV status, by subjecting them to physical threats and abuse, often in the form of medical neglect, and through discriminatory and harassing penal policies such as segregating HIV-positive prisoners.

Despite the disproportionately high HIV infection rate in women's prisons and the pressing needs of HIV-infected women, most penal systems in the United States do not have a comprehensive strategy for HIV treatment or prevention. The failure to adopt such strategies has led to the spread of HIV infection and the needless suffering and death of many prisoners, particularly women. This failure can be seen as a natural by-product of the goals and design of the contemporary prison industry.

1. The Substandard Medical Treatment Provided to Women Prisoners

Women's health care in prisons is even less adequate than men's.⁷⁶ Attorneys and prisoner activists Brenda V. Smith and Cynthia Dailard summarize the societal causes of the disparate care provided to women prisoners:

75. See GLOBAL AIDS POLICY COALITION, *supra* note 9, at 4-5.

76. See Smith & Dailard, *supra* note 11, at 79.

The failure of prison officials to ensure that women receive adequate healthcare while they are in prison reflects the low value society places on the provision of healthcare services to low-income women, the tendency of providers of healthcare services to dismiss the needs of these women, and women's inability to gain access to healthcare services in general.⁷⁷

The disparity between the level of care for men and women prisoners exists partly because prison medical care has been and continues to be designed to serve a predominantly male population⁷⁸ and partly due to the fewer number of women prisoners means that the cost of providing adequate health care to women is higher on a per prisoner basis because of the lack of economies of scale.⁷⁹ Many women receive substandard medical care, especially when dealing with pregnancy or sex-specific issues, since many women's prisons do not even have a gynecologist on staff.⁸⁰ This is a particular concern for HIV-positive women since they are at a high risk for cervical cancer and reproductive health problems.⁸¹

California's prison system provides a prime example of the disparity between the medical care provided in men's and women's prisons. For example, HIV-positive male prisoners at the California Medical Facility at Vacaville were treated with new FDA-approved protease inhibitors before those drugs were available, even irregularly, in the women's prisons.⁸² The medical staff at the men's prison at Vacaville includes a team of doctors and medical staff who specialize in treating infectious diseases.⁸³ Only recently has one of California's women's prisons, the Central California Women's Facility, hired a single infectious diseases doctor to care for the over 3,000 women confined at that institution.⁸⁴ That prison also has only one gynecologist on staff. Men housed at the Medical Facility at Vacaville are routinely provided special diets to combat AIDS-related wasting syndrome. At the two women's prisons in Chowchilla, California, the two largest women's prisons in the world,⁸⁵ women who are dying of AIDS-related wasting syndrome are routinely denied access to special diets

77. *See id.*

78. *See Siegal, Women in Prison, supra note 5, at 68; Kurshan, supra note 27, at 154-55 (relating that women's prisons have fewer medical facilities than men's prisons).*

79. *See Kurshan, supra note 27, at 154 (relating that "because the total number of women have been so relatively low, there are no 'economies of scale' in meeting women's needs, particularly their special needs").*

80. *See Siegal, Women in Prison, supra note 5, at 69.*

81. *See Greenspan, supra note 17, at 383.*

82. *See Siegal, Infected and Ignored, supra note 14, at 19.* This article was written at a time when such medications were not regularly available to women prisoners; based on my experience, such medications are now more available to women prisoners.

83. This description is based on my understanding, formed after meetings and discussions with medical and correctional staff from the California Medical Facility at Vacaville.

84. *See Tim Kingston, The Death Penalty: AIDS and Medical Care in California Prisons, S.F. FRONTIERS, Aug. 13, 1998, at 20, 22.*

85. These prisons are the Central California Women's Facility and the Valley State Prison for Women.

designed to help them put on weight.⁸⁶ One of my clients who was having difficulty maintaining her weight at 78 pounds was also refused partial dentures, making it extremely difficult for her to eat at all. She was literally forced to helplessly waste away. Additionally, male prisoners are trained in pastoral care to assist dying prisoners in the Vacaville prison infirmary so that men without families do not die there alone.⁸⁷ However, my understanding from working with women in the women's prisons in Chowchilla is that female prisoners are not allowed access to the infirmary in order to comfort those who are dying. Not only do many women prisoners die prematurely of AIDS in prison infirmaries because of inadequate care, but they also die alone, locked in the infirmary without family or friends.

2. The Conflict Between HIV Treatment and Institutional Control

United States prisons and jails were not designed to address the serious medical crisis caused by the HIV epidemic. There is a fundamental incompatibility within the incarceration setting between the goal of providing treatment and the need for institutional control.⁸⁸ A prison relies on order and uniformity to maintain control; however, HIV treatments may interfere with the level of authority and separation between guards and prisoners needed to preserve stability. The conflict between treatment and control is clearly illustrated when examining HIV care in the prison system.

Confidentiality, and the fear of discrimination when one's HIV status is leaked to others, is a constant concern for HIV-positive prisoners.⁸⁹ Yet, this concern falls to the wayside in an institutional setting where prison officials use knowledge as a means of control.⁹⁰ The complexity of HIV medication regimes, which include a variety of drugs that must be taken on an empty stomach, or with meals, or multiple times a day, without missing a dose, does not conform to regimented and limited

86. See Siegal, *Infected and Ignored*, *supra* note 14, at 19.

87. See Kingston, *supra* note 84, at 22.

88. See Smith & Dailard, *supra* note 11, at 81 (arguing that opportunities for self-empowerment necessary for effective control of the spread of HIV are contrary to the interest of institutional control in the prison setting); see also DAVID J. ROTHMAN, CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA 413-21 (1980) (examining one prison to argue that within prisons treatment will always give way to the overriding conflicting concern for security coercion and control).

89. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 147-48 (explaining that HIV-positive women may not want others to know of their status because of fear of stigmatization, verbal derision, shunning, and ostracization).

90. See Mason, *supra* note 16, at 151 (discussing that being HIV-positive in prison is regarded as a weakness which prison guards use against HIV-positive prisoners); see also Smith & Dailard, *supra* note 11, at 81 (arguing that the confidentiality needs of prisoners are in conflict with prison policies that lead to unguarded access to prisoners' medical records and cause the segregation and disparate treatment of HIV-positive prisoners).

medline⁹¹ and meal hours in a system of incarceration that stresses supervision and restrictions of freedom.⁹² Several of my clients reported feeling manipulated into stopping their lifesaving protease inhibitor triple combination drug therapies because they cannot correctly administer such therapies to themselves under medline time restrictions without the side effects becoming both unbearable and dangerous.

Within the context of the institutional control of prisoners and the "war on drugs," prison staff often refuse to prescribe pain medications to prisoners, particularly those with histories of drug abuse, ostensibly to prevent addiction.⁹³ However, many opportunistic infections common to HIV-positive women, such as neuropathy⁹⁴ and aggressive herpes zoster,⁹⁵ cause extremely painful nerve damage and require significant pain management. As result, I have witnessed HIV-positive women incarcerated in jail and prison needlessly endure extreme pain, even when near death. One of my clients was diagnosed with metastasized cancer that had spread to her bones, spine, and brain. Until it was determined that the cancer had completely eaten away both of her hips, my client was denied pain medication stronger than Motrin because the medical staff suspected she was fabricating complaints of pain in order to receive drugs to feed an addiction.

3. The Conflict Between HIV Prevention and Institutional Control

The inherent conflict between treatment and incarceration, combined with the correction system's tough stance on drug usage and other actions deemed inappropriate or illegal within the context of the "war on drugs," has also detrimentally impacted HIV prevention measures within prisons and jails. Despite the knowledge that sex and intravenous drug use occur in both women's and men's correctional systems, HIV prevention

91. The two most prevalent methods of medication distribution in prisons are medline and keep-on-person. Medline is a practice by which prisoners are distributed their medications at specific times, usually without any flexibility in when or where the medications can be taken. In contrast, keep-on-person allows prisoners to self-administer medication from a one month supply. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 148-49. Most prisons are currently administering HIV medications through the medline method. California has only recently switched its method of administration in women's prisons to the medline, over women prisoners' objections and complaints.

92. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 148-49.

93. See Kingston, *supra* note 84, at 22.

94. AIDS related neuropathy is an extremely painful and debilitating disease involving the peripheral nervous system. See AIDS PROJECT OF THE EAST BAY, SOCIAL SECURITY ADVOCACY FOR PEOPLE WITH HIV 52 (1995); see also STEDMAN'S MEDICAL DICTIONARY 1204 (Margory Spraycar ed., 26th ed. 1995).

95. Herpes zoster (also referred to as shingles) is caused by a reactivation of the chicken pox virus that manifests itself in the nervous system. This virus can become aggressive and recurring in HIV-positive individuals; it may cause chronic painful lesions and blisters, and in some cases it may attack internal organs such as the lungs and eyes. See RUTH SCHWARTZ, SAN FRANCISCO AIDS FOUNDATION, AIDS MEDICAL GUIDE 28 (3rd ed. 1992).

strategies, such as providing access to needle exchange programs, bleach for sterilizing needles, condoms, and dental dams, are not allowed in most United States prisons and jails. Needle exchange programs do not exist in any United States prison,⁹⁶ and bleach is distributed to prisoners in only two jails.⁹⁷ In jurisdictions where they are not permitted, possession of syringes, even clean syringes, is considered possession of unauthorized contraband and can lead to additional criminal or disciplinary charges against prisoners.⁹⁸ Condoms are only allowed in six correctional systems,⁹⁹ and dental dams are provided in only two jails.¹⁰⁰ Allowing prisoners access to condoms, dental dams, and clean needles in discreet, unmonitored locations would play a critical role in reducing HIV infection rates in prisons and jails. Importantly, the implementation of needle exchange programs in prisons in other countries such as Canada and Switzerland has been shown to not require increased prison security and to not have caused safety concerns.¹⁰¹

In order to maintain one's own health, protect oneself, and protect others, one must be empowered to use provided resources and knowledge.¹⁰² Yet empowerment, individual autonomy, and personal choice are at odds with correction's need to control and disempower. This conflict has had a particular impact on peer education efforts within prisons. Peer education programs, such as those that exist in New York's Bedford Hills Prison for Women¹⁰³ and in a few California prisons with model programs such as San Quentin's men's facility, have been shown to be an effective means of providing information to prisoners concerning how HIV is transmitted, how to reduce the risk of infection, and how HIV-positive people can best maintain wellness and good health.¹⁰⁴ Yet, while they are

96. See RONALD L. BRAITHWAITE ET AL., PRISONS AND AIDS: A PUBLIC HEALTH CHALLENGE 86 (1996) (reporting that no correctional system in the United States distributes needles); De Groot et al., *Barriers to Care*, *supra* note 5, at 85 (arguing that correctional authorities should "reassess their objections to needle distribution").

97. See De Groot et al., *Barriers to Care*, *supra* note 5, at 85. Bleach is provided only in the Houston, TX and San Francisco, CA jail systems. See *id.*

98. See, e.g., CAL. PENAL CODE § 4573.6 (West 1999) (providing that any state prisoner who possesses any "device, contrivance, instrument, or paraphernalia intended to be used for unlawfully injected or consuming controlled substances" is guilty of a felony).

99. See De Groot et al., *Barriers to Care*, *supra* note 5, at 85. Condoms are allowed in the following jail or prison systems: Mississippi; New York City, NY; Philadelphia, PA; San Francisco, CA; Vermont; and Washington D.C. See *id.*

100. Dental dams are provided only in San Francisco, CA and Washington D.C. See *id.*

101. See RALF JÜRGENS, CANADIAN HIV/AIDS LEGAL NETWORK & CANADIAN AIDS SOCIETY, HIV/AIDS IN PRISONS: FINAL REPORT 58, 60-61, 107 (1996).

102. See Cuccinelli & De Groot, *supra* note 13, at 225.

103. For a detailed description of this peer education program, see THE WOMEN OF THE ACE PROGRAM OF THE BEDFORD HILLS CORRECTIONAL FACILITY, BREAKING THE WALLS OF SILENCE: AIDS AND WOMEN IN A NEW YORK STATE MAXIMUM-SECURITY PRISON (1998).

104. See Smith & Dailard, *supra* note 11, at 81 (stating that the most effective way to control HIV is through grass-roots mobilization and community empowerment) and at 83 (offering as an example of a successful prisoners peer education program the ACE Program at Bedford Hills Prison); Mason, *supra* note 16, at 150 (arguing that peer education programs are seen as a threat to institutional control).

known to be an extremely powerful way of imparting knowledge to people with HIV, they are just that—powerful, or empowering. Not surprisingly, peer education programs have been discouraged or not permitted, particularly in women's prisons, by corrections administrations throughout the country.¹⁰⁵

4. Prospects for Improvement of HIV Treatment and Prevention within the Prison Setting

The probability that the barriers to treatment and prevention inherent in the contemporary incarcerated setting will be lifted in the near future is low. The current rise of the "prison industrial complex,"¹⁰⁶ or the integration of for-profit businesses into corrections within an environment where rehabilitation has been rejected in favor of retribution, has led to the redefinition of prisons as profit-generating ventures for private industry.¹⁰⁷ Prisons are increasingly contracting with private industry for use of prisoner labor, with prisoners sometimes working for well under a dollar an hour, often for over 40 hours per week.¹⁰⁸ Therefore, it is unlikely that prisons will provide even minimally appropriate HIV care since providing costly emergency medical and HIV/AIDS preventative care conflicts with this profit-generating goal.

Moreover, the "tough on crime" rhetoric of the "war on drugs" remains extremely viable. The California Correctional Peace Officers Association has grown to be one of the most powerful lobbying forces in California and controls a very generous and influential Sacramento-based Political Action Committee.¹⁰⁹ Correctional officers' collective interest lies in the continued supply of prisoners and the continued industrialization of prisons as a means of job stability and growth.¹¹⁰ Therefore, they use their significant monetary and political power to promote the election of candidates and to earn continued support from politicians, such as

105. See Smith & Dailard, *supra* note 11, at 81; Mason, *supra* note 16, at 150 (relating that "although education and peer support could be a crucial step in empowering and improving the lives of HIV-positive women, these women are being denied this opportunity").

106. Development of the term "prison industrial complex" is commonly associated with Professor Mike Davis, San Jose State University. For an example of his use of the term, see generally Mike Davis, *The Politics of Super Incarceration*, in CRIMINAL INJUSTICE, *supra* note 3, at 73. For a more in-depth discussion of the "prison industrial complex," see Angela Y. Davis, *Masked Racism: Reflections on the Prison Industrial Complex*, COLORLINES, Fall 1998, at 11.

107. See Patrisia Macías Rojas, *Complex Facts*, COLORLINES, Fall 1998, at 13, 13 (reporting that the prison industry generates an estimated 40 billion dollars per year in profit for private industry).

108. See Stefanie Kelly, *Nothing to Lose But Their Chains: Prison (and) Labor*, COLORLINES, Fall 1998, at 28, 29; Rojas, *supra* note 107, at 13 (reporting that Victoria's Secret pays prisoners twenty-three cents an hour to make lingerie). For information regarding prison labor exploitation, see generally Lichtenstein & Kroll, *supra* note 3, at 30-34.

109. See Davis, *supra* note 106, at 73, 74.

110. See *id.* at 74-75.

newly elected California Governor Grey Davis,¹¹¹ who espouse tough on crime policies.¹¹² The prison industrial complex continues to expand virtually unfettered.¹¹³ As a result, in 1990, fifty-three women's prisons existed nationally.¹¹⁴ At least fifteen more have been built since then with more being planned.¹¹⁵

III. REDUCING THE SUFFERING OF HIV-POSITIVE WOMEN: THE PRAGMATIC SOLUTION OF ALTERNATIVE SENTENCING

The prison system's inadequate attention to the needs of HIV-positive women, coupled with the disempowered social position of this particular population, allows HIV-positive women few avenues of recourse. Therefore, an alternative solution is needed, as illustrated by Jenny's story.

A. Jenny's Story

When I was nineteen, I moved from Manhattan to California to start a new life. I found a good job when I arrived. I had just given my life to Christ, and one of the first thing on my agenda was to find a Church to call home. When I met my husband through the Church, I was celibate. I took the law of God seriously.

My husband is from a very religious family. In fact, he is a minister. My husband was already HIV-positive when he entered our marriage. We were engaged to be married when I was twenty-one and pregnant. One day when I was pregnant, we were on the way to see his mother upon her request, and in the middle of the street, he told me that he had HIV. He thought his mother was going to tell me because she had recently found out, so, in the middle of the street, he told me.

I didn't know how to feel. Here I was pregnant. I had never had unprotected sex before. I loved him and I trusted him. He knew what he had and never protected me, but yet he claimed to love me.

111. See Erin McCormick, *The Price of Power: Top Ten Special Interest Groups Lavish Millions on Elected Officials to Steer the Course of State in Their Direction*, S.F. EXAMINER, Nov. 1, 1998, at A1 (reporting that the California Correctional Peace Officers Association endorsed Gray Davis in his gubernatorial election bid).

112. See Dan Schnur, *Davis Won by Toeing the GOP Line: Democratic Candidates Are Using the Conservative Agenda to Win Elections, But Where Does that Leave Republicans?*, L.A. TIMES, Nov. 5, 1998, at B9 (reporting that Gray Davis ran television advertisements during his gubernatorial election campaign claiming that he was "tough on crime").

113. See Rojas, *supra* note 107, at 13 (reporting that prison building expenditures increased by \$926 million in 1995).

114. See Siegal, *Women in Prison*, *supra* note 5, at 72.

115. See *id.*

When I found out about his infection, I had to make a decision—stay or go. I took into consideration a number of factors. First, I considered the fact that he lied—he said he loved me, but if he loved me why didn't he protect me? But, on the other hand, he never hit me or had any harsh words with me. This was important because I grew up in a very critical, downing, harsh, violent, alcoholic, and drug-abusing environment filled with physical and sexual abuse. I didn't understand then how emotionally abusive his lies were. I was thankful he wasn't physically abusive, and I thought of him as thoughtful and considerate. We shared the same hopes and dreams.

I also considered my outlook on marriage. I had never wanted to get married. I wanted to be a micro-surgeon, be rich, and have millions of cats, dogs, and cars. Seriously, I would create science experiments at home throughout my childhood. I took an interest in sewing and fashion design during my teens because I could see how sewing intricate patterns had a lot in common with surgery. From my background of poverty, having a drug-addicted mother, and never being encouraged to make anything of myself, let alone being a doctor, sewing seemed a more realistic way to earn money than becoming a surgeon. I earned a spot in the prestigious High School of Fashion Industry in New York based on talent alone—I couldn't afford preparation courses or materials because my mom and dad spent everything on drugs. I was very career driven. I was not going to be like my mother. No one was going to beat me down. I never had fantasies about marriage. But yet, being with him somehow I could see being "happily ever after." But what I really think I was looking at was "'til death do us part."

In deciding to stay or go, I also thought of my faith. This was a man of God! He never mistreated me physically, and that was the only way I knew to identify abuse at the time. And I believed God would bless us. I also knew enough about HIV to know that there were things that we could do to prevent the spread of HIV to me in our marriage. We postponed our marriage because I had a miscarriage. About a year later, in February of 1995, I became pregnant again and we were married. I was twenty-one years old. My first son was born about seven months later.

I didn't become infected with HIV until February 1996. My husband was constantly pressuring me to have babies, but I resisted having unprotected sex. On our one year anniversary, I got drunk, and he had his way. That was the day I became pregnant with our second child.

My second pregnancy came at the worst time. I wanted my baby, but I was ill prepared to be a mother again. It was just a few months after the birth of our first son. I was so emotionally and physically tired I didn't even notice I had missed my period for three months! I was shocked and distraught when I realized I was pregnant. Then there was something wrong with my medical insurance coverage, and I couldn't find a clinic to

go to for medical care. I didn't see a doctor until I was six months pregnant. I was so scared there might be something wrong with my baby or me. Later, I learned that all along my husband knew of clinics in the city that would see me for free since I had been exposed to the HIV virus, but he chose not to tell me because he didn't want anyone to know he was HIV-positive or that he had exposed me to the virus.

When my second son was six to eight months old he got very sick. I took him to a hospital and they asked me if they could test him for HIV. I said yes. The nurse who tested my baby treated me like trash. The first two hours of the appointment seemed more focused on how terrible she thought I was than on my son's health. I was so worried about my son, I asked to call my husband. The nurse gave me a hard time about wanting to call my "boyfriend". She made comments that let me know she assumed that the reason my baby was sick was that I was a drug addict, had been sleeping around, and was a bad mother. Not until my son's pediatrician showed up and straightened her out did the nurse give me any respect and take my son's condition seriously.

About two weeks after my son was tested for HIV, we got a call from a doctor asking that my husband and I come see him. He told us that my son tested HIV-positive. That was when I learned I was HIV-positive too. At that moment I cried out, "Oh God, my baby's going to die," not giving a second thought about myself. I could only see one thing, and that was the safety and well-being of my sons.

Despite all this, my husband kept pressuring me to have more babies. I was in shock and did not have the emotional strength to resist him. I told case managers that I either needed help to repair my relationship with my husband or I needed help to leave, but none of them could help me find a house to move to with my children. Just four months after the birth of my second child, I was pregnant again. The baby died in a very bad miscarriage that almost killed me. I hemorrhaged internally and required a transfusion.

Under the stress of caring for two young children, the younger of whom was very ill, learning that I was also HIV-positive, and trying to recover from my almost fatal miscarriage, my health began to deteriorate. Two months after I nearly died during the miscarriage, I started on HIV medications because my T-cells were dropping. But I developed Stephen Johnson syndrome from the medications. This syndrome is a known possible allergic reaction to the HIV medications I was given, and it causes chemical burns throughout a person's body, from the inside out. I had not been warned that it was a possible side effect. I was burned over 80% of my body, internally as well. I was hospitalized for two months and almost died for the second time in less than a year. My whole body is scarred. I had been a model, and now I have scars and scabs all over me. I suddenly didn't know my own body.

No one understood the pain I was in, and I didn't know where to go because within my marriage I had no one to turn to. My family is back East, and so all I had was my husband and his family. But my husband and my in-laws were in denial about my husband being HIV-positive. They denied his illness and blamed me for my son's sickness. They said what was happening to me was my own fault for being a sinner. His family abused me terribly. They even made me go before the parish on Mother's Day, just one week out of the hospital, to tell everyone that I got the burns as a punishment from God—they didn't want anyone from the Church to know my husband was HIV-positive. My husband would not come to my defense because he wouldn't take responsibility for having knowingly put me in a situation that he was totally unable to deal with.

I was so alone and afraid. I explained this to everyone I could, but no one was equipped to help me. No service or medical providers I went to intervened. Looking back, I cannot believe they could see me go through two close brushes with death, learn of my son's and my own illnesses, and of all those pregnancies so close together, without thinking something was really wrong in my life and marriage. I told everyone that I talked to that I wanted help for my family, or that I needed a place to live, because if my husband wouldn't take responsibility for what he had done to us I wanted a divorce. But no one told me how I could leave or where I could go.

I began to have a complete mental breakdown. Everyone around me seemed like leeches—now that I was sick, I was of no use to anyone. I had no one to turn to. My husband's emotional abuse and physical abuse (I now see his pressuring me to get pregnant and not telling me of or protecting me from the HIV as physical abuse) worsened. During another of his assaults, I began to understand what was taking place. It was like I was a kid again watching the abuse in my family. I completely broke down and fought back—the only way I knew how or had left.

The police were called and even though I was bruised and battered, I was arrested and charged with allegedly assaulting my husband. My husband was not arrested. I was prepared to fight it all the way, but the system wasn't working and I didn't know if the truth would come out in court. Then sometimes I would think that I might as well stay in jail because my life was over—if I lost my children because I was arrested I would have nothing else to live for. I felt like he had used me up and I was dying. I had to fight for my children, but everything was stacked up against me.

My aunt found Cynthia Chandler, and asked her to help me by educating the court about how ill I was and by finding a transitional home for HIV-positive women for me to live in where I could be safe from my husband. I didn't know Cynthia then, but all I heard in court and from people who interviewed me was, "Who is that woman?" "Where did she come

from?," "She's so persistent." I thought that was great because people in desperate situations need an aggressive person to advocate for them because sometimes with desperate cries we cannot articulate our needs and wants.

Cynthia talked to my doctors and told them how they could intervene and help. She took a housing representative with her to court and lined up my release plan. Her intervention really helped because so many service providers seem to be in denial or helpless when it comes to dealing with the criminal justice system, and no one in the jail or the courtroom knew anything about HIV, medications, Stephen Johnson syndrome, or the mental devastation I was suffering. There is so much discrimination in the HIV community against those who are arrested, and so much discrimination in the criminal justice system (and the rest of the world) against those with HIV. I don't doubt that I would be in prison if not for her intervention and her organizing my doctors and case managers. Jail was not the place for me. I needed and wanted help. I wasn't a bad person; I had had an emotional breakdown. I needed the chance to get the help that had been denied me and my children. If that chance had been denied me again, if it weren't for Cynthia, then my children would have no mother.

I was released to a transitional house and placed on probation. I've fought off attempts to strip me of my parental rights, and I have won joint custody of my children. When I was released from jail, everywhere I went everyone asked me who Cynthia was, like she was a spur on the system's heel. Because of the fact that they reacted to her that way, I knew she was the one I had needed in the beginning. They couldn't stand her because she pushed them to do their jobs differently, so I loved her—and I had never even seen her! I imagined her as some tough business-like old gray-haired rich corporate woman—I pictured Linda Evans in *Dynasty*. She would have to be that to blow up the system the way she did. I couldn't believe it when I went to her office to say thank you. There she was, a girl in jeans, talking on the telephone, twisting her ponytail. She looked like she couldn't help herself! So I told her I wanted to get involved to help change the system. That's why I'm writing my story. So I can help people understand how they can make a difference in someone's life.

My transition back into my community has been really hard. I'm healing from so many things—painful, shameful, ugly things. And the most degrading hurtful thing is I have to heal under a microscope, in public. If I didn't need to deal with being HIV-positive, maybe things would be better. I have no confidentiality around my HIV because of my disfigurement from Stephen Johnson syndrome, and people look down on me because I was arrested. I'm a battered HIV-positive woman stripped down to nothing and thought of as nothing. Everyone and anyone always reminds me about what I did. I never asked to be sick. I never asked for my mar-

riage to fail. I feel used and my spirit is broken. Now I'm a second class citizen. It's ridiculous.

We as a family needed help. I don't blame it all on my husband because he was ill too, and he was immature and in denial. What's really sad is that my situation could have been totally avoided if those who heard what was happening to me took it seriously and got me to someone who was equipped to help. In fact, from what I saw while I was in jail, I don't think we would have a need for prisons if we as a society intervened earlier. So many situations could be avoided. With as many people as I was reaching out to, it should never have happened to me. Even when I was in the burn unit in the hospital, I asked people for help. I told them I thought my husband hated me and that I might be in danger because he blames me for my son's illness, but no one listened.

But the problem also seems to be that people want to stereotype all HIV-positive people and people in the criminal justice system, and that's so sad. People need to stop herding us like cattle and deal with us on an individual basis and respond to our needs. If people try to separate themselves out from "those people" with HIV or in jail, they're just asking for trouble because then these epidemics will be free to spread—we won't really be addressing the root problems causing them.

B. The Need for Alternative Sentencing

As Gwen's and Jenny's stories demonstrate, we are losing valuable people to incarceration. Among them are a growing tide of physically ill women who are least able to defend themselves against a system not designed to provide them the care they need.¹¹⁶ Most criminal courts and corrections staff remain unaware of the problems facing HIV-positive women and are unable to allocate resources accordingly. Although the HIV service community has recently given increased attention to the needs of women, virtually no HIV/AIDS service agencies are prepared to assist this population in transitioning out of the criminal justice system. Instead, their clients flow in and out of jail and prison without any special intervention, to the detriment of both their health and society.

The human costs created by this situation have spurred attempts nationwide by prisoner rights attorneys and activists to address the needs of HIV-positive prisoners. Attorneys and activists have been somewhat successful in using impact litigation to win consent decrees, which force prison administrations to meet minimal standards of care.¹¹⁷ These advo-

116. See *supra* notes 76-115 and accompanying text.

117. See Smith & Dailard, *supra* note 11, at 78 (discussing how litigation has been used to improve health conditions for primarily male prisoners); De Groot et al., *Barriers to Care*, *supra* note 5, at 83 (noting that impact litigation resulting in consent decrees has created the few prison HIV-care programs satisfactory enough to rely upon to derive standards of care for other institutions); Sie-

cates also argue for the compassionate release of extremely ill prisoners with full-blown AIDS, who require extensive medical care which prisons are not providing.¹¹⁸ Strategies for making prisons more responsive to the needs of HIV-positive women prisoners include the expansion of social services available in prison¹¹⁹ and release planning.¹²⁰ Radical systemic solutions to this problem have developed as well. These include arguments for decriminalization of certain non-violent crimes, particularly drug offenses.¹²¹ Other more utopian solutions to the increased incarceration of women include equal training, education, and job opportunities for all, and the eradication of poverty.¹²²

However, until such institutional and social change is achieved, a pragmatic solution is required to address the special needs of, and to reduce the harms faced by, HIV-positive women within the current context of the prison industrial complex. One solution increasingly suggested by advocates is the development of sentencing alternatives to incarceration.¹²³ Proponents of such a solution argue that whenever feasible, people should be treated in their communities rather than be incarcerated in prisons and jails at great cost to the individuals, their families, and ultimately society.¹²⁴

C. Organizing a Community-Based Alternative Sentencing Response to the Arrest of HIV-Positive Women

As Gwen and Jenny's stories illustrate, women's lives can be drastically improved simply by connecting women with needed social services and by offering alternatives to incarceration that truly address their needs. Developing community-based alternative sentencing plans for HIV-

gal, *Women in Prison*, *supra* note 5, at 69 (describing class action suits brought to improve health care for California women prisoners).

118. See William B. Aldenberg, *Bursting at the Seams: An Analysis of Compassionate-Release Statutes and the Current Problem of HIV and AIDS in U.S. Prisons and Jails*, 24 NEW ENG. J. CRIM. & CIV. CONFINEMENT 541, 548-56 (1998) (discussing the arguments made by the proponents and opponents of compassionate release); Greenspan, *supra* note 17, at 384-86 (describing the activist movement for compassionate release of HIV-positive women prisoners).
119. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 161-62 (discussing the need for HIV education and support services, drug treatment programs, and sexual abuse recovery programs for prisoners).
120. See De Groot et al., *A Standard of HIV Care*, *supra* note 13, at 163-64 (discussing the need for discharge plans for HIV-positive women); Smith & Dailard, *supra* note 11, at 83 (arguing that a comprehensive strategy for addressing the needs of HIV-positive women prisoners must include the provision of social services necessary to help them transition back into their communities, including alcohol and drug treatment, education and vocational training, and emotional support following their release).
121. See Siegal, *Women in Prison*, *supra* note 5, at 72.
122. See *id.*; Siegal, *Interview*, *supra* note 2, at 73.
123. See Siegal, *Women in Prison*, *supra* note 5, at 71-72.
124. See *id.*

positive women provides a unique opportunity to aid women in re-entering their communities and enables them to avoid suffering in prison.

Although the work of developing such alternative sentencing plans is semi-legal, requiring some knowledge of the criminal court system, it can and should involve non-attorneys, such as case managers, doctors, church members, family, and friends. Non-attorneys often know the woman more personally and, as part of the woman's own community, are often better able to listen to, understand, and address her psycho-social and medical needs. Involving non-attorney community members strengthens the links between the woman and her community, decreases her disenfranchised status, and lessens her risk of future incarceration.

Alternative sentencing work does not require replacing a defense attorney, but merely providing additional advocacy and organizing skills to supplement defense counsel's work. Such advocacy involves the client's doctors, social service providers, church members, family, and friends in the defense. The process entails educating the client's community supporters about the lack of medical care and support the woman will receive in prison, helping them write informed letters to defense counsel and the court explaining the detrimental impact incarceration will have on her life expectancy and social well being, and asking them to commit to provide assistance to help ensure the woman's success in their community.¹²⁵ If a woman needs and is willing to attend a drug treatment program or a transitional housing placement, the advocacy work also involves finding a program or assisted living situation that will best fit her needs.¹²⁶ Once this work is done, it must be coordinated with the efforts of the defense attorney¹²⁷ and presented to the judge for consideration.¹²⁸

125. It is necessary to have the client sign release forms authorizing others to disclose to the advocate her physical/mental health concerns and needs and her HIV-diagnosis.

126. This is often the most important, yet difficult, task in creating a successful alternative sentencing plan. It is important because it provides the structure the court may require before accepting such a plan, and it is difficult because of the scarcity and rigidity of such programs. County medical case managers or case managers working with a client's doctor are often very helpful in determining possible programs to contact. In order to assess the appropriateness of the program, I recommend calling the program director, outlining the client's needs, and discussing whether the program fits these needs. Often programs require a client complete their intake protocol before they are willing to commit to providing placement, yet their intake policies are not usually conducive to the realities of incarceration. For example, the programs may require an in-person, on-site interview, yet the client may be incarcerated. In such instances I recommend offering positive solutions to these logistical barriers such as arranging for a jail tele-conference from the public defender's office in jurisdictions where that is possible, or seeking an order from the court allowing the advocate to personally transport the client from jail to the program and back for an interview. In cases where the program is particularly rigid and no other options appear available, I have contacted other social service agencies with both an interest in my client's welfare and with collaborative partnerships with the program, and have asked a representative to intervene. Such interventions have had positive results.

127. I recommend contacting defense counsel immediately upon beginning work on a case in order to keep the defense counsel abreast of any progress and to receive feedback on information that counsel feels would be helpful in court. Information should be presented to defense counsel before the court date to allow time for review. If for some reason defense counsel is unwilling to discuss the needs of the client or to accept information, I provide the client with copies of all in-

I have been surprisingly pleased to find courts receptive to alternative sentencing plans specifically tailored to meet the individual psychosocial and medical needs of my clients. Over the past three years, I have prepared approximately fifty such plans and they have resulted in favorable dispositions or mitigation of sentences in the vast majority of cases. However, in one rare case this strategy resulted in a reactionary sentence. In that case, the judge decided that my client would likely die during even a very short term of incarceration, and therefore used the case as an opportunity to posture a "tough on crime" position. Yet the primary obstacle to this work is not judges, but the fact that no mechanism exists within the criminal justice system to assist HIV-positive women in availing themselves of such alternatives to incarceration.

Because they represent clients during sentencing, criminal defense attorneys might appear to be best positioned to advocate for alternatives to incarceration. However, several factors work to limit defense counsel's effectiveness. Defense attorneys are notoriously overworked and understaffed. My experience has been that often they lack knowledge of the needs of HIV-positive women and the social services available to them, as this is not their area of expertise. They often lack the medical knowledge concerning HIV necessary to comprehend and communicate to the court the grave consequences of incarceration on the life expectancy of their clients. Furthermore, they may hesitate to expand their role beyond pure legal advocacy or to defer to others' expertise.¹²⁹ Therefore, as a whole, they do not have the resources needed to provide assistance in developing alternative sentencing placements that address the needs of HIV-positive women.

HIV social service providers, such as drop-in center employees, case managers, doctors, and mental health providers, often have the necessary knowledge that criminal defense attorneys typically lack. They have an

formation to bring to court. On occasion, I have sent information directly to the judge in the matter.

128. It must be stressed that none of this work should be done without the written consent and permission of the HIV-positive woman to allow her HIV-status and other relevant medical and psychosocial information to be shared with the defense attorney and to be used in court. Such consent can only be given after full disclosure is made to the woman regarding possible discrimination, segregation, and retaliation she may suffer as result of disclosing this information. Once a woman's HIV status is disclosed to the court, it will follow her to jail and prison if applicable. Additionally, all parties present in the courtroom may have access to this information and bystanders will likely hear this information discussed.
129. See Selbin & Del Monte, *supra* note 19, at 128 (relating that attorneys' professional and personal norms may interfere with needed community-based interventions since "[l]awyers are accustomed both to seeing their role as central and to having others view them that way") and at 129 (discussing that many attorneys view the legal realm as purely legal and separable from social advocacy in contrast to a holistic criminal defense model interested in promoting alternatives to incarceration, in which the attorney is only one of many voices needed to persuade a judge to consider options other than incarceration); *cf. id.* at 127-129 (suggesting similarly that perceptions of proper attorney roles have interfered with community-based holistic assistance of HIV-positive women within the civil legal system).

understanding of their clients' medical and psycho-social diagnoses and needs, as well as knowledge of the social and medical services available in their communities to offer as alternatives to incarceration. They are usually aware of their clients' support networks, including family, friends, and community groups. My experience has been that they are also often the first people to know when a client has been arrested, frequently even before an attorney is involved in the case, as desperate and worried family and friends contact them for help. However, HIV service providers frequently hesitate to get involved in criminal defense cases, either because they feel uncomfortable with their own knowledge of the workings of the criminal justice system, or because it involves working outside the usual scope of their jobs.

Distinct role expectations of attorneys and social service providers are powerful barriers to providing the care need by HIV-positive women caught in the criminal justice system. For successful alternative sentencing intervention to occur, social, medical, and legal advocates must put aside their uneasiness in order to represent women in an effective and integrated manner. This requires combining more generalized advocacy with legal representation. Attorneys and service providers must be willing to expand their roles in order to address the holistic needs of their clients.¹³⁰

IV. CONCLUSION

The problems inherent in mass incarceration are not disappearing. I believe the most difficult question facing us in the next century is how to reclaim the millions of men and women we are losing to a criminal justice system that has no goal but to control, dehumanize, and punish. This is a system that gets away with horrific treatment of people, human beings, by telling us that prisoners really deserve to be punished. But at the same time, it is a system that hides the realities of the conditions inside,¹³¹ because if people really knew what was happening, they would not accept it.

In discussions regarding prison conditions, I am often told that abuses, such as the lack of medical care in prison, deter crime, and that they are therefore an acceptable and necessary evil. I am also told that since many people on the outside lack good medical care, prisoners should not be privileged with better care. I agree that we should all be outraged at the lack of medical care provided large numbers of free people, particularly poor women of color. But I do not believe prisoners take that health care away from those of us on the outside—we all need care. The move-

130. *But cf. id.* at 127-129 (questioning attorneys' ability to respond to the generalized integrated needs of clients).

131. *See supra* note 21.

ment for providing adequate care to all will only be weakened if we allow divisive factioning to occur in this pursuit.

On occasion I have asked people with whom I have had such discussions whether they are prepared to sentence women to medical neglect, to hire government paid personnel to administer false diagnoses, or to deny medication. I do not believe that most people would accept such a charge, especially when considering a typical woman prisoner incarcerated on her first drug offense. Unless we as a society are willing to take moral responsibility for sentencing people to medical neglect tantamount to torture, such as dying of cancer with no pain medication or slowly starving to death without access to a proper diet, we have a responsibility not to tolerate its occurrence. The integrity of our society demands that we not tacitly accept the existence of such abuses.

Community-based alternative sentencing is a necessary and important form of resistance to the human rights abuses occurring within the expanding prison industrial complex. From my experiences, I have learned just what a community can do for an individual, a family, and for society as a whole, if its members are willing to reach out to a person in need and address the underlying problems that the individual is battling. While this work will require both attorneys and social service providers to re-evaluate and relax the perceived dichotomy between social and legal advocacy, it may provide one of the few means to reduce the suffering of HIV-positive women caught in the criminal justice system. Additionally, by working within women's communities to address the individualized needs of women with HIV, such alternative sentencing plans have the further effect of reducing the disenfranchisement of women. Only by empowering women through such methods will we truly address and reverse the epidemics of HIV and incarceration plaguing our society.