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Sex and Prisoners: Criminal Justice Contributions to a Public Health Issue

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Abstract: Research into sexual behaviors in correctional institutions has existed in the criminological/criminal justice literature for more than 60 years, yet little of that literature appears to be known in the public health discourse on this topic. The objective of this study was to canvass this criminological research for a public health audience. The goal was to integrate criminal justice research into public health to develop a clearer picture of the current state of empirical knowledge about sexual behavior in correctional settings. The study design took a public health approach to assess the extent of sex in correctional settings through critical review of the criminological literature. The relationships among sexual behavior, disease transmission, sexual violence, and correctional operations issues were explored with an eye toward hypothesis generation and testing. The conclusion: Partnerships between public health and criminal justice can better address issues associated with inmates’ sexual behavior in correctional settings in both research and operations.

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Introduction

Public health research attention to issues of sexually transmitted diseases (STDs) and the behaviors associated with them is relatively new. The study of sexual behavior within detained populations, while sparse, has a much longer history in the area of criminology/corrections research. Yet these two fundamentally interdisciplinary areas of study and practice rarely communicate with each other regarding their respective knowledge bases. This paper examines the criminological literature on correctional sexuality and places it in a public health approach in an effort to introduce public health professionals to a wealth of knowledge about the importation of behaviors and diseases in correctional settings. Sharing this knowledge should facilitate the development of public health and corrections partnerships to develop programs based on empirical research.

Sex in Correctional Settings: Individual and Public Concerns

Persons incarcerated in penal institutions are a vulnerable population for a variety of reasons. They are totally dependent on the state for all their needs, from basic health care to protection from abuse by other inmates and staff members. Correctional staff members control the movements and activities of inmates to a degree often unimaginable by persons in the “free world” (outside correctional facilities). Deprivation of liberty is considered by many the ultimate penalty for criminal acts. Among those deprivations, in most instances, is the loss of sexual relationships. Such deprivation has been alleged to lead to rampant sexual assault and rape in correctional settings, to the point that the imagery of prison sexual predation has become part of popular culture. At the same time, the criminal justice/criminological research on sex in correctional settings remains unseen by many in public health and medicine (e.g., Beck-Sague & Jenny, 1999; Spaulding et al., 2002).

Tewksbury and West (2000) provide three reasons why sexual behavior in correctional settings should be studied:

1. To “understand the dynamics of institutional culture, includ-
ing how culture is constructed and maintained”

2. To “study health problems related to sexual activities” and the implications these problems have for the inmates, staff, and the general public

3. Because of the unfortunate association with prison violence

The potential public health effect of sexual violence (and of unsafe consensual sex) between incarcerated persons is substantial. Estimates of the prevalence of sexual violence and consensual sex in jails and prisons vary widely (Saum, Surrat, Inciardi, & Bennett, 1995; Kunselman, Tewksbury, Dumond, & Dumond, 2002). The present article explores the best sources of empirical information regarding the prevalence of sexual activity between the incarcerated in an effort to integrate information from criminal justice sources and research into a public health framework for addressing the genesis of the problem and potential sequelae.

This article explores the existing empirical research regarding the prevalence of sex in correctional settings, outlines risk and protective factors in relation to sexual assaults in correctional settings, and examines ways in which public health and criminal justice can work to minimize harm in these settings and reduce possible exportation of sex-related problems back into the community. Criminal justice interest in sexual behavior in institutions has tended to focus on the institutional dynamics affected and possible exportation back into the community. Beyond specific incidents of sexually transmitted disease outbreaks, the public health community has paid little attention to sexual behavior within correctional settings or populations to date. Yet, this sexual behavior might negatively affect the individuals involved, the organizations that are part of the criminal justice system, and the broader community.

Prisoners engage in individual and interpersonal sexual behaviors, both consensual and nonconsensual (Hensley, 2002). These behaviors occur not only with other inmates but also with corrections personnel and visitors. Beyond the parties directly involved, it can affect the functioning of the institution and the morale of inmates and staff members. In most correctional settings, sexual behavior (consensual or nonconsensual) is prohibited between inmates and between staff members and inmates. Staff-inmate sex-
ual relations constitute criminal acts in many jurisdictions, or at least reason for dismissal of staff members. Such interactions, even when "consensual," can lead to issues of favoritism toward specific inmates, causing dissatisfaction among other inmates. Similar issues of favoritism can arise in inmate-to-inmate relationships, as well as sexual jealousy (Fleisher, 1989). Nonconsensual sexual relations are uniformly prohibited, though some would argue that they play a role in maintaining some aspects of social control in organizations.

Given the disproportionately high prevalence of human immunodeficiency virus (HIV) and other STDs in correctional settings (Hammett, Harmon, & Maruschak, 1999; Tewksbury, Vito, & Cummings, 1998), either form of behavior can present a high risk of HIV and other STD transmission. Depending on the length of a prison sentence and the point at which an STD is contracted, this may have implications both for the prison and for the postrelease health care system.

In sum, there are at least two reasons why both criminal justice professionals and public health professionals ought to be addressing sexual behavior in correctional settings. First, sexual behavior affects the ability to maintain order in the correctional setting, including differential treatment and morale associated with consensual sex and the impact of sexual violence and injury. This has been the usual focus of criminal justice researchers. Second, sexual behavior affects the physical and mental health of those in the correctional setting, as well as endangering the health of the community upon the release of inmates. Such concerns have been among the driving forces behind the relatively recent entry of public health programs into correctional settings. Yet much of the current concern has been based on localized disease outbreaks in prisons, or on popular images of sexual activity in prisons that are not consistent with the empirical research. Information from criminal justice can inform public health practice in addressing sexual behavior in correctional settings. The similarities and differences between the public health approach and criminal justice practices are discussed more fully elsewhere (Potter & Saltzman, 1999; Potter & Krider, 2000).
A Public Health Approach to the Criminal Justice Research

Surveillance

Limited information is available about the extent of STD services in correctional facilities. The surveillance deficit in this area makes it difficult to recognize the concentration of morbidity in correctional populations. Hence, when the STD burden is not documented, there is no perceived problem; when no problem is perceived, key agencies are less motivated to collaborate in addressing this public health issue and the spread of disease in communities continues. (Centers for Disease Control and Prevention [CDC], 1998)

The first step in the public health approach is surveillance, the systematic, continuing observation of a particular phenomenon. At present there is no systematic, continuing monitoring (surveillance) of sexual activity or sexual violence, or of treatment for STDs in correctional settings. Correctional settings include jails, detention centers, and, generally, three levels of state and federal prisons (minimum, medium, maximum security, and a handful of “supermax” institutions), and may be expanded to include community corrections activities by some. Maruschak and Beck (2001) provide an overview of the various surveys of inmates in federal and state prisons, as well as local jails, but note that none of these obtain measures of sexual activity among inmates, voluntary or otherwise. There is some surveillance of assaults among prisoners and against staff in correctional settings (“Injury Surveillance,” 1996; Camp & Camp, 1997), but little detailed information is collected on the degree or type of injury suffered in these events.

Saum et al. (1995) outlined three major problems with the methods of researching the sexual behavior of incarcerated populations. The problems include the issue of accuracy of self-reporting and official records data, the definition and measurement of sexual behavior in correctional settings, and the variability of populations and sample selections. The differences in organizational characteristics and levels of security in correctional settings (Struckman-Johnson & Struckman-Johnson, 2000) could be added to those.
Inmates in prisons constitute a much more stable population for study than do detainees in jails, suggesting that surveillance activities ought to be easier to accomplish in prisons than in jails or detention centers.

Lacking systematic surveillance data, cross-sectional studies of prisoners’ sexual behavior must be turned to to examine the incidence and prevalence of sexual behavior in correctional settings. The relatively small amount of literature on the incidence of the sexual behavior of incarcerated populations (primarily men’s prisons) has been reviewed by Tewksbury (1989), Saum et al. (1995), and in Hensley, Struckman-Johnson, and Eigenberg (2000; see also Hensley, 2002). Saum et al. noted the need to differentiate between consensual and nonconsensual sex that takes place in prisons, a distinction that remains often overlooked in the research literature (Tewksbury & West, 2000). Even when that distinction is recognized, most studies are of nonconsensual sexual behavior, partly because of the potential effect sexual violence can have on the individuals victimized and on the climate of the correctional system. Regardless of the context, most research since 1980 reports low (i.e., 2% to 24% consensual; 0% to 27% coerced, broadly defined) sexual activity between inmates. Studies before 1980 reported high rates of “homosexual rape” in prisons (Fishman, 1934; Weiss & Friar, 1974; Lockwood, 1980; Smith & Batiuk, 1989; Struckman-Johnson & Struckman-Johnson, 2000).

However, it is not only incarcerated men or correctional officers involved in coercive or assaultive sexual incidents; female inmates also have been shown to be sexually predatory. Such behaviors by incarcerated women are becoming more common (Alarid, 2000; Greer, 2000), but remain less frequent than by incarcerated men. In part this may be due to different attitudes regarding homosexuality; female inmates are more tolerant or even positive about consensual same-sex sexual behaviors than are male inmates (Hensley, 2000).

Health surveys conducted by the New South Wales (Australia) Correctional Health Service in 1997 and 2001 (Butler, 1997; Butler & Milner, 2003) asked state prisoners about their sexual activity before and during their incarceration, including STD history
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(excluding HIV/AIDS and hepatitis). Fifteen percent of the women and 5% of the men reported consensual sex during their imprisonment in 1997; in 2001, 23% of the women and 3% of the men reported consensual sex while in prison. In the 1997 survey, 2% of the women and 2% of the men reported engaging in nonconsensual sex in prison; by 2001, 1% of the women and 0.4% of the men reported the experience of nonconsensual sex while imprisoned. Females reported proportionately more STDs prior to incarceration than did males. If those reported STDs were untreated, and given the resistance to providing safe sex and harm minimization devices (i.e., condoms and dental dams) by both staff and some inmates, there is a high probability that the STDs could be spread within the institution and returned to the community upon the inmate’s release.

Risk Factor Identification

Surveillance activities ideally enable us to identify risk factors or markers that differentiate those at high risk of developing a disease or becoming a victim or perpetrator of violence. Risk factors may be modifiable aspects of an individual’s behavior or environment, areas where interventions can be developed to assist the person to change their behavior or aspects of the environment to reduce the likelihood of disease development or adverse behavioral outcomes. A focus on risk factors as well as on protective factors (those modifiable factors that provide resilience or insulation against disease development or adverse behavioral outcomes) has become a dominant model in public health thinking and programming in recent years. Identifying and working to enhance protective factors or reduce risk factors can be seen in efforts to combat public health problems such as teen pregnancy, HIV infection, and violence.

When risk factors cluster in population segments the term “risk group” is used to designate the common high-risk situations encountered by members of the group. In a technical sense, race and ethnicity are not risk factors as they cannot be changed (beyond the social construction of the two categories), but they may be risk markers in some situations, identifying groups at higher risk for
victimization. Intervening with members of a high-risk group will ideally lower the potential risk for members of the group, thus reducing the observed future incidence of disease or victimization of group members.

Surveillance information from the general community is used to suggest that jail populations are among the most at-risk members of the population (Tewksbury et al., 1998). Since the people entering jails are often young people from communities with high rates of drug use, multiple sex partners (especially those arrested for prostitution), and low use of condoms or other risk-reduction techniques, it has been asserted that jail populations are at high risk of having an STD when they enter the jail and that, if untreated, such populations may continue to spread the disease in the community after release (CDC, 1998, 2000).

Some criminal justice-based studies have attempted to develop risk-factor profiles of potential targets and perpetrators for prison-based sexual assaults. Chonco’s (1989) descriptive analysis suggests that physical weakness in an inmate is the greatest risk factor for victimization, heightened by being young, attractive, a first offender, first imprisonment, no “gangster” group affiliations, frightened, or greedy. Chonco’s data found that beyond age, no other demographic characteristics were important. At the same time, some of these same statuses could function as protective factors:

An inmate becomes a victim because of the configuration of factors that make him vulnerable to victimization. The problem with these factors is that they are not mutually exclusive. For example, an inmate may be young, but his past criminal behavior may be such that it scares off the aggressors, or he may have no institutional background but may have hardened criminals as friends, and therefore may not be victimized. (Chonco, 1989)

Chonco is not as direct about the aggressors, but he does indicate that sexual assault is used to “acquire status, to make other inmates stay away from others, for revenge, to dominate other inmates, and to release pent-up tension.”

Several researchers have attempted to assess personal characteristics of inmates likely to be sexual aggressors and contextual
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factors that are associated with increased likelihood of sexual assaults. Cooley’s (1993) research in Canadian federal prisons focused on victimization in general and showed that inmates more likely to be victimized are those who are younger, those who have been incarcerated for only short periods of time, and those in higher-security confinement. Sexual assaults were among the least frequent victimizations uncovered, though Cooley calculated a rate of 51.3 victimizations per 1,000 inmates.

Struckman-Johnson and Struckman-Johnson (2000) focused on sexual assault incidents and institutional factors and found that sexual coercion is more common in institutions with large populations, racial conflict, dormitory housing, inadequate security, and large portions of inmates incarcerated for crimes against persons. These should not be surprising factors. Clearly, these are indicators of opportunities and lack of effective/efficient supervision by staff persons.

The idea of racial conflict has long been a central component in the literature about coercive prison sex. Early research (Carroll, 1977) on the issue pointed directly to racial animosities and conflict as a force driving sexual assaults. Although some researchers (e.g., Chonco, 1989) failed to find race a significant factor in analyses of victimization and perpetration, others have continued to point to racial conflicts as important factors for understanding sexual aggression in correctional institutions. Specifically, Struckman-Johnson and Struckman-Johnson (2000) reported that whites experienced more sexual coercion and that African Americans were more often identified as aggressors.

Advocacy groups (e.g., Amnesty International, Human Rights Watch, and Stop Prison Rape) have alleged substantial involvement of corrections staff in the victimization of female prisoners, though little such attention has been focused on male inmates. Few of the studies reviewed for this paper have examined staff involvement. However, one issue that has been made clear in the literature is that correctional officers, while not necessarily perpetrating sexual assaults, may be facilitating or encouraging sexual assaults by other inmates through their actions, attitudes, and difficulties in distinguishing between consensual and coercive sexual incidents.
(Dumond, 2000; Eigenberg, 1994, 2000; Nacci & Kane, 1984a, 1984b; Wooden & Parker, 1982). Struckman-Johnson and Struckman-Johnson (2000) did question prisoners in their study of several midwestern state prisons about the role of staff members in sexual assault incidents. Among women prisoners, they found that “half or more incidents reported by female inmates were perpetrated by other female inmates.” Of the several women’s prisons surveyed, staff members’ involvement in sexual coercion ranged from 20% to 45% of the reports. For men in prisons, around 20% of the sexual coercion events involved a member of the staff, though a majority of these events involved other inmates as well. Therefore, though the vast majority of sexual victimizations of inmates are perpetrated directly by other inmates, staff members do play a significant, indirect facilitating role in the process of inmate sexual victimization. There is less information about “consensual” sex between inmates and staff.

Tewksbury and West (2000) note a second important level of risk-factor analysis conducted by criminologists in the area of sexual victimization in correctional settings: organizational factors. Essentially, these are social environmental factors that play a role in facilitating or hindering sexual behavior, including violence. For example, the highly controlled interactions between inmates from different dormitories and cell blocks limit the quality of information flow and encourage embellishment of rumors. Smith and Batiuk (1989) explored the social organization of inmate interaction and how such interactions framed the inmates’ perceptions of reality regarding sexual assault. They argue that it is these perceptions that structure inmates’ activities with regard to protecting themselves against assault, even though the observed likelihood of victimization is low.

Gardner (1986) examined male and female inmates’ and male and female correctional officers’ attitudes toward rape in prisons. These attitudes form part of the structure of social interaction and the beliefs about the incidence of and reaction to sexual assaults in prison. Gardner found no significant differences in acceptance of rape myths or support for rape between or within the groups. Eigenberg (1989) found, on the other hand, that the corrections
officers surveyed in her study held stereotypical views about male-to-male sex (e.g., men who have sex with men want to be raped). Stereotypical views, combined with the correctional officers’ degree of religiosity, explained the majority of variation in officers’ willingness to respond to reports of sexual assaults among male prisoners. The more stereotyped the views and the higher the religiosity scores, the less likely the officers were to respond to reports.

While not written in the risk- and protective-factor language of public health, these researchers have clearly identified a range of risk and protective factors that influence levels of sexual coercion in correctional (primarily prison) settings. Risk and protective factors have been found at the individual, organizational, and broader cultural levels. These findings provide a potential area of collaboration between public health professionals and criminal justice professionals, translating prior research into risk- and protective-factor language to focus attention on the mechanisms by which risk factors turn into actual sexual interactions, either assaultive or consensual (the last step discussed below). Public health professionals can further assist criminal justice professionals in the recognition of STDs (as well as a host of other diseases) so that justice professionals can attempt to provide treatment where necessary and primary prevention whenever possible (Skolnick, 1998; Tewksbury et al., 1998).

Programs and Evaluation

The third step in the public health approach is one with which professionals in both public health and criminal justice are familiar: program development and the evaluation of those programs. Published results from federally funded STD screening and treatment programs are beginning to appear in the literature (Silberstein, Coles, Greenberg, Singer, & Voigt, 2000; Powelson & Fletcher, 2000). Often these articles focus on the cost-effectiveness of jail-based screening and treatment programs. To date, the evaluations of these programs have been highly positive. Jails are proving to be very efficient locations to diagnose STDs, though the transitory nature of the population makes it difficult to provide treatment in
all cases. These evaluations are enabling public health practitioners to recommend new forms of rapid diagnosis and treatment to prevent the reentry of STDs into the community via those who pass through jails.

There are fewer examples of programs aimed at reducing the transmission of STDs between inmates (or with staff) or sexual assault prevention in correctional settings. In the free world, harm minimization techniques have been developed to reduce the likelihood of contracting or transmitting an STD. Most readers are familiar with the encouraged use of abstinence, monogamy, or condoms for those who have multiple sex partners, and so forth. However, certain harm minimization approaches (e.g., condoms, dental dams) often are not supported by correctional policy and administrators, staff, and sometimes inmates (Butler, 1997). Abolition of most sodomy laws in the United States has removed most statutory impediments to sexual harm reduction techniques such as these. Interestingly, Butler’s survey suggested that condoms were considered an encouragement to sexual assault because of the protection they offer against HIV and other STDs by both inmates and officers in New South Wales (NSW). A handful of jurisdictions (e.g., NSW Corrective Services, Canadian federal prisons, Los Angeles and San Francisco jails), however, do provide condoms to targeted inmates (e.g., openly gay, transsexuals) to reduce risk from sexual interactions.

Following from the successes of STD screening and treatment programs, public health professionals and criminal justice professionals need to work with one another to spread the implementation of health screening and treatment for STDs in jails, as well as a variety of other disease states (e.g., hepatitis and tuberculosis). Some large city jails have facilities to conduct regular health screening and to provide limited treatment for diseases. The utility of health screening in smaller jails should be evaluated.

While there is no standard public health approach to sexual assault prevention (Potter, Krider, & McMahon, 2000), the risk factors identified in earlier research can be developed into programs to reduce the risk of sexual victimization. One area, consistent with crime prevention programs generally, would be the design of pris-
ons to reduce sexual and other violence. A realist position to sex in correctional settings is that it will take place. The joint task is to reduce the risk that it will be unhealthful, that is, coercive or likely to spread disease.

Dissemination, Implementation, and Program Effectiveness

The final step in the public health approach is sometimes referred to as “dissemination.” Programs that have been evaluated and found effective are disseminated to different communities for implementation. Ideally, these new applications will be evaluated to ensure that the programs are also effective in their new settings. Program fidelity also becomes an issue in implementation: being sure that new programs are operating in the fashion they are supposed to, targeting appropriate audiences, and delivering the appropriate services or messages. In this phase it can begin to be discovered whether the program is effective in a variety of settings, or whether different environments require modifications to fit them. In essence, it is possible to focus in on whether a program or intervention is intentionally effective, or whether there are contextual factors upon which success is dependent.

Dissemination involves a range of methods for delivering information about proven and promising programs. Among these are professional newsletters, magazines, journals, conferences, and training programs. Both public health and criminal justice pride themselves on being interdisciplinary fields. Curiously, it often seems that the boundaries of these two interdisciplinary fields do not overlap, even though some of the core disciplines that comprise them are identical (especially in the social and behavioral areas). Specialization within these interdisciplinary fields may play a large role in the lack of integration. In corrections, for example, only a small group of practitioners and academics deal with health issues. This is evident by the fact that a small proportion of all articles appearing in the leading corrections journals during the 1990s addressed health care issues (Marquart, Merianos, Hebert, & Carroll, 1997; Tewksbury & Mustaine, 2001). In public health,
there is a tendency to specialize in epidemiology or health promotion, for example, and not to overlap. And, of course, there is the split between practitioner and academic in both camps.

Often what has been demonstrated to be effective in one field is unknown or unavailable in the other field. Only in the past few years have such groups as the American Correctional Association and the American Jail Association begun to feature public health issues prominently at their meetings and in their literature. Now it appears that attention to public health and medical issues will become a staple of several corrections organizations. The attention to correctional health issues in public health is demonstrated by nearly 20 presentations on corrections-based programs at the 2000 American Public Health Association meetings.

There are some criminologists on staff at schools of public health, though probably there are not many public health specialists on staff in criminal justice or criminology departments. Thus, one key way to expose future experts in both fields to the challenges and advantages of working with one another is missed. As a result, the boundaries and distances between the fields remain firm and wide.

**Conclusion**

This paper has briefly touched on how sexual behavior in correctional settings can be important to two fields, supposed by many to be different and distinct: public health and criminal justice. The core interests of professionals in these two groups have been examined and the existing state of knowledge regarding sexual behavior of incarcerated persons from each field has been summarized using the framework of the public health approach. In the end, it appears that there is substantial overlap of concern between the two fields and that there is substantial information about those concerns scattered across both fields. It is equally apparent that the information that exists in one field often is not communicated to the other field. If one accepts that professionals in both fields are motivated and are interested in solving these shared problems, the question then becomes what to do to improve this situation.
One of the first challenges is to incorporate the important and effective skills and techniques of one field into the other. For instance, in the case of sexual behavior in correctional institutions, developing a surveillance system to monitor the incidence of sexual behaviors is recommended, preferably based on inmates' self-report data. The Prison Rape Elimination Act of 2003 mandates the equivalent of a surveillance system for sexual assault behaviors in correctional facilities (available at www.spr.org). An earlier draft of this article and participation by the authors and many others whose work is discussed here led to the adoption of CDC-developed standardized definitions of sexual assaults for measurement purposes in the Bureau of Justice Statistics surveys of prison rape (Basile & Saltzman, 2002; see also, Saltzman, Fanslow, McMahon, & Shelley, 1999; available at www.cdc.gov/ncipc). In short, not only do skills and analytic techniques (which already often overlap) need to be integrated, but also concepts and definitions need to be made parallel.

Communication is, of course, a key component of the process. A quick perusal of the reference list demonstrates the variety of sources on which this paper has drawn. As a quick exercise, it is suggested that readers figure out what proportion of those sources are read regularly, if at all. Perhaps editors of professional publications might want to include a regular interdisciplinary feature linking research and programming related to public health and criminal justice in their publications. Corrections Today and The Prison Journal have led the way in featuring public health items for their justice system readers.

Featuring panels that combine public health and corrections researchers at the major public health and criminal justice conferences would be another way to inform each field of developments in the other. Inviting both criminological and public health researchers to conferences of such organizations as the American Correctional Health Services Association, National Commission on Correctional Health Care, and similar organizations also could have benefits to corrections and to larger communities.

Criminal justice, corrections, and public health have vested interests in the health of persons in correctional settings. These
interests are diverse, yet they have many common foundations, not the least of which is financial. It is only now beginning to be realized the necessity for closer communication and coordination between researchers and practitioners in the two interdisciplinary fields. It is believed that this enhanced relationship will be the key not only to helping to manage the health and wellness of those incarcerated and those who staff correctional systems, but also to reducing the burden of disease for the incarcerated individuals, as well as the diminished transmission of certain diseases back into the communities from which these individuals originate. Further, it may have an impact on the elimination of health disparities among racial/ethnic groups and the poor, as well as other social justice issues.

Common interests become the foundation from which work can begin to overcome any real or imagined problems to reduce the burden of STDs and sexual violence in correctional settings for the benefit of the organizations involved and society at large. These goals are at the core of the disciplines, and their achievement can be enhanced only by an integrative, interdisciplinary approach.

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