WHAT WORKS

IN HIV PREVENTION

for incarcerated populations

until it's over
AIDS ACTION

What Works in HIV Prevention for Incarcerated Populations is a product of AIDS Action.

What Works in HIV Prevention for Incarcerated Populations is the fifth in a series of AIDS Action HIV prevention guides. Others in the series include what works guides for gay men, substance users, youth, and women of color.

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AIDS Action is the national voice on AIDS. We are committed to advocating for people affected by HIV/AIDS "Until It's Over" – until no more people become infected with HIV, until people living with HIV have the care and support they need, and until a cure is found.

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chapter 1

INTRODUCTION

In the United States, the Centers for Disease Control and Prevention (CDC) reports that as of June 2000, there are 900,000 people living with HIV and AIDS. The CDC estimates that 300,000 people living with HIV do not know they are infected. Since the early 1980's, 438,795 people have died of AIDS in the United States. While the number of people dying from AIDS among the general U.S. population has declined in recent years due to advances in HIV treatment, the AIDS epidemic continues to be disproportionately found among incarcerated populations.

Community-based organizations (CBOs) are well positioned to provide HIV prevention and care services to incarcerated populations. With their roots in community service, CBOs can meet the HIV needs of incarcerated populations. Because CBOs may provide services to ex-offenders after their release, it makes sense for CBOs to consider developing relationships with incarcerated populations prior to their release.

HIV/AIDS is found among incarcerated populations at an alarming rate as a result of behaviors that place people at-risk for HIV infection. These high-risk activities include injection drug use, unprotected sexual activity, and tattooing in correctional facilities. While these activities are found in the general population, they are over-represented among incarcerated populations who may have engaged in high-risk behaviors before, during, or after their incarceration.

Disparate testing and reporting policies among correctional facilities makes it difficult to present an accurate portrayal of the number of individuals living with HIV in correctional facilities. Among incarcerated populations serving time in prisons only, AIDS-related deaths occur at a rate over three times higher than the general U.S. population, 19 percent and 6 percent respectively (Miles, 2001). Additionally, the rate of confirmed AIDS cases in U.S. prison systems was approximately five times higher than the rate found in the general public in 1997 (U.S. Department of Justice, 1999). HIV rates have been estimated to be as much as fourteen times higher in this population than the general U.S. population (Perez, 1997). Regardless of the HIV status of an inmate when they arrive at a correctional facility, the incarcerated population faces a disproportionate risk for becoming HIV positive either in a facility or upon their release if risk behaviors are not addressed.

The scarcity of knowledge about HIV prevention and care services for this population is overwhelming. This lack of knowledge and information places all inmates in correctional facilities at risk for HIV infection. It also impacts the general population, as most inmates will eventually be released into the community.

HIV transmission within correctional facilities has repercussions beyond the inmates themselves. Since 20 percent of people living with AIDS, and 13 to 19 percent of people living with HIV, in the general population have been incarcerated at some time, incarcerated populations and their sexual partners are a viable audience for CBOs to reach with HIV prevention and care services. Recent studies indicate that most men have unprotected intercourse within a few days of release from prison (Grinstead, 1999). Unprotected sex and/or needle sharing upon release can facilitate the spread of HIV throughout the community. These patterns have led correctional facilities to be described as virtual revolving doors for sexually transmitted diseases and HIV transmission. This is especially true since many inmates are

HIV-positive prior to incarceration but may not know their serostatus. Additionally, the recidivism rate of incarcerated populations in the United States is perpetually high. In California, more than 40 percent of parolees return to prison within one year and 66 percent return within two years (Grinstead, 1999). Of the estimated 35,000-47,000 HIV-positive incarcerated individuals in correctional facilities, one-third are released each year back into the community (Sternberg, 1999 and Hammett, 1999). Without CBO-sponsored HIV prevention programs in correctional facilities, education and support for incarcerated populations to minimize their risk of HIV and the possibility of transmission to others is extremely limited.

HIV prevention models for incarcerated populations need to be flexible. Incarcerated individuals in prisons are usually separated into two groups: long-term and short-term. The long-term inmates serve sentences over four years in length and short-term inmates are incarcerated for between two and four years. The length of time an inmate serves in jails and detention centers varies significantly. Jails are designed to hold inmates for a short period of time pending bail, trial, or sentencing and are administered locally by individual counties and city governments. Many inmates are only held for a few days, which makes it difficult to design and implement effective prevention programs. Large numbers of inmates cycle in and out of city and county jails, hampering HIV prevention efforts.

HIV prevention and education programs designed to meet the needs of individuals in prisons and jails can be difficult to implement for a number of reasons. Security is the highest priority for correctional personnel. Discipline is essential to ensuring the safety of those residing and working in correctional facilities. HIV prevention services provided by community-based organizations are secondary to the concerns of the correctional facility. For example, HIV prevention interventions utilize condoms and bleach kits to minimize the risk of contracting HIV through sexual activity and injection drug use; however, most jails and prisons forbid the distribution of either item. Additionally, "lockdowns" are common occurrences in correctional facilities. Lockdowns are used to control and suppress disruptions within a prison or jail by severely restricting movement; as a result, outreach programs may be cancelled or delayed during lockdowns (Prison Activist Resource Center, 2001). These are a few of the many issues that impact the provision of CBO-sponsored HIV prevention programs for incarcerated populations. This guide is intended to provide descriptions of HIV prevention models tailored specifically to meet the needs of incarcerated populations.

A survey in the mid-1990's found that only 13 percent of state and federal prisons systems and three percent of city and county jails systems in the United States offered peer-led HIV education programs in at least one of their facilities (CDC, 1997). Although the number of peer education programs has increased over the years, there is a need for more peer-led education programs. Inmate peer education projects have been shown to positively impact the success of HIV prevention programs within correctional facilities. Evaluations of specific peer-led programs have found that they have the potential to increase the perception of personal risk as well as reinforcing community norms for safer sexual and injection practices (Grinstead, 1999).

CBO prevention programs for incarcerated populations need to develop and maintain collaborations between correctional facility staff, state and local health departments, and CBOs. A number of CBOs are currently targeting incarcerated populations for HIV prevention programs with the help of correctional facility staff. These interventions strive to maintain open communication between CBOs and correctional facilities and have demonstrated high rates of success. In New York State, collaboration between the Dutchess County Health Department and the women's prison in Poughkeepsie increased the rate of voluntary testing among female inmates to 95 percent over a four-year period (Reuters Health Information Services, 2000).

CBOs providing HIV prevention services to incarcerated populations can also develop relationships with inmates that can have a lasting, positive impact, especially after individuals are released from a correctional facility. The clearest example of this is found in HIV prevention programs that support indi-

viduals in living drug-free. Post-release substance use relapse among ex-offenders has been linked with poor housing status and limited social supports, including less frequent visits with case managers (Polonsky, 1997). Therefore, pre- and post- release programs that incorporate discharge planning and intensive case management are essential to HIV prevention and care for incarcerated populations.

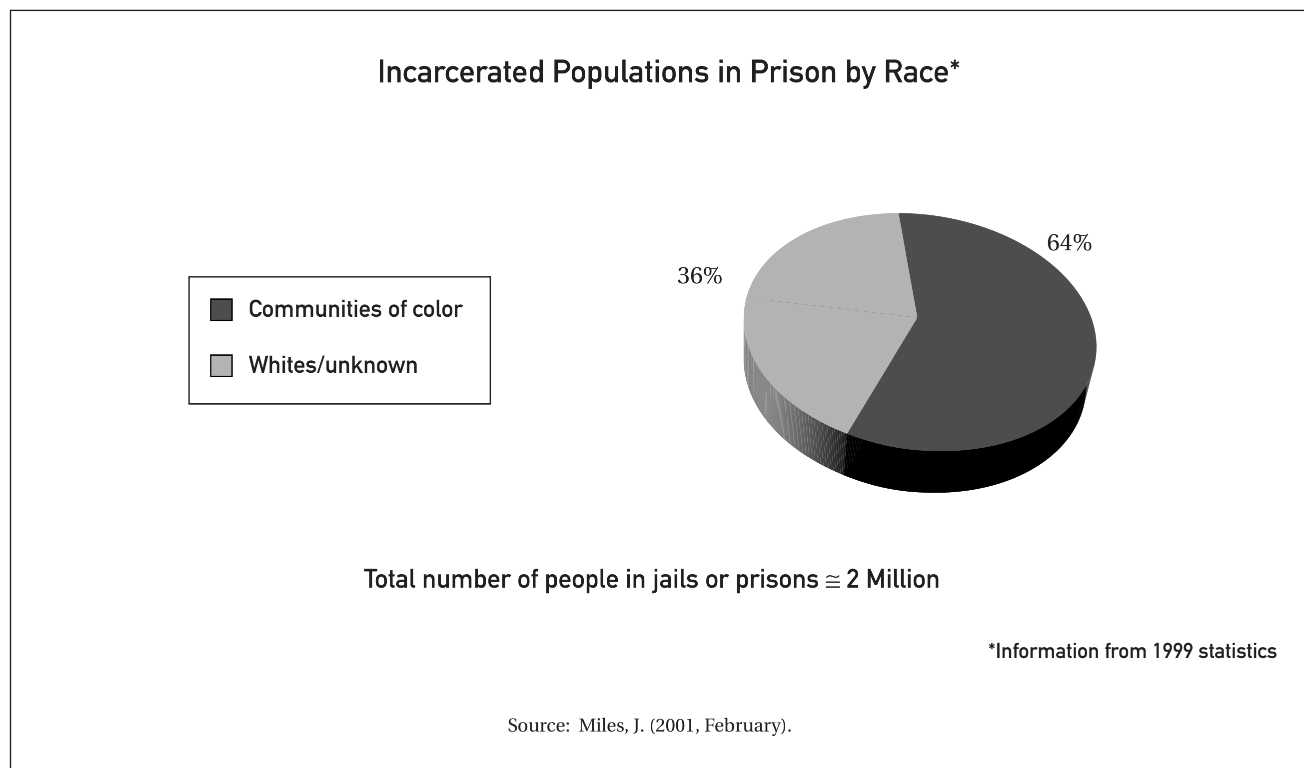
Given all the considerations previously discussed, designing HIV prevention programs for incarcerated populations requires creative tactics and flexible methods. This document showcases a number of strategies and techniques that CBOs have implemented. This is not a comprehensive catalog of all existing programs, but rather it is a collection of programs that have been implemented in various facilities around the country. HIV prevention programs for incarcerated individuals often require collaboration between CBOs, correctional facility staff, and other agencies to provide all of the essential components of a comprehensive HIV prevention program. The purpose of this document is to help community-based organizations and correctional facilities prevent the spread of HIV/AIDS in prison and jails, and also to reduce HIV transmission within the community once ex-offenders have been released. This guide includes a detailed outline of each program as well as contact information for further information. Finally, resources and references are found at the end of the document to aid in further research.

chapter 2

HIV/AIDS AND INCARCERATED POPULATIONS

The United States has the second highest rate of incarceration in the world. The link between HIV and AIDS infection and incarcerated individuals cannot be ignored. In 1999, over two million individuals were incarcerated in federal, state, county, and local prisons and jails in the United States (Bureau of Justice Statistics, 2000). Individuals who are incarcerated comprise 4.6 percent of the total number of U.S. AIDS cases; however, almost 20 percent of people living with HIV or AIDS have cycled through a correctional facility at some point in time. The incidence rate of HIV is between five and fourteen times higher in correctional facilities than the rates found in the general U.S. population. Although statistics are helpful in identifying the scope of the problem, the actual number of inmates living with HIV/AIDS may even exceed these estimates, as routine and voluntary testing and counseling is not universally available in all U.S. correctional facilities (Hammett, 1999).

The AIDS epidemic disproportionately affects communities of color. Communities of color comprise approximately 30 percent of the U.S. population, yet they account for more than 60 percent of all new AIDS cases. Incarceration also disproportionately affects communities of color. In most local jails, African-American men are nearly six times more likely to be incarcerated than Caucasians. Communities of color comprise 64 percent of the total number of people in prison (Miles, 2001). Specifically, in 69 prisons in the state of New York, 82 percent of the incarcerated population is African-American or Latino (Engle, 1999).



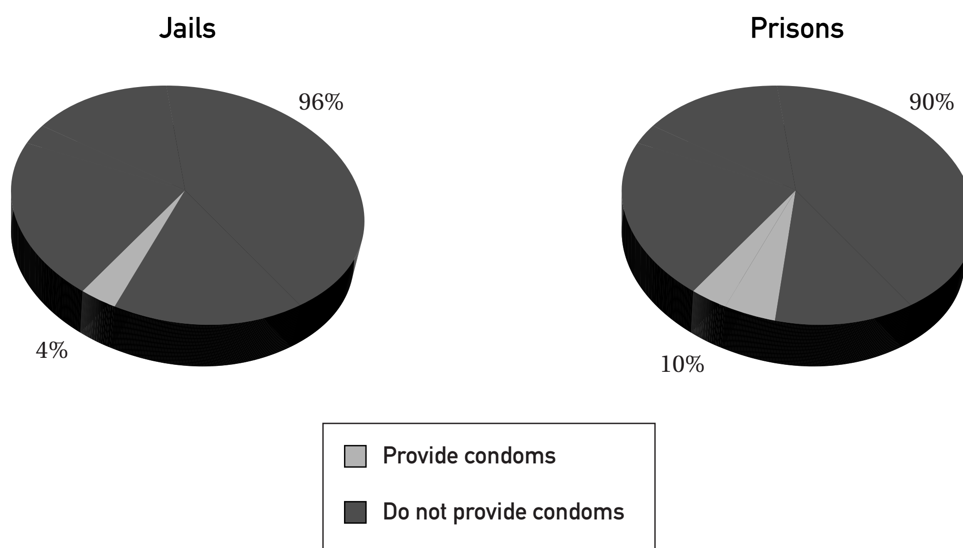
Source: Miles, J. (2001, February).

Women are also experiencing increasingly high rates of HIV infection. They represent the fastest growing group of new HIV infections in the country. This trend is found in correctional facilities as well, particularly as more women are incarcerated. Women represent 11 percent of the total incarcerated population in jails and six percent of the population in prisons (U.S. Department of Justice, 1999). The prevalence rate of HIV is twice as high for incarcerated women as their male counterparts and 35 times higher than non-incarcerated women. These numbers reflect the link between behavior that places women at-risk for HIV and the crimes that women are more likely to commit and be convicted of, such as drug offenses and prostitution. Studies have indicated that 40 to 60 percent of women who are incarcerated have a history of sexual or physical abuse. Incarcerated women are more likely to have participated in high-risk HIV behavior ranging from unprotected sex to sex work and/or substance use (NCCHC, 1994).

The geographic distribution of HIV/AIDS in prisons and jails across the United States is remarkably uneven. HIV rates in some prison facilities are as low as one percent, whereas other facilities' rates exceed 20 percent. This disparity may be geographic: eleven of the 50 state and federal prison systems accounted for 83 percent of all AIDS cases within correctional facilities (Kantor, 1998). Among the various regions across the United States, prisons in the Northeast house the largest number of inmates known to be living with HIV/AIDS (NMAC, 2000). Specifically, 7.5 percent of the incarcerated population living with HIV/AIDS is based in the Northeast. In 1996, one-third of all HIV-positive inmates were incarcerated in New York State prisons (Hammett, 1999).

In addition to the variation in HIV incidence by geography, policies regarding HIV infection in each correctional facility are different. Policies enacted at individual correctional facilities can affect HIV prevalence and incidence rates, such as the implementation of HIV testing and counseling programs, segregation of populations according to HIV serostatus, and HIV prevention and harm reduction programs (e.g., condom distribution or bleach kits). The Federal Bureau of Prisons reports that up to 30 percent of male federal inmates engage in homosexual activity while incarcerated. While sexual activity among inmates is not condoned by correctional facilities, it is occurring (U.S. Bureau of Justice and Statistics, 1999). Recent reports indicate that

Percentage of Correctional Facilities Providing Condoms to Incarcerated Populations



Source: Health Resources and Services Administration. (2000).

between one in ten and one in three inmates is sexually abused in the U.S. prison system (Human Rights Watch, 2001). Unfortunately, only four percent of jail systems and 10 percent of prison systems acknowledge this reality through the provision of condoms to inmates (Hammett, 1999).

It is important to note that studies suggest that the majority of prisoners testing positive for HIV were infected prior to entering jails and prisons (DeCarlo and Zack, 1995). Prior to incarceration, prisoners are more likely than the general population to have participated in high-risk activities that can lead to HIV infection. The incarcerated population is characterized by high rates of poverty, injection drug use, high-risk sexual activity, and poor access to preventive and primary health care. In 1997, 63 percent of individuals entering federal prisons had been charged with drug-related offenses, and 73 percent reported using illicit drugs during their lifetime (AIDS Action, 2001).

Substance use, specifically injection drug use, is as significant to the AIDS epidemic in correctional facilities as it is in the general U.S. population. The scarcity of sterile drug paraphernalia in prisons and jails increases the likelihood of inmates sharing needles. One quarter of prisoners have used needles to inject drugs, and nearly half have shared needles. Yet only 20 percent of correctional facilities make bleach kits available (Hammett, 1999). Even in these institutions, bleach is not necessarily allocated specifically for cleaning needles, but instead is available for general cleaning purposes. Tattooing practices also contribute to the high rates of HIV infection in correctional facilities. Metal points and other sharp objects are used to puncture the skin multiple times subsequently increase the risk of HIV transmission. Equally risky is body piercing. Like tattooing and needle sharing, it is difficult to obtain cleaning agents such as bleach to sterilize the piercing instruments.

To date, there is no uniform policy of HIV testing and counseling in correctional facilities across the country. HIV testing and counseling policies are unique to each state and, in some cases, to each facility. Although HIV testing is mandatory upon release from federal prisons, only certain state prison systems require testing prior to release: Alabama, Missouri, Nevada, and Virginia. Several states require that inmates be tested upon entering prison systems including Alabama, Colorado, Georgia, Idaho, Iowa, Michigan, Mississippi, Missouri, Nebraska, New Hampshire, Nevada, North Dakota, Oklahoma, Rhode Island, South Carolina, South Dakota, Utah, and Wyoming. State prison systems may also test inmates selectively for HIV according to specific circumstances. In 38 states, tests are performed if there is a clinical indication of HIV/AIDS. In 24 states, HIV tests are administered after an inmate has been involved in a high-risk incident. Routine tests, in which testing occurs unless the inmate refuses, are also enacted in several locations around the country. Most city and county jail systems have no mandatory testing; while HIV testing does occur, the circumstances vary greatly.

HIV Testing: Glossary of Terms

Voluntary Testing - Inmates decide whether or not to take an HIV test.

Random Testing - Inmates are tested randomly.

Mandatory Testing - Inmates are required to take an HIV test.

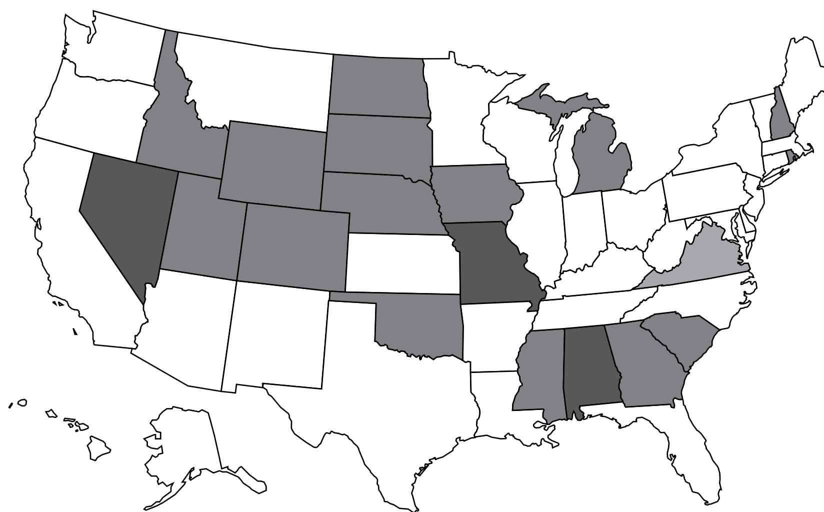
Selective/Circumstantial Testing - Inmates are tested if exposed to bodily fluids and/or are involved in an accident the correctional facility deems risky.

HIV testing and counseling is challenging for many correctional facilities because inmates often refuse HIV testing because of AIDS-related stigma. In one study, only 47 percent of inmates chose to be voluntarily tested for HIV. Yet one-third of the incarcerated population living with HIV/AIDS is identified through voluntary HIV testing (Grinstead, 1999), highlighting the importance of making HIV testing available to incarcerated populations. As a result of the lack of uniform voluntary testing and counseling policies within correctional facilities,

many inmates may be released who are unaware of their HIV serostatus.

Even when administered, HIV testing and counseling in correctional facilities does not provide a clear picture of the number of incarcerated persons living with HIV/AIDS. Many of the available statistics are likely to underestimate the rate of HIV/AIDS in correctional facilities, in part due to the unique barriers in compiling data from correctional institutions. The National Commission on Correctional Health Care identifies three key challenges in obtaining comparable data. First, correctional facilities may lack the capacity to electronically gather information and report data. Second, identification of one's HIV serostatus can have profound implications in a prison or jail, thereby reducing the number of inmates living with HIV and AIDS whom self-identify. Finally, it becomes a financial liability for correctional facilities to identify inmates living with HIV/AIDS and to provide care to this population (HRSA, 2000). The Correctional HIV Consortium estimates the total cost of providing adequate housing and security for an inmate diagnosed with AIDS at almost $106,000 per year. This figure is substantially higher than the average cost of housing a HIV-negative inmate, which is $38,500 (HRSA, 2000).

HIV Testing Policies in State Prisons Across the United States



- Mandatory HIV testing upon entering and exiting prisons
- Mandatory HIV testing for inmates entering prisons
- Mandatory HIV testing for inmates released from prisons
- No uniform HIV testing requirements

Source: Medical Management of HIV (2001, January).

chapter 3

KEY COMPONENTS OF HIV PREVENTION EFFORTS FOR INCARCERATED POPULATIONS

CBOs face unique barriers in serving incarcerated populations. Traditional prevention models focusing on the distribution of condoms and encouraging needle exchange programs are taboo in correctional settings. Priorities for correctional facility personnel are maintaining conformity and security to ensure safety – therefore, HIV prevention models must be flexible and abide by the rules of the particular facility. Policies on a variety of issues including HIV testing and counseling, segregation based on HIV sero-discordance, and HIV prevention efforts present significant challenges in creating a model that works for all prison settings.

In recent years, various CBOs and governmental organizations have compiled and released information on HIV prevention for incarcerated populations. Specifically, the Association of State and Territorial Health Officials (ASTHO) has identified key findings that facilitate successful collaboration between community-based organizations and correctional facilities. The report draws from the experiences of collaborative projects that were conducted in Michigan and Massachusetts. This information highlights what works in HIV prevention for incarcerated populations.

Key Findings

- Collaborations among public health departments, correctional agencies, and community-based organizations are effective in addressing HIV/AIDS among incarcerated populations, especially if the collaborations are comprised of a shared mission, have executive staff support, and are allotted designated program funding.
- Effective HIV/AIDS programs must address the issues of stigma and discrimination as well as the need for privacy and confidentiality associated with HIV/AIDS in corrections.
- Effective HIV/AIDS programs in correctional facilities have multiple components and support a continuum of care including services after discharge.
- HIV/AIDS programs within correctional facilities must educate inmates and correctional staff about HIV disease.
- Peer-led education and prevention efforts in prisons and jails can be an effective teaching method for inmates.
- Measurable outcomes of program success and client health are still being developed and evaluated.

Behind the Wall: Collaborative Responses in Massachusetts and Michigan to Address HIV/AIDS Among Incarcerated Populations, ASTHO, 2001

These findings are echoed in the CBO prevention programs highlighted in the next chapter. Peer-led HIV prevention programs are particularly successful in correctional facilities since peers are among the incarcerated population constantly and CBO staff may have limited access to correctional facilities. Many of the profiled CBO programs also support a continuum of HIV prevention and care services for incarcerated populations, either through their own organization or through linkages with other CBOs and support services.

Two of ASTHO's key findings highlight challenges for CBOs serving incarcerated populations. Privacy and confidentiality are critical for HIV programs but difficult to ensure in the controlled environment of a correctional facility. Correctional staff may not permit private meetings or provide meeting space for CBOs. Evaluating the success of HIV prevention interventions in correctional facilities is also challenging. Some CBOs, most notably Centerforce in San Francisco, have been able to collect data and publish results on the success of their HIV prevention interventions. Other CBOs are in the beginning stages of evaluating their programs and would benefit from additional support and identification of outcomes of program success.

The Centers for Disease Control and Prevention and the Health Services and Resources Administration have sponsored the *Corrections Initiative* to support CBOs in the provision of HIV prevention and care in prisons and jails. The *Corrections Initiative* specifically focused on addressing the needs of communities of color within correctional settings and funding projects that would improve HIV transitional services between corrections and the community as well as developing organizational support systems and networks of comprehensive HIV health care and social services for former inmates. Overall, the objective of the *Corrections Initiative* was to increase access to HIV testing and counseling, prevention and care services, and to provide HIV education and training to corrections and CBO staffs. The *Correction Initiative* supported a number of the prevention models that will be discussed in the next chapter.

chapter 4

HIV PREVENTION MODELS AND CBO PROGRAMS FOR INCARCERATED POPULATIONS

The following CBO-based HIV prevention programs strive to meet the holistic HIV prevention and care needs of incarcerated populations. Many CBOs are well positioned to meet the needs of this population, and the models discussed here are representative of the various HIV prevention programs that can be implemented. CBOs wanting to establish similar programs should keep in mind that these programs must be culturally relevant and provided in multiple languages to reach the diverse incarcerated population found in any correctional facility.

Often, HIV prevention programs for incarcerated populations are called upon to address both primary and secondary prevention needs. While the prevention models profiled below conduct primary HIV education, these and other CBOs also provide secondary prevention services to people living with HIV/AIDS in correctional facilities as well. HIV prevention models should support a continuum of care for people living with HIV/AIDS, including the development of ongoing relationships with inmates living with HIV/AIDS so they can maintain a healthy lifestyle both inside and outside of a correctional facility.

This chapter describes HIV prevention models and CBO programs. Each model highlights prevention principles and findings from the research literature. The models are followed by descriptions of actual programs that community-based organizations have implemented in correctional settings.

PREVENTION MODEL – PEER EDUCATION MODEL

Peer education programs for the incarcerated population can be an effective method of reducing high-risk behaviors. Research has shown that peer education as HIV prevention intervention works with a target audience that is culturally, geographically, and linguistically diverse (Grinstead, 1999). This is due, in part, to the fact that peer educators have the advantage of living with their targeted audience. Informal interactions with inmates in the yard or other locations around the jail or prison offer opportunities for open, honest dialogue with fellow inmates about HIV/AIDS.

In addition, peer educators are influential in encouraging other inmates to volunteer for HIV testing and counseling. HIV testing is an excellent opportunity for counseling and education regarding behaviors that place individuals at-risk for HIV infection. Also, increased HIV testing among incarcerated populations can assist correctional facilities and CBOs in identifying individuals in need of HIV-related services and care. One survey revealed that 44 percent of inmates volunteered for HIV testing after participating in a peer-led program, despite the fact that testing was not anonymous and those diagnosed with HIV or AIDS infections were housed separately (Grinstead, 1999).

Peer education is also cost-effective. Most peer educators are volunteers and therefore provide HIV education to others at no additional cost to the correctional facility. Peer-led education is beneficial for the peer educators themselves: those inmates who participate as peer educators report significant improvements in their self-esteem (U.S. Department of Justice, 1999). Additionally, many peer educators have become paid employees of CBOs after their release from an institution as a result of the skills developed in the peer education process.

When creating a meaningful peer-led education program, CBOs should consider particular components of HIV prevention programs that have been previously evaluated. The U.S. Department of Justice has reported that the following eight factors contribute to successful peer-led education pro-

grams. This information can assist CBOs in tailoring programs to fit the needs of their community and local correctional facilities.

CBO PROGRAM – CENTERFORCE

The incarcerated population in San Quentin State Prison, California is disproportionately comprised of communities of color. Nineteen percent of the incarcerated population identifies as Latino and 37 percent as African-American. The median age range of inmates in the prison is 18-39 years old. Thirty-two percent of those convicted report a history of substance abuse in the month prior to incarceration. Inmates also report engaging in other high-risk behaviors prior to incarceration: 45 percent of prisoners indicated they had never used a condom.

Since 1986, Centerforce, a community-based organization whose mission is to provide direct services to incarcerated individuals and their families in California, began providing HIV prevention programs within the San Quentin prison. Subsequently, Centerforce was able to modify the existing activities at San Quentin by adding a peer education component to the HIV program in 1990.

The peer-led HIV prevention education program was developed with Centerforce staff, prison administrators, correctional officers, HIV educators and counselors, university researchers, community-based service providers, and inmates. The program is currently funded by the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

Factors Contributing to a Successful Peer-Led Education Program

- Work closely with correctional officials in planning the program to address common objections. In addition, to overcome resistance, a written proposal should be submitted describing the program and its benefits.
- Involve outside organizations, such as public health agencies or AIDS service organizations, in leading and other key roles to demonstrate the program's independence from the correctional system and thereby to build credibility with the inmates.
- Screen peer educator candidates carefully for motivation, sincerity, commitment, and absence of emotional problems and inappropriate personal agendas. Candidates' length of service should be of sufficient time to allow them to contribute significantly to the program before they are released.
- Ensure that peer educators reflect the linguistic, racial, and cultural profile of the inmate population.
- Give peer educators specific goals and incentives, such as academic credit, prison job slots, or good time.
- Develop a peer-driven curriculum rather than one that is driven primarily by the goals of the correctional system so that the specific concerns and questions of the inmates are addressed.
- Be sensitive to the stigmas still associated with HIV/AIDS that are present in many correctional facilities and may adversely affect the recruitment of peers and attendance at programs.
- Provide counseling and support for peer educators as necessary.

U.S. Department of Justice's Issues and Practices 1996-1997 Updates: HIV/AIDS, STDs, and TB in Correctional Facilities.

Twice a year, between 25 and 30 potential peer educators receive 30 hours of comprehensive training by Centerforce staff, community experts, and other San Quentin prison staff over a period of five days. The training addresses a wide range of HIV/AIDS topics including HIV transmission, antibody testing, and the effects of HIV/AIDS on individuals, family, and the community. In addition, inmates are also provided with information on Hepatitis, Tuberculosis, and sexually transmitted diseases. After completing the training, existing peer educators and Centerforce staff conduct interviews with the trainees to determine which inmates will fill any vacated peer education positions. The peer educators work as full-time paid employees of the program. The prison administration determines the inmates' salaries and handles the administrative paperwork (i.e. timesheets). The remaining trainees are certified as volunteer peer educators and are wait-listed for future full-time peer education positions.

Inmate peer educators at San Quentin State Prison provide HIV/AIDS information during orientation sessions for 12,000 new inmates entering the prison each year. The HIV education information presented during orientation primarily addresses HIV transmission and related health issues such as Hepatitis. These sessions are held daily in a classroom designated for health education. Prisoners receive their orientation in small groups of 20-30 in order to facilitate dialogue and encourage questions regarding HIV transmission and related issues. Although orientation to the facility is required for all men entering the prison, only 60-70 percent of newly arriving inmates have participated in HIV education program due to scheduling and other logistical conflicts. Peer educators are also responsible for promoting voluntary HIV testing and counseling among all inmates entering San Quentin. Consent forms are distributed to all new inmates that must be completed in order for correctional health care providers to perform an HIV test.

In addition to the presentations delivered to new inmates, peer educators provide literature, including pamphlets and handouts, on HIV/AIDS and other health issues that have been written by peer educators. Department of Corrections of California and CDC grants subsidize the cost of these materials.

Centerforce staff spends roughly 10-15 hours per week on-site inside San Quentin to provide supervision, education, and other support to the peer educators. Over time, Centerforce staff found that the peer education program required more frequent contact with Centerforce staff and a full time peer education coordinator was hired to assist the inmate-educators. As a result, the Centerforce staff and peer educators are able to handle the coordination of orientation workshops and pre-release classes as well as providing regular updates of HIV/AIDS information. Three to four times per week, peer educators discuss current activities with Centerforce and prison staff.

The peer educators at San Quentin are a diverse group of individuals, both gay and straight, African-American and Latino, HIV-positive and -negative. The inmate/educators are responsible for educational presentations on the transmission and prevention of HIV, maintaining the peer education classroom, completing paperwork for HIV testing and counseling, and directing those with further questions to other health resources located in the peer education classroom. These resources include various educational materials including newsletters, books, and pamphlets that provide current information on HIV/AIDS issues. Both the Centerforce staff and peer educators update the resources weekly to reflect new information and materials.

HIV Prevention for Women Visiting Incarcerated Partners

Centerforce has incorporated a HIV prevention peer-led program for other populations that may be affected by HIV. This intervention addresses the HIV risks of women visiting their incarcerated partners. Peer educators lead women in an informative discussion about the transmission of HIV and encourage them to discuss safe sex and needle sharing with their incarcerated partners. This extension of the peer education project provides HIV information and related referrals upon request.

The peer education program at San Quentin State Prison was formally evaluated in 1993. This evaluation indicated the following: (1) peer-led education was just as effective as professional-led education, (2) inmates overwhelming favored HIV-positive educators over other types of educators, and (3) peer-led education is more cost-effective for correctional institutions (Grinstead, 1999).

San Quentin has also experienced higher rates of HIV testing since the peer educator program began. Fifty to sixty percent of orientation participants have voluntarily agreed to take an HIV test. This rate is higher than the testing rates in other correctional facilities that do not have peer-led education programs. Inmates have informally reported that their HIV/AIDS knowledge increased as a result of the orientation sessions. Centerforce staff has found that inmates are more comfortable discussing HIV/AIDS issues with their peers and are consequently more likely to reduce behaviors that place them at-risk for HIV transmission.

RESOURCES REQUIRED:
- Trainers and training materials for peer educators
- Classroom space for HIV education and training sessions
- HIV prevention materials such as posters and overheads
- Library/educational resources on HIV/AIDS

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PREVENTION MODEL – DISCHARGE PLANNING MODEL

Discharge planning programs are designed to assist pre-release inmates in preparing to return to the community. Discharge planning programs are not limited to individuals who are HIV-positive; however, people living with HIV/AIDS in correctional facilities have imminent needs that must be addressed prior to and immediately following release from an institution. These include medical and pharmaceutical coverage, financial and social support, and safe and secure housing. Although many inmates are HIV-positive before entering correctional facilities, they may be first be diagnosed with HIV while incarcerated. These prisoners are not likely to have an HIV specialist or health insurance to rely upon once they are released. Discharge from an institution presents challenges for those living with HIV/AIDS within prison walls; often they have little knowledge of the many resources needed to manage an HIV/AIDS diagnosis.

Seventy-six percent of jails and 92 percent of prisons report they provide some degree of discharge planning for inmates living with HIV (Hammett, 1999). The objective of discharge planning is to link inmates to resources and services before release and provide a smooth transition into the community. Most discharge programs begin three months before an inmate's intended release date. These programs refer individuals to medical care and housing, as well as substance abuse treatment and job training as needed. Discharge planning also addresses psychosocial issues that can contribute to risky behavior.

A report of recently released ex-offenders found a 54 percent decrease in the likelihood of an ex-offender returning to crime if he or she was participating in a discharge planning program (Wyman, 2000). However, the National Institute of Justice and the Centers for Disease Control and Prevention found that although 75 percent of recently released individuals had a referral for substance abuse treatment, only 22 percent actually made an appointment with the treatment facility (Hammett, 1999). These figures highlight the need for CBOs to facilitate relationships and referrals between correctional facilities and the community to support ex-offenders upon release.

Discharge planning requires flexibility on the part of CBOs. Information pertaining to an inmate, such as their date of discharge, may be difficult to obtain. It is challenging to schedule appointments for inmates based on their intended release date and time when dates and times are always subject to

change. Overcoming these obstacles requires creativity and flexibility.

CBO PROGRAM – EMPOWERMENT THROUGH HIV/AIDS INFORMATION, COMMUNITY AND SERVICES (ETHICS)

Empowerment Through HIV/AIDS Information, Community and Services (ETHICS) is a program sponsored by the Fortune Society in New York City to provide discharge planning for HIV positive inmates released from Rikers Island jail and New York State prisons. The ETHICS program is funded by the Health Resources and Services Administration (HRSA), the New York State Department of Health's AIDS Institute, and the New York City Medical Health and Research Association.

Ex-offenders and concerned community members founded the Fortune Society in 1977 to address the needs of prisoners, ex-offenders and young persons at risk for incarceration. With the onset of HIV/AIDS, the Fortune Society created the ETHICS program to empower people living with HIV/AIDS who are making the transition from incarceration into the community. Upon release from a correctional facility, many ex-offenders are at-risk of resuming behaviors that can jeopardize their health and their freedom. Discharge planning identifies people living with HIV/AIDS prior to their release in order to provide support and referrals during the initial months of re-integration.

The period immediately following release is a vulnerable time for inmates. Those incarcerated in state prisons are required to provide a valid, parole approved address in order to be released. If an address is not provided or approved by parole, inmates are sent to a city shelter. However, Rikers Island inmates are not required to provide an address prior to release. Many are homeless and are often discharged with nowhere to go. Moreover, a significant number of inmates from Rikers Island are released between 2:00 a.m. and 4:00 a.m. into areas known for drug activity and crime. During this time, few services are available. Whenever possible, the ETHICS program coordinates outreach staff and/or volunteers to meet inmates upon release to accompany them to pre-scheduled appointments or temporary housing.

Since many ETHICS staff members are ex-offenders, they understand life inside correctional facilities. Each month, a team of ETHICS outreach staff conducts outreach visits to several upstate correctional facilities in addition to conducting weekly presentations at local jails and prisons. It is during these visits that program-eligible inmates are identified and referred to a discharge planner for further services. The ETHICS staff has established relationships with several service providers within the New York City area which offer housing, medical care, substance use treatment, and other services needed by this population. The first priority of discharge planning is to establish emergency housing arrangement for inmates prior to their release. Housing, as well as primary medical care, are difficult services to access quickly. People living with HIV/AIDS are referred to state and federal programs that subsidize housing. The discharge planner often places released inmates in local, drug-free, single room only accommodations, such as the YMCA, until more stable and permanent housing is located.

Interaction between the discharge planner, outreach staff and correctional facility personnel is essential to communicating the needs of all parties. At Rikers Island (a local jail with ten separate holding facilities), correctional staff has the discretion to determine which pre-release inmates will attend ETHICS general education sessions and who will be directed to the discharge planning informational sessions. The information sessions provide an opportunity for ETHICS outreach staff to make initial contact with inmates identifying themselves as people living with HIV/AIDS. In addition, through word-of-mouth, a significant number of eligible inmates refer themselves to the ETHICS program by writing directly to the discharge planner. It is important to note that the vast majority of Rikers Island inmates are being held while they await final dispositions on pending criminal court cases. Those inmates living with HIV/AIDS who have pending cases are referred to Fortune's Alternative to Incarceration (ATI) program for court advocacy intervention.

In state prisons, general education sessions and discharge planning sessions attendees are pre-selected by ETHICS staff with input from correction-

al facility personnel. Discharge planning begins six months prior to release to ensure that appointments can be made and services, including housing, can be obtained. Discharge planning sessions focus on issues that are important to individuals living with HIV/AIDS, such as housing and medical status. Information on ETHICS' services is distributed to participants, but the development of a discharge plan does not begin until the incarcerated individual obtains his/her medical records from the correctional facility medical unit. The discharge planner works in collaboration with the institutional and field parole officers and correctional facility counselors. The relationship with these personnel has helped ETHICS staff obtain medical documentation and other information necessary to conduct effective discharge planning, which includes securing housing and benefits for inmates prior to their release.

The amount of time discharge planners spend at the jail and prisons is different as a result of the difficulty accessing correctional facilities that are beyond New York City. The outreach staff visits upstate prisons monthly and the local city jail weekly.

Latino Discharge Program (LDP)
Statistics suggest that Latinos comprise nearly half of all HIV/AIDS cases found in New York correctional facilities (Fortune Society, 1994-5). The Latino Discharge Program (LDP) provided discharge planning for 175 HIV-positive Latinos and Latinas in New York City jails and upstate New York prisons. This program was created by the Fortune Society to address the needs of the growing number of Spanish-speaking incarcerated people. The discharge planner refers up to 25 pre-release inmates to medical providers and HIV prevention programs, as well as other Fortune Society services.

In 1997, the ETHICS staff presented general information about the ETHICS program to 2,000 inmates and provided discharge planning services to 182 clients. The staff reported that many ex-offenders choose to work with the incarcerated population as volunteers or as permanent ETHICS staff. The discharge planning program has been particularly successful in stabilizing ex-offenders upon release from an institution.

RESOURCES REQUIRED:
Office space to conduct discharge planning in correctional facilities
HIV/AIDS literature and information for inmates
Extensive referrals in the community

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PREVENTION MODEL – TRANSITIONAL CASE MANAGEMENT MODEL

Case management differs from the discharge planning model in that the target population is comprised solely of ex-offenders who have been released from correctional facilities. Ideally, case management picks up where discharge planning ends. Once an inmate is released from jail or prison, he or she is assigned a case manager who is responsible for making referrals to address the psychosocial and medical needs of the ex-offender. Case managers often work with ex-offenders to locate permanent housing and secure financial support, medical care, counseling, and family services.

Women, in particular, face unique situations that may hamper HIV prevention efforts that include – but are not limited to – sexual and physical abuse, prostitution in exchange for drugs or money, and locating adequate childcare. Successful CBO case management programs incorporate a variety of services to assist their clients. For example, incarcerated women with children need help with the legal and emotional aspects of reuniting as a family, highlighting the need for case management to assess cases on an individual basis.

As one example, the Central California Women's Facility in Chowchilla, a case management program,

reduced recidivism rates among women with HIV/AIDS. Within the project's first two months, only 19 percent of female ex-offenders participating in the program returned to the prison. Prior to this intervention, the recidivism rate had been 76 percent. Case management can reduce rates of recidivism while addressing social, psychological, and mental and physical barriers that can hamper HIV prevention efforts.

CBO PROGRAM – TRANSITIONAL SERVICES UNIT (TSU)

Over 5,700 women are incarcerated in New York — the largest number of female inmates anywhere in the United States. Women of color comprise 90 percent of the female population in New York's correctional facilities. The female incarcerated population is at high risk for HIV transmission: approximately 80 percent of female prisoners in New York have a history of substance use and/or exchanging sex for drugs or money.

The Women's Prison Association formed the Transitional Services Unit (TSU) in 1992 to serve the needs of incarcerated women living with HIV/AIDS. Private donors and various federal, state, and city health, welfare, and criminal justice agencies provide funding for the Women's Prison Association. TSU receives financial support from Medicaid, the New York State Department of Health's AIDS Institute, Ryan White Title I funds, and the New York City Medical Health and Research Association.

The TSU staff consists of 32 permanent paid employees that provide transitional services to women in city and state correctional facilities and in the community. TSU offers case management services to HIV-positive and high-risk women leaving jail or prison for up to three months. At the end of that period, women are usually eligible to receive Medicaid and may subsequently participate in the Community Follow-Up Program. The Women's Prison Association prides themselves on helping women get on their feet as opposed to providing handouts.

Community Follow-Up Program (CFP)
The Community Follow-Up Program (CFP) is an important component of the Transitional Services Unit. The case management team works with women and their children, developing a service plan tailored to each family, continually assessing their needs and monitoring their progress while connecting them to entitlement programs. As long as the client remains in the community and is eligible to receive Medicaid, they are able to participate in the CFP.

Case management services begin after an inmate is referred from a correctional facility. Discharge planners already in contact with individual HIV-positive inmates make client referrals. Most of the initial services and referrals are done at the Bedford Hills and Taconic women's prisons and Riker's Island jail where TSU maintains permanent offices, but they also provide teleconference services for women incarcerated in the Albion Correctional Facility.

Case managers at TSU assess the needs of ex-offenders and provide the following services for women:

- Assistance in life-stabilization such as housing
- Child care services including foster care referrals
- Referrals to substance abuse treatment programs
- House calls and home visits
- Escorts for women to scheduled appointments
- Linkages to entitlement programs
- Gender targeted HIV-prevention information

Case managers also offer counseling and the development of individualized treatment plans for female ex-offenders. Case mangers assist clients in working through issues of substance use relapse and recovery, recurring patterns of abusive or negative relationships, and the challenges associated with family reunification. One client commented, "It feels more personal with my case manager. She's more like a human being" (Conly, 1998).

In a nationwide survey of programs for women offenders, Michigan State University found that "all of the promising programs focus on the diversity of women's needs and personalities, and thus case management—with individualized selection of program activities and services—is of paramount importance." Site visits found that the Women's Prison Association also had "well-trained and dedicated staff who care about the welfare of the women and their families and who serve as positive role models for program participants" (Morash and Bynum, 1995).

RESOURCES REQUIRED: Conference room/space for meetings and workshops
Referral information
Trained case managers and counselors

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PREVENTION MODEL – TECHNICAL ASSISTANCE OUTREACH MODEL

Training health care providers and correctional facility personnel can improve the lives of incarcerated individuals living with HIV/AIDS and increase HIV prevention efforts. Training programs attempt to establish linkages and provide additional resources for correctional staff that may not normally have access to HIV/AIDS resources. This model offers training for those in urban as well as rural correctional facilities. Institutions in rural areas may have less access to current information on HIV or no access to HIV/AIDS information at all.

The trainings include updated statistics on HIV testing and counseling, anti-retroviral therapies, and the latest figures on HIV transmission rates. Clinical information is also included for providers treating people living with HIV/AIDS to keep up with clinical practice guidelines and new advances in the medical treatment of people living with HIV/AIDS.

Technical assistance outreach to correctional facility personnel can assist in both primary and secondary HIV prevention efforts. Teaching attendees the importance of adherence to anti-retroviral therapies and prophylaxis as well as dispelling real or perceived stereotypes surrounding HIV contributes to HIV prevention efforts. Empowering staffs with accurate information on HIV/AIDS allows correctional personnel and health care providers to appropriately identify and treat those living with HIV/AIDS in a correctional setting in addition to preventing new HIV infections.

CBO PROGRAM – GEORGIA HIV AND AIDS EDUCATION

Georgia has a consistently high concentration of people living with HIV and AIDS. Additionally, because much of the state is rural, access to HIV/AIDS information and statistics may be less available to correctional workers. Training and technical assistance for correctional health care providers is one method of supporting HIV prevention efforts. The Southeast AIDS Education and Training program was developed as a five-year project to provide high-quality HIV prevention and education in southern rural states. This education was extended to correctional staff and included an evaluation of their HIV/AIDS knowledge before and after HIV training.

The Southeast AIDS Education and Training Center (SEATEC) is a part of Emory University and offered both on- and off- site training to the Georgia Department of Corrections staff from 1994-1999. The Health Resources and Services Administration's Special Projects of National Significance (HRSA/SPNS) provided financial support for these workshops.

The project consisted of two training models: off-site centralized training and intense on-site training. HIV and AIDS information was provided at both trainings; however, the information differed slightly depending on the site. All trainings reviewed current HIV/AIDS technology, HIV/AIDS guidelines in correctional facilities at the state and federal level, and advice on working within the confines of prison culture to provide meaningful HIV prevention and education. Training involved edu-

cating staff on the range of issues implicated in caring for incarcerated individuals living with HIV/AIDS. Information distributed at the educational sessions, as well as casual networking during the trainings, facilitated important networks of communication and referrals for attendees.

The trainings off-site were held in large, centralized, regional locations statewide once a month. In this setting, HIV/AIDS medical updates and related information were reviewed. On-site trainings occurred at eight randomly selected prison sites around the state. Similar to the off-site trainings, a variety of current HIV/AIDS information and updates were provided. At the prison sites, however, clinical teaching was individualized and provided by a preceptor. The trainings were individually designed with the HIV/AIDS concerns and knowledge of each particular prison in mind. Correctional facility personnel were encouraged to offer suggestions prior to the training.

One objective of the trainings was to increase the capacity of correctional health care providers to identify those inmates living with HIV/AIDS and offer appropriate care to those individuals. Additionally, the trainings evaluated the effectiveness of pre-existing HIV training and education for correctional facilities.

Over the span of the five years the program was operational, over 1,500 correctional staff attended the trainings. [More than half of the staff attended two or more training sessions, so the actual number of correctional personnel reached may be lower.] Pre-and post-intervention evaluation of attendees revealed that those participating in training knew more about HIV/AIDS after the trainings than before.

The off-site centralized statewide and regional training tended to attract personnel that were more informed about the issues surrounding HIV/AIDS than the trainings in correctional facilities. The intense on-site training tended to draw a more diverse mix of personnel as a result of the convenience of the on-site training. According to project personnel, on-site training was more effective in reaching those in rural areas who might be less knowledgeable about HIV/AIDS issues in a correctional setting.

RESOURCES REQUIRED:

Large meeting area for off-site trainings
Space within the correctional facility for on-site trainings
Evaluation sheets for pre- and post-tests
HIV/AIDS fact sheets, information, and statistics
Preceptor journal for on-site training
Educators/Trainers

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chapter 5

TAILORING HIV PREVENTION PROGRAMS TO FIT YOUR NEEDS

The intention of this guide is to provide various models of HIV prevention for community-based organizations. This guide does not present comprehensive prevention models or methods but rather serves as a stepping-stone to aid community-based organizations in developing their own programs. Elements of each model presented in this document can be applied to fit the unique situation of a specific community-based organization and correctional facility.

CBOs have their roots in the community, thus making them ideal candidates to work along side correctional facilities and public health departments to implement HIV prevention programs for the incarcerated population. Because inmates are frequently released back into the community, CBOs can serve inmates while they are in a facility as well as upon the individual's release. Additionally, CBOs can incorporate specific program aspects that directly affect their communities. For example, in particular areas substance use may be more prevalent, indicating the need for substance abuse programs to accompany discharge planning and case management.

Prisons and jails have the potential to avert the spread of HIV/AIDS through HIV prevention efforts. High-risk individuals concentrated in correctional facilities are a captive audience for HIV education, testing, and counseling. Community-based HIV prevention programs must recognize the restrictions on incarcerated populations and the subsequent impact these restrictions have on prevention efforts. While condoms and bleach have been found to be effective interventions with the community at large, they are not sanctioned within correctional facilities due to the political issues associated with drug use and sex within correctional settings (Grinstead, 1999).

Prevention efforts must be always tailored to a particular correctional facility and take the facility's policies into account, but should encourage at the very least voluntary HIV testing and counseling and care for HIV-positive inmates. As correctional facilities encompass a wide range of jails, prisons, county, and juvenile detention centers and halfway houses, CBOs can target specific facilities with programs to address the unique needs of inmates living with HIV and AIDS as well as the HIV prevention needs of the incarcerated community.

There is still much to be learned about what works in HIV prevention for incarcerated populations. Directing limited HIV prevention resources towards this population may result in greater success than other prevention programs due to the high incidence of HIV/AIDS among this population and the opportunity that incarceration presents for conducting outreach with individuals at-risk for HIV infection. More evaluation of existing programs is needed to promote a greater understanding of the best means of providing HIV prevention to this population in a culturally sensitive, appropriate manner.

RESOURCES

AIDS Action
http://www.aidsaction.org

American Red Cross Prison Project
http://www.redcross.org

HIV & Hepatitis Education Prison Project
http://www.hivcorrections.org

HIV, Hepatitis C and Prison
http://www.vnhs.net/teach.htm

Inmates Health Education Sheets
http://www.adc.state.az.us/Medical/iistoc.htm

National Alliance of State and Territorial AIDS Directors
http://www.nastad.org

National Criminal Justice Reference Service
http://www.ncjrs.org

National Institute of Corrections
http://www.nicic.org

National Institute of Justice
http://www.ojp.usdoj.gov/nij/

National Minority AIDS Council (NMAC)
http://www.nmac.org

Working with Corrections: What Social Workers Need to Know
http://hab.hrsa.gov/E/4web/snapshot.htm

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