FOIA Number: 2018-0758-F

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Subseries:

OA/ID Number: 21080

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Issues - Prisons

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Prerelease Program for Inmates with HIV: Cost-effective Case Management

Introduction

The California Department of Corrections administers the Transitional Case Management program. This program was developed to link inmates with HIV/AIDS to medical and support services upon their release to parole. These transitional services provide HIV/AIDS-infected prisoners released to parole the specialized care required for their illness, and reduces or eliminates instances in which individuals intentionally return to prison with a new crime to obtain HIV/AIDS-related care.

The program evaluation data suggest that the Transition Case Management program reduces the rate of recidivism of the more seriously ill who are the most costly to house in prison. The subsequent savings generated by this program were found to substantially exceed the costs of the program. This management and health care innovation involved contracting with a private vendor to provide case managers for the offenders with AIDS. The costly problem of parolees returning to prison for treatment could be prevented or reduced by making community-based treatment more available through better case management.

Background

In October 1992, the research branch of the department conducted a follow-up study of 520 inmates with HIV/AIDS who had been released to parole between 1989 and 1991. Seventy-one percent of these inmates were returned to prison within one year of their release. The return rate for all felons in the department released to parole during 1990 was 53 percent.

In response to the identified higher recidivism rate for parolees with HIV/AIDS, the department's Parole and Community Services Division developed and implemented the Transitional Case Management program.

Development

During the program-development stage, staff conducted a literature search for any interventions designed to prevent offenders' return to prison simply for HIV/AIDS treatment

service. In addition, federal, state, and county correctional agencies were surveyed to identify if such programs existed. No such programs could be found.

As of January 1, 1997, the California Department of Corrections housed 145,565 inmates in 32 state prisons and supervised 100,935 parolees at 119 parole offices in 65 locations throughout the state. All HIV/AIDS inmates are confined at 9 of the 32 state prisons. However, they are paroled to all locations throughout the state. The logistics involved in the development of the program were of considerable magnitude.

Asked to develop an innovative program, the parole division contacted individuals and agencies within the state's AIDS community known for their leadership and cutting-edge response to the AIDS' epidemic. Their expertise combined with staff knowledge of the offender led to the design of this highly successful program.

Program Design

The Parole and Community Service Division contracts with two service providers for transitional case management services. The first is the Tarzana Treatment Center, serving HIV/AIDS inmates paroled to Los Angeles and Orange Counties. The second is through the Volunteers of America, serving individuals paroled to Alameda, San Francisco, and Contra Costa Counties. These counties were selected because a majority of the target group are paroled to them.

Each service provider offers an interdisciplinary team consisting of a registered nurse case manager, a social worker, and a benefits counselor. Their services include:

- The scheduling of meetings with identified inmates ninety days prior to parole
- The provision of comprehensive medical and psychosocial assessments
- The development of a service plan based on the needs identified in the comprehensive assessments
- The linkage of HIV/AIDS parolees with services in the community upon release to parole
- The provision of assistance to parolees with their transition into the community, until the individuals are assigned to a long-term HIV/AIDS case manager

The teams work closely with correctional and medical staff within the institution, the parole agent of record, the client, and the client's family in the development of the service plan using existing community resources. The service providers participate in Title 11 HIV Comprehensive Care Consortia meetings. Title 11 HIV Comprehensive Care Consortia are federal- and state-mandated HIV/AIDS program planning bodies in local service areas.

The program was implemented through the support of the department's director, and was introduced to prison and parole administrators. In addition, advisory committees were formed consisting of department staff, local community representatives, and program participants, to guide the program's overall implementation.

Program Evaluation

Service providers submit monthly reports that include a client roster, documentation of the level of the disease's progression based on the categories defined by the Centers for

Disease Control and Prevention, and a record of the services provided. These data were used in the department's evaluation.

The evaluation used a quasi-experimental design to assess the effectiveness of the program. A classical experimental/control design would have denied treatment to the control group since there is no alternative program available. The evaluations showed that the program lowered the recidivism rate of HIV/AIDS positive parolees by nearly 20 percent over six months and 12 percent over one year. The program will be expanded based on those results.

Conclusion

This program is relevant to adult correctional management in several ways. First, it involves a partnership with nongovernmental bodies for services the private sector can provide better. Second, it expands the use of private case management services in the adult correctional system, thereby displaying the benefits of partnerships between community-based agencies and correctional systems. Third, the program generates correctional costs savings and reduces the demand for prison beds. Fourth, the success of this demonstration project triggered other funding streams for inmates with HIV/AIDS (for example, AIDS Education and Prevention Grants). Finally, the decision to continue and expand the program resulted in an administrative management policy that program decisions be based, in part, on cost-effectiveness as determined by acceptable research methods.

Program Recognition

The California Probation, Parole and Correctional Association has acknowledged the importance of the Transitional Case Management Program. In addition, the program was recognized in the American Correctional Association's October 1996 issue of *Corrections Today.*

Author:

Vicki Sanderford-O'Connor
Parole Agent
California Department of Corrections
Sacramento, California

Contact:

Marisela Montes
Deputy Director
Parole and Community Services Division
California Department of Corrections

P. O. Box 942883
Sacramento, California 94283-0001
(916) 323-0576

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DRAFT

Centers for Disease Control and Prevention

A National Public Health Strategy for Corrections

June 20, 1997

Submitted by John R. Miles, MPA

A National Public Health Strategy for Corrections

Introduction

According to the US Department of Justice, over five million persons are involved with the Nation's criminal justice system (1). Many individuals entering our jails, prisons, and drug courts are substance abusers and/or present with disease. Correctional populations sustain a higher prevalence of these diseases because their high-risk behaviors, including injecting drug use and unsafe sexual practice, contribute to transmitting these diseases within the population and also in the communities to where they return. These current elevated levels of HIV/AIDS, STDs, TB, and other infectious disease among persons in correctional settings demand attention from health officials and the public.

The twin epidemics of HIV/AIDS and substance abuse have brought to light many issues concerning the criminal justice system and the general population. These issues are very complex and difficult to tease apart. The complexities not only involve HIV/AIDS and substance abuse but also within the criminal justice system itself. Each State has its own unique system in the way that it interacts within the system and with other state governmental agencies. The dynamics between the key players in this nexus of public health and corrections are complicated by divergent goals, policies, and perceptions.

There is a lack of leadership in the area of correctional health care. The National Institute of Justice (NIJ) looks at the impact of crime on society, and only recently have they begun to look at "tangential" issues, such as public health. Another key agency in this arena is the Federal Bureau of Prisons (FBOP) which incarcerates over 100,000 persons and develops much documentation regarding correctional health care guidelines and practices. However, FBOP's ability to mandate these guidelines is limited to federal facilities. The National Commission on Correctional Health Care (NCCHC) develops health policies to establish the minimum standard of care within correctional settings for accreditation, and is more focused for jail settings. Additionally, while the American Correctional Association (ACA) is the largest correctional agency in the world, they primarily handle professional development for corrections staff, and have only recently begun to realize the important potential of collaborating with CDC.

Although these organizations deal with many correctional concerns, corrections administrators and medical directors recognize the limitations of these organizations and are now expressing the need for CDC to exercise its leadership as the Nation's prevention agency in correctional health care. They request our expertise and assistance in addressing gaps that are not covered by other corrections organizations. The request for CDC's technical assistance is not limited to just state and non-governmental organizations, but also includes federal agencies. NIJ currently collaborates with CDC on basic monitoring of HIV/AIDS, STDs, and TB in correctional facilities. Furthermore, both ACA and NCCHC have asked CDC to assist in updating and improving their policies. A major impediment to assisting these organizations is our limited

understanding of health care delivery within the complex framework of the criminal justice system.

This national strategy seeks the attention of public health, corrections, constituent organizations, community health care providers and the public to stimulate constructive discussion and action linkages necessary to provide the supportive infrastructure and resources necessary for success

Prisons are a growth industry in the United States. Already the country with the highest rate of incarceration, the U.S. is continuing to commit resources to locking up more people and building more facilities unprecedented growth in the prison population, which has tripled in the last 18 years. There are now more than 1.5 million people incarcerated in state prisons, and youth detention facilities throughout the country. We incarcerate a larger percentage of our population than any other industrialized nation. Federal and state spending on prisons has risen from $5.3 billion in 1980 to $27 billion in 1995. Overcrowding is challenging the ability of many correctional facilities to house and feed inmates, maintain order, and deliver health care. Several factors drive this growth. Convictions for drug offenses have tripled. Governors and state legislatures continue to push for tougher sentencing laws like California's "three strikes" law. Health Services are being stretched to the limits to meet inmate needs and are often limited through programs such as inmate co-pays.

Most prisoners are young men, usually minorities and often parents. Women make up only 6% of those incarcerated but they are increasing at a rate of about 12% per year. Over 70 percent of today's inmates have a history of injection drug use or substance abuse associated with high risk sexual activity. Prior to incarceration, these individuals have had little access to preventive and primary care. As a result, jails and prisons house a population that is disproportionately affected by HIV and AIDS (estimated 2.3% positive in 1994). Longer sentences is also increasing the numbers of elderly prisoners *(currently about 3%)*, and middle-aged prisoners *(currently about [illegible] of the prison population)* with HIV/AIDS who require more extensive and costly health care. As of December 1995, there had been at least 4,600 cumulative AIDS deaths in prisons and jails with approximately 6,500 AIDS cases. AIDS is now the leading cause of death in most correctional systems.

Despite these disturbing statistics, the majority of correctional HIV/STD prevention efforts rely heavily on the provision of prevention information. There is almost universal prohibition regarding the distribution to inmates of condoms, bleach and other materials required for

behavior change. Yet, risk behaviors that spread HIV/ STD infection, such as the sharing of contaminated injection paraphernalia and unprotected sexual intercourse, not infrequently occurs, and certainly tends to overcome the [illegible] correctional facilities. The incidence of TB among prisoners is four times that of non-

reporting of suspected or confirmed cases of disease is slow, incomplete, and frequently not sufficient to develop a meaningful public health response or control effort. Assessment and screening practices are usually restricted to a single point in time which may not give an accurate picture of inmates as they enter or leave the system and do not provide information about those who remain incarcerated. In addition, this point prevalence data depends on the method of testing and may not reflect actual disease. The mandatory or routine nature of testing (i.e., where inmates have a choice to "opt out" of testing) also confounds the information that is available.

No standardized methods exist to establish a month-to-month report on the number of inmates who have a communicable disease inside prisons and jails. Despite the existence of State reporting requirements and correctional health directives, little has been done to change the situation with the exception of disease outbreaks. The disease burden within institutions is also linked to the larger community and has an impact on "community" health outcomes. Without exception, systems must be put in place that will utilize existing data, identify and support the need for additional prevalence studies, and support enhanced reporting practices to improve decision-making on resource allocations for medical care, prevention programs, and evaluation of intervention strategies within correctional facilities.

Effective surveillance and information collection is essential to protect inmates, corrections staff, and communities from disease transmission. The following methods should be employed to improve assessment, screening, medical evaluation and availability of epidemiologic information to accurately profile the health needs of incarcerated individuals.

Methods:

1. Health departments, academic institutions (medical and public health schools), volunteer agencies, professional societies, corrections agencies, and constituency organizations must define the extent to which correctional populations are at risk for disease and the factors that place them at risk.

2. Federal agencies, health departments, and correctional agencies, and social service programs at state and local levels must determine the scope of existing data and its usefulness at various organizational levels. They must determine what additional surveillance and epidemiologic data is need to design and develop health care and prevention strategies for incarcerated populations and the communities that surround them.

3. NCHSTP should develop and implement a pilot sentinel surveillance project to establish baseline data from for jails and prisons for current program planning and to provide a framework for a system that will address national, state, and local data and reporting requirements.

4. Correctional physician, laboratory, and hospital reporting of cases to health departments

should be initiated for HIV/AIDS, STDs, and hepatitis and should continue for TB. These cases need to reported as residents of the correctional facility.

5. To implement case reporting, health departments should initiate telephone reporting systems for reportable infectious diseases as a replacement or supplement to written notification. This system should include a telephone answering machine to record off-hour reports. Computer-to-computer reporting should be developed and used as correctional systems gain computerized medical charting utilities to further improve surveillance.

6. NCHSTP and Corrections should identify sub-populations at increased risk of infection and transmission among incarcerated populations and establish prevention and control measures to protect inmates, staff, and the community at large. NCHSTP should build on the National HIV Serosurveillance Program to include incarcerated populations, as a starting point to profile this population.

7. CDC and NIJ must design and conduct prevalence studies and surveys to establish national, regional, and state profiles of the health status of incarcerated populations, especially women and youth, in jails, prisons, and detention facilities.

8. Federal agencies, public health and correctional officials, correctional health care providers, and community-based organizations should determine what data/information are necessary to support the continuity of care from corrections into the community for aftercare and support services.

Step 2 - Program Development

A. Improving Medical Care and Prevention Services

Correctional institutions across the nation are facing significant increases in HIV/AIDS, STD, TB, and many continue to report new outbreaks of drug resistant TB. The incidence of these and other infectious diseases among prisoners not only increases the risks for people around them, but to their families, and the community at large as an increasing number of infected individuals enter and leave correctional systems undetected and untreated. Prisoners have few advocates and even fewer who are interested in their health care. Often access to health care and prevention services (including educational programs) come only though lawsuits and consent decrees. The health of prisoners and their care, in and out of prison, has continuing social and financial cost to the entire society including dire implications for public health programs to intervene in disease transmission. Inmate populations are increasingly associated with substance abuse and high risk sexual activity within a complex web of psycho-social issues. Corrections systems provide unique "public health opportunities" to access these high risk and underserved individuals with medical treatment and prevention services. Incarceration is a critical period when health care contact can be made and interventions to reduce disease transmission can begin.

In addition there is a substantial population of high risk individuals circulating between correctional facilities and communities beset by poverty, drug use, violence, and disease. These facts combine to produce a serious public health problem.

Currently, medical care for inmates is reactive rather than preventive. According to the American Correctional Association's (ACA) Standards for Adult Correctional Institution (Third Edition), "sick call" is defined as the system through which an inmate reports and receives individualized and appropriate medical services for nonemergency illness or injury. Sick call occurs at a designated time and a certain number of times a week, depending on facility size. ACA suggests that periodic examinations should occur for all inmates at least biennially and annually for inmates age 50 or above, and prior to release to protect both inmate and public. However, little follow-up is done to monitor compliance with these recommendations. Correctional facilities are controlled settings where high risk populations can be efficiently accessed. Better prevention programs and medical care within jails and prisons can directly benefit the larger community since the vast majority of inmates in the United States do return to their home community.

To reduce the prevalence of infectious disease among the incarcerated and to prevent transmission, the following methods should be implemented:

Methods:

1. CDC, NIJ, FBOP, State health departments and corrections agencies, and national corrections accreditation bodies should establish minimal criteria for health care access and disease prevention in correctional settings that can be applied at all levels of the system (jails, prisons, and detention).

2. Assessment and screening for HIV/AIDS, STD, TB and other communicable disease should be readily accessible to all inmates in correctional institutions in accordance with state public health requirements and at their own request.

3. Health departments and corrections systems should work to ensure that HIV counseling and testing is available to all inmates upon entry into prison, anytime while in custody, and regardless of whether or not they have been exposed to HIV. Procedures to protect the confidentiality of the inmates HIV status and disclosure of medical information should be established.

4. Screening for infectious disease may be done to identify suspects, undiagnosed cases, diagnosed cases lost to follow-up, and infected persons in need of medical management, preventive therapy, and behavioral intervention. At a minimum health departments should ensure that such programs are extended to individuals entering and exiting jails, prisons, detention facilities, drug courts, and supervised probation or parole.

5. NCHSTP should collaborate with other federal agencies, public health and corrections

officials, and national corrections standard-setting organizations to develop guidelines

6. NCHSTP will develop two MMWRS; one should address screening policies and procedures in jail settings and the second should address HIV treatment in jail and prison settings.

7. NCHSTP should collaborate with other federal agencies, public health and corrections officials, and national corrections standard-setting organizations to develop optimal prevention and control guidelines for HIV/AIDS, STD, and hepatitis. Once developed, these guidelines will be integrated into current standards of correctional health care for accreditation.

8. Health departments and accreditation organizations should monitor and evaluate inmate's access to sick call to determine if prompt medical attention is provided to the inmate.

9. NCHSTP and health departments should monitor the utilization of protease inhibitors and combination therapy in corrections settings.

B. Program Collaboration and Integration

There is a major lack of understanding between public health and corrections. The opportunity to provide comprehensive education and prevention programs in correctional settings has been missed to a great extent due to the lack of collaboration and linkages between public health, corrections, criminal justice, and community service providers. Corrections knowledge and understanding regarding the incidence of infectious disease, cost of care, or health outcomes for jails and prisons is cursory at best and almost non-existent when viewed from the context of prevention. Few correctional officials appreciate the benefits of prevention. The sparse information available frequently is subjective and lacks any generalizability to enable public officials' motives and agenda. This lack of familiarity produces mistrust and suspicion that detracts from case management, follow-up, and support from communities for individuals as they return [illegible] those who remain under the supervision of the criminal justice system. Within prevention programs for HIV/AIDS, substance abuse, and communicable disease but within the criminal justice system itself. Each state has its own unique rules in the way it

interacts within the system and with other governmental agencies, including public health. Relationships between key players in this nexus of public health and corrections is further complicated by divergent goals, policies, and procedures.

Methods:

1. NCHSTP and NIJ should distribute findings from national surveys and research projects to assist public health, corrections, drug treatment, correctional health care providers and community-based organizations in program planning, resource allocation and evaluation of prevention programs targeting incarcerated populations.

2. CDC, NIJ, FBOP, and state and local public health organizations should explore ways to share information and experiences regarding corrections across institutional systems at multiple levels within their respective organizations.

3. To better understand public health and corrections linkages, existing policies, procedures, mandates, and information resources should be shared and actively disseminated across Federal, state and local public health and corrections organizations.

4. Cross-training initiatives should be implemented for both corrections and public health. Inter-agency job exchanges should be developed for gaining insight into the "other" organization. Communicable disease prevention courses should be integrated in National Institute of Corrections and NIJ training, ACA course-offerings, and state correctional officers training programs.

5. Federal, state and local public health and corrections agencies should meet periodically (at least once a year) to discuss issues, share information, and problem solve.

6. Federal funding from CDC, NIJ, FBOP should be used as seed money for implementing policy, disease technology, demonstration projects, and technology assessment. All funding guidance should include language that targets incarcerated populations. State and local corrections and national correctional associations should also continue to fund ongoing prevention efforts and eventually assume the cost of each new technology as its advantages become apparent.

7. NCHSTP should support the continuation and the expansion of the Inter-Agency Agreement between NIJ and CDC. The goals from this continuation include: a) information-sharing among the agencies and other external agencies, and b) describing collaborative ways of working to improve correctional health care through innovations in alternative sentencing and community corrections approaches.

8. CDC Public Health Advisors, their state and local counterparts, and existing state and directly-funded community-based organizations should continue to translate national

recommendations into programs targeting corrections.

9. NCHSTP should foster the inclusion of corrections in the HIV prevention community planning process by developing a information packet for adult and juvenile corrections administrators. This packet would be distributed by local community planning groups and would explain the importance of corrections participation in the community planning process.

10. NCHSTP should develop Corrections Information Fact Sheets [illegible]mination to its prevention partners, including health departments, [illegible]munity-based organizations, national and regional minority organizations, and [illegible]mmunity planning groups.

Step 3 - Behavioral Interventions

Many key players in corrections and public health recogni[illegible] public health opportunity to provide comprehensive prevention programs addressing [illegible]V/AIDS, STD, TB, and hepatitis within correctional facilities. The transient and invisible popula[illegible] that passes through correctional facilities are literally a "captive audience" available for [illegible]cation and intervention programs for the length of their sentences. Although understood, this opportunity has not been taken advantage of by health departments and [illegible]mmunity-based organizations.

The 1994 Update: HIV/AIDS and STD in Correctional Facilities includes a report on the scope of HIV/STD education and behavioral interventions conducted in correctional facilities (X). The conclusion of their findings is that this opportunity has not been full utilized. HIV knowledge among inmates has improved since the 1980's, but some misinformation still exists regarding transmission mechanisms and prevention measures. Between the 1992 report and the 1994 report, the number of State/Federal institutions offering instructor-led HIV education sessions for inmates declined. Only about [illegible] of State/Federal systems provide peer education and support programs. Much of the materials used for these programs lacks cultural sensitivity and accommodation for non-English speaking inmates (X).

Public health officials have a conscientious responsibility to foster effective disease prevention programs to all inmates and incarcerated juveniles. Not only will these prevention messages educate and protect inmates, but they will also safeguard the community to which the inmates return. The following methods should be accomplished to understand the range of education and intervention programs, the behavioral risk factors of this target population, and to provide for funding sources to begin best practices within correctional systems.

M[illegible]

1. NCHSTP and NIJ should design and conduct prevalence studies and surveys to establish national, regional, and state profiles of behavioral risk factors of incarcerated populations, especially women and youth, in jails, prisons, and detention facilities.

2. NCHSTP, NIJ, ACA, NCCHC, and community-based organizations should assess the current scope of behavioral interventions employed in corrections and should evaluate their cost, benefit, and impact.

3. CDC should provide grant monies to public health schools, state and local health departments, and community-based organizations for the development of innovative behavioral interventions; funding efforts towards this method have declined over the past few years.

4. CDC, NIJ, and other corrections associations should sponsor presentations by "experts" who have employed successful programs to offer technical assistance to correctional health care staff and corrections programs staff.

5. CDC, NIJ, and other corrections associations should evaluate corrections status on providing inmates with pre-release programs and referrals to aftercare. Afterwards, all NCHSTP should encourage collaboration between public health agencies at all levels and correctional systems for adults, justice systems for juveniles, and community-based organizations to strengthen HIV/AIDS education and prevention programs in facilities for adults and juveniles.

Conclusion

With the number of individuals entering the correctional system increasing, the more likely for an epidemic to occur among this invisible population. The majority of Americans view this population "out of sight, out of mind," whereas the contrary is true. Only 20% that enter the system remain incarcerated for a significant amount of time. The other 80% re-enter into our communities and represent the place that we and our children go. The community at-large can and is affected by the circulating population in drug treatment centers, correctional facilities, and our community. Disease screening, treatment, and intervention programs to prevent disease transmission could benefit disease prevention programs targeting correctional populations. HIV/AIDS the overall understanding of the criminal justice system is necessary for developing policies and procedures and for planning effective interventions. With commitment from government agencies, correctional associations, and community leaders, innovative corrections-base programming can work to reduce the disease burden among our invisible population.

References: *(to be added)*

1. U.S. Department of Justice, Bureau of Justice Statistics, "Prison and Jail Inmates at Midyear 1996" (Washington, D.C.: January 1997).

U.S. Department of Justice, National Institute of Justice/U.S. Department of Health and Human Services, CDC, 1994 Update: HIV/AIDS and STDs in Correctional Facilities (Washington, D.C.: December 1995).

#2

NCHSTP - Correctional Health Issues

[illegible]

The chaos of corrections arises from:

- lengths of stay in jail facilities averaging only 14 days;
- high rates of recidivism;
- over half of the arrests bonding out or getting released on their own recognizance within 24 hours; and,
- arrestees giving incorrect personal information.

These issues obstruct proper screening, testing, treatment, and education of arrestees or inmates, and ultimately, reduces our ability for accurate surveillance.

Only a handful of facilities report on STD prevalence, and a few more have on-going blinded seroprevalence studies to reveal HIV infection among correctional populations. Tuberculosis cases in correctional facilities are known through the residence variable on the Report of Verified Case of Tuberculosis form. The prevalence of hepatitis B and C is not well understood in correctional populations. Better methods of surveillance need to implemented within correctional settings, recognizing the capabilities and limitations of each type of setting.

Linking inmates to substance abuse treatment programs after incarceration will potentially reduce an inmate's high-risk behaviors, thereby preventing HIV transmission. The integration of HIV and substance abuse treatment and prevention provides a supportive framework for risk reduction.

more corrections meetings are including at least one session on health care issues. Corrections administrators and medical directors frequently express their need for CDC technical assistance.

#3

CCCWG Current Projects

Correctional facilities are critical settings for monitoring the cutting edge of the HIV/AIDS epidemic and for initiating efforts to address problems of TB, STDs, hepatitis, and other infectious diseases. Correctional facilities are overrepresented in correctional settings, and overcrowded and poorly ventilated correctional facilities are highly conducive for transmitting TB, if they lack effective programs of screening, prophylaxis, and prevention.

Especially in jails but in prisons as well, the vast majority of inmates return to the community after short stays, where they may resume or continue high-risk behavior, placing themselves and others at risk. Moreover, recidivism rates are high, meaning that many of these individuals will return repeatedly to jail or prison. There is a substantial population of high-risk individuals circulating between correctional facilities and communities in the "free world," already beset by poverty, drug use, violence, and disease, public health problem. At the same time, correctional facilities offer significant opportunities for intervention. They are ostensibly controlled settings where populations can be efficiently accessed and programs implemented with literally "captive audiences." Nevertheless, findings of Abt Associates, Inc.'s survey of HIV/AIDS, STDs, and TB in correctional facilities, conducted for CDC and the National Institute of Justice (NIJ) demonstrate that the opportunity to provide comprehensive education and prevention programs in prison, jails, and juvenile facilities, has been missed to a great extent.

A potentially important method of addressing HIV/AIDS, STDs, and TB in jails and prisons is through collaborations between public health and correctional agencies. Public health agencies offer scientific and programmatic expertise in disease prevention and control while correctional systems have the population in need of these services and, commonly, a desire to save scarce resources by finding other sources for necessary functions. Thus, such collaborations seem natural, however, they have not frequently occurred. Public health and correctional officials with their HIV/AIDS education and prevention programs, and there are some notable examples of successful and effective collaborations.

Within CDC, a cross-center working group has developed to address correctional health care issues. Its mission is to help focus and stimulate disease prevention activities in correctional settings. Since the Cross-Center Corrections Working Group's (CCCWG) inception, its members have been striving to bring corrections language to their Division's initiatives and projects and to receive funding from various CIOs for studies or projects in correctional facilities. The CCCWG's biggest accomplishment to date is development of partnerships with other federal agencies that deal with corrections (NIJ, Bureau of Justice Statistics, and the

Federal Bureau of Prisons) and with correctional agencies (American Corrections Association, National Commission on Correctional Health Care, American Jail Association, etc.). It is the collaborative efforts between CDC and other agencies that will begin to put forth solutions to this ever growing high-risk population that circulates through our Nation's correctional systems.

List of Current CCCWG Projects/Initiatives

1. NIJ/CDC Inter-Agency Agreement

CDC entered into an inter-agency agreement with NIJ to continue and assist with the national survey that NIJ conducts every two years. In addition to the survey, two complementary projects were added as components of this year's agreement. The first project will study factors fostering and/or inhibiting collaboration between public health and correctional agencies that address HIV, STDs, and TB, and the other case study will evaluate current education and prevention interventions in jail and prison settings.

Surveys were finally sent out to all chosen facilities in mid-April. The contractor has received 99% of the adult surveys in state/federal facilities and 90% of the adult surveys in city/county facilities. Aggressive telephone follow-up is being done by the contractor to obtain outstanding surveys.

B. Collaborative Case-Study Project

Site-visits for the collaborative case-study project were finished early April, and a draft of the cross-site synthesis will be finished by mid-May. Site-visits for the behavioral case-study project will be completed sometime this summer.

2. Accelerated Prevention Campaign -- Jail STD Prevalence Monitoring Project

Received funding in 1996 to award supplemental monies to five jails in order to [illegible] other jail sites over the next two years.

3. Accelerated Prevention Campaign – STD Screening for Women in Jails

Received funding in 1997 to award supplements to evaluate screening programs for gonorrhea and chlamydia using urine test for women admitted to correctional facilities.

4. Collaboration with National Commission on Correctional Health Care (NCCHC)

Since NCCHC was awarded a grant by NIJ to study soon-to-be-released inmates, they have contacted CDC for technical assistance and input on this study. We will be working with them to assist and collaborate whenever possible.

5. Collaboration with Department of Justice, Office of Justice Programs, Corrections Program Office (CPO)

Working with CPO to develop strategies for TB prevention within corrections, especially ways to improve collaboration between state and local correction and public health both at entry and discharge into the community.

6. HIV Serosurveillance

DHAP awarded $500,000 ($80,000 each) to Arizona, California, Connecticut, Illinois, and Louisiana to supplement their existing cooperative agreement. This money is earmarked for enhancing HIV prevention activities in correctional facilities.

7. DSTDP Jail Inventory

DSTDP Program Development and Support Branch has developed and administered an inventory of STD activities in each project area's largest jail facility. The survey examines surveillance, access to care, and prevention services. The gathered data should reveal data needs and areas for prevention.

8. "HIV and STD Intervention Research for Young Men in Prison"

DHAP Behavioral Intervention Research Branch developed Program Announcement #750. This project will stimulate the development of innovative science-based models that assist local communities in the prevention of HIV/STD infection and transmission among young men in prison who are ready to return to their communities. This five year project will include both formative research and intervention phases; four sites will be funded.

9. CDC's Dr. Satcher to be Keynote Speaker at the American Correctional Association's 127th Congress of Corrections

Our participation at this Congress will further the recognition of these issues and the need for collaboration with corrections partners.

#4

NCHSTP

National Center for HIV, STD, and TB Prevention

Cross-Center Corrections Workgroup

Correctional Settings: A Public Health Opportunity

- Over 5 million persons are under some form of criminal justice supervision, including 1.6 million behind bars
- A significant number of arrestees experience health services in jail settings for the first time
- Approximately 70% of people in prison today have a history of injection drug use or substance abuse
- High rates of recidivism
- Incarcerated populations are disproportionately affected by communicable diseases

Mission

To help focus and stimulate disease prevention activities in correctional settings.

New Info *

Function

- To provide an interdivisional forum on corrections for sharing information and expertise, identifying facilitators and barriers, and proposing solutions
- To strengthen the capacity of the Divisions in the following areas:

- Improve knowledge and understanding of factors that influence HIV, STD, and TB transmission and prevention, especially the interrelationship between incarcerated populations and the larger community
- Develop and disseminate comprehensive disease surveillance and behavioral risk factor information
- Establish policies that standardize optimum care and prevention services that foster community involvement and support
- Establish partnerships that promote policy development and translation of science to program

- Develop pilot projects/demonstrations that model effective service linkages
- Promote behavioral risk factor research focusing on individual, peer/social network, and community
- Support "health stations" within corrections which are independent of the punitive process, but supportive of community-based public health priorities

Internal Corrections Survey Report

Major findings:

- No comprehensive surveillance system
- Omission of juvenile, probation, parole, and court systems
- Lack of collaborations between substance abuse, criminal justice, and public health
- Minimal education/intervention programming for inmates, staff, and administration

Action Steps

Division:

- Develop model corrections-based surveillance systems
- Develop an epidemiologic profile and disseminate specific surveillance and risk factor information
- Identify barriers and facilitators of collaboration

Action Steps

Working Group:

- Present findings of the Ninth Annual CDC/NIJ Survey to the HIV/AIDS Advisory Committee and ACET and seek their recommendations
- Conduct two Correctional Forums to outline issues, action steps, linkages, and policy recommendations
- Sponsor a national conference on correctional health care to establish routine national and regional communication links

FAX (202) 785-1255

TELEX: 64245

THE MADISON HOTEL
Washington, D.C. 20005
(202) 862-1600

n:/issues.
prisons

Todd -

As we discussed, at the meeting of Correctional HIV Consortium in Atlanta last week, these individuals wrote these recommendations with assurances they would get to the White House

So whatever it is worth, I found Judy Greenspan to be knowledgeable →

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Judy Greenspan, Chairperson
AFFILIATION: HIV in Prison Committee of California Prison Focus
ADDRESS: 2489 Mission St, #28, San Francisco CA 94110
PHONE/FAX: (510) 655-2931; email judyg@igc.org

RECOMMENDATION

(1) Oppose all mandatory HIV testing schemes in correctional facilities on local, state and federal level

(2) Along with funding needle exchange, demand that prisoners have access to risk reduction tools such as condoms and bleach – support the adoption of a harm reduction model in prisons and jails

(3) Strongly support the development of system wide HIV peer education programs inside prisons and jails.

(4) Encourage community organizations to develop in-prison programs as well as prisoner-friendly transitional case management.

(5) A workable, effective & accessible compassionate release program for dying prisoners. In other words, release them before they stop breathing.

(6) Work for an exception to the 1995 Anti-Terrorism Act for HIV+ ~~people~~ immigrants caught in the criminal justice system. Stop the immediate deportation of undocumented immigrants who have HIV/AIDS after release from the criminal justice system.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Marty O'Neal, MSW, LSCSW

AFFILIATION: USA Meddac - SWS

ADDRESS: 550 Pope Ave
Ft. Leavenworth KS.
66027

PHONE/FAX:
ofc (913) 684 6771 home (913) 782 7718
FAX 913 684 6762

RECOMMENDATION

1. Descriptive and Outcomes Research be promoted/funded for programs that have a low incidence of seroconversion inside the walls, and/or followup post incarceration on compliance, treatment & [illegible] health [illegible]
2. Make available the curriculum for the Peer education program at the USDB (DOD) as a model for
3. Standards for HIV+ care
4. Standards for "harm reduction" in correctional settings w/ "high" incidence of HIV+ STD's.

5. Standards for
Case management approach
- management of care, treatment of any chronic, progressive, disease [illegible]
- aftercare [illegible]
- early identification +

6. Standards for adequate Discharge planning for HIV + STD or any chronic progressive diseases to include:
- clear aftercare plan for continuity of care

—

based on Standards now for condom distribution
7. The health [illegible] funds be used for condom distribution inside correctional facilities — tied to prevention education

8) Withhold funding from states who do not implement prevention, harm reduction, case management, discharge planning.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Marty O'Neal MSW LSCSW

AFFILIATION: United States Army

ADDRESS: 550 Pope Ave
Ft. Leavenworth, Ks 66027

PHONE/FAX: home 913 782 7718
wk. 913 684 6771
FAX 913 684 6764

RECOMMENDATION

1. I would like to nominate Brian Warden as a prisoner with HIV+ to be on the Subcommittee on HIV+ & Prisons & possibly to be a member of the President's Advisory Council.

Brian is an inmate at the United States Disciplinary Barracks at Ft. Leavenworth. He is a model inmate, on triple drug therapy, who manages his own meds inside the walls — has 100% compliance with treatment. He is elig for parole but our system is slow to parole. His [illegible] is in [illegible]. (over)

He is knowledgeable of the issues, very bright, and highly motivated to participate.

When he leaves the DB, he will discharge to Utah. He is Mormon, married.

Brian has participated in a model program at the DB for treatment of very mentally ill inmates. Group, support, discharge planning, network, literature + publications, research materials, speaking, etc.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Jacki David

AFFILIATION: Mich. Dept. of Corrections
HIV Case Management Coordinator

ADDRESS: P.O. Box 30003, Bureau of Health Care
Lansing MI 48909

PHONE/FAX:
517/241-7123 (phone)
517/335-0045 (fax)

RECOMMENDATION

Support condom distribution + bleach distribution in prison, particularly lower security level prisons. Prevention + care go hand in hand, but we need to be cognizant of security issues too. We provide them at discharge but that is insufficient (and the Mich. Dept. of Community Health supports/provides them, not MDOC). Even if they get them @ sick call or must pay a small fee (.25¢?) that's better than the nothing we have now! Dental dams?

→

Change conditions of parole/probation so ex-offenders can come back in as case managers. In mich, HIV+ ex-offenders are some of our best case managers but they cannot come in & meet w/ the inmate who is HIV+ prior to parole. Face-to-face contact is preferred in developing a trusting relationship as opposed to the phone.

We need more care consortia that have HIV+ ex-offenders and prisoners as members.

Look @ adopting "Principles + Standards of HIV Case Mgt" as a model.

Contact Rebecca Allen @ 517-335-9334 for a copy. ↳ or Randy Pope — MDCH/HAPIS

Maybe other states & entities should certify and recertify case managers.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Judy Byrnes

AFFILIATION: GA Divison of Public Health

ADDRESS: 2 Peachtree St Suite 10/410
Atl, GA 30303

PHONE/FAX: 404-657-3114
FAX 657-3133

RECOMMENDATION

The prohibition of Ryan White funds especially ADAP being used for persons in local jails is a barrier to care.

Also for persons being released from prison on HIV meds - there is a large gap in them being able to continue their treatment when not elig. for medicaid

ADAP has [illegible]

RW Clinics have backed [illegible] for appointments [illegible] months get 2 wks of meds [illegible] they [illegible] that [illegible]

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Jennifer Taussig

AFFILIATION: CDC - Div. HIV/AIDS Prev. - IRS

ADDRESS: 1600 Clifton Rd. MS E-35
Atlanta, GA 30333

PHONE/FAX: (404) 639-5200
639-5260 (FAX)

RECOMMENDATION

Advocate or recommend greater access to substance abuse treatment services which are known to be effective HIV prevention programs.

Also look at the issue of access to sterile syringes from community pharmacies. Needle exchange programs are only one part of a comprehensive approach to HIV prev. for drug users.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Kara Laine Barrett, RN

AFFILIATION: Grady Health Systems - Infectious Disease Program

ADDRESS: 341 Powell Leon Avenue
Atlanta, GA. 30308

PHONE/FAX: 404-616-6121
404-616-9700

RECOMMENDATION

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Willis Johnson

AFFILIATION: AMASSI, INC.

ADDRESS: 351 - 15th St.
Oakland, CA 94612

PHONE/FAX:
510- 433-9373
510- 835-4206 fax

RECOMMENDATION

- You need someone on the council that is an ex-Social offender and/or positive.
- Needle exchange behind bars.
- Condom distribution
- Federal standards for discharge planning
-

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Maestro A. Evans, LMSW, MSWAC

AFFILIATION: AID Atlanta

ADDRESS: 1438 W. Peachtree St. Ste. 100
Atlanta, GA 30309

PHONE/FAX: (404) 874-6517
(404) 888-4740 fax

RECOMMENDATION

Establishment of a transitional case management program within the Georgia Department of Corrections (as well all correctional systems)

Stronger and continued advocacy for the legalization of needle exchange programs

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Susan T Moore

AFFILIATION: MO Department of Health

ADDRESS: 219 N. Chestnut
Cameron, MO. 64429

PHONE/FAX: 1. 800- 663-1649
Fax 1. 816- 632-1636

- RECOMMENDATION

1) That a uniform 2-6 month notification of a HIV+ inmates' release date be given to Medical Services so that a Outreach discharge planner can be notified. It is vital for accessing A.D.A.P., particularly if there is a waiting list.

2) That more funding be available for pre-release programs linking HIV+ inmates to care prior to release.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Nichole Bowman

AFFILIATION: Rollins School of Public Health
Emory Univ.

ADDRESS: 1518 Clifton Road NE
Atlanta, GA 30322

PHONE/FAX:

RECOMMENDATION

Mandatory STD/HIV peer education programs for state & federal facilities. Curriculum reviewed by PACH and panel of health educators. Curriculum reviewed every 2 to 3 years.

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Cynthia Rinaldi, RDH, Infection Control Coordinator

AFFILIATION: Mt. Olive Correctional Complex (max. Security Prison for men - W. Va.)

ADDRESS: #1 Mountainside Way
Mt. Olive, WV 25185

PHONE/FAX: (304) 442-2250
(304) 442-2766

RECOMMENDATION

Needs / Recommendations:

- funding + technical assistance for double blinded seroprevalence studies + education to encourage voluntary testing for HIV/HBV/HCV in correctional facilities.
- data from above needed to develop fiscal planning + policy for 1) medical management/treatment of inmates with infectious diseases & 2) development of HIV/HBV/HCV prevention/education programs for correctional staff + inmates.
- need effective models + funding to develop effective peer-based inmate education programs
- adoption of realistic risk-reduction/harm reduction education + tools to reduce transmission of HIV/HBV/HCV in prisons/jails + ultimately back into the communities. (lift ban on condoms/dental dams (realize politically illegal needles for inmates out of the question - at least provide ed. + use of bleach!)

PRESIDENTIAL ADVISORY COUNCIL ON HIV/AIDS

JUNE 10, 1998

NAME: Celena Messiter

AFFILIATION: GA. Parole Board

ADDRESS: 2 Martin Luther King Jr. DR SE
Atlanta, GA 30334

PHONE/FAX: 404 651-6690

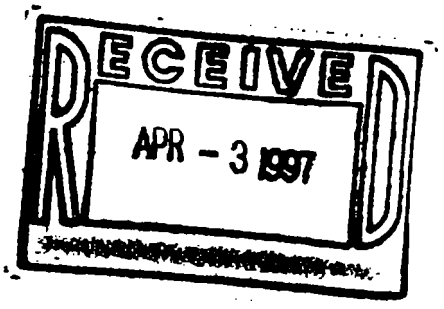
RECOMMENDATION

Pilot project be developed to test inmates for HIV on entrance and discharge from prison. This would give a more accurate picture of how many sero convert while they are locked up. It would help support risk reduction

DEE FARMER

P.O. Box 1000
Reg. No. 23288-037
Butner, NC 27509

March 31, 1997



Jackie Walker
The National Prison Project
of the ACLU Foundation, Inc.
1875 Connecticut Avenue, N.W.
Washington, D.C. 20009

Dear Jackie:

I am sending this to you priority mail so I hope that you will receive it in time; by April 3, 1997. I may try to call you on the 3rd to see if you received it. (I am sorry for the last minute.)

I believe that the BoP's biggest default in the treatment of HIV/AIDS inmates is the failure to offer anytype of comprehensive psychological counseling to those inmates. HIV/AIDS is still a very big taboo in the federal prisons. The only thing that the BoP offers is a video upon arrival and a little of this and that from the doctor when he/she informs the inmate of their positive test. Consequently, the inmates live in constant turmoil with absolutely nobody to talk to and afraid that someone will find out. It is absolutely terrible.

I am enclosing a brief from a Maryland case that also gives some discussion of the psychological effects upon HIV/AIDS inmates (although it deals with segregation). I am sending you my originals please make a copy and return to me.

I will also ask Dallas Denny of AEGIS (770) 939-2128 (American Educational Gender Information Service to fax you a copy of the writing that I have completed about the psychological effects of HIV/AIDS in prison.

Also, I wanted to mention that I am working with a law student, Alicia Hunter, who I believe worked at the Criminal Justice Center or something like that. She knows you from the Alabama case and speaks very highly of you.

Please let me know if I can be of any further assistance.

Sincerely yours,

Dee Farmer

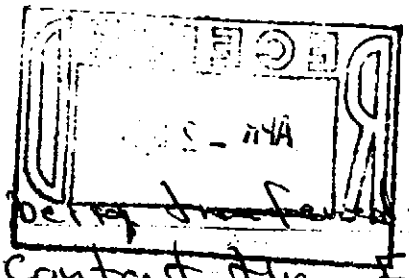
Dee Deidre Farmer

Dearest Jackie Walker [redacted] 3-26-97

Thank you for allowing me to say something!

The most ~~important~~ matter with many of us is being so far from home! My family lives in Wisconsin, I could be sent to either Oxford FCI OR Pekin FCI or several others one! my family have wrote to Senator Heb Kohl, Senator Kohl has requested the federal Bureau of Prison to investigate to get me closen to home! But still I sit here! My mother and father are to old an there health won't allow them to travel this far! Can Someone please help me with this matter! I'd love to see my family before I die! Please help me with this matter! (Please)! I WAS told unless your really really bad compassionate releases are out! and most people die before even being granted the compassionate releases! NO Condoms are allowed under No Circumstances! If this Sub-Committee really wants to help= please get all HIV. Inmate or those that have full blown Aids closer to home, so the family can spend the last remaining time with them through Visiting OR gave a person a compassionate release to die at home! Thank you again Jackie!

Jackie Could you please contact Senator Kohl



Situation with me being transferred closer to home is going. OR at least contact the Federal Bureau of Prison Dr Washington and help me with this matter!

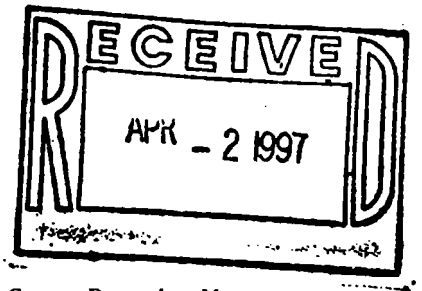
I just want to see my family before I die please help me. please. I'LL pray for your help my family is just plain worried!

Thank you,
Robert Sanders
02905-089

Jackie please maybe your telephone might make a difference!

May God Bless you!

TOBIE A. KROHE
80761 Unit 28-A
Parchman, MS 38738-0282



March 28, 1997

Dear Ms. Walker

Please recall that I did send you a copy of my letter to Lt. Gov. Ronnie Musgrove, of Mississippi. I hope you will address those concerns with the April 5th meeting.

Additionally, The Mississippi State Parole Board is not hardly giving any fair consider ations to HIV offenders. Some are given up to 4 year set-ffs, and never even having an opportunity to personally address the Board. The board sends their decision through the mail to the offender, letting them know they have been denied parole for such-in-su term (4 years, or 3, or 2...etc). Some have sevred SUFFICIENT time for their crimes, and the Parole Board simply does not consider one's good behavior nor accomplishments in rehabilitative efforts, e.g. educational accomplishemnets, etc.

The State Parole Board for the State Of Mississippi takes it upon themselves to indirec quarentine us by continuosly denying HIV offenders parole. There are, however, a very SMALL amount that do make it, but the most do not. They ones do not make parole, are the very ones that have sponsors out there that have submitted sworn statements to their ability to provide for the potential parolee if they were to be released, that they will financially be able to pay for the best medical care and needed medicati etc., whereby the state wont do it, so we are being held beyond our control when most of us can have access to the new drugs and clinical trials, if freed.

The M.D.O.C. medica; staff nurse who is assigned to the HIV unit, Susie Bruce, LPN, does a good job with regard to the education to inmates about it. However, the Medical staff has promised us the Protease Inhibitors if we would take AZT & 3TC for 3 months, and now say they can not obtain the drugs. We are not allowed to even be presented wit any opportunities to participate inclinical trials, and we all most certainly would if given the opportunity! [Reference to "AIDS/PRISON ISSUES, Final Request, letter C, included in the packet you sent to me recently].

Condons are available for distribution. The main emphasis is our tsrongest desire for the state to provide us with the Protease Inhibitors and more lenient consideration for Parole to those having HIV and having served at least ¼ of their time.

Thank you for addressing these issues, and please let me know what happened and what was addressed, particurly in behalf of the Mississippi Prison system.

SINCERELY,

TOBIE KROHE

RSVP

Parole Board
State of MS
723 N. President St
Jackson, MS. 39202

MDOC Medical Director, Dr. John Ber
PO Box E
(601)745-661

Tobie A. Krohe
80761 Unit 28 - D
Parchman, Mississippi
38738-0282

March 15, 1997

Honorable Ronnie Musgrove,
Luietenant Governor, State Of Mississippi
State Capitol Building
Jackson, Mississippi 39202

Dear Mr. Musgrove:

I hope this finds you doing well. I regret bringing this matter to your attention, firstly because I am unfortunately an inmate of the MDOC, and second and even more unfortunately, I have the AIDS virus as a result of intrevenous drug use, wherefore, due to these two mistakes in my part, I am now in dire need of your assistance. I should not, admittingly, be in this predicament, and if I could change the past, I most certainly would. But I have to live with these consequences, and for the most part, it's difficult being incarcerated, but the stress attached thereto is extremely magnified when living the double atrocity of being HIV Positive while incarcerated.

Realistically, Mr. Musgrove, I face an inevitable death, and quite frankly, it scares me more than any nightmare imaginable. If I ever get out of here alive, and I pray to God that I do, I want to strive so hard to preach to people about this disease, the consequences of substance abuse and unsafe sex. If I can do that, I would be living my life in a very positive mode which is imperative for surviving this battle as long as possible. I simply can not stand the thought of someone going through the emotional and physical pain which I have suffered with this powerfully fatal and painful disease.

The reason I am writing basically is to express my view toward the medical care here at Parchman. First of all, I know that we here at Parchman are nothing to the taxpayers but convicts and do not deserve maximum medical care. However, suffering from AIDS is a lot different from frivilous-filing, illness-milingering inmates. No one deserves having AIDS. There are children out there suffering and also heterosexual, such as myself, people that somehow inadvertantly contracted the virus WITHOUT homosexual contact what-so-ever.

I must emphasise that I do not mean to imply that I am impugning upon the medical staff here at the MDOC Hospital. Some are very professional. I just recently had a severe bout of the flu and they rushed me up there to get my fever down and I became symptom-free as a result of their treatment. However, someone there is withholding some serious, life-threatening information. All HIV positive inmates were promised the new cocktail drugs known as Protease Inhibitors. A brief synopsis of these drugs: several clinical trial studies have concluded that approximately 87% of groups of HIV patients participating in the trials, DID become HIV-free after a period of time on these "cocktail" drugs known as Protease Inhibitors. These drugs were the only drugs ever to be approved so rapidly by the FDA for HIV/AIDS treatment, as a result of these astonishing conclusions [43 days, FDA approved, March 10, 1996]. The criteria to be prescribed these drugs is that the HIV person must fir take a combination anti-virul drug treatment consisting of AZT (Retrovir) and 3TC (Epivir) for six (6) months. This prerequisite treatment prepares the HIV infected person's body and antibody functions to be stablised and strong enough to accept the possible toxidity effects of the Protease Inhibitors, i.e., one could not just begin taking the powerful Protease Inhibitors without first taking the prerequisite combination treatment of AZT & 3T for six months because the Protease Inhibitors simply would not work and could be even fata

NEXT PAGE

The MDOC Hospital, ever since the FDA's approval of the Protease Inhibitor drugs, has promised all the HIV positive inmates that they would recieve these promising medications, after their each respected six-month period of the AZT/3TC treatment. Some inmates were reluctant to ever start any such drugs, but did so with the promise of the MDOC medical staff that they would recieve these new drugs after six months prerequisite treatment.

I have recently learned from a very reliable source that now the reason for the delay in delivering their promise by distributing these drugs is because Merke Laboratories, the main manufactors/distributors of these new drugs [Protease Inhibitors] had apparently requested that the MDOC provide them (Merke) with all the HIV positive inmates' medical records, which if true, should have been done. MDOC apparently refused to comply with Merke in this regard because they claim is was a breach of doctor/client confidentiality. I think this is unfair because there is not one single HIV inmate here that would NOT consent to their release of medical records. No one ever has even asked any of us if we would consent (if that's the case) and I feel that if Merke wants this information, we have a right to provide it to them, but it appears that MDOC is forcing us to withhold it beyong our control. Even if this situation is not true, why are they continously trying to hide something from us? Some of us have even agreed to finance our own medical treatme for the use of these new drugs. I feel it is a right for us to be accessible to these medications; in fact, ANYONE suffering this seemingly inevitable fate is or certainly shou be entitled to obtain these drugs. Sir, you must realise that, in light of our imminant death, the news of these new promising drugs created extremely magnified hope, and to be denied this treatment, especially beyong our control, is overwhelmingly stressful.

Mr. Musgrove, I would be immeasurably greatful if somehow you can intervene in this dire matter concerning the HIV inmates being accessible to the new Protease Inhibitor "cocktail" drugs. Recently, the FDA has now approved the use of these new drugs for children with AIDS, so that news alone substantiates the fact that these drugs are so very effective in the combat of HIV, not only in adults, but children as well! I must tell you that should you make any telephone calls to the medical staff here to ascertain any pertinant information regarding all of this, in all liklihood you may be given misled information. It is only my opinion when I state that, the reason I feel that the medical department here at MDOC apparently denied Merke the HIV inmates' medical records, is primarily because of their (MDOC) fear of Merke discovering the many potential malpractice discrepancies in the many medical files parellel to the treatments MDOC has been giving to some HIV inmates that were inaccurate or inappropriate, perhaps even unethical. I do not think the majority of discrepancies were intentional; I only think that the medical staff may not be trained enough to adhere to the appropriate adducements of treatments necessary in proceeding with the modernised protocols and new treatments that is essential in the prolonging of life for those of us suffering with this disease.

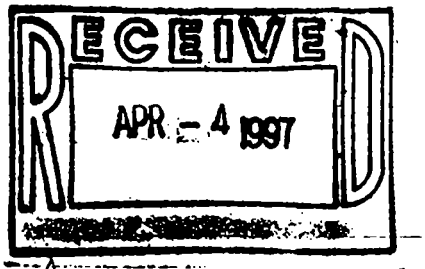
In conclusion, I respectfully plea to you to please assist in this matter and I assure you that not just the inmates suffering from AIDS would appreciate it, but the many affected families who are tax-payers of our State, and the many AIDS individuals and AIDS activists in the free-world would certainly appreciate your efforts as well. Please respond at your earliest convenience to me regarding this matter, and may God continue to richly bless you in every way. With kindest regards, I am

CORDIALLY YOURS,

TOBIE A. KROHE

cc: Mrs. Margie Krohe; Mr. & Mrs. Howard Houston; Mr. & Mrs. John McClanahan; Ms. Gerry Thompson; Dr. & Mrs. Clyde Stokes; Dr. Jacob Skiwski; Mrs. William Sanders; Mr. & Mrs. Thomas Lancaster; Mr. & Mrs. Jimmy Autry; Ms. Jane Simmons; Mr. Chris Duncan

1



To: Jackie Walker, Info. Coor.
From: Offender "Kenneth E. Newsome"
Re: Info. requested
Date: March, 29th 1997

Hello Jackie,

I have enclosed the comments on the following issues you requested. I am very elated, to hear from you at this time, because we desperatly need all the help we can get. The (A.C.L.U.F.) foundation in Jackson, says that it is so backed up & finanicially unable to help us at the present time because of the large number of cases it has. Therefore, we are glad that someone wants to hear our voice, I would hope that other organizations such as the "Federal bureau of Prisons", will also lend a helping hand in our battle of rights for (H.I.V.+ & A.I.D.S.) infected, chronically ill patients incarcerated.

Sincerely,
Kenneth E. Newsome

#A58295 Kenneth E. Newsome

Miss. Dept of Corr. (M.D.O.C.) At Parchman, Miss.

I. "Healthcare in prison": In our prison system the budget is always the problem and (#1) excuse. We have maybe 5 drugs readily available to us which is not good. Among them are: AZT (Zidovudine), 3TC (Lamivudine), Hivid (ddc), Videx (ddI), Zerit (d4t). Out of the (140)-(H.I.V.+ pos.) male inmates incarcerated, 26 are full-blown. To my knowledge over (75% percent) want to try some of these new therapies. However, most of this medication is very toxic, most inmates can't put up with the adverse side effects. There is a new drug called (ViraCept) that has no side effects, maybe a few if any, but is has a very low toxicity level. There are no clinical trials being done on the inmates here!

II. "Compassionate release": Unless you are on your dying bed, in a vegetable stage, our prison system will not let you go. You are considered full blown when the T-cell count is below - 200! We really need help in this area, along with other prisons. Dying inmates would like to see thier familys before they die.

III. Access to condoms: To my knowledge they have some condoms available at the main housing unit for (H.I.V.'s & A.I.D.S.) infected prisoners. However, we have (H.I.V.+) inmates at [closed-confinement] units where condoms are not issued, along with the hospital, condoms are not issued there either. Also they do not have enough condoms for everyone, making it easier for those who are in a homosexual relationship to participate in risky behavior. Also I don't think condoms are issued in general population outside the H.I.V. unit.

IV. Discharge planning: To my knowledge we have no type of discharge planning available to us in the prison system. We are in need of one, along with a lot of other things which I will mention later. We are one of the poorest states in the union, we need all the help we can get.

(Over →

A.) Nondiscrimination - we do not know the meaning of this word, because we are facing every area of discrimination possible at it's worst. We are segregated from the rest of the "general population", yet we still go to such areas such as the (Hospital, Law-Library, Gym) for our on well-being. We are housed at A 192 man Unit, segregated from other inmates.

We also are not allowed to work with other general population inmates, or attend any type of trade school, where we could learn such trades as: Welding, brick laying, carpentry, along with other important skills. We only have (G.E.d. & L.E.A.P.) programs available to use, NO (A.B.E.) Adult Basic Education.

B.) Condoms - we need more condoms passed out throughout the prison system as a whole, also more need to be distributed through the H.I.V. units, to include (Closed-Confinement) which also houses over (20 - N.I.V. +pos) inmates.

C.) Tuberculosis: A lot of work is being done about (H.I.V.+ pos.) inmates aquiring the germ as a whole. I also understand that a tougher strain of (TB) is in Prisons today, what is being done about that is very unclear.

D.) Education: for staff & inmates knowledge about this virus or disease is very low, a lot can be done in this area. H.I.V.+ & A.I.D.S. awareness classes were established, but however they did not last long. We need money to fund these classes for staff & inmates as well as a [redacted] library, for us to study & learn more.

E.) H.I.V. testing & confidentiality: We are in the process of testing prison-wide for the H.I.V. virus, whether that is a good idea or not, I don't know. It has it's "Pro's & Cons." As far as confidentiality is concerned that is very low around here, we could stand some help in that area.

F.) Working in kitchens: only at the N.I.V. segregated Unit is this allowed, because only N.I.V.'s are housed here. Before it was an N.I.V. complete camp, we shared it with disability inmates. We were not allowed to work in the kitchen then. We are also wondering when we will, if ever, be allowed to hold jobs as other "general population" inmates do.

I am coming up for parole in the next couple of months, I'd sure ~~not~~ would appreciate a recommendation for my parole via the prison commissioner & supt.:

Steve W. Puckett, commi.	James V. Anderson,
723 N. President St.	P.O. Box 1057
Jackson, Miss. [redacted]	Parchman, Miss. 387
39205	(601)
	ph# 745-6611
	# Fax (601) 745-8912

Parchman →

/ OVER →

To: Jackie Walker, Info. Coor.
From: Offender "Kenneth E. Newsome"
Re: Info. requested
Date: March, 29th 1997

Hello Jackie,

I have enclosed the comments on the following issues you requested. I am very elated, to hear from you at this time, because we desperatly need all the help we can get. The (A.C.L.U.F.) foundation in Jackson, says that it is so backed up & finanicially unable to help us at the present time because of the large number of cases it has. Therefore, we are glad that someone wants to hear our voice, I would hope that other organizations such as the "Federal bureau of Prisons", will also lend a helping hand in our battle of rights for (H.I.V.+ & A.I.D.S.) infected, chronically ill patients incarcerated.

Sincerely,
Kenneth E. Newsome

#A58295 Kenneth E. Newsome

I want to be an (H.I.V. & A.I.D.S.) Activist for the public & the incarcerated ones within the state of Mississippi. Your recommendation will greatly be appreciated on this subject matter also. Let them be aware of my plans if I'm granted parole. My date for parole is June 2nd, 1997. Thank you for all your support & efforts concerning this matter with (H.I.V.+ pos & A.I.D.S.) inmates in our state prison system.

Sincerely,

Kenneth E. Newsome

#A58295

KENNETH E. NEWSOME
UNIT 32 B-Bldg., B-ZONE,
PARCHMAN, MISS. 38738

P.S. This is a lock-down closed-confinement unit. Looking foward to hearing from you soon.

Dear Ms Walker. 3-28-97

Thank you for your letter of March 24, and for the opportunity to be heard by the Presidential Council.

In your letter you outlined several areas of concern. One issue; that of adequate medical care while incarcerated, would seem to be of concern to everyone including myself. I can only speak from personal experience as I am incarcerated in the Illinois state prison system. I have been incarcerated since June of 1995 and I won't be released until March of 1999.

During that period I have encountered both genuine concern and genuine contempt on the part of various medical staff throughout the Illinois Dept of Corrections.

It wouldn't be fair for me to say that all of these people were either good or bad in their approach to HIV since many of them operate under the guidelines of state policy in regard to accepted treatment.

I can only express to you my perception in regard to the quality of treatment made available to me at this time.

In June of 1995 when I first entered the Illinois Department of Corrections my CD-4 count was approximately 380. My Doctor at that time requested AZT because of my low T-cell count. I requested to think that my stay in Chicago's Cook County Jail, combined with the stress of being transfered through 3 facilities in order to get to them, may have contributed to that number in my CD-4 count. I refused AZT and suggested that a multi-vitamin supplement for 90 days would probably raise my count.

He was reluctant at first, but he finally agreed and after 90 days I was re-tested. My CD-4 count had risen to 580 where it remained for the next sixteen months.

In October of 1996 I was transfered to The Graham Correctional Center and immediately informed that my prescription for multi-vitamins was terminated. This information was provided even before I was interviewed by a doctor. Approximately 2 weeks later I received my first CD-4 evaluation and interview with Graham's doctor. He said my vitamin prescription was terminated because "there [illegible]

vitamin supplementation is suggested to people with HIV. My very most recent blood test indicated my CD-4 count had dropped to 300. A subsequent test 90 days later indicated my CD-4 was at 285.

I have challenged the Doctors position through the inmate grievance procedure during these past 6 months. It is a lengthy process which involves following the chain of command from my inmate counselor all the way to the Director of the Illinois Dept. of Corrections.

None of these people involved with the grievance process have any medical training; but they all concur with Dr Cullinan in regard to the benefits of vitamins for people with HIV and the continued termination of my prescription.

I have also used these past 6 months to research the Doctor's position in this regard. Imagine my surprise when after reading only 2 publications... "Nutrition and HIV=" and "Nutrition and AIDS=" I discovered at least 100 documented medical studies which advocate vitamin supplementation as a clinical approach to treating HIV.

These studies have been published in such locations as "The Journal of AIDS, 1993, 6(8), 949-957
The international journal for vitamin and nutritional research. 1987. 516, 219-234
The Journal of the American Medical Association 1981 245(1) 53-58.
The International Conference on AIDS 1989, 5, 467.
The Harvard Medical School Conference 1994.

I don't want to take up your time with the entirety of these studies as they are far too lengthy to be included with my letter. However as such, it would seem the list of these studies which advocate vitamin supplementation are also far too lengthy to have been overlooked by Dr. Feldman and the extensive resources available to him through The Illinois Department of Corrections.

I am not a Doctor, I am just a man who has lived with HIV since 1987. In that time I have never been interviewed by a Doctor who didn't recommend vitamin and nutritional supplementation in regard to viral progression. In fact I would venture to say that any Doctor who was truly aware of the characteristics of HIV viral progression would be concerned with such issues as vitamin deficiencies brought on by the binding

inability to absorb nutrients due to infection. In some cases the HIV virus itself can benefit from these deficiencies.

I don't think vitamins are a cure for HIV. I do think that proper nutrition is the basis for good health. Unfortunately people who are HIV positive experience deficiencies even when they consume normal amounts of vitamin and nutritional supplements. Normal = during the RDA. In my 10 years of living with HIV my CD-4 level has never been lower than what it is now even though 6 months ago it was at a level considered to be strongly present standards. My doctor has suggested aggressive treatment such as a three pronged assault of DDC, 3TC and saquinavir. It's a combination of nucleoside analogs and protease inhibitors that would cost the tax payers about $12,000.00 annually. It's also a combination that must be followed to the letter with regard to when and how it's taken. Any break in the schedule can cause the virus to have a chance to become resistant to the medication. Especially where protease inhibitors are involved

effects are involved. It is also worth noting that my CD-4 count remained above 500 while I was able to acquire vitamins. 500 is the level at which most Doctors begin treating patients with AZT etc...

I can't help but wonder if anyone involved in the termination of my prescription realizes that I wouldn't be at a level in regard to my CD-4 count that would warrant anti-viral medication if they hadn't terminated my prescription when I first arrived here.

When you consider the annual cost of vitamin-nutrient supplementation which would be perhaps 500 to $1,000.00 per year; compared to the cost of protease inhibitors combined with nucleoside analogs which would be about $12,000.00 annually. You really have to wonder where my present Doctor is trying to go.

In any case, it seems I have no choice in regard to treatment with the exception of no treatment at all unless I consent to Dr Cullions chosen path. It's very difficult for me to have confidence in a Dr whose

Still when you experience as dramatic a decline in your CD-4 level as I have, you realize you really don't have a lot of choices.

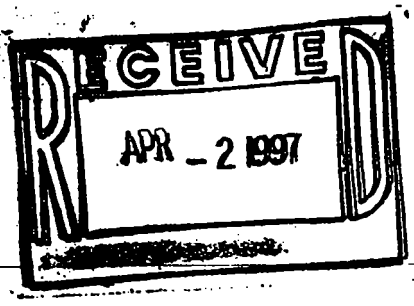
Between now and March 99 when I will be released I have to wonder if I will experience further declines in my CD-4 count. How much lower can it get before I begin to succumb to infections brought to bare by my depleted immune system.

I've read the particulars on such drugs as HIVID or DDC. Listed under potential side effects are ... peripheral neuropathy (tingling burning, numbness or pain in the hands & feet) fever, headaches. may cause lymphoma. I don't feel that bad now and I would hate to spend whatever time I have with peripheral neuropathy or lymphoma.

I haven't given up and I am hoping that through Civil Litigation I can reverse the Illinois Department of Corrections in regard to their idea of treatment. In my perception: it's no treatment at all.

Sincerely. David Rosen A-73771

D. Rosen
A-73771
P.O. Box 500
Hillsboro, IL.



MARCH 30-97

Mr. CHAVIS YVES St. LAURENTS
#28009-B
UNIT 32-B B-57
MS. STATE PRISON
PARCHMAN MISS 38738

TO. ADMINISTRATOR
AND (NORA) - SUBCOMMITTEE
AND NATIONAL PRISON PROJECT - ACLU

I'm VOICEING My Comments on Prison With AIDS I'm HERE in the Mississippi STATE PENITENTIARY, Along With 140 more INMATES, 26 ARE full blown. This Prison System is A VERY POOR ONE When comes to handleing HIV's AND AIDS INMATES, The officer ARE NOT TRAINED to Work With HIV's And AIDS INMATES HERE, NONE of the MEDICAL STAFF has little OR NONE EDUCATIONAL ON How to take CARE OF HIV'S AIDS INMATES. THEY is NO EXPERIMENTAL therapies for persons IN this prisons OR Counseling, mainly the one With HIV. AND AIDS, The only Drugs we got is AZT's And 3CT's and HIVID over half of the INMATES The Drugs has made them very sick, It's Been 35 INMATES to die From 1990 - 1997 All because

II

the Goverenment wont Spend money to get some of the new Protease Inhibitors, The Inmate are very much in need of some new Drugs, The ACTs are making and killing the Inmates here. We are very truely been Discriminated here in this System, They won't let Any HIV's go to trade Class, We Are been kept from geting A trade, Some of the Inmates will be able to get A job, He wont be able to get the job he want, be cause M.D.O.C is Discriminating By keeping them from going to trade class with other Inmates in this System, We gose to Court with none HIVs, law Liabary, Hospital Call, Eat with them whitaway, Then's only one Inmate working in the None HIV Correctional facilities. He's been working for 3 years Now, one dont make up for why the otha 139 HIV's Inmates, We been trying very Hard to get the New Treatment By writing the Gov Commissioner Steve Puckett) Also some of the case Could have got Medical Release they wait until the Inmates Die And then Send them home, They let one HIV Inmate go home And He wasn't Fullblown They keep telling us they dont have Any money to help us, The Gov, And the legislature gave So many of million of dollars to jackson 200, And to Southing, to take care big Cat's = That's money th

II

Could have got those new Drugs with Its very clear they dont Want us in this System, If so those 35 Would be heee With us. We been trying very have to get thing Right heee. But we get A Dead Told on Every thing. I was trying t Teaching class on AIDS And HIVs to the Inmates And Some officer here, They make me stop doing it, They didit Want to help get Any Infor on AIDS And HIVs, What little I was geting Was from organizations out side of this System To teach the Inmates With, I work very hard to get the Condoms, Its the only thing I've got so Fare, I'll love very much if we can get Some VCR TAPES on HIVs And AIDs, We got a VCR At the Camp M.D.O.C Alk Sending Inmate to the Camp From Rod in Rankin County Ms to pinehorne, And When they get heee. And I meet them And tell them this A HIV Unit, They Say I dont how Hiv or AIDS, Some Broke down And Cry, And Say how I am going to tell my people. I try very hard to counseling With the Inmates Because I've been Postive for 9 years, And never been Sick Not one day, So I take from my Experiences of been postive And pass it Alone to to other Inmates, I tell them All Feist let God

in to your life And the Rest will be taking CARE of, But you must believe in god Always, I Wish you'll CAN SEE This SERIOUS MATTER HERE in this System, It's A VERY SAD Situation HERE the WAY the HIV's ARE BEEN TREATED, WE'll PRAYING EACH And EVERY day for it to get better, It's been like this SENSE 1987, Now If A.C.L.U OR The NATIONAL Prison Project Come to Mississipp to See this matter, They only going to tell you lies in order to get the truth on this matter you'll must come to UNIT 28 It's the HIV UNIT, I may get in trouble OR get lock down for telling the truth. Please dont let them stop you'll from coming to See me on the UNIT It's Some things At the unit will Bring TEARS to your EYES.

THANK YOU'll For you'll Time
IN Behalf of my self And the OTHER IN mates HERE A M.D.O.C, WE feel Alot better to KNOW there's Some to help us out it this SAD Situation, And MAY god be with you'll ALWAYS

Chris yes St Laurents

Prisons and AIDS

UNAIDS
point of view

April 1997

UNAIDS *Best Practice* Collection

Facts and Figures

■ In many prisons around the world there are high rates of infection with the human immunodeficiency virus (HIV), the virus that causes AIDS. At the same time, prisoners often also have tuberculosis (TB), syphilis and various strains of viral hepatitis.

■ For example, HIV prevalence in French prisons is about ten times that of the general population, while the prevalence of TB is three times the national average. In south-eastern France, 12.7% of prisoners tested HIV-positive in a 1994-95 survey. In Santa Fe province, Argentina, between 11.3% and 14% of prisoners tested HIV-positive in 1995. In the United States in 1994, there were 5.2 cases of AIDS per 1,000 prisoners, almost six times the rate in the general adult population.

■ The prison population is not eternally sealed off, but is constantly changing, with people going in and out. In some places, the average stay in prison is quite short. For example, Ireland has an average prison population of around 2,200, with an annual turnover of about 10,000 and an average prison sentence of 3-4 months.

■ Several factors make prisons an ideal breeding ground for onward transmission of HIV infection. Overcrowding is one such factor. In 1995, the prison population of the United States was 1.6 million, a doubling over ten years. In a major Eastern European prison, individual cells hold up to 35 prisoners each. Violence, often a feature of prison life, produces tensions, recriminations and an atmosphere of fear.

■ Many of those in prison are there because of drug use or trafficking, and they often find ways to continue drug use inside. Drug injecting with shared, non-sterile equipment is the factor probably accounting for the greatest number of new HIV cases in prisons worldwide.

■ In Lower Saxony, Germany, a survey in a women's prison showed about a third of those sampled were injecting drug users, many continuing their habit in prison. Of those injecting, 4.9% were infected with HIV, as against 0.5% of the non-injectors. In Central Prison in Lisbon, Portugal, a survey of 1,442 prisoners entering between 1994 and 1996 found 63% to be drug dependent and potentially in need of treatment.

■ Unprotected sex between men is another important factor for HIV transmission among prison inmates.

■ A 1993 survey in Rio de Janeiro, Brazil suggested that 73% of male prisoners had had sex with other men in prison. In New South Wales, Australia, a study in 1994 found that 8% of prisoners reported having engaged in anal or oral sex in prison. As with other self-reported findings, the true figure is likely to be higher. In Kamfinsa prison, Zambia, 8.4% of men reported anal sex in a study in 1995.

■ Apart from consensual sex, male rape is not uncommon in some prisons. Given that force will be used, and that condoms will almost certainly not be employed, the risks of HIV transmission are high.

■ Tattooing and other forms of skin piercing are common and carry some risk of HIV transmission, since the equipment is rarely sterilized. Blood brotherhood rituals, involving the mixing and exchange of blood, also occur.

■ HIV transmission in prison settings can be reduced by:
- provision of liquid household bleach, and instructions as to its correct use for sterilizing needles and syringes, as well as for cleaning tattooing equipment;
- needle exchange programmes, whereby a used needle is exchanged free for a sterile (clean) one;
- discreet and easy access to condoms and lubricants for all prisoners.

■ Other factors which can help in reducing HIV transmission are an end to overcrowding in prisons, and control of prison health by the public health authorities, acting freely and independently of the prison service.

AIDS in prisons: a serious problem for society

AIDS in prisons – of concern for everyone

The AIDS virus has been found in prisons in most countries of the world. This should be a source of the utmost concern – not only for prisoners and prison staff, but for society in general.

HIV prevalence in many prisons is already high – higher than in the population at large – and still increasing. Many of those who are HIV-positive in prison were already infected on the outside. Many of them come from those segments of the population that carry a heavier than average burden of HIV infections. In Italy in 1995, around 13% of the prison population was reported to be HIV positive. And in Porto prison in Portugal, over 15% were positive that year. Why should this be so, and why should the community at large worry about what happens in these closed-off institutions?

Conditions ideal for HIV spread

Prison conditions are often ideal breeding grounds for onward transmission of HIV infection. They are frequently overcrowded. They commonly operate in an atmosphere of violence and fear. Tensions abound, including sexual tensions. Release from these tensions, and from the boredom of prison life, is often found in the consumption of drugs or in sex. When the drugs are injected, which they frequently are, needles – being scarce, illegal and difficult to hide – are almost always shared. In fact, the needles are often ingenious home-made devices, crafted from things such as ball-point pens.

Prison staff also at risk

Both prisoners and prison staff run the risk of HIV infection in prisons. Prison officers may become infected, for instance, if they stick themselves on a hidden, infected needle while conducting a routine search of lockers.

Not cut off . . . but part of society

Prisons, in fact, are not cut off from the world outside. Most prisoners leave prison at some point to return to their community, some after only a short time inside. Some prisoners enter and leave prison many times. In Ireland, with a prison population of around 2,200, the annual turnover of prisoners is about 10,000 and the average sentence 3-4 months. Furthermore, out of the estimated 1,600 people in that country with HIV, some 300 to 500 have been through the prison system.

What is so special about prison conditions as regards HIV, compared with the outside world? The fact is that inmates (and to a lesser extent staff) who are still free of infection are particularly susceptible to the virus. Prisoners are frequently denied the means to protect themselves from high-risk behaviours. They may also lack access to information, education and reasonable medical care.

> "HIV/AIDS in prisons remains a difficult and controversial subject. The activities in prisons that spread HIV - notably sex and drug use - are usually criminal within the prison environment and meet with disciplinary measures, not health measures. Often there are not enough resources to provide basic health care in prisons, much less HIV/AIDS programmes.
>
> Yet the situation is an urgent one. It involves the rights to health, security of person, equality before the law and freedom from inhuman and degrading treatment. It must be urgently addressed for the sake of the health, rights and dignity of prisoners; for the sake of the health and safety of the prison staff; and for the sake of the communities from which prisoners come and to which they return.
>
> With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community."
>
> *Statement by UNAIDS to the United Nations Commission on Human Rights at its Fifty-second session - April 1996*

How has this alarming situation arisen?

What are the main problems that have created the alarming situation existing today in most of the world's prisons – in some cases, the situation that exists as well in society at large?

Drug injecting

Many prisoners crave some form of drugs. Many of them are in prison in the first place because of offences related to drugs. The doubling of the prison population (to a total of 1.6 million men and women) in the United States in the decade up to 1995 – and its consequent overcrowding – are in large part due to a policy of actively pursuing and imprisoning those dealing in and consuming illegal substances. Whatever the legal merits of that policy, from the point of view of the spread of HIV it has proved disastrous. Recent figures have shown that 2.3% of inmates in state prisons, and 1.0% in federal prisons in the US are HIV positive. In 1992, 24% of all deaths in US state prisons were due to AIDS.

Sharing of injecting equipment is a highly efficient way of rapidly passing HIV around – much more so than sexual contact. A recent survey in a women's prison in Lower Saxony (Germany) showed that about a third of those sampled were injecting drug users. Of those injecting, 4.9% of them were infected with HIV, as against 0.5% of the non-injecting women.

In Thailand – a country that has endured one of the fastest spreads of the epidemic in Asia – the first wave of HIV infections occurred in 1988 among drug injectors. From a negligible percentage at the beginning of the year, the prevalence rate among injectors rose to over 40% by September, fuelled in part by transmission of the virus as injectors moved in and out of prison.

> "If there is one thing, more than anything else, which should be done, it is that health in prisons must come under the responsibility of the public health authorities. The link between health in the community and health in prisons must be made as strong as possible."
>
> *Professor Tim Harding, University Institute for Legal Medicine, Geneva*

Sex in prisons

Sexual contact between men is common in prisons around the world. Estimates vary considerably. A 1993 survey in Rio de Janeiro, Brazil, suggested that 73% of male prisoners had had sex with other men in prison, while surveys in Zambia, Australia, England and Canada have come up with figures of between 6% and 12% – figures which are probably low because of denial and under-reporting.

The sex may be consensual, but it can also be coerced, to a greater or lesser degree. Rape also exists, and in some prisons is considered usual, sometimes as a form of institutionalized initiation, where it can take the form of gang rape.

Many inmates are in prison for violent crimes. Some are mentally unstable. In the tense and claustrophobic atmosphere of prisons – with their own rules, hierarchies, alliances and enmities among the prisoners – attacks on prisoners, including sexual ones, can easily occur. Systems of enslavement also exist.

Sex between men in prisons includes anal sex. Unprotected, this is a high-risk factor for transmission of HIV. The risk is even higher if lubrication is not used, and if sex is forced, as in the case of rape. Condoms are not available in prisons as a rule.

In women's prisons where there are male prison staff, sex between men and women may also take place, creating a risk of HIV transmission.

Tattooing, skin piercing and blood brotherhood rites

Tattooing is common in prisons and equipment is frequently shared, creating a risk of HIV transmission.

How has this alarming situation arisen?

There are similar risks where skin piercing is practised.

The practice in some prisons of "blood brotherhood" rites, clearly presents a high risk of HIV infection.

Lack of education, information and medical care

The potential for the spread of HIV is usually increased by a lack of information and education, and by a lack of proper medical care. In particular, other diseases transmitted in prison are often not treated properly, including diseases which can be transmitted by shared blood. Apart from HIV and syphilis, these include hepatitis B and C. And other sexually transmitted diseases (STDs), such as syphilis and gonorrhoea – if left untreated – can greatly increase an individual's vulnerability to HIV through sexual contact.

Tuberculosis

A particularly serious health consideration is tuberculosis (TB), which can easily spread in overcrowded prison conditions. People with HIV are especially vulnerable to TB, and HIV-positive people with TB can transmit this disease to those not infected with HIV.

Overcrowding

The contribution of overcrowding to the climate of violence and tension in prisons is great, as is, indirectly, its contribution to the spread of HIV and TB.

The Hindelbank experiment: providing clean needles

A one-year experiment to provide sterile needles was launched at Hindelbank women's prison, Switzerland, in June 1994. A year later, because of the success of the project, it was decided to continue with it. The prison holds up to 100 women, in six wings, with most of the prisoners serving sentences for drug offences. In the project, dispensing machines were set up in various accessible locations (showers, toilets, storage areas) to provide sterile needles. Prisoners were allowed to keep one (but no more than one) piece of injecting equipment, and only in a specially designated cabinet. The evaluation at the end of the first year of the project's operation showed that there had been no new cases of HIV or hepatitis in the prison and that the prisoners' health had improved. Furthermore, a significant decrease in needle sharing was observed, there was no evident increase in drug consumption, and needles had not been used as weapons.

What can we do to stop the spread of HIV in prison?

Demand reduction, harm reduction and treatment for drug-dependent prisoners

What can be done to stop the spread of HIV in prisons through injecting drugs? One of the first measures is to offer treatment for those who wish to continue substitution therapy (e.g. with methadone) that may have been started on the outside. Offering treatment to reduce demand or to help break addiction is another important measure.

These steps are crucial and respect the rights of prisoners to the kind of care and concern that is available on the outside, rather than simply denying that drug injecting takes place inside, a reaction that is still all too common.

But long experience has shown that drugs, needles and syringes will find their way through the thickest and most secure of prison walls. In the past few years prison authorities in a number of countries have taken active steps to find constructive ways to reduce the risk of HIV spread through injecting. These usually come under the heading of "harm reduction" or "risk reduction". They are not necessarily easy options to embark on, and they have ethical as well as practical problems attached to them. They have usually been undertaken as a pilot project, or a form of experiment, in the first place. Success with them to date has led to their being continued, and indeed extended into other prisons and other countries.

Hindelbank (see box) was not in fact the first prison to make clean needles available free to prisoners, though it was the first to evaluate such a scheme scientifically. Oberschöngrün, also in Switzerland, started an unofficial scheme in 1993. Since the success of Hindelbank, other prisons – including two in Germany and one in Geneva – have launched their own schemes.

An important way for a prison service to get started on such a scheme, and to overcome all the objections that are liable to be raised, is to treat it very much as an experiment in the first place, and to evaluate it after, say, a year of operation.

Another strategy is to provide liquid bleach, together with instructions on correct use, to sterilize needles and syringes. This is perhaps an easier intervention to introduce into prisons, partly for the reason that bleach already exists – almost unnoticed – in many prisons, for the purposes of cleaning toilets. Several prisons in Europe, Australia, Africa and Central America have brought in this policy. There was a fear that bleach could be misused, for attacks on prison staff or other prisoners, for instance, but this has not been a problem.

UNAIDS recommends that prison services should actively find ways of setting up pilot schemes to reduce the risk of HIV infection among drug-using prisoners through treatment programmes and through risk reduction by distributing free, clean needles and syringes, as well as by providing bleach, together with appropriate instructions. This is already being done in a growing number of prisons throughout the world.

Peer educators (including ex-prisoners, and ex-injectors) can provide education on using clean injecting equipment, as well as help in drug cessation programmes. Only through these means will the appalling spread of HIV through needle sharing in prisons – with its direct impact on the general community – be reduced.

Providing condoms

Recognizing the fact that sexual contact does occur and cannot be stopped in prison settings, and given the high risk of disease transmission that it carries, UNAIDS believes it vital that condoms, together with lubricant, should be readily available to prisoners. This should be done either using dispensing machines or supplies in the prison medical service. Over the past decade, a good number of countries have begun to distribute condoms in their prisons. Unfortunately, there still exists a

strong current of denial in many places about male-to-male sex (especially in prison) and a corresponding refusal to do anything which might be seen as condoning it. These attitudes will have to change if societies want to see the rate of HIV infection – inside prison and outside of it – decrease.

An end to overcrowding and a lessening of violence

The risk of disease transmission and the atmosphere of violence created are two more reasons for actively seeking reforms to reduce prison overcrowding.

It is important to prevent violent attacks on prisoners, including sexual abuse and rape – condoms are not going to be of use. Prison staff should be trained to avoid unnecessary force or brutality, and to respect the rights, dignity and well-being of prisoners.

Making tattooing safe

For tattooing, a simple expedient is to provide bleach to sterilize tattooing needles and guns. Since tattooing is generally regarded as a more acceptable practice than drug injecting (even many prison officers are tattooed – in Europe, about 30% of them), this preventive measure can be introduced more easily than bleach for injecting needles. In fact, bleach for tattooing equipment can be a way of introducing the option of bleach for drug injectors.

However, blood brotherhood practices cannot be made "safe" by using clean equipment. Education on the high disease risks of such practices may eventually discourage them from taking place.

Adequate health care and information

Facilities for general health checks, including particularly for STDs, should be provided in prisons, along with all necessary information.

As regards tuberculosis, its prompt detection and proper treatment in prison settings are particularly important from a public health point of view, all the more so since multi-drug-resistant TB is becoming more common.

No isolation of prisoners on grounds of HIV status

Sometimes prisoners are isolated or placed in a particular wing of the prison. Measures of these kinds, if they are to be carried out, should be done without any reference to whether the prisoners are or are not infected with HIV.

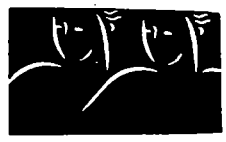
Health in prisons – whose responsibility?

All the methods so far listed are of vital importance. But there is one structural change which, on its own, could have a very great impact in the long run on AIDS in prison. This is to transfer control over prison health to public health authorities. Of course, in making such a move, proper resources must be provided at the same time, and freedom of action of the new prison health authorities guaranteed.

Some countries have already introduced such a change in prison health administration. Norway was one of the first. And in France, where prison health was transferred to the Ministry of Health in 1994, a positive impact is already evident. Each prison in France is twinned with a public hospital. Condoms are available in the medical unit and there are discussions in progress on distributing clean needles and syringes. In Les Baumettes prison in Marseilles, conditions have improved noticeably since the transfer of responsibility for health.

CANADIAN HIV•AIDS LEGAL NETWORK | RÉSEAU JURIDIQUE CANADIEN VIH•SIDA

Société canadienne du sida



Canadian AIDS Society

HIV/AIDS in Prisons: Final Report

prepared by

Ralf Jürgens

Canadian HIV/AIDS Legal Network
Canadian AIDS Society

September 1996

HIV/AIDS in Prisons: Final Report

Prepared by

Ralf Jürgens
Project Coordinator
Project on Legal and Ethical Issues Raised by HIV/AIDS

Canadian AIDS Society
Montréal Project Office
Tel: (514) 987-3000 ext 8773
Fax: (514) 987-3422

Canadian HIV/AIDS Legal Network
4007 de Mentana
Montréal, Québec
H2L 3R9
Tel: (514) 526-1796
Fax: (514) 526-5543
e-mail: aidslaw@web.net
web-site: http//www.odyssee.net/~jujube

Acknowledgments

The Project Coordinator wishes to acknowledge the contributions to this project by the following individuals:

Russell Armstrong
Sharon Baxter
Bruno Guillot-Hurtubise
Anne Stone
Elsie Wagner

Many thanks also to all the other individuals and organizations who have contributed to the project; the respondents to the *Discussion Paper;* the members of the National Project Advisory Committee; the staff at the office of the Canadian AIDS Society; the members of the board of the Canadian HIV/AIDS Legal Network; Reeta Bhatia, Tracey Donaldson, Betsy MacKenzie, Anne Malo, and Robert Shearer, Health Canada, and Alan Sierolawski, Correctional Service of Canada; Garry Bowers for his help in editing the English version of the text; Grant Loewen for layout; Ray Johnston and Econo Presse (Montréal) for printing; and Jean Dussault for translation of the English original into French.

Funding for this project was provided by the AIDS Care, Treatment and Support Unit and the HIV/AIDS Prevention and Community Action Programs, Health Canada, and by the Correctional Service of Canada under the National AIDS Strategy, Phase II.

Ce document est également disponible en français.

Responding to HIV/AIDS in Prisons: History

The Expert Committee on AIDS and Prisons

In Canada, the National Advisory Committee on AIDS[7] the Royal Society of Canada,[8] the Parliamentary Ad Hoc Committee on AIDS,[9] the Federal/Provincial/Territorial Advisory Committee on AIDS,[10] the Ontario Regional HIV/AIDS Advisory Committee,[11] and the Prisoners with HIV/AIDS Support Action Network (PASAN),[12] have each issued a variety of recommendations aimed at reducing the risk of HIV transmission in Canadian prisons, and at ensuring that care, treatment and support be available for prisoners living with HIV/AIDS. Internationally, similar recommendations have been made, most notably by the World Health Organization.[13]

Perhaps the most comprehensive analysis of the issues raised by HIV/AIDS in prisons has been undertaken by the [Canadian] Expert Committee on AIDS and Prisons (ECAP). The Committee was created on 15 June 1992 to assist the federal government in promoting and protecting the health of inmates and of staff, and preventing the transmission of HIV and other infectious agents in federal correctional institutions.

During its 18 months of existence, ECAP visited federal correctional institutions in British Columbia, Ontario, and Québec; interviewed prison authorities, staff and inmates about issues raised by HIV/AIDS and drug use in the prison environment; reviewed Canadian and international policies and reports relating to HIV/AIDS and drug use in prisons; received submissions from Canadian and international bodies, groups and individuals; sent questionnaires to prison staff and to prisoners to obtain information regarding their concerns about HIV/AIDS and drug use in prisons; and released a Working Paper containing the Committee's preliminary conclusions in July 1993.[14] More than 1000 copies of this Working Paper were distributed in Canada and internationally to stimulate discussion and to give people interested in the issues raised by HIV/AIDS and drug use in prisons an opportunity to review the Committee's work and proposals. In March of 1994, the Committee's *Final Report* was released.[15]

[7] National Advisory Committee on AIDS. Minutes of Meeting, Ottawa, 22 April 1987, and Statement Concerning Correctional Settings. This statement was prepared by the Working Group on HIV Infection and Injection Drug Use of the National Advisory Committee on AIDS, and approved by the Committee on 14 December 1989. The statement is published as an appendix in Parliamentary Ad Hoc Committee on AIDS. Confronting a Crisis: The Report of the Parliamentary Ad Hoc Committee on AIDS, 1990. See also *Report. The First National Workshop on HIV Infection and Injection Drug Use: Strategies for Prevention, Montreal, Quebec, March 26-27, 1990.* Ottawa: Canadian Public Health Association, 1991, at 5.

[8] Royal Society of Canada. *AIDS: A Perspective for Canadians.* Summary Report and Recommendations. Ottawa: The Society, 1988.

[9] Parliamentary Ad Hoc Committee, supra, note 7.

[10] The Federal/Provincial/Territorial Advisory Committee on AIDS. Draft Statement on HIV/AIDS in Correctional Facilities. Ottawa: National AIDS Secretariat, 22 November 1991.

[11] Regional HIV/AIDS Advisory Committee, CSC, Ontario Region. Regional Strategy for the Health Education, Assessment, Treatment, and Community Follow-Up of HIV/AIDS Offender Patients. Submission to the Regional Management Committee. Kingston: The Committee, May 1992.

[12] PASAN. HIV/AIDS in Prison Systems: A Comprehensive Strategy. A Brief from the Prisoners with HIV/AIDS Support Action Network (PASAN) to the Minister of Correctional Services and the Minister of Health. Toronto: The Network, June 1992.

[13] WHO. Statement from the Consultation on Prevention and Control of AIDS in Prisons, Global Programme on AIDS. Geneva: WHO, 1987; and the WHO *Guidelines on HIV Infection and AIDS in Prisons.* Geneva: WHO, 1993.

[14] *HIV/AIDS in Prisons: A Working Paper of the Expert Committee on AIDS and Prisons.* Montréal: McGill Centre for Medicine, Ethics and Law, 1993. For a brief discussion, see *Criminal Law Forum* 1993; 4: 581.

[15] Correctional Service Canada. *HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS and Prisons.* Ottawa: Minister of Supply and Services Canada, 1994. The Report comprises two other documents: *HIV/AIDS in Prisons: Summary Report and Recommendations*; and *HIV/AIDS in Prisons: Background Materials.*

The Committee's Final Report and Recommendations

In its *Final Report*, the Committee examines the full range of medical, educational, institutional, legal, and social concerns raised by HIV/AIDS and by drug use in federal correctional facilities in Canada. The Report further provides a review of the federal and provincial prison policies relating to HIV/AIDS of Canada and 14 selected countries, and of the policies issued by international organizations.

ECAP concluded that making sterile injection equipment available in prisons "will be inevitable."

The Report takes a strong public health approach to the problem of HIV infection in prison, and a harm-reduction approach to the problem of drug use. It contains 88 recommendations designed to protect the health of inmates and staff, and relating to:

- the incidence of, and testing for, HIV infection;
- confidentiality of offender medical information;
- housing and activities of HIV-positive prisoners;
- educational programs for inmates and for staff;
- consensual and non-consensual sexual activities;
- drug use, tattooing, and piercing;
- protective measures for staff;
- health care;
- tuberculosis;
- compassionate release;
- aftercare;
- female offenders; and
- aboriginal offenders.

The Committee's recommendations are consistent with the recommendations issued by the other national and international organizations and, in particular, with the World Health Organization's 1993 *Guidelines on HIV Infection and AIDS in Prisons*.[16] Among the recommendations are that

- anonymous testing for HIV be made accessible to inmates;
- in general, an inmate's personal medical information remain confidential between medical personnel and the inmate;
- existing educational programs for inmates and for staff be improved by including more input from external, community-based organizations or experts, and from peers;
- condoms, dental dams and water-based lubricant be easily and discreetly accessible to inmates;
- protective measures for staff be improved;
- the care of inmates with HIV infection or AIDS be comparable to that available in the community;
- inmates with progressive life-threatening diseases, including AIDS, regularly be released earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety;
- full-strength household bleach be made available to inmates;
- injection drug users have access to methadone.

The Committee further concluded that making sterile injection equipment available in prisons "will be inevitable," particularly because of serious doubts that have arisen in relation to the efficacy of bleach in destroying HIV.[17] ECAP

[16] WHO 1993, supra, note 13.
[17] ECAP: *Final Report*, supra, note 15 at 68.

was concerned that, in prisons, the scarcity of drug-injection equipment almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment, and pointed out that only access to sterile equipment would ensure that inmates would not have to share their equipment. However, the Committee was also aware that making needles and syringes available in prisons raises many contentious and potentially divisive issues:

> First, because needles and syringes have not been made available in any prison system, data on the efficacy, benefits, risks, harms and cost-effectiveness of making them available are lacking. For example, it is not clear whether the model developed for needle exchange outside prisons could be adapted to prisons. Whereas the impact of needle distribution or exchange on levels of injection drug use outside prisons appears to be negligible, its impact in prisons is unknown. Second, there is concern for the safety and security of fellow prisoners and staff. It is feared that needles could be used as weapons, although there is no inherent reason to believe that the needles that would be made available would be more dangerous than those already present in penitentiaries. Third, providing sterile needles in prisons is often rejected because it would appear that, in an environment designed to uphold the law, to encourage or condone illegal drug use would be a contradiction in terms.[18]

CSC has "a responsibility to do all we can to prevent the spread of this fatal disease."

- Mr John Edwards former Commissioner of CSC

ECAP concluded that, while making it available would be inevitable, sterile injection equipment could not be made available immediately. Therefore, ECAP recommended that research be undertaken "to identify ways and develop measures, including access to clean injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use." It further recommended that this research include one or more scientifically valid pilot projects, and that it be accompanied by planning, communication and education "that will expedite making sterile injection equipment available in the institutions."[19]

CSC accepted ECAP's recommendation to reaffirm and strengthen its policy of maintaining the confidentiality of inmates who have HIV infection or AIDS.

CSC's Response to ECAP's Report

Promises Made

The CSC accepted many of the recommendations made by ECAP, acknowledging that AIDS represents "a serious public health problem for all of society and that there are particular concerns about inmates in federal penitentiaries." The Commissioner of the Correctional Service added that, "[g]iven that over 80 per cent of inmates are serving fixed sentences and will eventually be returned to the community, the Correctional Service is particularly sensitive to its responsibility to protect the public, including staff and inmates, from the consequences of HIV/AIDS transmission." He concluded by saying that CSC has "a responsibility to do all we can to prevent the spread of this fatal disease."[20]

In its official response to the Report,[21] the Service announced, among other things, that it

[18] ECAP: *Summary Report*, supra, note 15 at 20-21.

[19] Ibid.

[20] News Release. Correctional Service of Canada Announces Response to Final Recommendations Submitted by the Expert Committee on AIDS and Prisons. Ottawa: CSC, 24 March 1994.

[21] Backgrounder: CSC Response to the Expert Committee on AIDS and Prisons (ECAP). Ottawa: CSC, Health Care Services Branch, 24 March 1994.

- accepted ECAP's recommendation to reaffirm and strengthen its policy of maintaining the confidentiality of inmates who have HIV infection or AIDS;
- agreed to build on and improve educational programs on HIV/AIDS and drug use for staff and inmates, and design special programs for female and aboriginal inmates;
- agreed that condoms, dental dams and water-based lubricant be more easily and discreetly available to inmates through a variety of distribution channels throughout institutions;
- agreed to permit inmates to engage professional tattooing services at their own expense;
- agreed with ECAP's recommendations relating to health care, and would provide inmates with health care and treatment comparable to that in the community, including (1) maintaining strong links with external health-care services; (2) facilitating inmates' access to specialized or experimental treatments, including possible transfer where security permits; and (3) assessing health-care services for HIV/AIDS in each institution; and
- agreed with ECAP's recommendation of regularly recommending to the National Parole Board the release of inmates with progressive, life-threatening diseases, including AIDS, earlier in the course of their disease, before they are terminally ill, and whenever they do not constitute a threat to public safety.

Bleach is made available to inmates in many prison systems.

At the time, ECAP's recommendations that (1) bleach be made available to inmates, and (2) access to testing for HIV in prisons be increased by introducing non-nominal and anonymous testing were rejected. CSC agreed only to pilot-test anonymous HIV testing and a bleach-distribution program in one institution. However, in the spring of 1995 this decision was reversed and the Commissioner of the Correctional Service, with approval from the Solicitor General, instructed CSC to initiate the implementation of anonymous HIV testing and bleach distribution in all institutions.

The following is a description of the main initiatives that have been undertaken or are being prepared in response to ECAP's Report:

- distribution of bleach;
- increased access to HIV testing;
- an inmate peer health-promotion project; and
- revisions to Commissioner's Directive 821: Infectious Diseases.

There are no reported incidents of any negative consequences of making bleach available.

Promises Kept?

Distribution of Bleach

Background

In its Report, ECAP recommended that:

- Full-strength household bleach be made available to inmates in federal correctional institutions as a general disinfectant. ECAP suggested that small quantities of bleach and instructions on how to clean needles most effectively be included in a "health kit" given to every inmate on entry into the institution and offered to every inmate on exit from the institution, and that bleach be made available to inmates in a manner similar to that for condoms, dental dams and lubricant; that is, small quantities of bleach should be easily and discreetly accessible.

- In making bleach available in correctional institutions, CSC's policies be revised as follows: until bleach is made available, and thereafter, possession of small quantities of bleach should not be classified as an institutional offence, nor should it be considered to be presumptive evidence of illicit drug use.
- The impact of making bleach available in federal correctional institutions be carefully evaluated, with participation of experts independent of CSC.
- In order to re-emphasize CSC's strong commitment to reducing drug use in federal correctional institutions, making bleach available be accompanied by a clear warning to inmates that possession or use of illicit drugs will not be tolerated in correctional institutions[22]

ECAP reported that bleach is made available to inmates in many prison systems: 16 of 52 systems surveyed around the world late in 1991 made bleach available to prisoners, often accompanied by instructions on how to clean needles.[23] For example, in Spain a bottle of bleach is included in the sanitary kit that inmates receive at entry into the prison system and monthly thereafter, "and more is provided whenever needed." In Switzerland, "first-aid kits" containing small bottles of bleach have been given to inmates since June 1991. Bleach is also available in some prison systems in Germany, France and Australia, in prisons in Belgium, Luxembourg and the Netherlands, and in some African and at least one Central American prison system.[24] In some prisons systems, bleach has always been available as a general cleaning agent and prison authorities have tolerated that it also be used for the purpose of cleaning injection equipment. In others, it has been made available specifically for the purpose of cleaning injection equipment, and various ways have been devised to make it available.

There are no reported incidents of any negative consequences of making bleach available. This is consistent with the Canadian experience. Bleach had been available in Canadian institutions for a long time without any suggestion of it being a threat to institutional security, until it became associated with the sterilization of injection equipment. Further, in some institutions it is still informally available, and there is no evidence that this has created any problems.

ECAP felt that making bleach available in prisons is "mandated by the fact that, because prisoners have reduced possibilities of protecting their health, and because this results from state action, the state has special responsibility for their health." It further emphasized that "[m]aking bleach available in no way condones drug use, but rather emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved and of the community as a whole."[25]

Making bleach available in no way condones drug use, but rather emphasizes that in correctional facilities as elsewhere, the overriding concern in any effort to deal with drug use needs to be the health of the persons involved and of the community as a whole.

The Pilot Project

A pilot project for distribution of bleach started in December 1994 at Matsqui Institution. Its purpose, as stated in the 1994-1995 Annual Report of CSC's National AIDS Program, was to:

- provide CSC with a model of how best to distribute bleach (strength, amount, filtering and packaging);
- track participation and the use bleach is put to;
- measure the impact on needle-cleaning behaviour; and
- document security problems.

Activities Undertaken

A working group including Trudi Nichol, the Project Coordinator,

- developed a communication strategy for all institutional staff that included

[22] ECAP: *Final Report*, supra, note 15 at 78 (Recommendations 6.3(2)-(5)).

[23] See TW Harding, G Schaller. HIV/AIDS Policy for Prisons or for Prisoners? In: JM Mann, DJM Tarantola, TW Netter (eds). *AIDS in the World*. Cambridge, MA: Harvard University Press, 1992, 761-769

[24]. See ECAP: Final Report, supra, note 15 at 69, with many references.

[25] Ibid at 76.

Support for the bleach distribution program among inmates was overwhelming.

a one-day information fair in the institution to ensure their support for the pilot;
- devised a way to distribute bleach to inmates easily and discreetly;
- prepared, with support from the British Columbia Centre for Excellence in HIV/AIDS, a questionnaire to track inmate participation, use, and impact on needle-cleaning behaviour;
- distributed the questionnaire twice, at the beginning and end of the project;
- prepared a video for inmates, explaining the project and how to properly clean needles;
- started bleach distribution on 5 June 1995; and
- evaluated the project and made recommendations about how to best continue bleach distribution.

Inmate Questionnaire Data: Project Beginning

Although the survey results cannot be generalized to all inmates at Matsqui Institution because only 182 of 423 inmates (43 percent) responded to the questionnaire distributed at the beginning of the project, the data were nevertheless significant in many ways: they provided evidence of both the necessity of easy access to bleach for prisoners, as well as the support for such a program from prisoners, particularly those most at risk of contracting HIV:

- 54 percent of respondents admitted having received tattoos in prison.
- 21 percent had had piercing done while in prison.
- 71 percent reported having used IV drugs. Of these:
  - 12 percent reported drug use only in prison;
  - 20 percent only on the street; and
  - 68 percent reported having used drugs both inside and outside prison.
- 89 percent admitted having shared a needle at least once:
  - 19 percent reporting having shared on the street;
  - 23 percent in prison; and
  - 47 percent both in prison and outside.

Most respondents reported having cleaned their equipment before sharing it, whether they shared it inside or outside prison.

Ninety-four percent of all respondents expressed the view that all federal prisons should have a needle exchange.

Support for the bleach distribution program among inmates was overwhelming: 99 percent of respondents felt that having bleach available to inmates is "very important," with only one inmate saying it is "not important at all." Equally significant is that the vast majority of respondents said that they would use bleach if it was given to them in prison. Of injection drug users responding to the survey, only one responded that he would not use the bleach.[26]

Inmate Questionnaire Data: Project End

Results of the first questionnaire were confirmed by a second questionnaire distributed to 350 inmates in January 1996 (however, as with the first survey, results cannot be generalized to all inmates because only 126 inmates (35 percent) responded):[27]

- 67 percent reported ever having used IV drugs:
  - 17 percent reported drug use only in prison;
  - 2.5 percent only on the street;
  - 44.5 percent both inside and outside prison;
  - 3 percent reported having quit using.
- 63 percent had received a tattoo or piercing while in prison.

[26] T Nichol. Bleach Pilot Project. Unpublished account of the introduction of bleach at Matsqui Institution, 1995. On file with author.

[27] T Nichol. Bleach Pilot Project. Second unpublished account of the introduction of bleach at Matsqui Institution, dated 28 March 1996. On file with author.

- 71 percent of respondents reported having participated in the bleach pilot project by obtaining their own bleach kits:
  - 37 percent used bleach mostly to clean syringes;
  - 18 percent to clean syringes and tattoo/piercing equipment;
  - 14 percent for laundry and other cleaning and disinfecting purposes only;
  - 14 percent had never obtained any bleach at all; and
- the remaining had used bleach for other purposes or never used it, but given it to someone else.

Other important results of the survey include:

- 94 percent of all respondents (and 99 percent of those reporting IV drug use) expressed the view that all federal prisons should have a needle exchange;
- a majority of those who had not been tested for antibodies to HIV said that they would have a test if it was completely anonymous;
- only 6 percent said that they thought that enough is being done to stop the spread of HIV in federal prisons;
- 70 percent said that they thought that more education needed to be done for inmates, and 65 percent said that more needed to be done for staff; and
- only 2 percent thought that the bleach pilot project had not been a success.

Only 6 percent said that they thought that enough is being done to stop the spread of HIV in federal prisons.

To the question: "In your opinion, how many inmates in this institution use IV drugs on a regular basis?",

- 2 percent responded 90 percent or more;
- 8 percent responded 80 to 90 percent;
- 20 percent responded 70 to 80 percent;
- 17 percent responded 50 to 70 percent;
- 16 percent responded 30 to 50 percent;
- 2 percent responded less than 30 percent;
- 30 percent responded don't know; and
- 5 percent gave no response.

Of those reporting IV drug use,

- 84 percent reported always using bleach before and after using syringes or tattoo equipment;
- 93 percent felt they know how to clean their syringe properly;
- 19 percent own their equipment and do not share with others;
- 41 percent own their own equipment and share with others;
- 35 percent do not own equipment and always use other people's equipment;
- 6 percent reported using approximately every day while in prison;
- 21 percent 2 to 3 times a week;
- 27 percent once a week;
- 31 percent 1 to 3 times a month; and
- the remaining reported using less frequently;
- 90 percent had been tested for antibodies to HIV (56 percent had been tested in the last six months); of these, 3 percent reported having tested positive;
- 46 percent had been tested for hepatitis C, and 20 percent tested positive;
- 18 percent responded that they had ever shared a needle with someone who has tested positive for HIV; and
- 33 percent responded that they had ever shared a needle with someone who has tested positive for hepatitis C.

Many staff thought that it was a waste of time to study how bleach could best be handed out to inmates and that, instead, a needle-exchange program should be made available to inmates.

Staff Questionnaire

A questionnaire was also handed out to staff, although only before the project started. Of 220 questionnaires, 49 were returned. Because of the low response rate, the results cannot be generalized to all staff:

- 86 percent of responding staff expressed concern about the spread of HIV in the institution, and 92 percent were concerned about its spread in the community;
- 63 percent felt that making bleach available to inmates as a preventative measure is important; and
- 51 percent did not have any concerns about one-ounce bottles of bleach being distributed in the institution.

Some staff opposed distribution of bleach because, in their view, this would mean condoning drug use, or because they were concerned that bleach could be used as a weapon. Surprisingly, many staff thought that it was a waste of time to study how bleach could best be handed out to inmates and that, instead, a needle-exchange program should be made available to inmates.[28] Some staff said that they "felt less threatened by a needle exchange than by giving inmates bleach and others were just the opposite."[29] Generally, the difference in the staff's attitude between the beginning of the project and its end was "very noticeable."

Conclusion

The Project Coordinator concluded her report by saying that she believed the project had been an overwhelming success, that staff and management at the institution had been very supportive, and that she was hoping that other institutions would be as successful as they were.[30]

National Implementation of Bleach Kit Distribution

"There is no doubt in my mind that we have a duty to protect offenders, staff and the public."

- Mr John Edwards, former Commisioner of CSC

As a result of the decision to initiate the implementation of bleach distribution and anonymous HIV testing in all institutions, a National Bleach Distribution and Anonymous HIV Testing Working Group was established even before the results of the bleach pilot project became available. Its mandate is to establish successful bleach distribution and anonymous HIV testing programs, and to develop national guidelines that will ensure equal implementation of both programs across Canada.

On 21 June 1995, the former Commissioner of CSC, Mr John Edwards, attended the Group's meeting to express his "full support" for the work of the Group. He pointed out that the reported cases of HIV/AIDS in Canadian federal prisons have been rising steadily, and emphasized that offenders are human beings and deserve to be protected. "We do believe in respecting offenders' needs," he stated, and added that there "is no doubt in my mind that we have a duty to protect offenders, staff and the public." The former Commissioner pointed out that CSC has a public health responsibility to the communities to which offenders return: "Whatever concerns we have [about making bleach available to inmates] are superseded by public health concerns." He continued by emphasizing that making bleach available is not in conflict with CSC's Drug Strategy. "We need to do both well," he concluded, "protect the health of inmates, staff, and the public, as well as continue CSC's efforts to reduce drug use in prisons."

At the time of writing, although bleach kit distribution had not started in other institutions, the design of a national bleach kit distribution program had been completed and actual implementation of bleach kit distribution was expected to start soon. A completion date of end of September 1996 has been set by the

[28] Nichol 1995, supra, note 26.
[29] Nichol 1996, supra, note 27.
[30] Ibid.

Commissioner of CSC for national implementation at all sites. Reports on the progress of implementation by region will be provided to the Commissioner on a monthly basis.[31]

As stated by CSC, developing an implementation framework for bleach kit distribution "has proven to be a complex and challenging task as we had to devise a mechanism to work closely with regional staff, guarantee uniformity in our approach as well as accountability for the implementation of the initiative in each institution."[32] In Phase I, a safe, practical and effective method of distributing bleach kits to inmates in all institutions according to national guidelines was devised. Members of the National Working Group have addressed:

- the health aspects of the program (the choice of instructions on how to use bleach, first aid for staff and inmates, the composition of the kit, and the promotion of a harm-reduction philosophy); and
- the logistical aspects (securing all the necessary equipment and supplies, finding the best way to filter and decant the bleach and the best way of distributing it to inmates and of handling refills; devising a communications strategy for staff and inmates and developing a bleach kit distribution education package).

In Phase II, after consultation with the unions, the education package served as the basis for a regionally delivered training course, by members of the National Working Group, to a coordinator chosen from each institution. Once trained, the coordinators are responsible for implementing the program in their respective institutions in conformity with national guidelines.

CSC's Working Group agreed that the issue of testing cannot be separated from the issue of confidentiality, and that efforts to better protect confidential medical information need to be an absolute priority.

Increasing Access to HIV Testing and Protecting Confidentiality

Background

In its Report, ECAP recommended that:

- testing be readily accessible to all inmates in federal correctional institutions at their own request;
- that it always be voluntary and accompanied by counselling and education before and following testing;
- that all inmates have access to HIV testing from CSC health-care personnel as well as from primary-care or community clinic personnel who are independent of CSC; and, finally,
- that all inmates have access to anonymous HIV testing.[33]

ECAP felt that making non-nominal and anonymous testing available to inmates would be important because many inmates do not seek testing in prison for fear that their test results will immediately become known to everyone in the institution.[34]

The Work of the National Working Group

At the first meeting of the National Bleach Distribution and Anonymous HIV Testing Working Group, a model for anonymous testing in the prison setting was presented to the Group by Alison McConnell, who has been carrying out an anonymous HIV testing program in a provincial prison in Saskatchewan for some years. The Group recognized the importance of offering anonymous testing to prisoners, but identified a number of issues that needed further

[31] Communication received from Health Services, CSC, Ottawa, dated 28 May 1996.

[32] Update. Correctional Service of Canada's National AIDS Program. Ottawa: CSC, November 1995.

[33] ECAP: Final Report, supra, note 15 at 27-28 (Recommendation 2.(1)-(2), (4)-(5)).

[34] Ibid at 26-27.

Scotland: A Report on Drug Use and Prisons

According to the report, the primary objective of prison is secure custody for those sentenced by the courts:

> Such deprivation of liberty constitutes the punishment which is imprisonment. Drug rehabilitation should not be seen as a primary objective of prisons, and for drug users to be sent to prison on that basis would be a retrograde step.[168]

"Drug rehabilitation should not be seen as a primary objective of prisons, and for drug users to be sent to prison on that basis would be a retrograde step."

The report urges governments and prison systems to address the possible adverse effects of sending drug users to prison, in particular the potential impact of prisons in increasing risk in terms of HIV and AIDS:

> This involves both examining what happens to drug users in prison, and after they are released. A coalition of services is required to liaise with prisons to minimise the harm which results to prisoners, to lessen the impact on prisons, and reduce the risk to public health.[169]

The report concludes that it

> would be advantageous if prison authorities were to adopt the aims and objectives of a harm reduction response to drug use and HIV. This would involve a pragmatic response, and the realisation that the idea of a drug free prison does not seem to be any more realistic than the idea of a drug free society, and that stability may actually be better achieved by moving beyond this concept. In addition, adopting a harm reduction perspective puts prisons in the best position to ensure that they are not identified with major areas of concern for public health, such as the spread of HIV.[170]

Needle Exchange in Prisons

> The FOPH [Swiss Federal Office of Public Health] is of the opinion that inmates should have the same possibilities as people outside prisons to protect themselves against HIV infection. Making sterile needles and syringes freely available is now part of AIDS prevention measures for injection drug users. The same rights – to have access to clean needles and syringes, and to counselling and medicosocial help – apply to inmates.[171]

Background

In Canada as elsewhere, providing sterile needles to inmates has been widely recommended as a health measure necessary to reduce the spread of HIV in prisons.[172] In its *Final Report*, ECAP observed that the scarcity of drug-injection equipment in correctional facilities almost guarantees that inmates who persist in drug-injecting behaviour will share their equipment:

[168] D Shewan, M Gemmell, JB Davies. *Drug Use and Scottish Prisons: Summary Report*. Scottish Prison Service Occasional Paper, no 5, 1994, at 24.

[169] Ibid at 3.

[170] Ibid.

[171] Press conference, 16 May 1994, Information and Public Relations Bureau of the Canton of Berne, as cited in *Canadian HIV/AIDS Policy & Law Newsletter* 1994; 1(1): 1 at 3.

[172] See ECAP: *Final Report*, supra, note 15 at 70-72.

> Some injection drug users have stated that the only time they ever shared needles was during imprisonment and that they would not otherwise have done so. Access to clean drug-injection equipment would ensure that inmates would not have to share their equipment.[173]

ECAP concluded that making injection equipment available in prisons will be inevitable.

The Committee concluded that making injection equipment available in prisons will be inevitable, particularly because of the questionable efficacy of bleach in destroying HIV.[174] As jointly stated by the Centers for Disease Control and Prevention, the Center for Substance Abuse Treatment, and the National Institute on Drug Abuse, "based on recent research, bleach disinfection should be considered as a method to reduce the risk of HIV infection from re-using or sharing needles and syringes (and other injection equipment) **when no other safer options are available**."[175] The centers emphasized that sterile, never-used needles and syringes are safer than bleach-disinfected, previously used needles and syringes.

ECAP therefore recommended that "research be undertaken that will identify ways and develop measures, including access to sterile injection equipment, that will further reduce the risk of HIV transmission and other harms from injection drug use in federal correctional institutions."[176]

Three years after the distribution of disinfectants began, 62 percent of inmates still found it difficult to gain access to them.

ECAP's recommendation - which is consistent with the recommendation of many national and international committees and organizations - has since been repeated in a number of other reports and in an Australian study on bleach availability and risk behaviours in prisons in New South Wales.[177] That study is important because it was the first in the world to allow the independent monitoring of a bleach distribution program for prisoners. It investigated the access of prisoners in New South Wales to disinfectants for syringe decontamination and the prevalence of injection drug use, syringe sharing, tattooing and sexual activity in prison. It found that three years after the distribution of disinfectants began, 62 percent of inmates still found it difficult to gain access to them. It concluded that "[e]ven if an acceptable and effective form of disinfectant was identified, operational problems may still compromise the effectiveness of a syringe cleaning program for prisoners... ." The study pointed out other shortcomings of a syringe disinfecting program, such as uncertainty about whether other bloodborne viruses such as hepatitis B and C can be effectively and rapidly decontaminated from injecting equipment with the use of bleach. It concluded that other prevention measures need to be explored and that one such measure that requires consideration is piloting a syringe-exchange program in prisons.

One year later, a follow-up study found that there had been significant improvement in easy access to bleach from the first study: 56 percent of respondents found it easy to obtain one of the two forms of bleach (Milton tablets and liquid bleach) available in prison. Nevertheless, the study found shortcomings in the bleach program and again recommended that consideration be given to a pilot study of syringe exchange in prisons.[178]

While CSC rejected ECAP's recommendation to undertake such a pilot study, an increasing number of prisons worldwide has established - or is planning to do so in the near future - needle and syringe exchange programs. The following is a review of these programs.

[173] Ibid at 77.

[174] Ibid.

[175] US Department of Health & Human Services, Public Health Service, Centers for Disease Control and Prevention. *HIV/AIDS Prevention Bulletin*, 19 April 1993 [emphasis in the original].

[176] ECAP: *Final Report*, supra, note 15 at 79 (Recommendation 6.3(6)).

[177] Bleach Availability and Risk Behaviours, supra, note 108.

[178] K Dolan et al. Bleach Easier to Obtain But Inmates Still at Risk of Infection in New South Wales Prisons. Technical Report. Sydney, National Drug and Alcohol Research Centre, 1996, at 23.

Switzerland: A Tale of Pragmatism

The Hindelbank Pilot Project

> The distribution of sterile needles, a preventive measure which has proved effective outside of the penitentiary environment for many years, has up to now not crossed the threshold of prison doors. The primary argument against such a strategy has traditionally been the apparent incompatibility of such a protective health measure with the illegal status of drugs. The controversy resulting from this dilemma has, above all, been marked by speculations and fears concerning the possible repercussions of introducing this pragmatic measure to a prison environment.
>
> An attempt to dispel such uncertainties was one of the primary objectives of the pilot project created at the Hindelbank Penitentiary, which among other measures included the distribution of sterile syringes. The target of the project was by no means to give 'a green light' for the consumption or misuse of drugs. Instead, the project's aim was to reduce the associated health risks faced by the prisoners.[179]

A one-year pilot AIDS prevention program including needle distribution started at Hindelbank institution for women in June 1994. One year later, a decision was taken to continue the program because evaluation by external experts demonstrated clear positive results:

- the health status of prisoners improved;
- no new cases of infection with HIV or hepatitis occurred;
- an important decrease in needle sharing was observed;
- there was no increase in drug consumption; and
- needles were not used as weapons.

Hindelbank Institution

Hindelbank Institution is the only prison for women in the German-speaking parts of Switzerland. It can house up to 110 inmates in its six divisions. During the year in which the pilot project took place, 99 women entered and 112 left the prison, for a mean occupancy rate of 87. The majority of the prisoners have been sentenced for narcotics offences, and one-third of prisoners reported having consumed heroin or cocaine before their incarceration.

History of the Project

At the end of the 1980s, because of the appearance of HIV/AIDS, health-care workers at the institution became concerned about the increased harms deriving from injection drug use and began requesting that new and more effective preventive measures be implemented.[180] In 1988, the institution's health-care services – without having obtained permission from the competent authorities – decided to hand out sterile injection equipment to injection drug users, on their request. When authorities became aware of this decision, they prohibited the handing out of injection equipment. As a result, a physician of the institution decided to poll inmates on drug use and needle exchange. He found that almost all the women who were injection drug users had exchanged needles with other inmates. Armed with this information, he proposed, with the agreement of the director of the institution, launching a pilot project to provide sterile equipment

[179] J Nelles, A Fuhrer. Drug and HIV Prevention at the Hindelbank Penitentiary. Abridged Report of the Evaluation Results. Berne: Swiss Federal Office of Public Health, 1995, at 2.

[180] See ibid, and A Baechtold. Projet-pilote de prévention du sida dans les établissements pénitentiaires de Hindelbank. Rapport final à l'attention de l'Office fédéral de la santé publique. Berne: September 1995.

inmates. At first the proposal ran up against opposition, but thanks to the llaboration of the Swiss Federal Office of Public Health, authorization was ally granted in 1994. After a fairly long process of political decision-making d a short preparatory phase, the pilot project was launched at Hindelbank on June 1994.

ms of the Project

e aims of the pilot project were as follows:[181]

- to study the feasibility of needle distribution in the prison environment;
- to make sure that the project is accepted by all persons concerned (inmates and staff);
- in the short term, to reduce the harms from drug use;
- in the short term, to prevent infection or reinfection by dangerous pathogenic agents (HIV, hepatitis B virus, hepatitis C virus, etc); and
- in the medium or long term, to reduce the number of new drug users and of former users who relapse.

rther, with the help of the independent scientific evaluation, the project med at:

- assessing the impact of the project on drug use, risk behaviours, and, generally, the health of inmates; and
- drawing conclusions and making recommendations regarding the application of the adopted measures in other institutions.

"Drugs are a reality in prisons. I can't close my eyes and ignore it.... Staff support this project. Needle distribution has become part of our daily work, a non-issue."

- Ms Heimoz, Warden of Hindelbank, at the symposium on harm-reduction on 28 February 1996

lethods

he methods used to achieve these goals were directed to all inmates and ıcluded demonstrations, group meetings that used exercises, role playing, onsultations with the project director and his co-workers, a hotline for iscussion of problems, supplementary prevention measures, and written and udiovisual materials.

he provision of sterile syringes was basic to the project. During their first ıterview with the project director or his co-workers, inmates received a syringe, vhich could not, however, be used for injection purposes. The secretariat of the nstitution provided new inmates with such a syringe, together with instructions n their mother tongue, upon their arrival. With the help of this subterfuge (a real yringe without a needle), or with a syringe that had already been used, inmates ould operate an automatic dispenser to get a sterile, ready-to-use needle. Automatic dispensers were installed in each of the six sections of the institution, n different locations – such as showers, toilets, storage areas, etc – that are easily ıccessible by prisoners. Prisoners were allowed to keep one (but not more) piece of injection equipment, but only in a designated toilet cabinet.

Evaluation

Evaluation was undertaken by a group of external experts. Structured interviews were carried out with the prisoners and the personnel before launching the project, and three, six and twelve months thereafter. The interviews included questions concerning the socio-cultural context of the individual, consumption of drugs (past and present), risk behaviours, the level of knowledge concerning AIDS and hepatitis, and the acceptance and use of preventive measures. Additional data were also gathered, eg, the number of needles distributed, the number and nature of sanctions, particular incidents, and the results of the prisoners' medical examinations.

[181] Nelles & Fuhrer, supra, note 179 at 10-11. See also the account of the pilot project. Press conference, 16 May 1994, Information and Public Relations Bureau of the Canton of Berne. Reported in R Jürgens. HIV Prevention Taken Seriously: Provision of Syringes in a Swiss Prison. *Canadian HIV/AIDS Policy & Law Newsletter* 1994; 1(1):1-3.

A total of 137 prisoners and 48 staff participated in at least one interview; 70 staff answered a questionnaire.

Drug Use

One third of prisoners interviewed admitted to using heroin or cocaine while in prison, with three-fourths doing so by injection.[182] Only women who already used drugs on a regular basis before entering Hindelbank continued to do so once in prison. Among women who used heroin or cocaine in the month preceding their incarceration, three-fourths continued to do so once in prison.

The number of prisoners using heroin or cocaine while in prison has not fluctuated significantly since the installation of the needle-dispensing machines. The frequency of consumption and the manner of absorbing drugs (smoking, injecting, sniffing) also remained more or less the same during the course of the project. Finally, there was only one case of overdose at Hindelbank during the course of the project, whereas there had been 16 cases in one year, two years before the project started.

Distribution of Needles

During one year, 5335 needles were distributed, an average of 14 per day (with a maximum of 78 and a minimum of 0), or one needle per prisoner every six days. The use of needles decreased during the second half of the project.

Utilization of needles seemed to depend primarily upon two factors:

- the availability of drugs; and
- prisoners' capacity to purchase them.

Consumption of drugs, and need for needles, typically increased during a period of several days after prisoners received their wages and whenever larger than usual quantities of drugs were available in the institution.

Sharing of Needles

> Between 1989–1992, 14 studies were conducted in Switzerland concerning the effects of the distribution of sterile syringes to drug consumers (outside of the penitentiary system). All of the above studies revealed a marked decrease in the sharing of used syringes. The same observations have been made on an international level.
>
> The evaluation of this preventive measure at Hindelbank supports the above findings.[183]

In May 1994, before installation of the distribution machines, eight of 19 intravenous drug users declared having shared needles with other drug users. One year later, only one individual continued sharing. Generally, after installation of the machines, needles were shared only when the machines were out of order or when a situation of trust had been established between friends who knew themselves to be HIV-negative. Decrease of sharing was gradual:

- before the project started, eight prisoners declared sharing;
- after three months, four prisoners declared sharing;
- after six months, two declared sharing; and
- after 12 months, one declared sharing.

[182] The following data are taken from Nelles & Fuhrer, supra, note 179 at 6-16.

[183] Ibid at 11.

Medical Examinations

Upon their arrival at the prison, 94 women underwent a voluntary blood analysis. A high percentage tested positive:

- 6 percent for HIV;
- 73 percent for hepatitis A;
- 48 percent for hepatitis B; and
- 37 percent for hepatitis C.

Fifty-one of the women were re-tested at the time of their release from prison; no new infections were diagnosed. This result is significant, but should nevertheless be taken with caution because only a fairly short period of time had passed since the first test.

The results of the pilot-project undertaken at Hindelbank Institution do not provide any argument against the continuation of the distribution of sterile syringes.

Acceptance of the Prevention Measures

Only about 20 percent of staff did not agree with the installation of the needle distribution machines; the vast majority either agreed or "totally agreed." As expressed in the final report about the project,

> a clear majority of staff at the institution has in the meantime approved of prevention measures including distribution of sterile needles, even if this approval is not dictated by feelings but by reason.[184]

It should be emphasized that during none of the phases was any active resistance shown. Further, the intervention gave rise to open discussions about what had gone on that would previously not have been talked about:

> It is an important step when it comes to motivating staff to look more, and more deeply, into questions relating to infectious diseases and drug use and, in this respect, to develop greater competence.... [P]reviously, the various sections would have tended to hide the drug-related problems they had with their inmates and would have pointed out other sections, whereas now it almost goes without saying that there is an exchange of experiences.[185]

According to the project director, concrete statements such as the following helped to overcome the resistance of some staff, and to explain to them why sterile needles need to be made available:

- Many inmates are in the Hindelbank institutions because of violations of drug laws. Some have continued to use drugs although they have been submitted to insecurity-producing tactics. Where fraud is concerned, wealth of imagination seems to have no bounds; in spite of the controls, "dope" is always available.
- The statements made by women when they were consulted in relation to the prevention project highlighted what had been understood from the outset: women who were never drug-dependent don't need them and don't have to refuse to use them because they're afraid of dependency developing rapidly, independent of the availability of syringes. For women who used drugs or who still do, the fear of damage to health from the use of unclean syringes is not a reason to abstain. When they are in withdrawal, they look for, find, and use drugs, whether or not the available syringes are clean or already used.
- The HIV/drug prevention project did not promote the use of drugs. Abstinence remains the goal. This involves a long journey during which the question is one of avoiding further harms - health policy measures,

[184] Baechtold, supra, note 180 at 27.
[185] Ibid at 27.

not drug policies.
- The project is an attempt to live with contradictions and to find compromises after weighing the judicial benefits.
- With regard to infectious diseases, the aim of an HIV/drug prevention project does not only concern AIDS, but also other dangerous pathogenic agents such as the hepatitis B and C viruses.
- An HIV/drug prevention project in a penal institution likely has repercussions with respect to the state of health of the rest of the population.[186]

Staff have realized that distribution of sterile injection equipment is in their own interest.

Conclusions

The evaluation report concludes:

> The results of the pilot-project undertaken at Hindelbank Institution do not provide any argument against the continuation of the distribution of sterile syringes. The fears expressed at the beginning - that drug use would increase, that needles would be used as weapons or accidentally cause injuries, etc - were unjustified.[187]

According to the report,

> the feasibility of distributing needles and syringes, the positive consequences it had on the sharing of needles, and the considerable acceptance of the project by inmates and staff...lead to the conclusion that the distribution of sterile needles and syringes could also be justified in other prisons.

The Future of the Project

Following the evaluation, the prison authorities have decided to continue the project.

"The biggest change for us is that we are not chasing after syringes any more. This has also had the biggest positive impact on our safety."

- Mr Fäh, Warden of Oberschöngrün, in an interview on 1 March 1996

Oberschöngrün: Distribution of Sterile Injection Equipment at a Men's Prison

Hindelbank was not the first institution to distribute sterile injection equipment to inmates, but was the first to scientifically evaluate such a program. It was in another Swiss prison, the Oberschöngrün prison for men, that sterile injection equipment first became available to inmates in 1993. Oberschöngrün is a minimum-security institution housing approximately 75 prisoners, of whom 10 to 15 "seek to use illicit drugs on a daily basis, so as not to go into withdrawal."[188]

History

> Dr Franz Probst, a part-time medical officer, working at Oberschöngrün prison in the Swiss canton of Solothurn was faced with the ethical dilemma of as many as 15 of 70 inmates regularly injecting drugs, with no adequate preventive measures. Unlike most of his fellow prison doctors, all of whom feel obliged to compromise their ethical and public health principles daily, Probst began distributing sterile injection material without informing the prison director. When this courageous but apparently foolhardy gesture was discovered, the director, instead of firing Probst on the spot, listened to his

[186] Ibid at 12.

[187] Nelles & Fuhrer, supra, note 179 at 18.

[188] Projet-pilote de prévention du VIH et d'aide à la survie en prison. *Spectra – prévention et promotion de la santé* 1995; 1(1): 3.

arguments about prevention of HIV and hepatitis, as well as injection-site abscesses, and sought approval from the Cantonal authorities to sanction the distribution of needles and syringes. Thus, the world's first distribution of injection material inside prison began as an act of medical disobedience.[189]

Results

Three years later, distribution is ongoing, has never resulted in any negative consequences, and is supported by prisoners, staff, and the prison administration:

> Distribution of syringes is giving altogether satisfactory results. Given the fact that HIV tests are not mandatory, it is impossible to precisely evaluate the effect of distribution on the transmission of the virus. However, a reduction in the number of cases of hepatitis and the complete absence of new abscesses has been observed. Nothing indicates that drug use has increased as a result of these measures.[190]

"It is more important to make sure that prisoners who are injection drug users can always use sterile equipment than to insist on a one-for-one exchange scheme."

- Mr Fäh, Warden of Oberschöngrün, in an interview on 1 March 1996

According to the warden, Mr Fäh, initial scepticism by front-line staff has been replaced by their full support:

> Staff have realized that distribution of sterile injection equipment is in their own interest. They feel safer now than before the distribution started. Three years ago, they were always afraid of sticking themselves with a hidden needle during cell searches. Now, inmates are allowed to keep needles, but only in a glass in their medical cabinet over their sink. No staff has suffered needle-stick injuries since 1993.[191]

Fäh continued by saying that staff have been told not to use the fact that they may see injection equipment in a prisoner's medical cabinet as a reason for asking him to submit to urinalysis: "Because inmates trust this, they keep the syringes in the cabinet – and this in turn increases staff's safety."

About 700 sterile injection units are handed out yearly by Dr Probst, at a cost of only 400 Swiss francs (approximately CDN$440), "much less than would be the costs of caring for the cases of hepatitis and abscesses we avoid by handing out sterile equipment".[192] A decision was taken not to install dispensing machines, as at Hindelbank, for two reasons: fear that inmates in a prison for men would vandalize the machines, leaving injection drug users without supply when needed. Further, prisoners who obtain injection equipment from Dr Probst feel that this better ensures anonymity than if they had to retrieve equipment from a dispensing machine: nobody else knows why they visit the physician, nobody can see them while they are with him, and he is bound by a professional obligation of confidentiality not to reveal who obtains equipment from him. From the physician, who comes to the institution once every week, inmates can obtain more than one injection unit at a time, and distribution is not undertaken on a strict one-for-one basis (one used against one new, sterile, unit). As emphasized by Mr Fäh,

> it is more important to make sure that prisoners who are injection drug users can always use sterile equipment than to insist on a one-for-one exchange scheme. We have a fairly good return rate, and are not concerned about not all equipment being returned to Dr Probst. What we do care about is safety of staff – and staff has not been exposed to any hidden needles.[193]

[189] J Nelles, T Harding. Preventing HIV Transmission in Prison: A Tale of Medical Disobedience and Swiss Pragmatism. *The Lancet* 1995; 346: 1507.

[190] Projet-pilote de prévention, supra, note 188.

[191] Personal communication with P Fäh, Warden of Oberschöngrün, on 1 March 1996.

[192] Ibid.

[193] Ibid.

Rationale

Fäh emphasizes that the objective of making sterile injection equipment available to inmates is not the legalization of drugs, but rather the prevention of AIDS:

> Knowing the danger that HIV infection represents, we cannot give up distributing syringes because we would thereby be forcing drug-using inmates to shoot up with dirty needles – which is an ethical issue.[194]

Needle exchange was established as a health activity carried out by the prisons' health service rather than an activity carried out by custodial staff.

Discovered in the course of urine testing or cell searches, the possession and/or consumption of drugs (but not the possession of injection equipment, provided it is kept in the designated cabinet in the inmate's cell) is still a ground for disciplinary measures. In 1993, a total of 623 urine probes were analyzed to detect prisoners' drug use: 194 tested positive, 412 tested negative, and 17 had been "faked." Urine is tested only for traces of opiates, cocaine, barbiturates, amphetamines, methadone, and benzodiazepines, but not for traces of cannabis products. This decision was taken because use of cannabis products is not considered a safety and discipline problem in the institution and because of fear that prisoners using cannabis products would switch to other, more harmful, drugs if testing for traces of cannabis was undertaken.

In a pamphlet describing the reasons why injection equipment is distributed in the institution, the administration concludes that

> our goal is and will remain to prevent inmates from using drugs, or to reduce their drug consumption.... Since we began making injection equipment available, we have not noticed any significant reduction or increase in drug use. But surely we have done something useful for the health of our inmates, and for prevention of the spread of HIV in general.[195]

Geneva: Availability of Injection Equipment in Men's Prisons

As announced by Prof Harding at the interdisciplinary symposium on harm-reduction strategies in prisons in Berne, Switzerland, on 3 March 1996, distribution of sterile injection equipment to injection drug users started in at least one prison for men in Geneva on 1 March 1996. The equipment is made available through health-care services, and is exchanged on a one-for-one basis.

Lessons from the Swiss Experience

One of the issues debated at the symposium on harm reduction strategies in prisons in Berne was whether the results of the Swiss experience could be applied to other prison systems – or whether there was anything "special" about Switzerland and/or the institutions in which sterile equipment has thus far been made available, that would make it impossible elsewhere. After days of debate, experts from around the world agreed that the lessons learned in Switzerland could indeed be applied elsewhere.

Staff Safety Issues

In Switzerland as elsewhere, one of the major potential obstacles to the success of needle distribution programs has been the attitudes of prison staff. At Oberschöngrün, prison officers were fully involved in the decision to trial the needle exchange, while officers at Hindelbank were less involved and initially more hostile to the program. In both cases, attitudes to needle exchange in prison became more positive over time.

[194] Projet-pilote de prévention. Supra, note 188.

[195] Spritzenabgabe im Oberschöngrün. Kanton Solothurn: Strafanstalt Solothurn. No date.

The "clash of values" that occurred when prison officers and managers first considered the possibility of providing needles and syringes in prisons was minimized by ensuring that needle exchange was established as a health activity carried out by the prisons' health service rather than an activity carried out by custodial staff. Further, as emphasized by Dr Margaret Rihs-Middel, Co-ordinator of Drug Research and Evaluation at the Swiss Office of Public Health in Berne, the involvement of staff in the decision to proceed was very important to the success of the program, as were rules about where needles can be kept to increase safety for custodial staff.[196]

The Swiss experience has shown that sterile injection equipment can be made available in a manner that is non-threatening to staff and indeed seems to have increased staff's safety; it has further shown that staff can be brought to understand that making sterile injection equipment available to inmates does not mean condoning drug use and "giving up" on drug use in prisons, but is a pragmatic health measure that is warranted by the fact that prison authorities have a responsibility to:

- protect the general public: preventing the spread of HIV in prisons and, after release of the prisoners, to the general public, is a vital part of this; and
- protect the health of inmates in their custody: prisoners are in prison as punishment, not to contract a deadly disease.

Because staff don't feel threatened by the distribution of sterile injection equipment, and because they understand the rationale behind it, they are supportive of it.

The Swiss experience has shown that sterile injection equipment can be made available in a manner that is non-threatening to staff and indeed seems to have increased staff's safety.

Applicability to Different Institutional Settings

There is not one Swiss model of distribution of sterile injection equipment. Thus far, every institution has chosen its own model: installation of dispensing machines, one-for-one exchange, or distribution through the physician or health-care services. What can and should be done in a particular institution depends on many factors, including, but not limited to, the size of the institution, the extent of injecting drug use, the security level, whether it is a prison for men or for women, the commitment of health-care staff, and the "stability" of the relations between staff and inmates. In Switzerland, it has been understood that a measure such as making sterile injection equipment available could not, and does not necessarily have to be, introduced in all institutions at the same time and in the same fashion, but can be undertaken immediately, easily, and at low cost, with good results, in some institutions. In other institutions, other measures may be more feasible and are being introduced, such as methadone maintenance programs or the establishment of drug-free wings.

Judicial Admissibility

Making sterile syringes available in prisons in Switzerland was preceded by a study and consultation phase dealing with the complex range of legal and policy issues this measure raises. As part of the process, the Swiss Federal Office of Public Health requested that the Federal Office of Justice examine the judicial admissibility of the measure. In a report tabled in July 1992, the Federal Office of Justice concluded that the provision of sterile syringes and the making available of disinfectants in prisons was judicially admissible and compatible with responsible health policy.

In its opinion, the Office of Justice held that "drug use in prison establishments is a reality."[197] According to the Office, it could be stopped only through very strict

[196] Cited in: D Burrows. Needle and Syringe Exchange in Swiss Prisons. [Australian] *National HIV/AIDS Legal Link* 1995; 6(1): 14. See also HIV Prevention Taken Seriously. Supra, note 181.

[197] Federal Office of Justice. Provision of sterile syringes and of disinfectant: Pilot project in correctional institutions; judicial admissibility. Berne, 9 July 1992. All quotations are taken from this document.

measures that would not be compatible with a liberal enforcement of sentences. The Office acknowledged that

> drugs are rather easily introduced into prisons, but not syringes, which are a rare commodity, and this means that they are often exchanged between prisoners dependent on drugs.

In Switzerland, common sense, pragmatism and cost-effectiveness have become the guiding principles of health policy in the area of drugs and HIV.

The report analyzes the meaning and scope of the right of prisoners to adequate medical assistance in prisons, and favours a broad interpretation that includes prevention:

> Such medical assistance should not be available only when a disease has already spread...but it is necessary to attempt to prevent the transmission of this disease through adequate preventive measures.... The provision of sterile syringes is...one, if not the most important, strategy for preventing the transmission of HIV/AIDS to IV drug users. As in civilian life, it is clear that AIDS prevention for those serving sentences is not entirely dealt with simply through the provision of sterile injection equipment, but that it...must also include measures involving therapy, withdrawal and substitutes. Nevertheless, the provision of sterile syringes is the most urgent measure.

Because abstinence in prisons is not achievable, prison establishments must, according to the report's authors, adapt their internal health policy. They conclude that, if prison establishments wish to fulfil their duty to provide medical assistance, the provision of syringes and disinfectants is recommended and that the establishments will have to comply.

The report also examines the issue of the punishability of those who provide sterile syringes, including the punishability of prison staff responsible for providing syringes and the punishability of drug-using prisoners, and compatibility with criminal law. The authors note that the criminal liability of staff comes into play only in cases of complications due to negligent handling in the provision of syringes and that, furthermore, the availability of syringes in a prison establishment does not in any way affect the punishability of drug use. The report concludes that, because drug use remains a punishable act, "if one wishes the provision of syringes to be a success...it must be done anonymously."

Finally, the authors deal with the question of predicting whether such measures could put prison staff in danger:

> The argument has been put forward that the syringes provided...could be used as weapons by prisoners against staff and that for this reason the provision of syringes must necessarily be rejected. This argument, although far from insignificant, is nevertheless an insufficient reason to prohibit the provision of syringes. Even now, syringes are circulating in prison establishments; staff have already had to deal with this danger for some time. Moreover, this is a problem with which staff are already confronted, in the sense that prisoners have many opportunities to obtain weapons or to make them themselves.

Swiss Pragmatism

The Swiss approach to drug use in general and to drug use in prisons in particular is one characterized by pragmatism and by the desire to reduce the

harms from drug use. Accepting that many years of experience with a "war-on-drugs" approach to drug use outside and in prisons have demonstrated that drug use is here to stay - and that governments do not only have a responsibility to reduce levels of drug use, but first and foremost to reduce the harms from drug use - common sense, pragmatism and cost-effectiveness have become the guiding principles of health policy in the area of drugs and HIV. Politicians, the public, the media, and those working in prisons are supporting the new, pragmatic approach, because adherence to the ideal directed at eradicating drug use has proven to increase the harms to drug users and to society and, generally, is extremely costly, without resulting in the hoped-for reduction of drug use.

In particular, with respect to prisons, all stakeholders have:

- faced the fact that drugs are consumed in prisons;
- faced the fact that needles and syringes are used (and shared) in prisons;
- accepted that HIV prevention is more important than upholding "morality";
- realized that provision of sterile injection equipment is not contrary to staff's mandate, and provides more security for staff and inmates; and
- realized that harm reduction is more cost-effective than total prohibition.

Programs in Other Countries

As a result of the positive experiences in Swiss prisons, more and more prison systems around the world are announcing that they will also make sterile injection equipment available. At the symposium on harm-reduction strategies in prisons in Berne, representatives of several German prison systems, as well as the Spanish system, presented their programs or talked about their intention to start one soon - probably the best evidence that the lessons learned in Switzerland can be applied elsewhere.

Germany: Lower Saxony[198]

In November 1994, the Minister of Justice of Lower Saxony established a panel of experts charged with investigating whether measures such as provision of sterile needles in prisons could result in an improvement in the health of inmates. The Minister was concerned with the high prevalence of infectious diseases, in particular hepatitis and HIV, among drug-using inmates in Lower Saxony. The panel of experts consisted of prison directors and personnel, some representatives of drug- and HIV/AIDS-service organizations, and one general practitioner. The recommendations of the experts[199] served as the basis for a cabinet decision by the Government of Lower Saxony, giving a green light to the implementation of a two-year pilot project for the distribution of sterile injection equipment and provision of communicative methods of prevention, in a women's prison with 170 inmates in Vechta and a men's prison with 230 inmates in Lingen.

At the time of writing, distribution had started at Vechta, using four of the same dispensing machines used at Hindelbank since 1994. Distribution at the men's prison was expected to start during the summer of 1996.[200] Cooperation between the two prisons in Lower Saxony and the Swiss prisons started a while ago and includes exchange of staff between Hindelbank and Vechta.

The projects will be scientifically evaluated, with two main aims:

[198] See R Meyenberg, H Stöver. Presentation of a Scientific Evaluation of the Pilot-Project "Prevention of Infectious Diseases in the Penal Institutions of Lower-Saxony (Germany)." Unpublished account of the pilot project, 1996 (on file with the author). The following text is a slightly edited version of that account. See also The Editor. Needle Exchange Programs Now Also in German Prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(2): 18.

[199] Mitglieder der Expertenkommission (eds). *AIDS und Hepatitisprävention im Strafvollzug Niedersachsens. Empfehlungen der Expertenkommission.* Hanover, 19 May 1995.

[200] J Voges. Schuß Sauber im Knast. *die tageszeitung* [Berlin] 16 April 1996.

- to present an objective and realistic account of the projects; and
- to assess the usefulness and efficacy of the measures undertaken, beyond the various interests of the persons and institutions involved.

According to the recommendations given by the panel of experts, scientific evaluation aims at "closing the gap in the knowledge about drugs, drug usage, and infections with HIV and hepatitis in prisons on the one hand and, on the other, at achieving generalizable and practically relevant recommendations for the effective prevention of AIDS and hepatitis infections."

"The state has a legal obligation to care for prisoners in its custody. This includes measures directed at preventing threats to the health and well-being of prisoners."

- Expert Commission, Hamburg, Germany, 1995

Germany: Hamburg

In Hamburg, distribution of sterile injection equipment in a prison for men with a capacity of 300 started in May 1996. At the symposium in Berne, the participant from the Hamburg prison system emphasized that the decision was warranted by the fact that, outside prisons, drug policy had changed over the last years, emphasizing harm reduction rather than abstinence, and including wide availability of injection equipment and methadone programs:

> The press, all political parties, and the public are seeing the positive results of this shift in policy: there are fewer deaths related to drug use, less criminality, the costs of drug policy have diminished, and persons dependent on drugs are healthier than they used to be. The gap between what was being done outside and inside prisons was getting bigger and bigger, and people started to see that this was counterproductive.

He continued by saying that

> staff are members of the public as well. They started seeing that what was done outside is to the benefit of all, drug users and the public, and started questioning themselves whether it would not be possible and beneficial to extend harm-reduction measures to prisons.[201]

In 1995, a commission mandated, by Hamburg's Senator for Justice, with the development of a drug policy for prisons, emphasized that

> the state has a legal obligation to care for prisoners in its custody. This includes not only activities directed at caring for the sick, but measures directed at preventing threats to the health and well-being of prisoners.[202]

It continued by saying that, where the goal of abstinence cannot or cannot yet be reached, saving the lives of inmates who inject drugs needs to have a higher priority than achieving a drug-free prison environment. The commission recommended distribution of injection equipment in prisons as an "absolutely necessary health-prevention measure," referring to results of studies showing the correlation between rates of hepatitis and HIV among injection drug users and their length of stay in prisons.[203] Commenting on some of the arguments against making sterile injection equipment available in prisons, the commission said that drug use would likely not increase in prisons as a result of making equipment available: it depends on the availability of drugs, not of injection equipment; and that acceptance of the measure would increase over time, according to the principle "learning by doing." After extensive meetings with staff, the commission noted that, while a majority of health-care staff already support needle distribution, many correctional officers are resistant, "out of a mixture of fears and information deficits." It acknowledged that the issues raised by correctional officers need to be taken seriously, but said that – in view of the very serious

[201] A Thiel, Referent Strafvollzugsamt, Justizbehörde Hamburg, Strafvollzugsamt, in a discussion group at the symposium in Berne on 29 February 1996.

[202] Abschlußbericht, supra, note 70 at 61.

[203] Ibid at 62-63.

and potentially life-threatening consequences that inaction would have for inmates and the public – these issues should not "be allowed to be the decisive factor in decision-making":

> For reasons of health prevention, and because of the legal responsibility and ethical obligation of prison systems, distribution of sterile injection equipment in prisons has become an absolute necessity. In the unanimous view of the Commission, prolonged inaction could not be justified.[204]

The commission recommended that prisoners be allowed to have no more than one injection unit in their possession; and that there be a requirement to store it in a place where it cannot pose any danger to others, and to dispose of it in an "appropriate way." Further, the commission recommended that clear guidelines be established according to which possession of one injection unit, when kept in the designated way, cannot be subject to disciplinary measures, while injection equipment kept in any other way can be taken away from prisoners.

Germany: Berlin

As reported in the German media, the Senator of Justice of Berlin has expressed her intention to implement a needle-exchange program in a prison for women.[205]

Spain

At the symposium in Berne, representatives of the Spanish prison system announced that distribution of sterile injection equipment would be piloted in a prison in Northern Spain where a methadone maintenance program is already available to inmates.

Australia

A recent study by the Australian National Drug and Alcohol Research Centre (NDARC) found that needle and syringe exchange is feasible in Australian prisons.[206] As a result, the Australian Federation of AIDS Organizations (AFAO) is calling for pilot programs of needle and syringe exchange in prisons across Australia.[207]

Introduction of syringe-exchange programs in Australian prisons had previously been recommended by the Community Policy on Prisons and Blood Borne Communicable Diseases.[208] Both the then Australian Minister of Health, Dr Carmen Lawrence, and the then President of the Australian Medical Association (AMA), Dr Brendan Nelson, had also urged that "serious consideration be given" to introducing syringe exchanges in prisons.

The study was conducted to consider the issues raised by syringe-exchange programs in prison and to assess their possible benefits, adverse consequences and the feasibility of implementing them. This was done by documenting – in facilitated discussion groups – issues raised by key stakeholders in the New South Wales (NSW) prison system.

The researchers asked groups comprising correctional officers, prison health-care staff, ex-inmates, community agencies, and politicians to provide information on likely safety issues associated with an exchange program. The groups

- emphasized the necessity for effective, broad-range treatment and harm-minimization programs in prisons for injection drug users;
- questioned the implementation and effectiveness of existing HIV

[204] Ibid at 67.

[205] S Koch. Politik der Nadelstiche. *die tageszeitung*, 20 February 1996 at 3.

[206] S Rutter et al. *Is Syringe Exchange Feasible in a Prison Setting? An Exploration of the Issues.* Technical Report No 25. Sydney: National Drug and Alcohol Research Centre, 1995. See also The Editor. Australia: Needle Exchange in Prisons. *Canadian HIV/AIDS Policy & Law Newsletter* 1996; 2(3): 15.

[207] Adapted from D Burrows. Needle Exchange in Prison: The Next Step. [Australian] *HIV/AIDS Legal Link* 1996; 7(1): 14-15.

[208] See supra, note 166.

prevention programs; and
- addressed the likely impact on the wider community.

Based on the discussions undertaken, the researchers concluded that syringe exchanges in prisons are feasible, but only under certain conditions. In particular, they pointed out that the cooperation of prison staff would have to be secured before implementation of a syringe-exchange program could be considered. Among other things, they recommended that a working committee with representation from health-care and correctional officers discuss syringe exchanges in prisons to identify an option that does not represent any risk to staff and is acceptable to correctional officers.

The researchers found that conditions such as the following would be needed before considering a syringe-exchange pilot:

- establishment of a specialist drug-treatment wing;
- special training for custodial and health staff;
- policy of strict one-for-one distribution of needles and syringes;
- selection of distribution option by a joint committee of custodial and health staff and inmates, from the following: (1) vending machine; (2) nursing staff; (3) outside agency; (4) injection room; and
- assessment of the pilot by measurements such as increase/decrease in risk of infections to staff or inmates or visitors, from assault or from occupational or accidental injury.

The researchers further recommended that

- bleach be made available to all prisoners;
- all inmates be assessed and offered methadone maintenance treatment if suitable;
- peer educators be trained;
- a pilot syringe-exchange program be rigorously evaluated; and
- for evaluation purposes, participants be tested for hepatitis B and C and HIV every six months.

AFAO welcomed the study's overall findings, and its Acting National President used the release of the report to call for trials of syringe-exchange programs in prisons across Australia, expressing support for the report's recommendations that condoms, methadone, and bleach should also be made available.

Since then, the AMA has also renewed its call for needle-exchange programs for prisoners. In its February 1996 *Position Statement on Blood Borne and Sexually Transmitted Viral Infections*, the AMA states that "[e]ffective prevention among prison populations requires the establishment of preventative education programs, needle exchange programs for intravenous drug users and safe sex programs for those involved in high risk sexual behaviour."[209]

[209] Reported in [Australian] *HIV/AIDS Legal Link* 1996; 7(1): 7.

HEALTH RESOURCES AND
SERVICES ADMINISTRATION
Bureau of Health Resources Development
Office of Science and Epidemiology

Progress and Challenges in Linking ıcarcerated Individuals with HIV/AIDS to Community Services

JUNE 1995

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Executive Summary

With the impetus of initiatives like the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, correctional administrators and health care professionals have begun to recognize the critical role that prisons can play not only in identifying and treating HIV infection while the individual is incarcerated but in combining medical management during incarceration with linkages to community services upon release from prison. This monograph describes six programs that deliver such services in the criminal justice system. Four programs received Title II Ryan White funding for Special Projects of National Significance (SPNS). Funded in fiscal year 1991, these programs address the linkage of incarcerated and recently released inmates with HIV/AIDS and their families to community services. Two additional programs that have delivered services to this population but received funding from other Federal entities are also described in this publication.

The six projects described in the monograph include:

1) **The ETHICS Project: Linking Ex-Prisoners with HIV/AIDS to Community Services**, a SPNS project, conducted by The Fortune Society (New York, New York);

2) **Case Management for HIV Prevention Among Drug-Involved Arrestees**, a jointly sponsored project of the National Institute of Justice and National Institute on Drug Abuse, conducted by Abt Associates in two sites (Washington, D. C. and Portland, Oregon);

3) **The Rhode Island Prison Release Program**, a SPNS project, conducted by the Rhode Island Department of Health in collaboration with the Rhode Island Department of Corrections (Providence, Rhode Island);

4) **Specialized Medical and Social Service Interventions for Inmates with HIV in Maryland**, a SPNS project, conducted by the Maryland Department of Public Safety and Correctional Services (Baltimore, Maryland);

5) **Cermak Health Services: Linking Pretrial Detainees with HIV/AIDS to Community Services,** a project supported by Titles II and IIIb of the Ryan White CARE Act, conducted by Cermak Health Services (Chicago, Illinois); and

6) **The Philadelphia Linkage Program**, a SPNS project, conducted by The Circle of Care (Philadelphia, Pennsylvania).

In addition to basic project descriptions, the monograph highlights each project's successes, barriers and issues, and proposed strategies for overcoming them. Project evaluation and dissemination activities are also addressed. These projects are models that illustrate considerable success in linking inmates to medical and community services, providing support to people who are changing behavior patterns, and reducing recidivism rates.

Progress and Challenges in Linking Incarcerated Individuals with HIV/AIDS to Community Services: An Overview

Christine J. Hager, Gloria Weissman, and Marilyn M. Massey

The estimated incidence of Acquired Immunodeficiency Disease Syndrome (AIDS) in 1992 was 195 cases per 100,000 in State and Federal corrections systems in the United States (U.S.) compared with 18 cases per 100,000 in the entire population; that is, the incidence among prison inmates was 14 times higher than among the U. S. population in general (Hammett, 1994; Vlahov, et. al., 1991). The higher AIDS incidence rates among correctional inmates are predictable given the concentration in these populations of individuals with histories of high-risk behaviors, particularly injection drug use (Hammett, 1994). Each year more prisons list AIDS as the leading cause of death (Brewer and Derrickson, 1992) Finally, an estimated 17,479 inmates (2.2 percent of the incarcerated population) are infected with Human Immunodeficiency Virus (HIV).

Despite the high number of incarcerated individuals infected with HIV and AIDS, medical care in prison for inmates has received relatively little focused attention. Few prisons deliver HIV-specific medical care or discharge planning to link released inmates with necessary community services. However, prisons can play a central role in identifying and treating HIV infection. Programs that combine medical management during incarceration with linkages to community services upon release can have a strong, long-lasting impact on the health of individuals and their communities. For many incarcerated people living with HIV, incarceration may provide the first opportunity to access HIV testing, counseling, specialized medical care, and psychosocial support.

This monograph describes six programs that deliver services such services in the criminal justice system. Four of these programs were funded by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 which provides that up to 10 percent of the funds in Title II be set aside for grants to Special Projects of National Significance (SPNS). In fiscal year 1991, four projects were funded by SPNS to address the linkage of incarcerated and recently released inmates with HIV/AIDS and their families to community services. Each SPNS project has a dual purpose: 1) to provide services to clients through innovative service delivery designs; and 2) to provide valuable knowledge that will advance the quality of care for people with HIV/AIDS. In addition to the four SPNS projects that collaborated with correctional institutions, two additional projects delivering services to this population are described in this publication; both of which received

funding from other Federal entities.

The six projects described in this monograph include:

1) **The ETHICS Project: Linking Ex-Prisoners with HIV/AIDS to Community Services**, a SPNS project, conducted by The Fortune Society (New York, New York);

2) **Case Management for HIV Prevention Among Drug-Involved Arrestees,** a jointly sponsored project of the National Institute of Justice and the National Institute on Drug Abuse, conducted by Abt Associates in two sites, (Washington, D.C. and Portland, Oregon);

3) **The Rhode Island Prison Release Program**, a SPNS project, conducted by the Rhode Island Department of Health in collaboration with the Rhode Island Department of Corrections (Providence, Rhode Island);

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6) **The Philadelphia Linkage Program**, a SPNS, conducted by the Circle of Care (Philadelphia, Pennsylvania).

GOALS OF THE PROJECTS

While the specific goals of the projects varied because they were working with different systems of service delivery and contacted individuals at different points, each sought to link incarcerated individuals and recently released inmates with HIV/AIDS to community services. All of the projects included case management as part of their intervention. They sought to counsel and test people for HIV and to link people with HIV to appropriate medical and social services. While some projects concentrated on the delivery of discharge planning services using case management techniques, others attempted to integrate medical and case management into a continuum of services. Secondary goals of these projects included decreasing recidivism and discouraging high-risk behaviors associated with HIV transmission.

SUCCESSES

All of the projects evaluated their successes, noted the barriers to accomplishing their goals, and recommended solutions. Their successes focused on three factors:

1) ***Changes in behavior.*** Clients were assessed with respect to their adoption of healthier behaviors and the avoidance of criminal activity;

2) ***Linkages to services.*** All projects tracked the extent to which clients achieved access to needed health, social, educational, and subsistence resources and services.

3) ***Process accomplishments.*** Assessments were made with respect to client participation rates, as well as the strengths and barriers in staffing and implementing the interventions.

Overwhelmingly, the most important factor contributing to the success of the projects was the personal connection between the client and the case manager or health care provider. Establishing mutual trust takes time, skill, and perseverance on the part of the client and the staff. Once trust was established, personal relationships between clients and staff remained a key factor in successful interventions and interactions often continued after the client was officially "discharged" from the program.

The other factors identified as key elements for project successes included 1) the case management approach, 2) staff skills and training, 3) intra- and interagency network of referrals, 4) client participation in discharge planning, 5) use of former clients as service providers, and 6) recognition of HIV as a problem by the jail and prison systems and the community agencies.

BARRIERS

The authors of these project descriptions are candid about their problems, the barriers they encountered, and their strategies for overcoming their success obstacles. They identified some common barriers:

Inadequate access to health and social services. The availability of adequate community-based HIV prevention and treatment, as well as social and human, services is key to assisting inmates to reintegrate successfully into their communities. Long waiting lists, limited placements, and increasing demands for services make it difficult to establish linkages with community services.

Staffing constraints. Extremely high caseloads, inadequate training, and management instability have resulted in staff burnout, dysfunctional behavior, and excessive turnover. More attention and resources need to be devoted to staff supervision and support.

Lack of knowledge of the correctional system and client referral sources. The projects stressed the importance and the challenges of cooperating with the criminal justice system and the community. The early and continued collaboration of correctional system staff in project planning is paramount.

Lack of discharge planning prior to inmate release. Inadequate discharge planning results in gaps in medical care, delays in accessing entitlements and critical social services, and missed opportunity to build a trusting relationship with the client and smooth the transition for the client with family members.

Difficulties in maintaining accurate data. Program and client assessments were often constrained by the lack of resources and training for data gathering and recordkeeping, as well as by special processing requirements of the prison system.

Communication difficulties. Literacy and foreign language barriers increased the diffficulty of communicating information to inmates.

MAINSTREAM ISSUES

Each of these projects was aware of society's shortcomings in providing the necessary resources to assist this population. The authors of the project papers emphasized the following needs:

HIV testing and counseling. Prisons must recognize their central role in the identification and treatment of HIV infection in the community. Prisoners account for a relatively large proportion of the HIV-seropositive population. Incarceration may be the first opportunity an inmate accesses HIV testing. counseling, and specialized medical care;

Enhanced and immediate postrelease support. An immediate caring link is needed to increase the released inmates' ability to navigate the especially difficult first days after release and to overcome the stigma of a prison record as well as the violent and antisocial culture of prison;

Expanded discharge planning. In addition to addressing HIV and medical concerns, discharge planning must respond to issues such as sexual behavior, substance use, criminal activity, family/neighborhood, entitlements, employment and income. Adequate resources must be made available for them.

Lack of services and support. The effectiveness of case management is limited when the demand for available services and resources outstrips the supply. The lack of essential human services such as food, housing, employment, and substance abuse treatment lead to relapse in drug use, other high-risk behavior, and reincarceration. Meeting these needs for women is especially challenging.

SUMMARY OF PROJECTS

This section summarizes the strategies, successes, and challenges in linking incarcerated and recently released inmates with HIV/AIDS to community services. Each description addresses project goals and objectives, a profile of the client population, the nature of the intervention, staff, funding, successes, barriers, evaluation methods, mainstream issues, and project dissemination activities.

The ETHICS Project: Linking Ex-Prisoners with HIV/AIDS to Community Services (The Fortune Society; New York, New York)

The ETHICS (Empowerment Through HIV Information, Community, and Services) Project was established in 1989 by The Fortune Society, a walk-in service agency in New York City for released prisoners and youth at risk. Fortune was founded on a principle of ex-offenders helping ex-offenders help themselves, and the organization retains a strong commitment to prisoners' rights, advocacy, and community education. The Fortune Society made HIV education and services the highest priority of the agency after recognizing that almost all of its clients and most of its staff were living with HIV, affected by loving someone with HIV, and/or fearful of becoming infected with HIV.

The Fortune and ETHICS programs provide services in an accepting, self-help, community atmosphere. A majority of the staff have experienced incarceration, substance abuse, or both. These men and women serve as powerful role models for The Fortune Society clients and are responsible in large part for the program's success. Clients learn to take charge of their lives and make social service systems work for them. The Fortune Society interjects information about HIV and the ETHICS Project into all activities of the agency to encourage clients to feel comfortable about revealing their HIV status and to seek services.

The ETHICS Project established two goals: 1) to meet the complex social and medical needs of newly released prisoners who have HIV/AIDS; and 2) to help these clients modify their self-destructive behaviors and adopt healthier, more productive ones. To reach their goals, the ETHICS Project employs several strategies: HIV education and outreach, treatment referrals, a supportive drug-free environment, and a proactive access to care approach.

During the 4 years since its inception, the ETHICS Project has found that linking ex-offenders living with HIV with community resources requires an innovative, holistic service delivery strategy. The ETHICS model of reaching recently released prisoners and empowering them to help themselves provides valuable information and guidance to policymakers and providers of HIV/AIDS services. The project's aggressively enterprising approach to accessing services has resulted in a rich referral network for their clients. The program also reports impressive results in clients' abstinence from drug use and other high-risk behaviors. As a result of staff observations and ongoing client feedback, the program also has achieved an extensive understanding of the factors leading to successful outcomes as

well as responses to the many challenges in linking ex-offenders living with HIV with community services. This knowledge has presented numerous opportunities for innovative solutions and program refinement.

Case Management for HIV Prevention Among Drug-Involved Arrestees (Abt Associates; Washington, DC and Portland, OR)

This program, sponsored by the National Institute of Justice and the National Institute on Drug Abuse and conducted by Abt Associates, was organized as an experiment to test the effect of case management in reducing HIV related high-risk behaviors among heavy drug users who had been arrested, booked, and released. In addition, qualitative studies provided important insights into the process of case management.

Participants of the project were drawn from two sites: one in Portland, Oregorn and another from Washington, D.C. The approximately 1400 arrestees who volunteered to participate in the project were assigned at random to case management or to two less intensive comparison conditions:

- **"Control" condition or minimal intervention**, where participants viewed a videotape and received a guide to relevant services;
- **Intermediate intervention condition**, where participants were exposed to one counseling and referral session with a specialist in addition to viewing the videotape and receiving the referral guide; or
- **Enhanced intervention condition**, where participants were assigned for 6 months to case management that emphasized referrals to community agencies in addition to viewing the videotape and receiving the referral guide.

The principal outcome of interest in this project was decreased high-risk behavior associated with HIV infection. Additional outcome measures were decreased drug use, increased exposure to both drug treatment and self-help programs, and decreased recidivism. The entire population of project participants appeared to adopt lower risk behavior across almost all measures. In general, if measured outcomes accurately reflect the impact of case management, the reported reductions in heavy drug use are significant. All participants reduced their drug use, often dramatically, and increased use of substance abuse treatment. Participants also reported dramatic reductions in illegal activity. Case management participants reduced their criminal behavior and time in jail more than the other groups.

The Prison Release Program (Rhode Island Department of Health/Department of Corrections; Providence, RI)

Rhode Island, with a population of approximately 1 million people, has an inmate population of about 2,500 men and women. Approximately 4 percent of the men and 12

The ETHICS Project: Linking Ex-Prisoners With HIV/AIDS to Community Services

Tracey Gallegher and JoAnne Page

Since its inception 27 years ago in New York City, The Fortune Society has served incarcerated and recently released prisoners by offering them a support network and helping them to access the resources they need to return to the community. Fortune was founded on a principle of ex-offenders helping ex-offenders help themselves. It retains a strong commitment to prisoners' rights, advocacy, and community education.

The Fortune Society is a walk-in service agency for released prisoners and youth at risk. Annually, more than 2,000 people benefit from Fortune's outreach and discharge planning efforts while in prison. Another 1,000 recently released prisoners receive referral and on-site services, including tutoring, job training and placement, counseling, treatment for substance abuse, court advocacy, and HIV-related case management.

In 1989 The Fortune Society made HIV education and services one of the highest priorities of the agency. In New York State, HIV-related illnesses and complications of AIDS are the leading cause of death among ex-prisoners. From 14 to 16 percent of the 60,000 prisoners in the State's corrections facilities are infected with HIV.[1] Of the 86,000 offenders incarcerated each year in New York City, 25.9 percent of the women and 12.3 percent of the men test positive for HIV.[2]

Fortune began to address the urgent need for HIV-related services specifically through the establishment of the Empowerment Through HIV Information, Community, and Services (ETHICS) Project. This project was funded by the Health Resources and Services Administration (HRSA) as one of its Special Projects of National Significance (SPNS). During the 4 years since its organization, the ETHICS Project has found that linking ex-offenders living with HIV with community resources requires an innovative, holistic service delivery strategy. The ETHICS Project emphasizes client initiative and client-staff interaction to help clients access an array of needed services.

PROJECT DESCRIPTION

Goals

Typically, ETHICS clients are HIV symptomatic and struggling with deteriorating

health. They need medical care, assistance in obtaining entitlements, drug-relapse prevention, housing, clothing, civil legal services (including living wills), food employment, home health care, and education. In addition, many HIV-symptomatic prisoners receive woefully inadequate discharge planning. Delays in acquiring benefits after discharge from prison jeopardize their health and motivation.

The ETHICS Project recognized that, despite their many needs, ex-offenders living with HIV have great difficulty obtaining help. As a result of incarceration and living with HIV/AIDS, they often feel isolated, depressed, and powerless. Most lack the skills and self-confidence needed to navigate New York City's fragmented service delivery system; they respond to the red tape and other barriers with hostility or resignation. They seldom receive any guidance or referrals for services. Thus they remain without needed resources. However, unless they access these services, they are at high risk for resuming previous activities— substance abuse, unprotected sex and prostitution, and criminal activity. To respond to these conditions, the ETHICS Project established two goals:

- To meet the complex social and medical needs of newly released prisoners who have HIV/AIDS; and

- To help these clients modify their self-destructive behaviors and adopt healthier, more productive ones.

Profile of Client Population

To participate in the ETHICS Project, individuals must test positive for HIV infection and have a history of involvement with the criminal justice system. Disqualifying characteristics include severe mental illness or active psychosis, active drug abuse requiring medically supervised detoxification, violent and/or abusive behavior, and bringing weapons on the program site.

Clients come to ETHICS with a host of critical health and social service needs. Typically, they are symptomatic and facing deteriorating health. Most need a place to live; approximately 70 percent are homeless at some point during program participation. Virtually all new clients are unemployed; approximately 95 percent do not have jobs. The average age of clients is 36 years.

Sources of Clients. The ETHICS Project relies on client self-referrals, referrals from other Fortune programs, and referrals from external sources such as prison staff and service providers in the community. ETHICS refrains from aggressively recruiting clients because the demand for services, especially case management services, exceeds the number of Fortune's staff available to provide them. Figure 1 illustrates the distribution of sources from which clients are referred to ETHICS, and Table 1 lists the specific referral sources.

percent of the women test positive for HIV at any given time. The Rhode Island Department of Health, in cooperation with the Department of Corrections and the Miriam Hospital, Brown University AIDS Program, developed the Prison Release Program. This program was developed in response to a disproportionately high HIV seropositivity rate for the inmate population and a treatment program that ended for inmates upon release from prison. The goal of the Prison Release Program is to link inmates with agencies that can provide them with or assist them in obtaining medical care, psychosocial support, and substance abuse treatment. The objectives are to extend these services to inmates while still in prison and to facilitate linkages to appropriate resources upon discharge.

From July 1992 through August 1993 a total of 115 inmates participated in the Prison Release Program. The program evaluates all inmates with HIV prior to their release from prison and identifies needs for medical appointments, financial assistance, drug treatment, and housing. Through the Prison Release Program, prison-based case managers maintain contact with former inmates, attempt to continue their service plans, and coordinate their postrelease progress.

The primary measure of success of the program is the extent to which inmates link with community resources after release. All inmates, upon release, are given medical appointments and counseling regarding appropriate treatment and case managers follow their progress. Individuals then receive appointments to obtain financial assistance, referrals to community housing agencies, and followup sessions with substance abuse treatment agencies. Over 75 percent of the program clients have succeeded in following up with their medical appointments and substance abuse treatment.

Before the Prison Release Program, it was not unusual for individuals to be in and out of prison six times a year. Since instituting the program, recidivism has declined. Among female clients, for example, there has been an impressive decrease in recidivism.

Specialized Medical and Social Service Interventions for Inmates with HIV in Maryland (Maryland Department of Public Safety and Correctional Services; Baltimore, MD)

A second program that focused on medical management and discharge planning for incarcerated individuals with HIV operated within the State of Maryland correctional system. The Maryland Division of Corrections (DOC) houses 21,000 offenders, with a HIV seropositivity rate of approximately 8 percent for men and 15 percent for women. The goals of the DOC program are to expand medical treatment options for inmates with HIV and to maintain continuity of those services in the community for released inmates.

These goals are accomplished by three program emphases: medical case management, expeditious medical parole, and clinical trial participation for targeted inmates. As soon as an inmate is diagnosed with HIV, case management services begin with regular contacts. A release date is anaticipated and an aftercare plan developed at least 3 months before the anticipated release. The DOC implements a medical parole procedure for inmates with

endstage HIV disease if their condition precludes their compromising public safety. Access to experimental drugs in federally funded clinical trials is another treatment option made available to inmates through a collaborative arrangement with the Johns Hopkins University.

Medical case management has resulted in discharge planning services for 320 inmates while awaiting release and linkages have been established with a number of community agencies. Among the inmates released on medical parole since 1991, none have been reincarcerated for violent crimes and only five for nonviolent crimes. The program has also succeeded in expanding access to investigational drug protocols via clinical trial programs.

Linking Pretrial Detainees with HIV/AIDS to Community Services (Cermak Health Services; Chicago, IL)

Cermak, as the health care provider at the Cook County Department of Corrections in Illinois, provides comprehensive medical, dental, psychiatric, and substance abuse services to approximately 9,000 pretrial detainees drawn from communities within Chicago and suburban cook County. The majority of detainees testing positive for HIV were asymptomatic and listed their main risk for infection as injection drug use; many indicated injection drug use plus sexual behavior as risk factors.

Cermak's first goal is to provide an array of prevention, advocacy, and discharge planning services. It offers educational information on HIV infection and AIDS as well as other chronic diseases. It also teaches risk reduction and behavior modification techniques and provides HIV counseling and testing. Its second goal is to help clients meet their needs for ongoing treatment after discharge by directing individuals to appropriate community services and enabling those individuals to continue care in the community. Clients voluntarily participate in case management services that begin with an initial interview with each detainee with a diagnosis or a history of HIV infection. The needs of an interested client are assessed and a treatment plan is set based on those needs and the existence of services. Clients are then seen regularly and linked to needed community services.

Project success is defined as the achievement of positive behavioral changes as well as the delivery of appropriate support services, and the establishment of contact by the client to community services. While the uncertain outcome of court cases and the potential for clients to unexpectedly "bond out" makes it difficult for case managers to establish linkages and reduce waiting time for ancillary services, over time the program has established a network of community agencies willing to work with clients. In addition, many program participants have achieved behavioral changes. The current rate of recidivism for the entire corrections facility is 30 percent; Cermak's clientele receiving case management services has a recidivism rate of 8 percent.

The Philadelphia Linkage Program (Circle of Care; Philadelphia, PA)

The Philadelphia Linkage Program was funded by SPNS as a project of The Circle of

Care, a pediatric, adolescent, and family AIDS demonstration project in Philadelphia, PA. The program sought to link incarcerated persons with appropriate community services before and after their release from prison. Initially, the program also had a goal of linking the families of inmates with The Circle of Care's family services. However, because of inmates' reluctance to divulge names of family members, the focus was changed to individual case management. Case managers met with the inmates and conducted assessments of their needs. Then, they followed the inmates for 3 to 6 months after release to ensure that they accessed services.

The program confirmed the value of the case management approach. It also identified problems and possible solutions in planning such projects. For example, the program learned the importance of knowledge of the prison system and the prisoner's culture. Attempts to link inmates with family members also proved more difficult than expected because few of the inmates had any contact with their families and few had disclosed their HIV status to family members. Second, bureaucratic delays and difficulty finding work space in the prison hampered attempts to start the program. Third, turnover in case management staff affected the program's ability to develop relationships with inmates and to provide meaningful discharge planning.

Greater interaction and planning with the prison social workers, security, and other staff was identified as essential for a successful program, as was effectively publicizing the program and recruiting participants. The authors of this project paper emphasize the need for interaction case managers to spend time building trust with clients before attempting to link with family members.

CONCLUSIONS

These projects are models of what can be done by supporting people with HIV while they are in prison and assuring that they receive necessary services when they are released. All of the projects emphasized the need for personalized attention and involvement of the client in his or her care. The needs for services include those specifically related to HIV/AIDS (e.g., medical followup, prescription drug treatments, and case management), but all of the projects stressed the importance of helping released inmates obtain basic services such as safe housing, food, drug rehabilitation, social support, employment, and education.

Several of the projects noted that women present multiple, complicated needs for services for themselves and their families. Locating drug rehabilitation slots, housing, and other community services are particularly difficult for women.

The project descriptions in this monograph illustrate considerable success in linking inmates with medical and community services, providing support to people who are changing behavior patterns, and reducing recidivism rates. In addition, all of the project descriptions emphasize the importance of establishing relationships between the medical team, case

managers, and inmates prior to discharge. The extent to which clients develop postrelease plans is extremely useful for negotiating referrals, setting up medical appointments, and continuing contacts after discharge. The period immediately after discharge is crucial and a supportive relationship with in-prison case managers appears to help reduce recidivism rates.

To be effective, linking inmates with community services must begin in prisons and jails *and must continue* when clients are released. To insure successful reintegration of clients into the community and medical management of HIV is a big challenge. People at all points of contact--community organizations, correctional facilities, caregivers, family members, and case managers--need to be involved. When they are, the rewards to clients, families, and society are impressive. Given the increasing prevalence of HIV in State and Federal prison systems, these projects provide effective, informed models for addressing the concerns of incarcerated and recently released individuals with HIV/AIDS.

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AUTHORS

Christine J. Hager, Ph.D., Economist
Gloria Weissman, M.A., Deputy Director

Office Of Science and Epidemiology
Bureau of Health Resources Development
Health Resources and Services Administration
5600 Fishers Lane, Room 7A-07
Rockville, MD 20857

Marilyn M. Massey, M.P.H.
President
MasiMax Resources, Incorporated
1300 Spring Street
Suite 511
Silver Spring, MD 20910

A sample of 114 ETHICS clients provides a snapshot of client demographics and substance abuse history. These data reveal some differences between ETHICS clients and those who participate in other Fortune programs, for example, ETHICS clients are more likely to be women and/or Hispanic with histories of substance abuse.

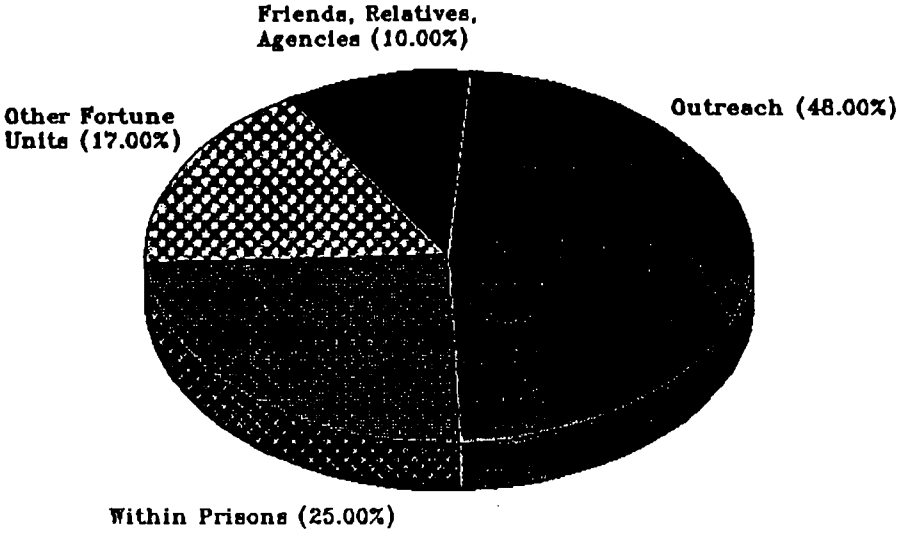

Figure 1. Client Population by Referral Source

Gender Distribution. Approximately 38 percent of ETHICS clients are women, as compared to approximately 11 percent of those in New York State correctional institutions. The high number of women participating in ETHICS may be related to the outreach activities of a an ex-offender volunteer who made weekly visits to the Taconic Correctional Facility (where she had been incarcerated) for 36 weeks, conducting educational workshops and providing counseling to women inmates. A group of women became regular participants in the weekly sessions. A surprisingly high percentage of these prisoners who received postrelease referral dates to visit the Fortune Society came to Fortune for an initial visit and were retained by the ETHICS Project.

Ethnic Distribution. The ETHICS Project attracted a higher percentage of Hispanic clients (48 percent) than is represented in the New York State prison system (32 percent), perhaps because the ETHICS staff member who visited 5 upstate New York prisons, a Hispanic man, conducted outreach activities in Spanish as well as English. African Americans constituted 32 percent of the ETHICS population; 19 percent were white.

Ethnic/Gender Breakout. Hispanic men are the largest group of ETHICS clients (30.70 percent), followed by African-American men (20.18 percent). This distribution is different from what we would have expected, because more African-American men are imprisoned in New York State and seek assistance at Fortune Society. Figure 2 illustrates the combined ethnic/gender profile of the ETHICS population.

Table 1. Sources of ETHICS Clients and Sources of Information about ETHICS Referrals

Self-Referrals, triggered by:

- Word-of-mouth
- Workshops taught by ETHICS staff in schools, churches, community centers
- Articles in *Fortune News*, the agency's monthly newspaper circulated in prisons nationally
- Public television, which airs a relevant video
- Listings about Fortune programs in resource guides and program directories

Referrals from Other Fortune Programs

- For Fortune clients who have specialized HIV-related needs requiring ETHICS' intensive case-management
- For Fortune clients who have come to terms with their HIV status sufficiently to benefit from the ETHICS case management approach

Referrals from Prisons, from:

- Parole Officers
- Other prison staff
- Follow-up contact with ETHICS staff who conduct workshops for prisoners

Referral from Community Service Providers

- Hospitals
- Drug Treatment Programs
- Shelters
- Social Service Agencies

Nature of the Intervention: The ETHICS Modified Case Management Model

To achieve the project goals, ETHICS uses several strategies:

- HIV education and outreach to prisoners;
- HIV education and related services within the context of health education, career development, and other programs that are sought by recently released prisoners;
- Promptly delivered services, either onsite or through referrals to providers in the community;
- A combination of onsite services and offsite referrals in a treatment plan that is tailored to the needs of each client;
- A safe, supportive drug-free environment, staffed by counselors and volunteers who are ex-prisoners, former substance abusers, and/or people living with HIV; and
- An emphasis on both staff and client initiative and participation in getting clients access to care.

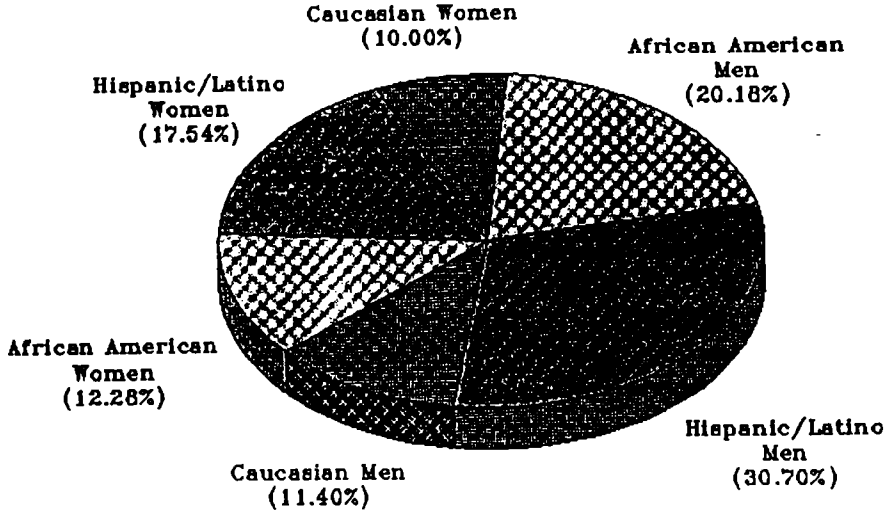

Figure 2. Ethnic/Gender Profile of ETHICS Population

The ETHICS Project follows an intensive, comprehensive approach to case management that extends beyond the basic needs assessment and referral process used in more traditional models. Key aspects of ETHICS case management include:

- Treatment plans tailored to the client's needs;
- Intensive use of counseling (both individual and group support sessions) to prepare clients for referral to outside services and to support them during the often difficult process of accessing and using these services;
- Communication with the client prior to release, either through prison outreach visits or through responding to prisoner correspondence, whenever possible;
- Ongoing structure and no set time limits, i.e., clients can enter (or reenter) the program at any time and participate as long as they want;
- A broad referral network of services provided within The Fortune Society or by organizations in the community;
- An array of activities to help clients live with HIV, including wellness seminars, support groups, social activities, and one-on-one counseling;
- Integration of HIV-related education with other services, allowing earlier HIV intervention and greater client retention than would otherwise occur; and
- Reliance on staff and volunteers who are ex-offenders, former substance abusers, and people infected with HIV.

Each of these elements is incorporated into the three phases of ETHICS case management described below.

Phase I: Counseling and Needs Assessment. ETHICS clients are assigned a case manager who remains with them while they are in the program. The initial counseling sessions are meant to help clients feel at ease with their case managers and to facilitate the needs assessment. The case manager seeks the client's acknowledgement of his or her basic needs. The intensity and duration of case management is primarily determined by the individual needs of each client. Although most clients are involved from 6 to 8 months, no end dates are set, and some clients participate even longer. Typically, the most urgent case management needs are medical evaluation and care; safe, suitable housing for the short term; clothing; and assured access to nutritious meals.

Case management is intensive at the beginning because clients usually have many social service and medical needs. ETHICS clients receive one-on-one counseling, up to three times a week during the first 3-6 weeks. Each session lasts approximately 45 minutes.

In these sessions, clients are allowed to express their feelings freely and to talk about their most immediate and distressing problems. Staff have found that clients with HIV often need hours of counseling before they have enough hope and confidence in the future to follow through on referrals and make the best use of the services.

Phase II: Referral and Followup. Once the most urgent needs of clients are met, case managers begin to focus on long-term needs, including permanent housing and medical care. For example, if clients are using drugs or have had a substance abuse problem, they are encouraged to begin relapse prevention activities, using ETHICS drug treatment services or another community-based program. During this phase of case management, case managers also analyze and research entitlements appropriate for clients and assist them with entitlements applications and advocacy.

Clients are involved, to the greatest extent possible, in developing their treatment plans and coordinating their referrals. This gives the clients a sense of accomplishment and the knowledge necessary to deal successfully with service providers once they have left the ETHICS program.

ETHICS refers its clients to community-based organizations located in the neighborhoods where clients live, tailors the referrals to meet individual client needs (e.g., programs oriented to particular ethnic and/or language groups or support groups serving gays and lesbians) and offers a wide array of mainstream and alternative modalities or approaches (e.g., acupuncture).

Clients are asked to sign confidentiality release forms so that Fortune can coordinate services with referring agencies and keep abreast of client progress with offsite programs. Twice monthly, counselors conduct a telephone case conference with the primary counselor at the referring agency. In addition, the senior case manager meets weekly with each counselor. The supervising case manager and the primary case manager review case notes and discuss the progress made by individual clients toward achieving case management goals.

During this period, clients receive individual counseling as needed, usually a minimum of one session per week. Each ETHICS counselor sees 10 to 13 clients. These 1-hour sessions address more deeply rooted counseling concerns, such as disclosing HIV status, living with HIV/AIDS, fear of dying and physical suffering, and incidents of victimization and abuse in the client's past. Clients also learn how to manage their leisure time and receive basic life skills training.

Phase III: Counseling, Stabilization, and Social Reintegration. After referrals have been made and clients have followed-up, they are encouraged to remain with the ETHICS Project for an additional 2-4 months. During this time, through services provided at The Fortune Society, clients participate in an array of activities that promote wellness and help them pursue serious life-change goals. These activities include:

- *Social and Fitness Activities.* Clients socialize informally in the ETHICS living room, and they frequently share meals with staff and volunteers. They can also participate in organized events, such as picnics, bowling, movies, cultural events, and, on one occasion, fishing on a party boat. Clients are also encouraged to take advantage of in-house fitness classes, such as yoga and tai chi chuan, or participate in fitness activities for ETHICS clients at the local YMCA.

- *Support Groups.* The ETHICS Project runs three weekly support groups. Two of the support groups are composed of ETHICS clients. ETHICS-trained peer volunteers attend the third support group. On average, three out of four support group sessions address a specific topic; the fourth session is open-ended. Examples of topics for support groups include "Caretaking—When Your Partner Relapses" and "Managing Leisure Time." Support groups are semistructured; ETHICS staff facilitate group discussion. Usually, the staff who lead the support groups consult other staff, as well as their case notes, to tailor the discussion to issues that a majority of clients are confronting at that time. All sessions are facilitated by a staff member; on occasion, a trained peer volunteer assists a staff member in leading the discussion.

  Counselors are responsible for encouraging clients to participate in a support group; however, all support group participation is voluntary. On average, five to ten clients attend each support group. A total of 15-30 persons attend the support groups in any given week. ETHICS graduates sometimes elect to continue their participation in a support group, even though their cases have been closed.

- *Educational Seminars on Health and Nutrition.* Representatives from God's Love We Deliver, an HIV service organization based in New York City, conduct seminars at least bimonthly at Fortune. The seminars last 2 hours or more and are offered to clients and personnel throughout the agency and to clients from other agencies. In the past, workshop topics have included general nutrition, learning how to access home delivery of food, and nutritional supplements.

- *Advocacy Activities.* Clients are encouraged to attend conferences, rallies, and roundtable meetings sponsored by AIDS activist groups. Through these activities, clients can help educate the public about AIDS issues and advocate for rational, aggressive public policy regarding AIDS and HIV. Clients are also encouraged to take advantage of other services in the community, such as the lunch program provided by Gay Men's Health Crisis and the dinner and groceries program provided by Momentum.

  ETHICS often invites members from the HIV/AIDS advocacy community to address clients and discuss broad issues affecting the HIV/AIDS community in New York City and the Nation. As a result of these efforts, some clients join groups involved in community education, organizing, and lobbying. Some clients

are also trained to become community educators and gain experience in public speaking.

- *Peer Education Training*. Through support from the New York AIDS Fund, Fortune has developed a training curriculum for HIV peer educators. Training workshops address such topics as "HIV 101," social bias, listening skills, homophobia, diversity, and sensitivity. Four to five times a year, 12 trainees attend an 8-week training course to become HIV peer educators. A majority of trainees are graduates of the ETHICS Project; the remainder come from other Fortune programs and other social service agencies in the area. ETHICS seeks individuals with the maturity and sensitivity necessary to empathize and communicate effectively with new clients. Although having HIV is not a requirement, all peer volunteers who are not living with HIV have been affected by HIV, having loved someone with HIV or AIDS.

- *Celebration of Success*. Approximately twice a year, ETHICS holds a graduation ceremony to honor participants who have successfully completed the program. These celebrations serve as important rites of passage for many clients as they receive a certificate and recognition from peers and counselors.

Staff

The Fortune Society pursues an affirmative action policy with regard to the recruitment of former offenders and persons affected by HIV/AIDS as counselors, case managers, and HIV educators.

Its staffing approach is deliberately diverse to maximize sensitivity to the culture, language, and life experiences of its clientele. Fortune believes that trained, talented former offenders and recovering substance abusers can overcome some of the initial barriers in developing client-counselor relationships more quickly than persons who have not lived through the prison or drug experience. Staff members who are former offenders also speak the language of former offender clients. They know the clients' fears and defenses, are aware of the conditions experienced in prison, and understand the rigors of transition. Because of their own experience with high-risk lifestyles, staff and volunteers are quick to notice signs of such activities as renewed drug use, and they speak assertively with clients about subtle changes in dress or behavior that might pass unnoticed or untranslated by persons with only straight-world life experiences.

More than 75 percent of the staff is African American or Hispanic, and approximately two thirds are ex-offenders and/or people in recovery. Eleven of its 22-member Board of Directors are people of color and 10 members are ex-offenders and/or recovering substance abusers. The ETHICS Project recruits persons living with HIV for the administration of the program and the provision of services. Candidates are considered for employment only

when they demonstrate compassion, commitment, and imagination in addition to concrete skills in effectively managing cases and caseloads.

Search committee members who interview candidates for ETHICS Project counselor/case manager positions are also, in large part, former offenders and recovering substance abusers themselves. They listen carefully to gauge job candidates' willingness to discuss their transitional issues and their awareness of their personal risks or self-destructive behavior. Committee members expect to hear candidates acknowledge their difficulties and express some understanding of the emotional and behavioral dynamics associated with recovery and transition. However, candidates must make clear their understanding that they cannot necessarily apply their own experiences directly to clients.

The ETHICS project's current staff structure calls for a project director, a senior case manager, three case managers, an administrative assistant, and trained peer volunteer educators.

Project Director. The project director administers the ETHICS Project. Responsibilities include supervising professional staff, preparing reports to funding agencies, further developing linkages with other service providers, accessing ongoing HIV-related training for ETHICS and Fortune staff, and expanding and enhancing service provision. In addition, the project director coordinates ETHICS' public education and lobbying efforts, such as inviting speakers to the program site and training ETHICS participants to educate the public about HIV-related topics. The project director holds weekly unit meetings in which the staff discuss problematic cases, service delivery concerns, and other program and administration issues. The project director is actively involved in the Mayor's Voluntary AIDS Task Force and in an HIV technical assistance consortium organized by the New York City Department of Health.

Senior Case Manager. The senior case manager, working under the project director, supervises the three case managers. This entails weekly supervisory sessions with each case manager to review client progress and ensure that services are being coordinated. The senior case manager conducts ongoing training for the case managers on case management, counseling techniques, and proper documentation of client charts. In addition, the senior case manager belongs to a number of HIV-related task forces throughout the city.

Case Managers. Case managers conduct prison outreach, plan discharge (when possible), admit new clients, and counsel and manage cases of ETHICS participants. Average caseloads range from 10 to 13 cases. Case managers conduct site visits of various programs to which ETHICS clients are referred. These programs include medical service, drug treatment, transitional housing programs, HIV support groups, and the social services of other agencies. Case managers participate in community HIV groups and task forces throughout the neighborhoods from which clients come and conduct "safer sex" workshops for all of Fortune's clients.

HIV Coordinator. The HIV coordinator maintains monthly calendar of ETHICS activities, setting up appointments for speaking engagements in the community, record keeping, and greeting walk-in clients and making them feel comfortable. The HIV coordinator also supervises the trained volunteer peer educators.

Trained Volunteer Peer Educators. The ETHICS Project trains many of its peer volunteers. Working 10-20 hours a week for a 16-week-period, the volunteers provide crucial support for new ETHICS clients. They accompany clients, if necessary, to appointments with medical and social service providers to ensure that clients receive services. They counsel clients, spend time with them, serve as "buddies" and, by their example, reinforce program goals of sobriety and self-help. In turn, their work with new clients reinforces the peer volunteers' commitment to a stable, productive, healthy lifestyle. Peer volunteers testify at hearings, participate in conferences on the needs of ex-prisoners living with HIV, and conduct workshops on HIV/AIDS issues for ETHICS clients. They also provide clerical help and staff Fortune's HIV telephone hotline.

In addition, peer volunteers join staff in prison outreach efforts by conducting workshops, recruiting clients, and corresponding with prisoners living with HIV. While they are incarcerated, many prisoners are willing to disclose their HIV status in a letter but tell no one else. Consistent and reliable correspondence provides a vital link and engenders hope for the individuals. At the same time, the trained peer volunteers who respond to this correspondence benefit as well. Such letter writing reinforces engagement and retention by creating a community of support for persons in and outside of prison.

Funding

Because Fortune's HIV services are provided throughout the agency, with intensive services provided by ETHICS, the $680,157 in funding reflected in the chart below represents the total of Fortune's HIV-related programming, not just services provided directly by ETHICS. Fifty-four percent of Fortune's funds come from the New York State Department of Health, 32 percent from Title II of the Ryan White CARE Act SPNS, and 14 percent from Title I of the Ryan White CARE Act (Table 2). In addition to payment for direct services, these contracts pay for necessary support functions, including bookkeeping, reception/switchboard, keeping computer records on clients, and clerical assistance.

PROJECT SUCCESSES

The ETHICS Project developed outcome measures to correspond to its two general goals:

- To meet the complex social and medical service needs of newly released prisoners who have HIV/AIDS; and

Table 2. Expenditures by Source of Funding

	NYS AIDS Institute	Ryan White/ SPNS	Title I
Salaries	$229,250	$136,000	$65,800
Fringe benefits	55,547	32,953	15,943
Occupancy	43,322	25,500	2,520
Other expenses (*e.g.*, equipment, supplies)	36,881	23,889	12,552
Total Budget	$365,000	$218,342	$96,815

- To help these clients modify their self-destructive behaviors and adopt healthier more productive ones.

With regard to the first goal, ETHICS tracks the rates of success in accessing and directly providing needed services. The measures used to indicate outcomes include:

- Percentage of clients seeking entitlements who were satisfied;
- Percentage of clients seeking goods or clothing who received them;
- Percentage of clients requiring housing who were housed;
- Percentage of clients requiring medical attention who received it;
- Percentage of clients seeking employment who found jobs;
- Percentage of clients who wished to further their education who were enrolled in an education program; and
- Percentage of clients self-identifying as substance abusers who remained abstinent during involvement with ETHICS.

With regard to the second goal, ETHICS relies on rates of program retention and sobriety as proxies for positive "behavioral change." The outcome measures of interest are:

- Average length of time clients participated in the project; and
- Percentage of clients remaining sober and clean during participation.

The ETHICS Project believes that sobriety is among the most reliable proxies for "positive behavioral change." In the staff's experience, drug relapse is strongly associated with other self-destructive behaviors such as sharing needles, prostitution, unsafe sex, and involvement in criminal activity. Fortune tracks sobriety through self-report, staff observation, and behavioral indicators. Most clients who experience drug relapse drop out of the program or change their behavior in negative ways.

Length of Time in Program

ETHICS clients remained involved with the program for an average of 8 months--a surprisingly long time, considering that this population is usually transient and hostile to intervention.

Abstinence from Drug Use

Of the 114 ETHICS clients recorded, 102 (89.5 percent) reported significant histories of substance abuse. The records of 24 ETHICS clients who received alternative-to-incarceration and HIV services show an average of 10 years of use for cocaine/crack abusers and 14 years for heroin abusers. Primary drugs used were heroin (60 percent) and cocaine/crack (40 percent), with daily use prior to incarceration.

Staying drug-free is a surrogate indicator of low-risk behavior. Clients reported that when they use alcohol or other drugs, they are less likely to use condoms; conversely, when they are working toward healthy goals, they feel they have a reason to protect their future and their use of condoms increases. Given the large percentage of clients who reported substance abuse histories (102 of the 114 studied), the results are impressive; 81 percent of those identifying abstinence from drugs as a need and 69 percent reporting significant substance use histories remained abstinent during the period of their involvement with ETHICS.

Accessing Services

ETHICS staff tap into a rich referral network to access needed services for their clients and are aggressively enterprising. For example, ETHICS graduates working for other medical and social service providers have proven to be an invaluable resource. One graduate who now works in an area hospital helps Fortune expedite admissions of clients in emergency situations. Another staff member's mother works in a hospital and helps ETHICS negotiate the application processes to access medical services. ETHICS also frequently barters for services with other providers. Project records indicate that 114 clients accessed services while they were involved with the program (Table 3).

Table 3. Rates of Success by Needs Categories		
Needs Category	**Clients Presenting Need (n=114)**	**Clients Meeting Goals (%)**
Medical Attention	86	100
Entitlements	84	98
Abstinence	83	81
Clothing	63	100
Housing	56	93
Employment	16	88
Education	6	100

Case Histories

"John." John is an African-American man in his thirties. He had a 15-year history of injection drug use and tested positive for HIV when he came to The Fortune Society after being released from prison. He was homeless and in need of medical attention. According to him, he had not received a copy of his medical records when he was released so he had no documentation of his HIV serostatus and could not qualify for entitlements. ETHICS Project staff arranged to have John seen immediately by a medical professional, who helped him obtain the necessary medical records to link him with services. Project staff assisted him in obtaining entitlements and locating permanent housing. John saw his ETHICS counselor every day for the first 2 months and twice weekly for the remainder of the 4-month period. He received counseling for relapse prevention, early childhood sexual abuse, safer sex practices, health maintenance, and other issues. He is doing well, his health has improved, he received his GED, and he is now attending college.

"Leni." Leni is a 40-year-old woman with HIV who came to Fortune after serving 10 years in prisons in four States for grand larceny. She was frightened and disoriented when she came to Fortune and needed to learn how to support herself. She had to contend with many complications that had arisen due to her illness and she wanted to mend her relationship with her teenage daughter, who resented her mother for being in prison. Fortune counselors helped Leni get the medical care she needed and the benefits for which she was entitled through the Division of AIDS Services. Fortune arranged housing and further support through Services for the Underserved, a nonprofit agency. Her relationship with her daughter improved, partly because Leni secured a home and received counseling.

Leni volunteered at Fortune 3 days a week as an HIV peer counselor and visited Taconic Correctional Facility once a week to provide HIV education to the women inmates. She says that going back to the prison where she was incarcerated was her therapy as well.

"It gave me a boost. I liked to be there for people to see that, hey, I'm doing good." Once Leni's daughter visited Taconic with her. The women cried when her daughter expressed her feeling about her mother's illness and the future; she is proud of her mother and glad to have her home. Leni visited schools and churches on her own time, giving presentations on HIV to young people. Recently, to preserve her health, Leni has reduced her volunteer activities.

"Darion." Darion, a 27-year-old African-American man, came to Fortune 2 months after his release from prison. He was in denial about his serostatus and extremely introverted. As a result of the patience and persistence of Darion's counselors and peer volunteers, Darion began to feel more comfortable with the ETHICS unit and began to address HIV-related concerns. He found the social activities provided through ETHICS especially helpful. He was concerned about how to organize his leisure time and stay drug free. Darion learned that living with HIV did not preclude having fun and that it is possible to socialize without using drugs. He participated in drug-free social activities such as bowling and theater.

Darion's counselor worked hard to gain access to an HIV clinic known for its case management team, its flexible approach to working with hard-to-reach clients, and its convenient location. Although the clinic had reached capacity and had no available slots, Darion's counselor made a minimum of 12 contacts over a 3-week period and leveraged a slot based on favors owed for accepting referrals from the clinic. Such "bartering for services" is especially effective in getting clients limited services. Accessing a slot in this clinic proved to be vitally important and increased the likelihood that Darion would achieve his case management goals and comply with medical treatment. Darion now works as a HIV coordinator and counselor.

FACTORS LEADING TO SUCCESSFUL OUTCOMES

Since its inception, the ETHICS model has evolved as a result of staff observation and ongoing client feedback. The ETHICS unit's approach to addressing substance abuse and drug relapse illustrates how the ETHICS model has been refined over its 4 years of operation. For example, during its first year of operation, the program offered only short-term counseling and a limited number of referrals; once a client was referred to the New York City Division of AIDS Services, his or her case was considered closed. Since then, ETHICS has added long-term counseling and case management, support groups, seminars on nutrition and health, peer counseling, and record keeping.

Emphasis on Staff Training

Fortune makes available to its staff numerous training sessions to support their continuing professional development. Training includes 8 weeks of intensive training on HIV/AIDS; pre- and posttest counseling in collaboration with the New York State Department of Health/AIDS Institute; relapse prevention counseling provided in-house by

five times a week and stay for 6 months, with specific goals, such as getting a GED or finding a job. The program includes a substance abuse relapse-prevention component. Clients self-refer to ATI with open court cases and are referred by judges, prosecutors, and defense attorneys. Recently, Fortune provided ATI services to 24 defendants with AIDS to save these people from the health-threatening stress and poor medical care found in prisons.

Career Development is needed by most ex-offenders who go to Fortune because they have little or no stable work history. Clients are often desperate to find work immediately and cite the need for a job as their foremost priority. A 3-day career development workshop teaches crucial job-hunting skills, including how to discuss criminal convictions and substance abuse history with a prospective employer; how to conduct a newspaper and telephone job search; and how to construct an effective resume. Videotaped and mock interviews enable clients to observe how they look to others so they can discuss problems with counselors and other participants. A job developer works with each participant, guiding the job search, developing a resume, and encouraging the client to go to interviews. However, in keeping with Fortune's emphasis on self-help, the workshop teaches participants how to conduct an independent job search.

Job retention seminars help clients who have been out of the job market for a long time but who demonstrate potential for becoming responsible workers. The seminars cover budgeting, employee's and employer's rights, self-confidence, decision making, and prevention of relapse into crime and substance abuse. As a result of the program, job retention has improved dramatically for Fortune's clients.

Educational Services are provided to clients. They receive one-on-one tutoring, tailored to their individual needs, in basic literacy and mathematics to GED test preparation and beyond. Fortune offers day, evening, and Saturday hours, so students who find jobs can continue with their studies. Students stay in the program as long as they like and work at their own pace, attending tutoring sessions twice a week for an hour or more. Each student is tested after 24 lessons to measure progress. All tutors are volunteers, trained and supervised by Fortune's six staff teachers. In 1992, Fortune opened a computer lab, complete with eight terminals and a full-time instructor. Clients learn word processing skills and use the educational software to study reading, math, geography, and spelling on their own.

Effective Engagement of Clients

Most clients who are referred to the ETHICS Project elect to participate in the program. However, a small minority reject services. It is likely that they have recently learned of their HIV seroprevalence and have not yet disclosed it to close family members or friends. Often, these individuals return to Fortune once they accept their HIV status and decide to seek assistance. The program deliberately allows participants to enter, drop out, and return, or to reject services and later seek them when they have come to terms with their HIV status and are better able to take advantage of the services.

Clients receive intensive, individual attention. This approach is reassuring for clients who during their first visit to Fortune report feeling terrified and scared, not in control of their lives, powerless, in denial of their HIV status, impatient, nervous, distrustful, and worried about discrimination and rejection. Intensive personal care results in improved client retention, which is essential to positive behavior change. Such efforts include extended and intensive individual counseling, the pairing of new clients with more experienced buddies or trained volunteer peer educators, and simply spending social time with clients. Although ETHICS clients cannot stay overnight at the Fortune facility, the ETHICS living room provides them with a quiet, comfortable place to rest and talk with ETHICS staff, volunteers, and other clients. Clients also report that they find great relief in being with other people who are living with HIV/AIDS and with counselors who express faith in them. In addition, client focus groups reiterate the importance to the clients of having a counselor who is a former offender in promoting their continuation with the program and providing an "ex-offender friendly" agency that reinforces a feeling of safety and love.

Extensive and Effective Use of Volunteers

After they have achieved stability in their own lives, many clients want to serve others and continue their involvement with the ETHICS program by volunteering at Fortune. These volunteers expand the ETHICS Project's ability to provide services and peer support. In addition, their newly assumed responsibilities help reinforce such case management goals as sobriety and stability. Other clients use their skills at other AIDS-related organizations. Giving them that opportunity benefits both them and their work site, as well as the community.

Peer educators, who have made positive changes in their own lives and with whom clients can identify, play an indispensable role in creating an atmosphere conducive to growth and change. Peer educators are able to reinforce positive behavior change, encourage clients to make maximum use of ETHICS services, and help clients to be optimistic about their future.

Cost-Effectiveness

Case management is an extremely labor-intensive process; a single concrete problem may take a case manager half a day to resolve. Nevertheless, because case managers are known and respected in the community, they are able to place clients in permanent housing in a short period of time (within 2-3 months). Permanent housing costs an average of $550 per month, instead of $200 per day in typical temporary housing such as "welfare hotels." Similarly, linking clients with medical care providers ensures not only more personalized care but also a tremendous saving over the costs of emergency rooms. Perhaps the greatest saving is that medical complications, including opportunistic illnesses, can be diagnosed and treated early, rather than advancing to later stages when they may require extreme intervention, including sustained hospitalization.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

The ETHICS Project has encountered many challenges in linking ex-offenders living with HIV with community services. These challenges provide opportunities for innovative solutions and further program refinement. Some of these obstacles and recommended actions are outlined in this section.

Noncompletion of Program

Drug relapse is one of the major reasons for noncompletion of the ETHICS program. Of the 83 identified substance abusers participating in ETHICS, 16 either lost contact or relapsed. A very high percentage of ETHICS clients present histories of long-term, multiple-drug use, crack cocaine and heroin being the most common drugs used. For recently released prisoners, maintaining sobriety, especially during the period immediately following their release from prison, often proves to be an unattainable goal without sustained support and effort. Other reasons clients do not complete the program include 1) transferring to a different unit or agency, 2) getting rearrested, or 3) leaving the area. Fortune implemented a computerized record-keeping system to better document dropout rates and reasons for attrition.

Limitations on Counseling/Program Capability

Ready access to counseling for clients with HIV is necessary to address the difficult issues associated with adjusting to new lifestyles and new life goals. Fortune staff counsel clients during office hours only; for some clients, the hours spent away from Fortune present temptations that prove stronger than their determination to resist.

Dissatisfactions reported by clients have helped ETHICS refine its program. For example, clients expressed dissatisfaction with the lack of services in the evening, so ETHICS arranged for each staff member to work one evening a week, added an evening support group, and allotted more time for case management during the client's initial involvement with the project. In addition, ETHICS has addressed this service gap by referring clients to programs that provide services during the early and late evening and during weekend hours. ETHICS also encourages "the buddy system," where more experienced clients make themselves available to newer clients.

Additionally, ETHICS staff found that clients who are ill have difficulty keeping appointments, and embarrassment or frustration about missing a scheduled appointment may deter some clients from trying again. Recognizing the instability of many recently released prisoners and their distrust and ambivalence about seeking services, ETHICS developed a flexible, open admission policy. ETHICS encourages clients to walk in, without an appointment, any time Monday through Friday, 9 a.m. to 5 p.m.

Staff Training, Burden, and Turnover

Generally, the ETHICS program has found that caseloads of 10-13 clients per case manager are manageable and reasonable. However, since it is impossible to anticipate client intake rates in advance, frequently case managers have caseloads of 15 and 16 clients. During high-intake periods, an additional staff person could make a vital difference in ETHICS's ability to meet client needs. One primary counselor is assigned to each client, but regular staff conferences about each individual client ensure consistency and coordination.

Counseling clients with grave and dire needs is draining and stressful for all staff; therefore, Fortune implements strategies for relieving such strains and addressing concerns of staff members about difficulties in managing stress. Efforts include providing staff with training opportunities, organizing staff retreats, and raising issues during staff meetings and supervisory sessions. ETHICS also refers its case managers to outside support groups for HIV caregivers. Ideally, case managers attend support groups without their clients so they can discuss their concerns openly. Whenever possible, clients attend support groups led by staff members other than their own case managers, a practice that exposes each client to at least two staff members and decreases the effects of turnover.

Inevitably, some staff will leave Fortune's programs to advance their careers, pursue salary increases, or take on additional responsibilities with other agencies. Clients may abandon the program when a staff member leaves the agency for another job or, more rarely, if a staff person to whom a client has become attached experiences a reversal in his or her own struggle.

Staff Drug Relapse

Because a majority of staff are in recovery, Fortune believes drug relapse by some staff to be inevitable. Given that staff serve as role models for clients, the drug relapse of an individual counselor can present a serious threat to the progress of clients who have developed a strong attachment to this individual.

Fortune pursues a multipronged strategy to reduce the likelihood of staff relapse and to minimize the disruptive impact of any occurrences. Fortune nurtures and builds the 12-step philosophy into its programs and strongly emphasizes the ongoing nature of recovery. Second, the ETHICS unit tries to involve individual clients with more than one counselor so that clients avoid becoming overly dependent on one staff member.

MAINSTREAM ISSUES

There are several social, cultural, and resource issues over which ETHICS has no control, but that still affect the program. The ETHICS Project has identified three areas in which further development and enrichment of services would help clients become stable after being discharges from prison, improve intervention, and provide a continuity of care for

prisoners with symptomatic HIV disease. Several strategies have emerged to address these issues.

Need for Expanded Discharge Planning

Because of current resource limitations the ETHICS project does little discharge planning. Generally, interactions with clients begin when they are released from prison and arrive at The Fortune Society for assistance. Experience indicates that this approach misses two critical windows of intervention—the prerelease planning period and the period immediately after release. The lack of adequate discharge planning results in gaps in medical care and delays in accessing entitlements that can seriously endanger clients' health.

Prerelease intervention offers the opportunity to carefully plan the prisoner's return to the community, ensure that documentation is in order, begin processing entitlements, schedule clinic appointments, and establish critical services such as food and housing. Discharge planning allows staff and volunteers to build a trusting working relationship with the client *prior* to the crisis-ridden release period.

An essential part of discharge planning should be outreach to family members of those prisoners who have given their consent to such contact. The period before release offers a chance to reach family members when their motivation to be supportive is highest and before the stresses associated with the period of release have set in. This is an optimum opportunity to intervene in a manner that will smooth the transition for the client and the family. Family members need to be given an opportunity to anticipate the issues and process the feelings surrounding the prisoner's return and to arrange for the supportive services that they might need. In addition, prerelease contact with family members would provide program staff with an opportunity to independently assess whether the prisoner's family will be a help or a hindrance to the prisoner's health, stability, and sobriety upon release. Discussions with prisoners whose family members are involved with drugs or unstable might suggest that alternative housing will be needed.

Need for Enhanced Support During Initial Postrelease Period

The second critical window of intervention occurs immediately upon the prisoner's release. State prisoners released to New York City arrive at a bus terminal located in an area with easy access to drugs and sex, the two most pressing desires. To be most effective, intervention should begin by meeting released prisoners as they step off the bus, helping them through their initial fear and disorientation, starting them in a positive direction, and providing an immediate and caring link that will increase their ability to navigate the first excruciatingly difficult and precarious days after release.

Non-HIV-related crises affect many released prisoners when they arrive at Fortune. These concerns include the use of nonprescription drugs, homelessness, and lack of income. Other challenges include overcoming the stigma of a prison record and remaining drug free.

Finding a job is a tremendous challenge, particularly for those with little or no education, and supporting oneself, much less a family, on the wages most ex-prisoners can earn is difficult. Released prisoners speak of "prisonization"—the accommodation to the violent and antisocial culture of prison, which can make it difficult to stay out of trouble once released. They struggle to remain drug free in neighborhoods infested with drugs, where all of their former social life revolved around getting high. Each of these needs must be handled before HIV-related concerns can be effectively addressed.

By working with the New York State Department of Correctional Services and the Division of Parole, organizations such as The Fortune Society can greatly improve discharge planning. Presently, The Fortune Society is developing a proposal to identify prisoners with HIV and link them with necessary services upon release.

Lack of Appropriate Housing

Although the ETHICS program is usually able to find its clients housing, the number of transitional housing facilities that are safe (i.e., crime free and drug free) is very small. Many prisoners symptomatic with HIV are held in prison beyond their release date because they lack housing. Sometimes the housing located requires unacceptable compromises in terms of clients' physical safety or risk to sobriety. Short-term, closely supervised transitional housing is badly needed and currently lacking for prisoners returning to communities from which most prisoners come, for clients whose housing situation becomes unstable or unsafe, and for clients whose personal stability would benefit from a structured, drug-free environment.

Lack of Necessary Medical Records

Clients discharged from prison without proper documentation of their HIV seropositivity and their previous medical care present another serious barrier to assuring continuity of medical care and applying for Medicaid. Health-threatening delays occur in receipt of such benefits as medical and dental care, prescription medication, and home health care. Clients without records may wait weeks to get a clinic appointment and undergo blood tests again, further extending their wait by 2 weeks. Such delays hamper acquisition of benefits, jeopardizing clients' health and motivation.

Insufficient Number of Appropriate and Effective Drug Treatment Slots

Unfortunately, New York City does not provide adequate access to drug treatment, and many clients face long (sobriety threatening) waiting lists prior to entry into residential drug treatment. In addition, many of the traditional therapeutic communities fail to engage and retain Fortune clientele. Thus, there is a need not only for expanded traditional drug treatment programs, but for innovative and additional treatment approaches and modalities.

Fortune would like to develop an intensive, in-house drug treatment intervention. Such an effort could entail long-term planning for a residential treatment program or expansion of activities during hours when the agency is closed. It might involve the establishment of a short-term residence to keep newly recovered substance abusers away from their accustomed "places and faces" and provide a safe and supportive haven during crises that jeopardize clients' stability. Currently, the financial resources are not available to implement such a program.

Lack of Adequate Funds

Many community-based organizations address the problems mentioned, but they are overwhelmed by the breadth of the problems and are unfamiliar with Fortune's clientele. They need significant increases in funding to better serve the people who need their help. More organizations such as The Fortune Society that provide a holistic, friendly environment for people released from prison, particularly those with HIV, are needed. One of The Fortune Society's core beliefs is that dollars spent expanding the prison system could have a greater impact on crime if they were spent improving the impoverished communities that nurture most prisoners.

EVALUATION METHODS

The Fortune Society evaluated the ETHICS Project using case histories, client satisfaction surveys, focus group interviews, and intensive case reviews. The ETHICS orientation of individual attention was extended to the assessment of the program; case-specific reports of the needs, experiences, and outcomes of individual clients added a useful dimension to the program's perspectives on program and client accomplishments. Clients also rated their satisfaction with the ETHICS program by responding to client satisfaction surveys. Questions included 1) Did your counselor give you adequate help in attaining your goals? and 2) What was the most important service you received at Fortune? ETHICS refines its programs in response to dissatisfaction noted on the client satisfaction surveys.

Focus groups conducted in November 1992 and January 1993 asked clients to reflect on their experiences and to answer two questions: 1) How did you feel during your first visit to Fortune? and 2) What helped you to remain in the program? The ETHICS project director acted as primary interviewer, following a structured format.

In addition, when supervisors review client folders with case managers, any unmet client needs are noted on supervision note forms, together with an action plan for meeting the needs. The project director and senior case manager conducted an intensive folder review to assess each client's needs at intake and at 90-day intervals to determine whether the needs had been met when the client exited the program.

DISSEMINATION OF THE PROJECT CONCEPT

ETHICS developed the following activities and materials to inform people about its services and culture:

- *Brief video documentary about the program.* Through interviews with staff and volunteers, this video conveys the methods and the culture of the ETHICS program.

- *Brochure about the program.* Aimed primarily at potential clients, this attractive brochure contains a substantial amount of information about the ETHICS program's services and culture.

- *Comprehensive evaluation of the program.* Completed in December 1993, this report has been shared with the AIDS Institute of the New York State Department of Health, the HIV Center for Clinical and Behavioral Studies, Daytop Village, and Gay Men's Health Crisis. Fortune wanted to share its case management model and increase the likelihood that the special needs of recently released prisoners will be taken into consideration as the AIDS Institute develops its own protocols for case management and COBRA implementation.

- *1994-5 ETHICS dissemination and technical assistance program.* This program, funded by SPNS, was designed to help expand the availability of effective counseling, case management, and other services for ex-prisoners living with HIV by training organizations to provide these services. The Fortune Society serves as a demonstration site for HIV-related services to ex-offenders, but it is anticipated that the organizations receiving intensive training in the ETHICS model will adopt or adapt it to their own and their clients' needs. It is hoped that this program will result in more organizations in New York City offering high-quality HIV-related services to ex-prisoners.

  In December 1994, an orientation to the program was presented, and commitments to train four agencies were formalized. The program includes the following elements:

  - A preliminary needs assessment of the agency;
  - 25 hours of a comprehensive interactive curriculum on HIV/AIDS (January-February 1995);
  - 25 hours of hands-on training at Fortune (February-March 1995);
  - Individualized plan for technical assistance (March 1995);

- Weekly contact from Fortune staff on progress and needs for technical assistance (March-July 1995);

- Evaluation of training/technical assistance program and of agency's progress (March-July 1995); and

- Followup evaluation of agency (by April 1996).

Fortune is planning other activities that will include outreach to organizations that serve high-risk populations. Recently, ETHICS staff presented their program to social workers, medical doctors, and counselors at the Columbia Presbyterian Hospital HIV Center for Clinical and Behavioral Studies. Future presentations of this sort can incorporate ideas on how programs could replicate the ETHICS model. More media coverage of the needs of ex-prisoners living with HIV would create a climate favorable to legislators' funding of programs that would help meet the enormous need.

NOTES

1. Data from Criminal Justice Initiative, a joint program of the New York State Department of Health and the New York State Department of Correctional Services.

2. Data from "Baseline HIV Needs Assessment, City of New York, Title I EMA: HIV Seroprevalence Estimates and Service Needs Assessment for the Five Boroughs of New York City," October 1993. Issued jointly by the New York City Department of Health and the Mayor's HIV Health and Human Services Planning Council.

AUTHORS

Tracey Gallegher
Project Director

JoAnne Page
Executive Director

The Fortune Society, Inc.
39 West 19th Street
New York, New York 10011

Case Management for HIV Prevention Among Drug-Involved Arrestees

Michael Gross, William Rhodes, Catherine Conly, Tammy Enos Theresa Mason, and Linda Truitt

People at risk for exposure to the human immunodeficiency virus (HIV), including heavy drug users who have been arrested, often cite their preoccupation with multiple life needs (e.g., job, housing or shelter, and drug treatment) as interfering with their motivation to address HIV risk behaviors. Given the complexity of needs of many persons at risk for HIV infection, case management is a recommended means of addressing drug injection and use and other HIV risk behaviors (Ashery 1992; Martin and Scarpitti 1993; McLellan et al. 1993; Centers for Disease Control 1993). Case management typically combines the following components: assessment, treatment planning, linkage, referrals, monitoring, and advocacy (Weil et al. 1985; Anthony et al. 1988; Applebaum and Austin 1990). It may also include elements of counseling, therapy, or social support (Rothman 1991).

Because case management focuses on leveraging services that are difficult to access, it is particularly appropriate for persons with both criminal and drug involvement. Because of the large at-risk population filtering through the criminal justice system, there is an opportunity to educate inmates about HIV prevention. However, correctional agencies have limited ability to take proactive steps to reduce the spread of HIV (Hammett et al. 1992; Wish et al. 1990;). Most arrestees are released within hours of arrest. Those convicted often avoid jail and prison where they might be exposed to HIV prevention programs.

An intervention to reduce risk behaviors related to sex and drug injection implicated in the transmission of HIV was integrated into a broader research project aimed at reducing drug use and recidivism and at increasing the use of substance abuse treatment services. Sponsored by the National Institute of Justice and the National Institute on Drug Abuse, case management was delivered for 6 months to drug-involved arrestees released after booking. Approximately 1,400 arrestees participated in the project between August 1991 and April 1993 in two sites, the District of Columbia and Portland, Oregon. Although participants were recruited from an arrestee population, case management was strictly voluntary. High levels of participation were sustained without either criminal sanctions for noncompliance or material rewards for participating.

In the project, participants were randomly assigned either to case management or to one of two alternative treatment groups. Outcomes measured by self-report were consistent

what features required improvement. Taken together, these data suggest how, with specific refinements, the case management model might improve outcomes associated with HIV prevention for this population.

PROJECT DESCRIPTION

Goals and Objectives

The overall goal of the HIV intervention was to determine the effectiveness of case management in reducing HIV-related, high-risk behaviors among heavy drug users who had been arrested, booked, and released. The outcome objectives for high-risk HIV behavior were the following:

- To decrease the use of unsterile drug injection equipment;
- To decrease unprotected sex with other than monogamous, HIV-seronegative partners;
- To increase use of drug treatment and self-help programs; and
- To decrease self-reported criminal activity and incarceration.

Specific process objectives were the following:

- To learn how best to conduct a case management intervention and
- To identify barriers to implementing a case management intervention and their solutions.

Profile of the Client Population

Project Sites. The populations for the project were drawn from jurisdictions where the courts, sheriff, and other criminal justice authorities would cooperate with the study, which included not interfering with recruitment or random assignment of participants or seeking sites' assistance with supervisory functions. An extended site selection process permitted documentation of the following site capacities:

- Sample sizes sufficient to detect program effectiveness;
- Experience in conducting followup studies or other evidence of an ability to maintain contact with the study population in order to achieve high followup rates;
- Expertise in providing case management to similar populations; and

- Experience in conducting behavioral research.

The Treatment Alternative to Street Crime (TASC) agency in Portland, Oregon, and the Bureau of Rehabilitation in Washington, D.C., met the above criteria and had long-established working relationships with the corresponding pretrial supervision agencies in their respective cities. Because TASC and the Bureau of Rehabilitation had ongoing contractual relationships with the criminal justice system, project interventions were delivered through new operational units that had no visible association with the criminal justice system or the parent organization. The operational units were given new agency titles.

In Portland, the TASC agency established the Rose Center, an office located near but clearly separate from local court and jail settings. In Washington, D.C., the Bureau of Rehabilitation, a local agency with decades of experience providing services to substance-abusing clients referred from the criminal justice system, established the Community Health Awareness Project (CHAP). CHAP's location was readily accessible to arrestees released from the District's combined court and lockup facility. The offices at both sites were on public transportation routes. They were designed to help participants feel comfortable, with lounge seating in waiting areas equipped with coffee, sodas, and snacks.

Demographic Characteristics of Participants. At both sites, nearly 700 arrestees, three fourths men, volunteered to participate in the study. In both cities, African Americans were represented proportionally higher in the study than in the criminal justice system population (Table 1). In Washington, D.C., almost all participants were African American; in Portland, one-third were African American. More than one-third of the recruits in both cities had not completed high school.

Substance Use History. Enrollment in the project was not restricted to injecting drug users; however, one-fifth of those recruited in Washington and over half of those recruited in Portland were injecting drugs in the month before they were arrested (Table 2). Among current injectors, 23 percent in Washington and 39 percent in Portland shared injection equipment. More than one-third of the Washington sample had injected drugs at some point in the past, as had two-thirds of the Portland sample. Almost half of those recruited in Washington and more than one-third of those recruited in Portland were using heroin, cocaine, or both, at least four times a week at the time of arrest; most other participants used drugs at least weekly.

Risk of Sexual Transmission. Only 7 percent of the Washington sample reported having high-risk partners (injection drug users), but another 10 percent were unsure of their partners' level of risk. Consistent with higher rates of drug injection in Portland, 20 percent of the sample had an partner who injected drugs. Another 6 percent had multiple partners whose level of risk was unknown. Nine percent of the Washington sample and 3 percent of the Portland sample indicated that they exchanged sex for money or drugs.

Table 1. Participant Characteristics

Characteristic	Washington, D.C.		Portland, Oregon	
	Baseline Participants (%) (n=673)	CJS Population[1] (%) (n=57,960)	Baseline Participants (%) (n=696)	CJS Population[2] (%) (n=21,445)
Gender				
Men	74	84	74	80
Women	26	16	26	20
Race/Ethnic				
African-American	95	81	34	25
White	3	18	51	57
Other/Unknown	2	4	15	18
Age (years)				
18-19	1	12	7	14
20-29	30	39	33	35
30-39	50	31	41	32
40-49	16	12	17	14
50+	3	6	2	5
Education		(n = 7,585)[3]		(n = 1,141)[4]
11 years or less	44	43	37	35
High school/GED	52	42	59	59
Bachelor degree	4	15	4	6

Notes: Percentages are rounded.
CJS refers to criminal justice system.
Sources:
[1] D.C. Metropolitan Police Department (preliminary figures)
[2] Oregon Uniform Crime Reporting
[3] Pretrial Services Agency of D.C.
[4] Drug Use Forecasting System (1990)

Half of the sexually active sample in Washington and 60 percent of the sexually active sample in Portland said that during the month before they enrolled in the study they never used condoms with any of their partners. These rates were the same for sexually active participants who either injected drugs or were sexually active with partners who injected drugs. Consistent with findings in other projects, 75 percent of sex workers in Washington and 55 percent of sex workers in Portland reported that they used condoms always; 17 percent in Washington and 24 percent in Portland reported that they used condoms sometimes.

Table 2. Drug Use and Injection During the Month Before Baseline

Drug Use and Drug Injection*	Washington, D.C. (n=673) %	Portland, OR (n=696) %
Heavy heroin (≥ 4 times/wk)	19	13
Percentage of heroin users also:		
Using cocaine/crack daily or weekly	66	57
Injecting drugs	84	95
Heavy cocaine/crack** (≥ 4 times/wk)	28	25
Injecting drugs	7	55
Weekly cocaine/crack** (≤ 4 times/wk)	35	30
Injecting drugs	6	4
Injected drugs	21	51
Users who shared needles	5	20

* Categories are mutually exclusive.
** Includes amphetamine use at same rate in Portland.

Criminal Activity. Self-reported criminal activity was similar in both cities. Participants said they had committed 13-14 crimes in the month before enrollment, yielding an average income for the month of $450-$500. Over half of these crimes involved drug dealing.

Service Needs. The populations in both cities had multiple needs, especially for employment, health care, counseling, and housing (Table 3).[1] Portland reported greater needs for psychiatric care, housing, and social support. A larger percentage of clients in Portland had a high composite need score (49 percent) than in Washington (24 percent).

Nature of the Intervention

Project Design. The interventions in this project focused on two sets of factors believed to be associated with behavioral change: 1) social support, including perceptions of peer norms favoring risk reduction and encouragement from others to change behavior; and 2) removal of practical barriers that might discourage behavioral change. Volunteers who agreed to participate in the project were assigned at random to one of three intervention conditions (Figure 1):

1. *Minimal intervention or "control" condition.* Participants viewed a videotape developed specifically for this population and received a guide to relevant services in their community. The videotape sought to motivate help-seeking behavior about drug use and HIV prevention through health promotion techniques consistent with the health belief model, social marketing principles, and social learning theory. It emphasized the existence of community support for behavior change in the forms of drug treatment, support groups, and self-help programs. (See Appendix A and Gross et al. 1992.)

2. *Intermediate intervention condition.* In addition to viewing the videotape and receiving the referral guide, each participant attended one face-to-face counseling and referral session with a referral specialist. The referral specialist completed a needs assessment, then recommended an action plan comprising a staged sequence of referrals tailored to the participant.

3. *Enhanced intervention condition.* In addition to viewing the videotape, receiving the referral guide, and attending the counseling session, participants were assigned for 6 months to the case management program.

Table 3. Need for Social Services Before Baseline

Service Need	Washington, D.C. (n=673) %	Portland, Oregon (n=696) %
Health	47	54
Psychological counseling	44	37
Psychiatric care*	36	47
Housing	29	49
Social support	24	35
Full-time employment	82	84
Income:		
$300 or less	35	38
$301 to $799	31	32
$800 or more	34	30

* Evidence of mental illness, based on Referral Decision Scale.

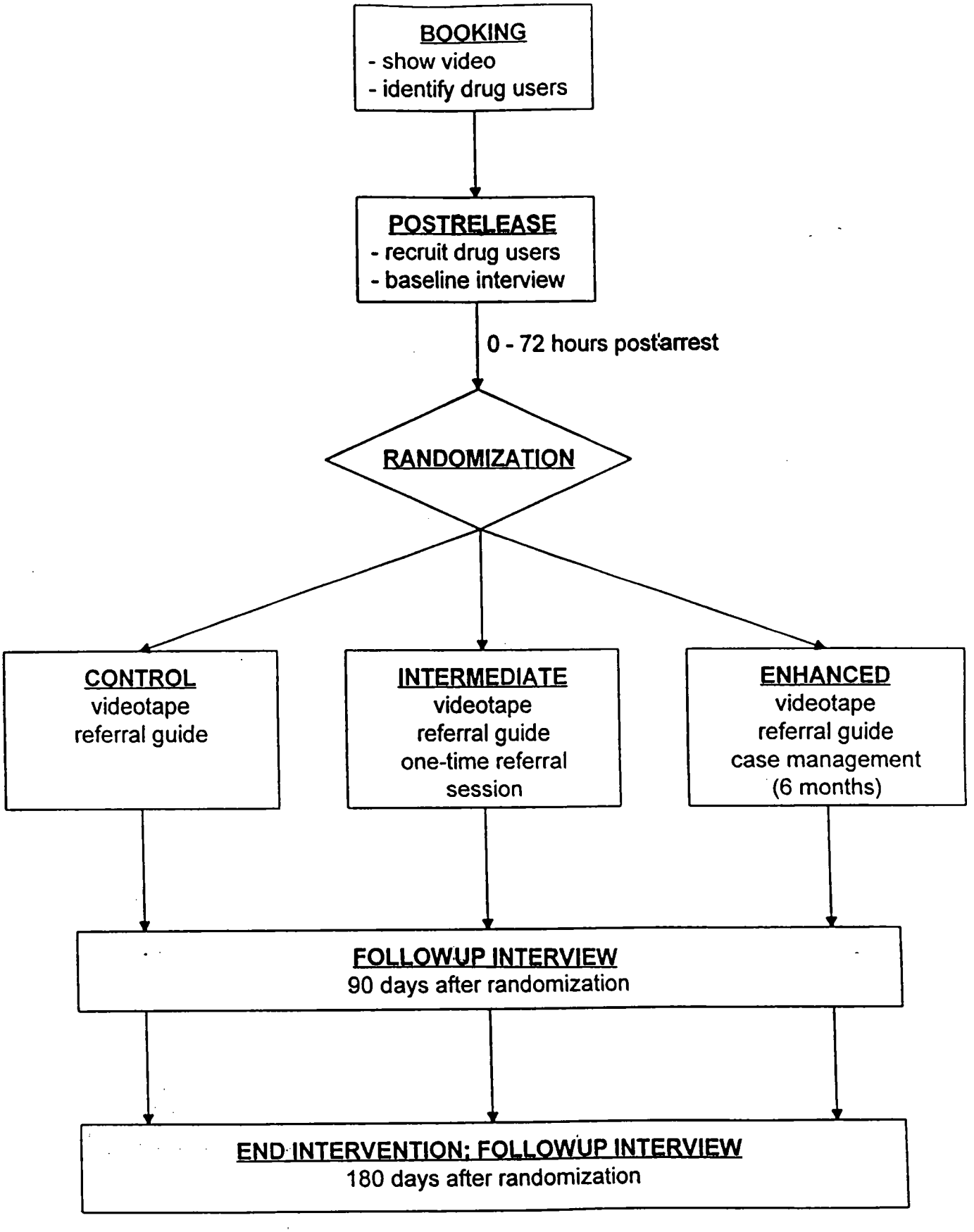

Figure 1. Process of Recruitment, Randomization, Intervention, and Data Collection

Project staff recruited substance-abusing arrestees (identified in Portland through self-reports and in Washington through urine analyses) as they were released from jail after booking[2] (Figure 1). Volunteers were asked to report to the project site for a full description of the program. After securing their informed consent and completing locator information forms, project staff conducted structured interviews with arrestees at baseline and 3 and 6 months later.

The purpose of the interviews was to learn whether behavior improved between the baseline and the third-month interviews, whether improvement was sustained between the third-month and sixth-month interviews, and whether improvement was greater for the case management group than for the other two groups. At the conclusion of the baseline interview, each participant was randomly assigned to one of the three experimental groups by a staff member who had no information about the results of the interview or knowledge of the client's level of HIV risk or other factors salient to the intervention.

At the conclusion of the project, researchers interviewed 33 case management clients and compared case files to their descriptions of the case management. Interviews by the case managers and by the other staff with six other arrestees not assigned to the case management group provided information about strategies, barriers to service delivery, support for behavioral change, and attitudes about HIV prevention.

Approach to Case Management. The design of key program elements relied on the experience and judgment of the agencies contracted to implement the projects in Portland and Washington, D.C. The contracting agencies were told to hire appropriate case managers; to identify qualified supervisory staff and arrange for staff training; to broker and monitor access to relevant services; and to provide adequate protocols and forms for conducting needs assessment, treatment planning, and clinical monitoring. The sites were given latitude in implementing case management consistent with their understanding of best practices. Nevertheless, their contracts stipulated minimal parameters, including:

- An average caseload size of 30 per full-time case manager. An average of two face-to-face contacts and two telephone contacts per month was established as a minimum level of service to each active participant.

- Required categories of community service providers with which to negotiate formal referral arrangements and agreements. Given constraints inherent in the criminal justice system, case management emphasized referrals to community agencies that could deliver comprehensive HIV prevention services. These included drug treatment programs, HIV counseling and testing sites, HIV prevention programs, and other key health and human service agencies (e.g., job training, employment counseling, medical clinics).

Because "compliance" was to be strictly voluntary, case managers were held accountable for preventing attrition of participants in case management and for their use of

referrals. That is, case managers were told that *a critically important part of their job was to engage clients in the case management process and to motivate them to seek help from appropriate sources*. Case managers were encouraged to be creative and were afforded wide latitude in the methods they could use. Program coordinators were encouraged to be flexible about making reassignments without blame if the first case manager assigned did not establish satisfactory rapport with the participant.

Staff

Sites were encouraged to hire case managers who could empathize with the client population and who had compatible racial/ethnic backgrounds. Minimal educational and experience credentials were not specified, based on the assumption that specific skill deficits would be addressed by in-service training and continuing supervision.

The project coordinator at each site was responsible for selecting and directing staff and ensuring consistency in case management and data collection. Other staff identified relevant social services, negotiated agreements, produced a referral guide, and evaluated local service agencies.

Half of the case managers in Portland and all case managers in Washington, D.C., had bachelor degrees; the remainder had completed high school. Many had social service experience in social work, probation, and drug counseling. Others came with hands-on experience in crisis intervention, AIDS education, or client advocacy. Three of nine case managers in Portland and one of five in Washington, D.C., acknowledged histories of drug or alcohol abuse; all had been in recovery less than 5 years. None of the case managers had a known criminal history.

Additional office staff at both sites included a receptionist, recruiters, interviewers, and social service coordinators. For many participants, the receptionist in each office became a key point of contact; these staff members were a consistent, highly visible presence. Recruiters were stationed at the jail, court, or pretrial supervision offices to identify potential study participants and provide them with information on the project. In Portland, the roles of interviewer and case manager were kept separate. In Washington, D.C., case managers conducted some interviews but never with their own clients.

PROJECT SUCCESSES

The principal outcome of interest in this project was decreased high-risk behavior associated with HIV infection, that is, reductions in unprotected sex with other than monogamous, HIV-seronegative partners, and in use of unsterile injection equipment. Additional outcome measures were decreased drug use, increased exposure to both drug treatment and self-help programs, and decreased recidivism as measured by self-reported criminal activity and time incarcerated during the followup period. The entire population of project participants seemed to adopt lower risk behavior across almost all measures,

irrespective of the intensity of intervention to which they were assigned. Broadly speaking, case management had a measurable impact on reducing drug use and criminal behavior. It was not demonstrably successful at reducing risky sexual behavior, however, and the evidence about improved needle hygiene is equivocal.

Participation Levels

The intervention group assigned to case management participated at a high level. Of the 229 participants assigned to case management at CHAP in Washington, D.C., only one had no contact with a case manager. Twenty-six percent met or exceeded the original goal of 24 contacts. Significantly more women than men received 24 or more contacts (36 percent versus 23 percent, respectively; $p = .05$). The majority (62 percent) had two or more contacts of some sort each month. Each of five case managers carried an average caseload of 33 participants, with a range from 30 to 42. In Portland, 94 percent (217) of all case management participants had at least one case management session; 35 percent had two or more contacts a month. Maximum caseloads ranged from 10 to 40 clients per case manager, with an average case load of 22.

Both programs were more office based than expected. In Washington, D.C., only 17 percent of all face-to-face contacts with case managers occurred outside the office; in Portland, 11 percent occurred outside the office. A case manager physically accompanied a participant to a referral site in only 2 percent of contacts at either program. On the other hand, the availability of case managers at the project office made it feasible to encourage drop-in visits by clients, a flexibility they seemed to value.

Of the 228 individuals assigned to case management in Washington, D.C., three-fourths or more received at least one referral to each of the following: HIV testing, employment, alcohol and drug abuse treatment, and self-help groups. More than 90 percent of CHAP participants received at least one referral to drug or alcohol abuse self-help groups and drug and alcohol abuse treatment programs (Table 4). Of the 217 case management participants at the Rose Center in Portland, Oregon, 52 percent were referred to drug and alcohol abuse treatment (Table 5). The next most frequent referrals were to employment-related services (45 percent), housing assistance (39 percent), and financial assistance (35 percent). When participants resisted taking advantage of referrals because of previous negative experiences with social service agencies, drug treatment services, and criminal justice agencies or logistical impediments, case managers continued to meet with them to help them evaluate earlier experiences and barriers, reinterpret them, and renew their motivation to get help.

Outcomes Related to HIV Prevention

Because the Washington, D.C., sample had few needle users, changes in needle use practices were examined only in Portland. All participants reduced needle sharing and

Table 4. Washington, D.C.: Case Management Participants Referred by Service Category

Service Category	Percentage of Clients (n=228)
Self-help group	91
Drug/Alcohol treatment	90
Employment	73
HIV testing	72
Medical	64
Education/Training	63
Legal	56
Housing	54
Financial	49
HIV/AIDS prevention and education	27
Psychological counseling	25
Social/Recreational	21
Dental	12
Contacts with no specified referral	86
Miscellaneous (e.g., child care, transportation, and paperwork)	48

increased needle cleaning (Table 6). Case management participants were most likely to increase needle hygiene, but the sample was too small to establish statistical significance.

In both cities, significantly fewer participants reported multiple partners between baseline and followup interviews (Tables 6 and 7). Sexually active participants appeared to increase their use of condoms in Washington, D.C., but not in Portland. Case management was associated with no additional incremental reduction in sexual risk behavior.

Outcomes Related to Drugs and Crime

All participants reduced their drug use, many dramatically, and increased participation in drug treatment (Tables 6 and 7). Case management participants reduced drug use to a greater extent than participants assigned to the other two intervention groups in both cities (Figures 2 and 3). In Washington, D.C., case management participants were significantly more likely to be in a drug treatment program based on self-reports (Figure 4). In Portland, self-reported enrollment in treatment was not measurably greater for case management participants (Figure 5), except for the subgroup of clients who received higher doses of case management. (Dose was measured as the number of contacts with case managers.) Compared with public treatment records, entry into treatment is overreported by all Portland

participants.[3] On the other hand, treatment enrollment records show that, self-report notwithstanding, case management participants were more likely than others to receive treatment.

Table 5. Portland, Oregon: Case Management Participants Referred by Service Category

Referral Target	Percentage of Clients (n = 217)
Drug/Alcohol treatment	52
Employment	45
Housing	39
Financial	35
HIV testing	24
Education/Training	23
Self-help group	22
Medical	20
Psychological counseling	20
Legal	16
Dental	12
HIV/AIDS prevention and education	12
Social/Recreational	5
Contacts with no specified referral	92
Miscellaneous: (e.g., child care services, pediatric medical care, transportation agencies, detoxification programs, assistance with obtaining birth certificates and other paperwork, assistance with resume writing, providing referral letters, jail visits, receipt of social services information/ literature, and receipt of bus tokens)	56

Participants in this project, many of whom were under criminal supervision for part of the period of enrollment, reported dramatic reductions in illegal activity compared to the prearrest period (Tables 6 and 7). Case management participants reduced their criminal behavior and their self-reported time in jail more than other participants (Figures 6 and 7). In Washington, D.C., the reported reduction in criminal involvement was corroborated by criminal justice system data showing that case management participants were less likely to be rearrested than were other participants. For Portland, secondary data from the Oregon Justice Information Network show no difference across intervention groups with regard to rearrest or reincarceration. However, those data appear to be incomplete: 16 percent of the project sample could not be matched with these records for the corresponding period.

Magnitude of the Impact

If measured outcomes accurately reflect the impact of case management, the reported

reductions in heavy drug use are significant. During the followup period, heavy drug use was reported by an estimated 23 percent of the case management participants and 30 percent of the other participants in Washington, D.C. In Portland, approximately 30 percent of the case management participants reported heavy drug use during the followup , compared with approximately 35 percent of the other participants. These success rates are comparable to results for outpatient drug-free treatment. For 6 months of services, case management costs approximately $2,400 per arrestee in Washington, D.C., and $1,800 per arrestee in Portland,[4] which is comparable to the average cost of an episode of drug treatment ($2,640), although more costly than outpatient treatment only ($790).[5]

Extensive analyses were performed to determine whether case management increased the use of services. Referrals offered to individual case management clients were not strongly correlated with needs reported on the baseline interviews. Use of services other than drug treatment was not significantly greater for case management participants than for participants assigned to the less intense interventions.

Table 6. Behavior Change and Case-Management Impact, Portland, Oregon

Target Behavior	Prevalence at Baseline (%)	Prevalence* at 6 months (%)	Impact of Case Management	
Substance abuse related				
Heavy drug/alcohol use	76	27	?	(p=0.10)
Drug treatment	22	38	X	
Needle sharing	39	27	X	
Always clean	26	38	X	
Never clean	39	27		
Sexual risk				
Multiple partners	21	11	X	
Never use condoms	42	33	X	
Crime-related				
Illegal activity	60	25	✓	(p=0.05)
Rearrest		25	X	

* All changes from baseline to 6 months are significant for the cohort as a whole except for the "never clean" needles outcome among those share (n=164). Exposure to treatment is measured by public records and agrees with self-report only when dose of case management is considered in estimating the impact of case management.

? denotes a trend that does not reach statistical significance.

X denotes no significant change.

✓ denotes statistically significant change.

Table 7. Washington, D.C.: Behavior Change and Case Management Impact

Target Behavior	Prevalence at Baseline (%)	Prevalence at 6 months (%)	Impact of Case Management	
Substance abuse related				
Heavy drug/alcohol use	86	23	✓	($p = 0.01$)
Drug treatment	13	27	✓	($p < 0.04$)
Sexual risk				
Multiple partners	29	12	X	
Always use condoms	37	57	X	
Crime-related				
Illegal activity	62	14	✓	($p = 0.05$)
Incarceration		18-27	✓	($p = 0.05$)

* All changes from baseline to 6 months are significant for the cohort as a whole except for the "never clean" needles outcome among those share (n=164). Exposure to treatment is measured by public records and agrees with self-report only when dose of case management is considered in estimating the impact of case management.

✓ denotes statistically significant change.

X denotes no significant change.

The statistical results may understate the effects of case management on behavior. First, a tendency to underreport socially undesirable behaviors during the baseline interview or the 6-month interview would tend to underestimate any improvements specifically associated with case management.[6] Second, case management tends to keep people out of jail, so that reductions in drug use or criminality among clients without case management could result in part from lack of opportunity for criminal activity and possibly drug use. Similarly, opportunities for participants without case management to commit crimes and to engage in targeted high-risk behaviors during the reference period just before the interview may have decreased during the period of interest if they were reincarcerated. Third, random assignment to the case management group included participants who clearly are unsuitable for case management services; therefore, the success rate among self-selected clients might be higher than in this experiment.

This project achieved positive effects on drug use, drug treatment, and recidivism despite a variety of obstacles and limitations. These results lay important groundwork for integrating a public health approach into a criminal justice setting. Case management may have played an effective part in improving retention in those services that the participants used or in improvement in the use of the services. The importance of case management

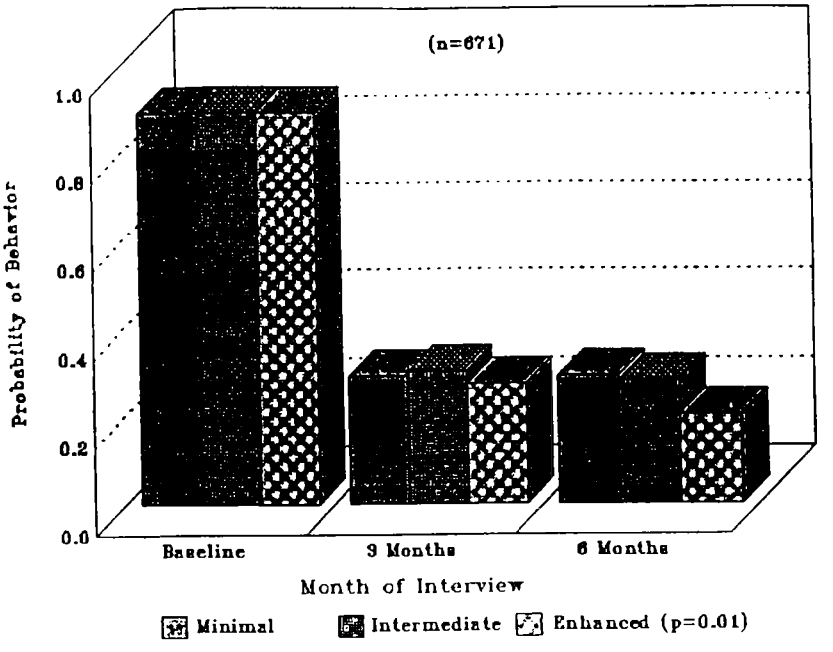

Figure 2. Washington, D.C.: Probability of Heavy Drug Use

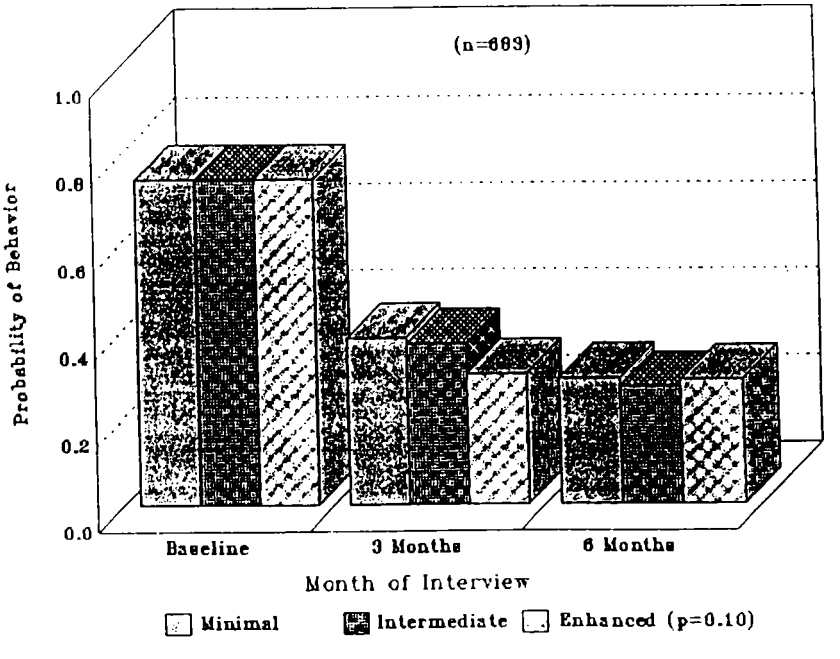

Figure 3. Portland, Oregon: Probability of Heavy Drug Use

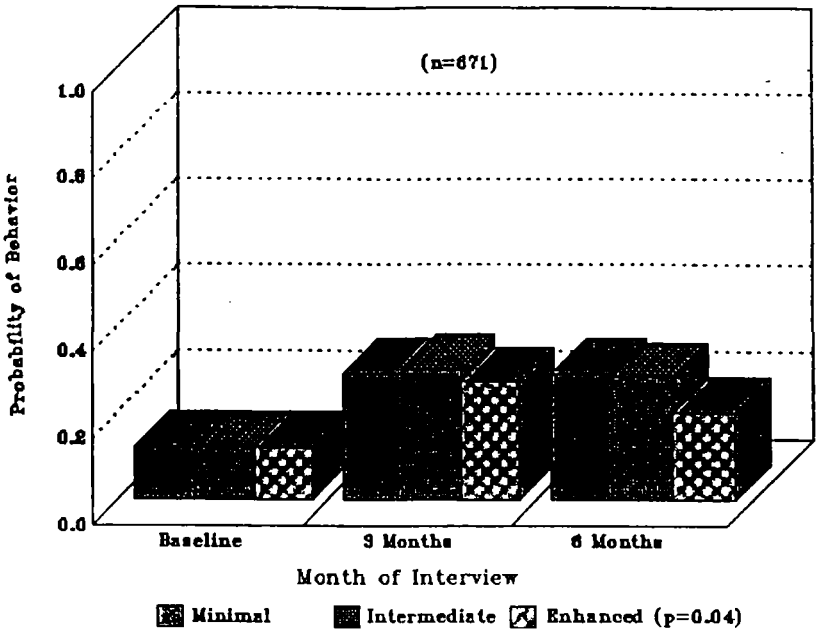

Figure 4. Washington, D.C.: Probability of Being in Treatment

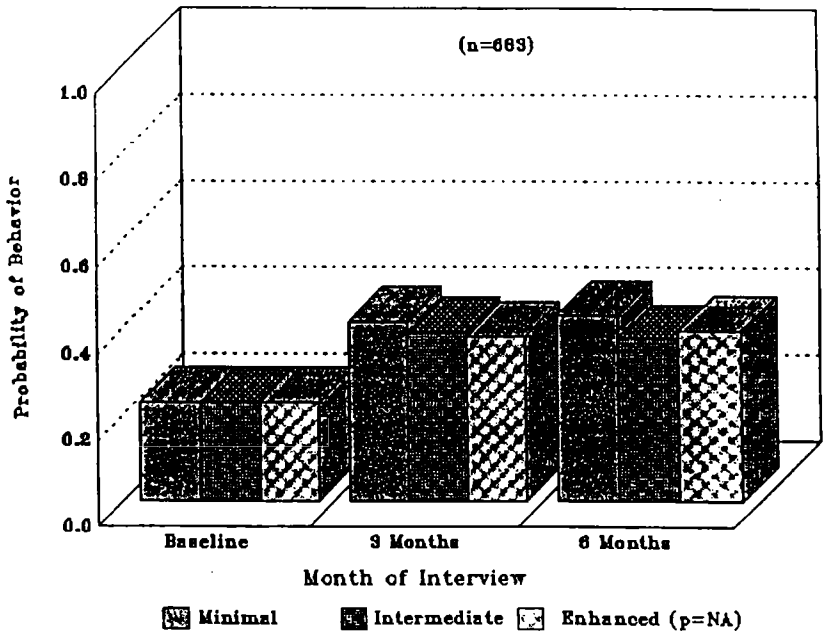

Figure 5. Portland, Oregon: Probability of Being in Treatment

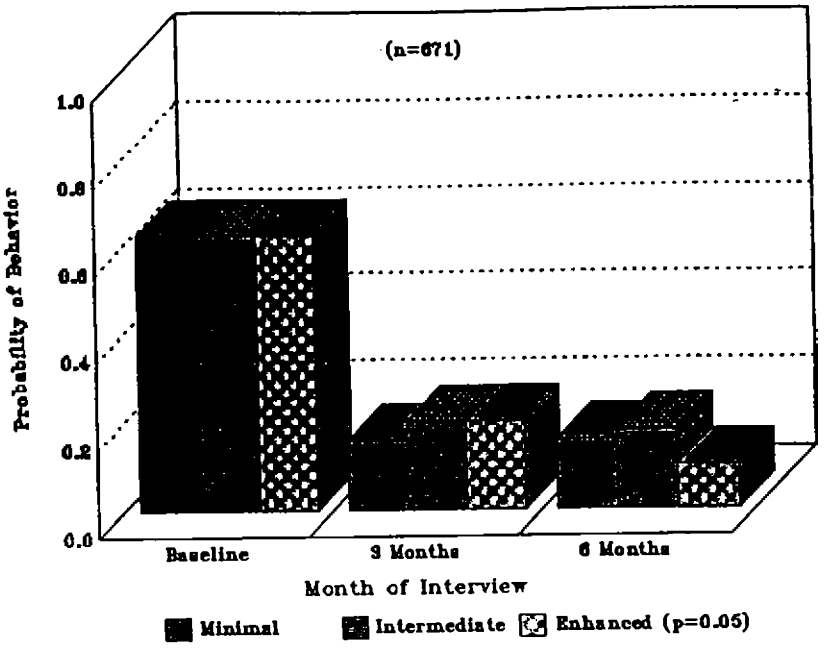

Figure 6. Washington, D.C.: Probability of Criminal Activity

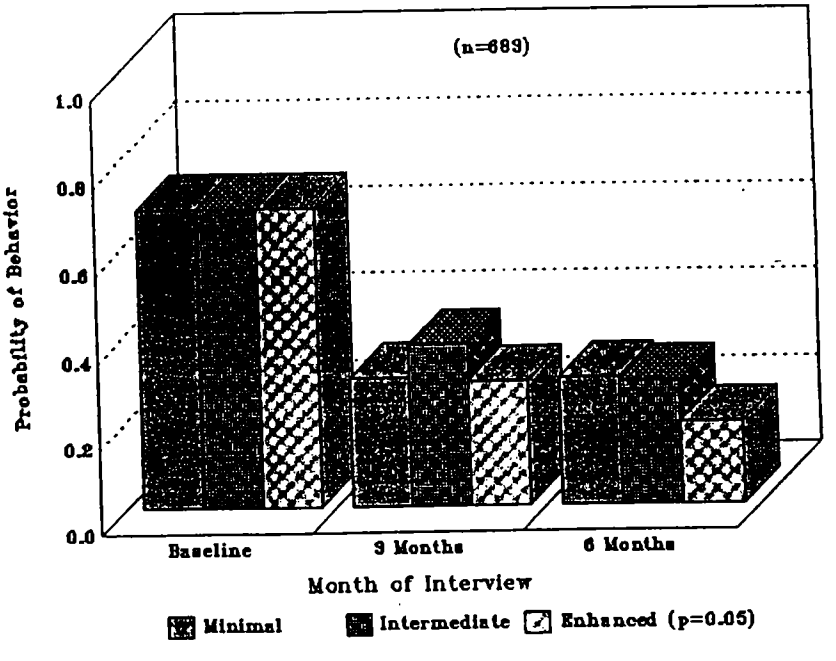

Figure 7. Portland, Oregon: Probability of Criminal Activity

might have less to do with making referrals and may be more a function of helping to solve problems associated with receiving services (e.g., practical concerns such as transportation and child care and attitudinal problems arising from contact with less responsive agencies or less empathic providers). The absence of critical services such as adequate HIV prevention programming in a community may also be addressed through case management. Evidence suggests that case management as practiced in these two sites fulfilled these roles and did not operate exclusively by linking clients to services, although a more sensitive needs assessment and systematic surveys of provider agencies would have been valuable to clarify this issue.

Long-term, in-depth case history interviews of case management participants contain ample testimony of the importance of the case manager's role in motivating efforts at self-improvement. Important dimensions of that role include providing support during periods of crisis, enhancing clients' self-esteem by emphasizing their past accomplishments and current strengths, and encouraging sustained improvement without blaming or recriminating participants when they relapse. Even individuals who participated infrequently expressed favorable attitudes about the relationship with their case manager, reflecting the value of talking to someone who cared. Development of rapport between staff and participant became a catalyst for behavioral change.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

Inasmuch as case management did have an impact on drug- and crime-related behaviors, refinements of the case management approach might improve those outcomes and might increase the likelihood of an impact on HIV-related risk behaviors. During the implementation process, a number of barriers were encountered and overcome, resulting in initial refinements of the approach.

Setting and Condition of Prospective Participants During Recruitment

Although the period following booking and release is the time when the recruitment pool is largest, interventions with an arrested population pose procedural problems. An intensive intervention cannot be carried out in the jail environment because facilities are seldom designed for either group education sessions or confidential interviews. Booking and release usually occur within 2 or 3 days and often on the same day. During that period, arrestees often are inebriated or in withdrawal and otherwise suffering from the stress of incarceration. Some topics seem unsuitable for a jail environment. For example, teaching needle-cleaning techniques or safe sex practices runs counter to the criminal justice message that drug use and prostitution are illegal. Thus, lockups and booking facilities were used in this project as points of contact with prospective participants, but the interventions occurred in the community. As a result, case managers were perceived as unlike "typical" parole or probation officers, but as "friends" who could be trusted with information about illicit behavior. These programs had an identity as "new agencies," without overt associations with the criminal justice system, which apparently increased their appeal.

Agencies with reputations for conducting criminal justice system supervision may have difficulty separating the coercive components of the criminal justice system and the supportive and trust-related aspects of case management. On the other hand, the combination of capabilities and experiences— working in the context of the criminal justice system, familiarity with addiction and drug treatment modalities and services, experience working with the affected demographic groups, and knowledge of HIV prevention strategies—may be difficult to find in a community-based agency.

Voluntary Participation in Services

Even the parent agencies doubted that volunteers would participate in case management without sanctions for noncompliance or material incentives for compliance. Open-ended case study interviews suggest that the absence of criminal sanctions actually strengthened the rapport between participants and providers by helping case managers convince participants of their authentic concern.

Case managers developed flexible and creative approaches for engaging participants, including the following:

- Eliciting participants' interests and favorite activities (such as sports, music, their families) and then engaging them in conversation about those things;
- Contacting participants by telephone or by mail to show continuing interest in their progress and to keep them informed about developments in the community that might be beneficial to them;
- Developing a telephone relationship with friends and family of participants when the participants were unavailable to respond to the call;
- Mailing special announcements (about job or training possibilities) and personal notes (e.g., for birthdays); and
- Meeting participants at their homes or in the community, visiting them in jail, taking them to lunch on occasion, and personally accompanying them to agencies.

Concern About Confidentiality and Usual Reporting Requirements

Although the intervention programs recruited from the criminal justice system, they did not provide the criminal justice system with any information about their clients. Local officials were concerned about this prohibition against releasing information about clients' positive accomplishments to criminal justice system authorities. Their concern was addressed by pointing out that referral agencies could provide such information.

Inadequate Staff Training and Instability of Supervisory Staffing

Several factors suggest that training and stability of clinical supervision of service delivery staff need to be taken seriously. Problems attributable to inadequate training and supervision include unevenness in the delivery of services and episodes of dysfunctional staff behavior (e.g., bickering, hostility, and inappropriate personal relationships between staff and clients).

Instability associated with management changes and two periods of uncertainty about continuity of funding led to staff turnover. In Portland, three different individuals served as full-time project coordinators (one of whom resigned during the initial start-up period). Reassignment of case managers to other duties necessitated the hiring of additional staff. Over the life of the project, nine individuals served as case managers in Portland and six in Washington, D.C.

Testimony from case managers at both sites about staff dissension and burnout suggests that case management projects must devote attention and resources to supervision and staff support. Periodic review and revision of treatment or "action" plans and insistence on a carefully planned termination process are minimal requirements. Given the fluidity of the case manager role and the value in case managers relaxing some of the traditional provider-client boundaries (e.g., by meeting with clients outside the office or by working to build rapport through self-disclosure), clinical supervision assumes an even more important role. Factors such as productivity and record keeping are valid indicators of job performance and appropriate considerations for managerial oversight of staff performance. Qualitative aspects of job performance (*e.g.*, thoroughness of assessment, comprehensiveness of treatment planning, and appropriateness of referrals) should be addressed in the context of a clinical supervision process that is clearly distinguished from administrative management.

Also, to provide effective HIV prevention counseling, less experienced staff require substantial training on routes of HIV transmission, techniques of HIV prevention education and counseling, strategies for counseling clients with HIV infection, and clinical issues in the client-case manager relationship.

Targeting the Duration and Recipients of Treatment

An arbitrary increment of 6 months may not be the optimal duration for this or other approaches to reducing HIV risk behavior. For some individuals, the period is too long; for others, too short. A high proportion of participants reported histories of psychiatric hospitalization or other indications of mental illness. These individuals may require long exposure to intensive case management, combined with professional mental health services, in order to achieve any meaningful improvement. In severe cases, dealing with such clients may be beyond the means of case management programs. Other individuals, well served by a relatively brief initial period of intensive case management to help them get back on their feet may benefit from further case management services on an as-needed basis thereafter.

In addition to a more flexible and responsible method for assessing the appropriate duration of treatment, future projects might consider developing methods to focus resources on those participants most likely to benefit from case management. Qualitative findings suggest that persons who benefit most from intensive case management are those who are motivated to change, who are able to sustain prosocial and stable lifestyles at least for intermittent periods, and who lack current access to social support. Development of an effective screening method to identify such individuals would contribute to more efficient use of limited resources.

Program or Service Termination

Many case management participants were disappointed when informed that their case manager was closing their case and ending their participation in the program. Both sites had official policies about termination, but these policies were carried out erratically. Termination must be integrated into treatment planning and thoroughly discussed with clients to assure that gains made through program participation are not threatened by the abrupt end of service provision.

MAINSTREAM ISSUES

Limitations Imposed by the Criminal Justice System

Traditional probation and parole can be considered a form of case management (Rothman 1971). Case management within the criminal justice system has a surveillance as well as a supportive role, but it may be associated with pretrial supervision and a variety of correctional programs for community-based supervision. The goal of probation to reduce criminal activity differs from the goal of decreasing high-risk behaviors associated with HIV infection, which may be best achieved by linking participants to community HIV prevention programs through case management.

Unfortunately, the criminal justice system presents some restrictions that seriously limit program design for HIV prevention. As a condition of funding, the Justice Department prohibited needle-hygiene instruction and required promotion of sexual abstinence or mutual monogamy as instruction on safer sex. Given that restriction, the only way to provide sustained counseling and education for HIV risk reduction was to link participants to community programs that could deliver comprehensive HIV prevention counseling. Consistent with the criminal justice system's emphasis on refraining from illicit behavior and a program philosophy at the project sites that other behaviors would not change until addiction was addressed, both programs emphasized elimination of drug use as a means of reducing HIV risk behavior. However, while effective at reducing heavy drug use, this strategy had no significant effect on HIV risk behavior.

This approach to HIV prevention was too indirect to be effective for three reasons. First, recovery is a fragile achievement and relapse is common. Second, participants do not

always follow up on referrals. Third, the community may not have adequate HIV prevention programs for this population.

Given the opportunity, adequate training, sufficient direction, and consistent supervision, case managers are well positioned to provide sustained counseling about reducing risk of HIV infection through education about injection drug use and sexual risk. Although the integrity of the criminal justice system is a concern, these projects established that a clear boundary can be maintained between case management and the supervisory activities of the criminal justice system. Such a separation should allow a relaxation of restrictions on the content and approach of semiautonomous programs conducted under criminal justice system auspices to permit a more direct and comprehensive HIV/AIDS intervention.

HIV prevention counseling should be individualized. Because the case management process leads to a comprehensive picture of the individual's life situations, crafting such tailored HIV counseling and education is possible. Thus, a case manager working with a client attempting to remain abstinent from drugs would reinforce that intention and would not emphasize instruction in needle hygiene or access to needle-exchange programs unless there was a significant likelihood of relapse. In contrast, for clients not motivated to reduce their injection drug use, case managers might continue to emphasize the possibility of drug treatment while ensuring that these clients are aware of methods to prevent parenteral transmission of HIV. With regard to sexual risk reduction, similarly tailored messages might be delivered, in which case managers affirm that abstinence or mutual monogamy with an uninfected partner are the surest means to prevent sexual exposure to HIV but counsel clients with multiple unknown or high-risk partners about how to use condoms effectively.

Scarcity of Services and Opportunities

In 86 percent of CHAP contacts and 92 percent of Rose Center contacts, case management contacts did not involve a referral . On those occasions, case managers met with the participants to discuss their status, changing needs, and progress in finding assistance. Such conversations were especially likely when an appropriate service provider could not be identified. For instance, when drug treatment slots were full, case managers continued to meet with participants to plan alternative strategies or to discuss ways of coping until participants could make other arrangements.

Inevitably, the effectiveness of case management is limited by the availability of services and opportunities in the community. For example, it is difficult to persuade clients to enter job training programs in settings where high rates of unemployment exist. And few cities have enough inpatient substance abuse treatment slots subsidized by public funds. Drug treatment was not the only service for which demand outstripped supply, but also psychiatric and dental care. In those situations, case management in effect becomes "waiting-list management."

EVALUATION METHODS

Data Collection

Process forms were completed from case management records at every contact (telephone and face-to-face) between project staff and all participants (including case managers or others). These one-page forms recorded referral targets, location of contact, whether the referral appointment was scheduled in advance, and intensity of the referral as measured by whether the case manager made a referral, called the referral on the participant's behalf, or accompanied the participant to the referral.

Observers for each site made impromptu visits, certified that participants were assigned randomly, reviewed forms for data accuracy and completeness, inspected case management files for evidence of breadth and depth of service delivery, observed staff meetings, and interacted informally with project staff. On-site monitoring provided early warning of operational problems such as deficient rates of recruitment, inconsistencies in or misunderstanding of certain items on the interview forms, noteworthy inconsistencies in performance among service delivery staff, and insufficient followup rates. Other members of the research staff frequently visited the Portland and Washington sites.

At the conclusion of the project, evaluators completed a total of 33 open-ended case study interviews with case management clients and 10 such interviews with arrestees assigned to the other two groups. These interviews focused on the context and consequences of the incident arrest and, for case management clients, on incentives and disincentives to participate, the nature of the case management relationship, and factors that may have facilitated or inhibited case management effectiveness. Evaluators examined these participants' case files to compare their descriptions of the process with the case managers' documentation of the course of treatment. Researchers completed open-ended interviews with all case managers and project staff. These interviews focused on philosophies of case management, case management strategies, barriers to service delivery and supports for behavioral change, and attitudes about HIV.

Secondary data about program participants and about similar arrestees who did not participate in the project were analyzed for validation of and comparison with the outcome data. For Washington, D.C., the analysis used criminal histories and drug test data following arrest and release from jail for 7,585 arrestees. For Portland, the analysis used similar data on criminal histories ($n = 1,408$) and data about substance abuse treatment following arrest and release from jail ($n = 331$). The project did not require urine testing for several reasons. Maintaining both the fact and the appearance of a strict separation from the criminal justice system was essential, and participants associated urine testing with criminal justice system supervision. In addition, urine testing is an indicator of recent drug use but cannot reveal the duration or intensity of drug use. Finally, if urine testing were voluntary, it could introduce self-selection among participants who otherwise are willing to answer interviews.

Baseline and Followup Interviews

To measure change, the researchers used repeated measures on an instrument designed expressly for this project. By 1991, researchers sponsored by National Institute on Drug Abuse had gained considerable experience interviewing injection drug users and their sexual partners about HIV-related behaviors (Brown et al. 1993, NOVA Research Company 1992) in the context of the a National AIDS Demonstration Research program of community-based outreach demonstration projects. They modified previous instruments, given concerns about reliability and response rates,[7] and added scales to measure other factors relevant to the program and evaluation: social desirability (scales designed to measure a respondent's propensity to deliver socially desirable responses to questions); service needs; and attitudes regarding help-seeking, drug treatment, and HIV preventions.

Data Concerns

Two concerns arose in considering the conclusions about the impact of case management: 1) the lack of data about service use (systematic spot checks, period surveys of key target agencies, or clinical record abstractions) and 2) the lack of information about the extent to which case management sessions included elements other than referrals, such as assessment, treatment planning, advocacy, and generalized drug counseling. Given the importance of sessions devoted to issues of motivation and support, other programs might consider how to document those areas of case manager attention, perhaps by asking case managers to record topic areas such as self-esteem, social relationships, and motivational obstacles to seeking help.

The project identified the need for a protocol to guide new staff as they joined the projects and the use of interim findings to offer valuable feedback for the site coordinators, clinical supervisors, and case managers. Barriers to implementing the model that were not apparent when it was designed might have become evident, such as the absence of adequate HIV prevention interventions in the community. These observations also would have called attention to the need to document and possibly expand the services that were proving particularly useful to clients, such as motivational counseling or help with resume writing.

DISSEMINATION OF THE PROJECT CONCEPT

To make wider audiences aware of the videotape developed for this project, a descriptive account of its production was published in the *Journal of Drug Education*. The National Institute of Justice has reprinted that article and has distributed it to a 400-member mailing list of criminal justice officials in the National Criminal Justice Reference Service (NCJRS) database, which includes administrators of drug treatment programs, jail administrators, and sheriffs who run jails. Copies of the videotape in either English or Spanish version may be ordered through NCJRS at (800) 851-3420.

Major findings on the impact of case management were reported during an oral presentation at the November 1994 annual meeting of the American Public Health Association. With cosponsorship by the National Institute on Drug Abuse, the National Institute of Justice plans to publish an issue of its "Research in Brief" series describing the design and results of the project. In addition, the *NIJ Journal*, with a circulation of 60,000, will include in a future issue a one-page summary of the project and the videotape. These publications will reference the availability through NCJRS of both the videotape and, once approved, the final report of the National Institute of Justice on the project. Upon approval of the final report, one or more papers will be prepared and submitted to peer-reviewed journals.

NOTES

1. The statistics appearing in Table 3 are from scales based on participants' responses to the baseline interview. Some scales are simple indications of unmet needs, but most are based on factor analysis, latent variable construction, or extant instruments. (See M Gross, W Rhodes, C Conly, M Mason, L Truitt, T Enos, P Scheiman, and S Langenbahn: *AIDS/HIV Education in Lockups and Booking Facilities*, report submitted to the National Institute of Justice and the National Institute on Drug Abuse, May 13, 1994.) The scale cut-off, on which table 3 is based, is subjective; other cut-off criteria would show participants to be somewhat more or less "needy." It is doubtful, however, that any reasonable cut-off criterion would fail to show that these arrestees have high latent service demands.

2. Candidates were informed that the project sought volunteers for a study of people with substance abuse problems, and that the candidates would be compensated for their participation in three interviews designed to understand their life circumstances and to determine how to help others like them. They were also informed that they would be randomly assigned to one of the three research groups. (Arrestees in both sites were compensated for their participation in the baseline, 90-day, and 180-day interviews. In Washington, D.C., participants received $20 for each interview; in Portland, they received $15 for the baseline and 90-day interviews and $30 for the 180-day interview.)

Candidates were reassured that their participation was completely voluntary and would have no effect, helpful or harmful, on their pending court cases. To support that claim, a certificate of confidentiality and court orders from each jurisdiction protected from subpoena project-related information about participants. After giving informed consent to participate, newly enrolled subjects answered questions that would help project staff locate them. [Recruits provided information on the following: name, nickname, sex, race, age, date of birth, court identification number (later confirmed using court records), social security number, lawyer's name and phone number, home address and phone number, work address and phone number, alternate address and phone number, and other important contacts and their phone numbers.] Those who agreed to participate were scheduled for a baseline interview, after which they received their intervention assignment.

3. It is, of course, entirely possible that various forms of intervention were considered to be treatment. The interview distinguished between treatment and self-help or 12-step programs. However, communities typically have a diversity of agencies and individuals who provide services they define as drug treatment. The public treatment data corroborate that study. Participants who report increased drug treatment are not referring to the case-management services provided by this project (in which case managers did counsel their clients about substance abuse to varying degrees in the context of referrals to treatment).

4. These figures are based on the operating budgets for the two sites. They include labor and other direct and indirect costs for case management. Arbitrarily, half of the cost of program administration was attributed to case management operations, the other half to research-related administration. All social service and clinical supervision and nonresearch-related training expenses were attributed to case management. Occupancy was allocated by the fraction of total personnel costs associated with case management relative to total personnel. Direct costs for case management included half of all duplication costs and all expenses for refreshments and transportation assistance, but none of the costs for interview stipends (paid in three increments over a period of 6 months to all research participants). The difference in costs for case management in Washington, D.C., and Portland is almost directly proportional to differences in the average annual salaries of case managers in the two cities. In addition, occupancy and indirect costs were lower in Portland (while research-related costs for recruitment and arrestee tracking were higher).

5. According to the Drug Services Research Survey (Batten et al. 1991, Table 38), drug treatment costs an average of $2,640 per client ($790 per client for outpatient drug-free treatment). The report's authors warn that these are charge data for clients who were billed the full amount for services, not cost data, and they may differ from cost data. Thus, the costs of case management are in the same range as the costs for substance abuse treatment, although case management is somewhat more expensive than outpatient drug-free treatment. Also, the costs of formal drug treatment must be added to the costs of case management for case management arrestees who entered substance abuse treatment. Thus, estimates of case management costs understate the true costs of "treating" drug users.

6. Suppose that 20 percent of case management participants report heavy drug use during the followup , while 25 percent of the other participants report heavy drug use during the same time. The apparent effectiveness of case management is 5 percentage points. However, if only half of all participants tell the truth about heavy drug use, the difference would be 10 percent rather than 5 percent. The effectiveness of case management is greater than it appears.

7. AIDS Outreach to Pregnant Women and Their Children (Gross et al. 1992) in two sites, AIDS Outreach to Female Prostitutes and Sexual Partners of Injection Drug Users (Hammett et al. 1992) in three sites, and Evaluation of an AIDS Outreach and Prevention Program for Injection Drug Users not in Treatment and Their Sexual Partners (Finn et al. 1992).

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AUTHORS

Michael Gross, Ph.D.
Senior Analyst
Abt Associates
4800 Montgomery Lane
Suite 600
Bethesda, Maryland 20814

William Rhodes, Ph.D.
Senior Scientist

Catherine Conly
Tammy Enos
Theresa Mason
Linda Truitt

Abt Associates
55 Wheeler Street
Cambridge, Massachusetts 02138

APPENDIX

Drugs and AIDS — Reaching for Help: A Health Promotion Videotape for Criminal Justice Populations

This 27-minute videotape* uses a drama-based approach to influence behaviors of inmates in jails, lockups, and booking facilities. The videotape depicts both criminal sanctions for illicit drug use and the results of advanced HIV disease. Its real emphasis, however, is to encourage viewers to link with resources in their own communities.

The videotape presents three stories about people whose lives have been seriously affected by drug abuse, who have experienced multiple brushes with the law, and who have in some way been affected personally by AIDS or HIV infection. The stories emphasize the complementary roles of formal treatment and informal support from self-help programs, friends, and family in dealing with addiction and HIV prevention. Personal stories portray abandoning a criminal lifestyle as a positive step, one that restores physical and spiritual well-being, builds self-esteem, reinforces positive connections with family members, and sets the stage for further life-enhancing opportunities. Consistent with the emphasis on seeking help from others, the videotape concludes with a list of resources for finding assistance in one's own community.

After an initial script was written and recorded, edited audiotaped segments were synchronized with appropriate images and transferred to videotape for a pretest version. For this pretest, 14 focus groups, with an average of 12 participants per group, were conducted in Chicago, IL, Phoenix, AZ, and Prince George's County, MD. Focus groups suggested that the final version of the videotape place greater emphasis on the importance of condom use, the impact of HIV status on life, and the difficulty of finding effective drug treatment and persisting at it.

The videotape integrates the message that incarceration is a constant threat in the lives of many addicts. Each story also addresses susceptibility to HIV through sexual exposure. Especially important are the vivid and emotional renderings of the treatment process, particularly group meetings and self-help sessions. Although the videotape is frank about the difficulties to be encountered in trying to free oneself of addiction, it emphasizes throughout that social support can be found and that success can be achieved.

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*The videotape can be ordered from the National Institute of Justice/National Criminal Justice Reference Service, Box 6000, Rockville, MD 20850, phone (800) 851-3420. Other videotapes developed on AIDS prevention used a drama-based approach to promote risk reduction, such as "Olga's Story" and "Alicia" (both distributed by Modern Learning Aids, St. Petersburg, FL) but productions using this approach had not been designed for persons under the supervision of the criminal justice system.

The videotape also acknowledges obstacles, for example, treatment failures occur, effective treatment may be difficult to find, and staying with a treatment program requires hard work. Conditions that maximize the chances of success, such as strong social support, are accentuated. Participation in groups and meetings and recreational activities with drug-free friends are depicted as a part of the fabric of a rewarding, drug-free life. Presenting characters similar to the viewers themselves supports the belief that success in treatment is within reach with sufficient motivation and social support.

Drug treatment specialists and people in recovery have endorsed the approach in the videotape, noting that it is essential to convey positive reasons for embracing a drug-free lifestyle and to give people the conviction that when they reach for help, recovery will be within their grasp. Many jail and prison officials have reacted favorably to the videotape. However, some officials who viewed the pretest videotape discounted its approach because it did not depict graphic portrayals of people suffering withdrawal symptoms in jail and hard-headed, no-nonsense messages that AIDS is a "death sentence" for illegal drug use. Criminal justice officials who are suspicious of this "nonpunitive" approach might reconsider: promoting health behaviors emphasizes what people will gain, not just what they might lose.

Several factors suggest that training and stable clinical supervision of service delivery staff need to be taken very seriously. Problems attributable to inadequate training and supervision include unevenness in the delivery of services and episodes of dysfunctional staff behavior (e.g., bickering, hostility, and inappropriate personal relationships between staff and clients). To provide effective HIV prevention counseling, less experienced staff require substantial training on routes of HIV transmission, techniques of HIV prevention education and counseling, and strategies for counseling clients with HIV infection substantial training on clinical issues in the client-case manager relationship.

The Rhode Island Prison Release Program

Timothy P. Flanigan, Denise Bury-Maynard, Kevin Vigilante
Joseph Burzynski, Gary Bubly, Joo Kim, Josiah D. Rich
Sally Zierler, Mary Lou DeCiantis, Lenore Normandy
Mary Snead, Ann DeGroot, Paul Loberti, and Barbara A. DeBuono

Rhode Island, with a population of about one million people, has an inmate population of approximately 2,500 men and women in its only prison facility, the Adult Correctional Institute (ACI). Of these inmates, 4 percent of the men and 12 percent of the women test positive for HIV at any given time (Dixon et al. 1993), a rate highly disproportionate to the 2 percent HIV-seropositivity rate for the State. Each year from 1989 through 1993, approximately one-third of individuals in Rhode Island who tested positive for HIV were tested at the ACI.

To meet the health care needs of inmates living with HIV, the ACI, in conjunction with the Rhode Island Department of Health and the Miriam Hospital, have operated an AIDS/HIV clinic on site since 1989. Initially the clinic did not provide linkages to community services. Medical, psychosocial, and substance abuse treatment ended for an inmate upon release from prison. Not surprisingly, this lack of resources for the former inmate now in the community led to rapid relapse in drug use, high-risk behavior, and reincarceration. Of the 160 inmates seen at the clinic in 1990, 27 percent were lost to medical followup upon release. It was not unusual for individuals to be in and out of prison six times a year.

In December 1991, the Rhode Island Department of Health, in cooperation with the Department of Corrections and the Miriam Hospital, Brown University AIDS Program, instituted a practical, low-cost program, the Prison Release Program, to help bridge the gap in services between release from prison and enrollment in community-based support programs. The Prison Release Program initiates discharge planning and medical followup. It provides comprehensive case management with referrals for substance abuse treatment, housing, and other resources to reduce the recidivism rate. This program has been supported as one of the Special Projects of National Significance (SPNS) through Title II of the Ryan White Care Act.

PROJECT DESCRIPTION

Goal and Objectives

The *goal* of the Prison Release Program is to link inmates with agencies that can either provide them with or assist them in obtaining appropriate medical care, psychosocial support, and substance abuse treatment. The *objectives* are to extend supportive counseling, medical care, and substance abuse treatment for inmates while still in prison and to facilitate linkages to appropriate resources upon discharge. The *measure of success* of the program is the extent to which inmates are linked with community resources after release. Upon release, appointments are scheduled for medical care and counseling regarding appropriate treatment (including use of antiretroviral medications and prophylaxis treatments to prevent opportunistic infections); followup is conducted to assess whether inmates keep their appointments. In addition, appointments are scheduled for individuals to obtain further financial assistance, referrals to community housing agencies, and followup sessions with substance abuse treatment agencies.

Profile of the Client Population

From July 1992 through August 1993, a total of 115 inmates participated in the Prison Release Program. Of these 115 inmates, 74 were men and 41 were women. Sixty-four percent of all eligible men with HIV participated in the program and 75 percent of all eligible women with HIV participated. The mean age at the time of testing was 34 years. Approximately half of the inmates were Caucasian, a third African-American, and a sixth Hispanic/Latino.

Women. Of the 41 women participating, 90 percent spent less than 12 months in prison, 2 percent spent between 12 and 30 months in prison, and 2 percent spent more than 30 months in prison (Figure 1). Criminal charges for the women were distributed as follows: 20 percent for drug-related crimes, 34 percent for prostitution, 41 percent for both, and 2 percent for other charges.

Men. Men spent more time in prison than women. Of the 74 men participating, 46 percent spent more than 12 months in prison. Criminal charges for the men were distributed as follows: 59 percent for drug-related crimes and 41 percent for other charges such as breaking and entering, robbery, sexual assault, homicide, larceny, and fraud.

Nature of the Intervention

Although this paper focuses on discharge planning and postrelease intervention, these services are only part of the continuum of HIV care provided to the inmates (also including HIV testing, counseling, and education; medical management; and discharge planning).

Testing, Counseling, and Education. All persons processed at the ACI Intake Service Center are given a physical examination, tuberculin skin test, and a VDRL blood test. These blood samples are used for the HIV test, with the signed consent of the individual. Persons who refuse the HIV test but are subsequently convicted of a crime are required by State law to be tested for HIV. Since 1990, between 9,000 and 10,000 inmates were tested each year. A total of 242, 142, and 141 tested positive in 1990, 1991, and 1992, respectively.

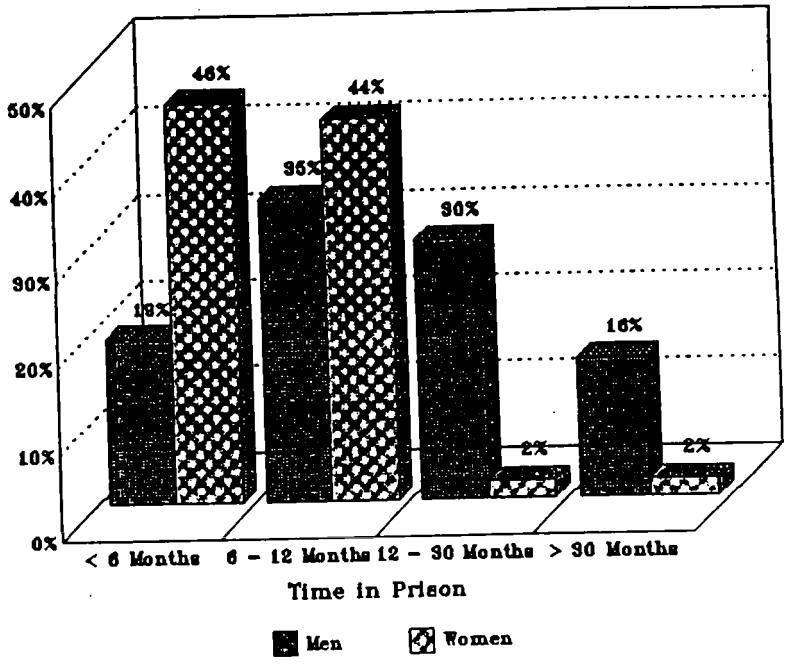

Figure 1. Distribution of Time Spent in Prison by Gender of Client

All individuals who test seropositive receive one-on-one counseling with a trained counselor. A full-time psychologist and a nurse provide backup and support to the counselor as needed. During the posttest counseling sessions, the counselor explains the services available within the prison and asks the inmates if they want to be followed by the HIV medical management team. Inmates are scheduled for HIV medical clinic visits at their request.

HIV posttest counseling includes an explanation of the voluntary notification program. In this program, a person is offered two choices: 1) partner referral, through which the tested person agrees to notify all contacts; or 2) provider referral, through which a trained Department of Health outreach counselor will attempt to notify all contacts named as possibly exposed to HIV. (Contacts are made anonymously and are offered counseling.) A full-time employee of the Department of Health provides outreach to all areas of the community for

provider referral. Approximately 20-30 percent of inmates with HIV choose to use the provider referral system.

All inmates and correctional personnel have access to general, ongoing AIDS education. Emphasis is directed to the importance of risk avoidance and prevention. In addition, a peer counseling service that allows inmates knowledgeable about HIV to educate others was developed. Many of these peer counselors are living with HIV. The AIDS educational programs are initiated while the patient is in prison and continue upon release. There are support programs for referrals, group discussions, stress reduction, and HIV education for individuals and their families.

Medical Management. The majority of inmates with HIV are asymptomatic. For many, the period of incarceration is the first opportunity to begin antiretroviral therapy and prophylactic medications; in fact, for many inmates, this is the first experience with any system that provides continuing health care. The HIV management team uses the same medical facilities as the prison medical staff but operates as a specialized consultation service. All inmates living with HIV are referred to the team for initial evaluation and counseling, but they are entitled to request evaluation at any time. This initial evaluation includes a baseline blood analysis and physician recommendations concerning medical regimens. During the first clinic visit, an initial needs assessment is performed and a more comprehensive assessment is scheduled.

Inmates diagnosed as HIV-asymptomatic are scheduled for periodic medical evaluation at intervals no greater than 3 months. The evaluation includes a medical history, a physical examination, complete blood cell counts, and CD4 lymphocyte counts. Those with more advanced disease or with cytopenias are evaluated more frequently, as are inmates recently discharged from the hospital. Standard recommendations for the initiation of antiretroviral agents are followed. All approved antiretroviral and prophylactic medications are available. No experimental therapies are allowed.

Medical management of women with HIV is similar to that for men with the exception of special attention to the gynecological manifestations of HIV. All women receive a comprehensive gynecological examination and a Pap smear with cultures for gonorrhea and chlamydia, regardless of symptoms.

Discharge Planning. The newly developed HIV discharge planning program evaluates all inmates living with HIV prior to their release from prison. Discharge planning includes an evaluation of inmates' needs for medical followup, financial assistance, housing, family support, care of children, and employment. Nurse case managers work with inmates with HIV while they are in prison, maintain contact with former inmates, attempt to continue their service plans, and coordinate their postrelease progress. During the first year, the program evaluated 115 inmates: 104 required medical appointments, 100 required financial assistance, 90 needed drug treatment referrals, and 47 needed housing referrals. All

individuals sign consent forms to verify followup with the referrals. All former inmate files are kept open until stable community life is achieved.

Referrals. Five hospitals collaborate with the Department of Corrections and the Department of Health to deliver care to incarcerated individuals. These facilities have specialty HIV clinics. An in-house drug rehabilitation program extends residential treatment after the patient is released from prison. Four other residential drug programs in Rhode Island and one in nearby Massachusetts provide beds for former inmates. In addition, four outpatient drug counseling facilities, three of which offer methadone maintenance, are contacted for referrals. Agency co-affiliation agreements, implemented between community-based agencies and the Prison Release Program, were made to monitor inmates' progress of reintegration into community life and long-term compliance with the case management plan.

The Prison Release Program also has developed an innovative relationship with Sunrise House, which provides comprehensive long-term housing and support for individuals with AIDS who have nowhere else to turn. This facility serves the needs of individuals who cannot be cared for by family members or significant others or who do not have the resources to provide comprehensive home care. Sunrise House is not a substance abuse treatment program and therefore is not appropriate for people who need residential drug rehabilitation services. The program does reimburse individual and group counseling at CODAC, a drug treatment facility in Rhode Island.

Staff

Case Managers. The Prison Release Program component is coordinated by two prison-based nurse case managers, each sharing HIV clinic and case management responsibilities. Originally, the program included one full-time nurse case manager. Given that the Prison Release Program dovetails with the HIV clinic program, it was determined that the goal of continuity of care could be improved by hiring an additional nurse case manager and assigning each person responsibility for half-time service to each program.

The case managers are registered nurses and report to the project director for monitoring and evaluation. They carry a combined caseload of 100 to 200 inmates and families. They coordinate referrals, make follow-up contacts to track progress, and work closely with the Partner Notification Specialist to assure continuity of care. They are part of the overall prison HIV Service Network, the "A-Team." With the substance abuse treatment facilities in the state, the nurses develop contacts that facilitate their obtaining a slot or a bed and following the progress of their clients.

Partner Notification Specialist. The partner notification specialist, a full-time employee with the Rhode Island Department of Health, is responsible for interviewing inmates living with HIV who agree to participate in the program. This specialist is responsible for the Prison Release Program field work, which includes referring contacts to counseling and HIV testing sites and locating inmates released to the community prior to

receiving notification of their serostatus. With an office at the ACI, the Partner Notification Specialist communicates regularly with the staff of the prison, the nurse case managers, and the Rhode Island Department of Health.

Medical Management Team. The HIV management team includes two attending physicians, an infectious disease fellow, and a registered nurse who serves as the on-site coordinator. The team evaluates patients at the ACI 4 half days a week on a regular schedule. The physicians are trained in internal medicine and infectious diseases as well as HIV-related diseases. Both physicians are full-time faculty members of the Brown University-affiliated Miriam Hospital. The team uses the same medical facilities as the prison medical staff but operates as a specialized consulting service.

Program Administration Staff. The Rhode Island Department of Health provides overall direction of the project, project evaluation, progress monitoring, administrative oversight, computer assistance with data collection and reporting, and information dissemination and report writing. Staff meet with the Prison Release Program personnel on a regular basis to discuss data generated from client intake and information forms.

A psychologist at the Department of Corrections provides 10 percent time for on-site supervision and support to the "A-Team." As on-site supervisor, this individual leads interdisciplinary case conferences, facilitates meetings, and acts as an on-site administrator.

Social Worker. A clinical social worker (1 full-time equivalent) and evening supervisory staff (.75-time equivalent) are located at the Sunrise House, a comprehensive, long-term residential housing program for adult men and women with symptomatic HIV. The social worker is responsible for developing and maintaining a supportive, permanent housing program; coordinating prerelease counseling and admission planning with ACI personnel; providing crisis intervention and on-call services; and constructing and monitoring counseling and support during the extended postrelease adjustment period.

Funding

The Rhode Island Prison Release Program component initially received funding from Title II of the Ryan White Care Act, Special Projects of National Significance (SPNS). It was supported also by a grant from the Centers for Disease Control and Prevention and by the Rhode Island Department of Health. The Prison Release Program is now funded by the Department of Corrections and the Department of Health. The testing and counseling and the medical management program components are also funded by these two departments.

PROJECT SUCCESSES

From July 1992 through August 1993, a total of 115 inmates participated in the postrelease program. Sixty-four percent of all eligible men living with HIV and 75 percent of eligible women participated. The principal outcome measures of interest were successful

referrals for housing, financial assistance, medical assistance, drug rehabilitation; reunion with families; and psychosocial services (i.e., linkage of the community service with the inmate at least 3 months after release). A secondary measure of success was the change in the rate of recidivism for women who received referrals.

Referral Followup

During the first year of the program, 74 men and 41 women received discharge planning. Over 75 percent of former inmates followed up with medical appointments and substance abuse treatment. For women, the most common referral was for medical followup (88 percent, or 36 women); 78 percent received the service. The second most common referral was for financial assistance (85 percent, or 35 women); 80 percent had a successful referral. The third most common need was for drug rehabilitation (76 percent, or 31 women); 65 percent followed up on these referrals. The fourth and final category was housing; 34 percent (14) of the women were referred, and 57 percent of them received the service.

The most common referral for men was medical followup (92 percent, or 68 men were referred) 71 percent of those referred followed up with appointments and treatment. The second most common need was for financial assistance (88 percent or 65 men); 89 percent of these referrals were successful. Drug rehabilitation referrals were the third most common category (80 percent or 59 men); 61 percent attended treatment. The fourth and final category was housing; 44 percent (33) of the men needed this service, and 61 percent secured housing during the analysis period.

Through the Prison Release Program discharge planning process, 68 percent of the inmates living with HIV were evaluated in the first year. Most of the remaining 32 percent remained at the ACI less than 2 weeks. The nurse case managers observed that clients who actively participated in their discharge planning were more successful than those who expected the nurse to develop plans for them. They predicted that the involvement of the inmate in developing their individualized referral process would be the major determinant for successful reintegration into the community.

Reduction in Recidivism

The Prison Release Program's discharge planning significantly reduced recidivism rates for women; that is, fewer women in the program returned to prison, even for minor charges such as failure to pay a fine. In the first year of the program, 41 women received prerelease counseling and appropriate referrals. These women were followed for 12 months. The outcomes of three groups of women were compared: 1) women who participated in the program between June 30, 1993 and July 1, 1993 and returned to prison; 2) women who tested positive for HIV in 1991 and were never in the program; and 3) women with matching release dates and charges irrespective of HIV status. The results for these three groups are presented in Table 1. Even though these numbers are small, the decrease in recidivism for

those participating in the Prison Release Program is impressive. Over 17 percent of the women in the Prison Release Program returned to prison within 12 months, compared with at least 39 percent in the comparison groups.

Case Studies

Two case studies also illustrate the effectiveness of the Prison Release Program. These individuals have been released from prison for approximately 1 year and have successfully reintegrated themselves into the community.

"Al." Al is a white man, 38 years old, with a long history of drug abuse. To support this habit, he committed crimes such as larceny, assault, and breaking and entering. He spent 4 years in prisons. He earned his Graduation Equivalency Diploma and five

Table 1. Distribution of Recidivism for Women by Group

Group Description	Number of Women	Returned within 6 months		Returned within 12 months	
		Number	Percent	Number	Percent
Prison Release Program	41	5	12	7	17
HIV-Positive in 1991 and not in program	41	11	27	16	39
Matching release dates and charges	41	9	22	15	41

college credits while incarcerated. In addition, he participated in drug addiction classes and addressed his own history of addiction. Taking advantage of the community services available, Al applied and was accepted to the Salvation Army Drug Rehabilitation Program. When he completed this program, he established a home for himself and reunited with his mother. He received an educational grant to continue his college education. The family services agency that continues his case management maintains contact with him. He maintains ongoing communication with the prison outreach nurse and schedules followup medical visits. By actively participating in his discharge planning and by accessing community-based services, Al has ensured continuity in achieving his case management goals.

"Irene." Irene is a young African-American woman, 34 years old, with a long history of injection drug use. She committed crimes to obtain money to support her drug habit. She was incarcerated and served 2.5 years of a 4-year sentence while her mother

cared for her child. During incarceration, Irene became aware of the services available to her and participated in the discharge planning process. Since her release, she has complied with all medical appointments and is an active participant in the prevention program for high-risk women. She is counseling peers in alternatives to drug use and attends college on a part-time basis to earn a degree in social work. Irene's family issues have been successfully addressed. Her relationship with her mother is greatly improved and they are raising the child together.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

Lack of Housing Facilities

The major barrier faced by the Prison Release Program was locating housing services in the community. Inmates with criminal histories are disqualified from most housing facilities. Housing is a crucial issue for many people with HIV. Hospice services and home care depend on the resolution of housing issues; homeless shelters are not necessarily the most practical solution for this population. Frequently, released prisoners return to their old neighborhoods and are offered cocaine, heroine, and opportunities to exchange sex for money or housing. For many inmates, the first step in breaking the cycle of violence, substance abuse, and homelessness is a new, safe environment. One suggestion for overcoming this barrier is to recommend that housing authorities waive the 1-year waiting period for recently released inmates in the Prison Release Program. The Sunrise House has an agreement with the Rhode Island Department of Health, with SPNS funds, to provide services to a specified number of released inmates requiring a residence and ongoing case management. Prior to release, each inmate referred to Sunrise House receives a psychological evaluation conducted by a trained credentialed consultant. These evaluations assess the inmates' potential for admission to the residence.

After the first medical visit, a registered nurse records the patient's history of substance abuse, previous substance abuse treatment, and future treatment options. The most difficult but important part of the program is the link with an active substance abuse treatment program upon release. Occasionally, there are problems placing inmates into residential drug treatment programs. Residential programs often are full, and methadone maintenance programs often have a wait of 2-6 weeks. During this waiting time, former inmates might relapse to drug use in their old neighborhoods. Outpatient drug treatment is an option, but the lack of family housing, particularly for women with children, presents a problem. The family was often not available to care for children while the woman was enrolled in a halfway house program. Halfway houses able to accommodate children and provide child care for the recovering parent would help overcome this barrier.

Communication Difficulties

Program staff encountered numerous problems communicating with the inmates. Literacy and foreign language barriers increased the difficulty of communicating information

to inmates. Interpreters were not available at the prisons. In addition, inmates were not always ready or willing to process the information and outreach prior to release.

MAINSTREAM ISSUES

Prisoners infected with HIV represent a major health care challenge, particularly because they account for a relatively large proportion of the HIV-seropositive population and because many have had limited access to HIV-related education, counseling, and health care services. In addition, as discussed above, the placement of inmates in residential treatment programs and the availability of safe housing for patients with HIV and AIDS are critical problems not only in Rhode Island but in most of the country.

As stated by the Presidential Commission on the HIV Epidemic, effective programs to provide "care and treatment to HIV-infected inmates—equal to that available to HIV-infected individuals in the general community—are necessary" (Presidential Commission on the HIV Epidemic, 1988). A subsequent report of the National Commission on AIDS addressed HIV disease in correctional facilities and recommended that "given the dearth of anecdotal and research information on incarcerated women, incarcerated youth, and children born in custody, federal and state correctional officials should immediately assess and address conditions of confinement, adequacy of health care delivery systems, HIV education programs, and the availability of HIV testing and counseling, for these populations" (National Commission on AIDS, 1991).

Incarceration may be the first time an inmate has access to HIV testing, counseling, specialized medical care, and support; thus, prisons play a central role in the identification and treatment of HIV infection in our community. A program such as the Prison Release Program in Rhode Island combined with medical management during incarceration can have a strong, long-lasting impact on the well-being of individuals with HIV infection, can assist in decreasing high-risk behaviors, and can slow the further spread of the infection.

EVALUATION METHODS

The evaluation of the Prison Release Program focused primarily on determining if individuals have succeeded in linking up with the appropriate community resources to which they had been referred, thereby meeting their needs for medical care, substance abuse treatment, financial support, housing, counseling, and spiritual support. After being released from prison, individuals are followed for at least 3 months. Community agencies and service providers are contacted to confirm participation of the former inmates. In addition to service linkages, the program assessed recidivism rates for women within 6 months and 12 months of prison release.

DISSEMINATION OF THE PROJECT CONCEPT

The Prison Release Program model has been presented locally in talks and in an article published by the Centers for Disease Control (*HIV/AIDS Prevention*, Winter 1995, pp. 4-5). Program staff have also presented the merits of the program to State agencies; in fact, funding for continuation of the program has been "mainstreamed" by the Department of Corrections and the Department of Health. Plans for future projects, if funding can be obtained, include extending the Prison Release Program to inmates testing negative for HIV who are substance abusers. The extension of the program to this population would be critical in preventing continued high-risk behaviors among these individuals.

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AUTHORS

Timothy P. Flanigan, M.D.
Kevin Vigilante, M.D.
Joseph Burzynski, M.D.
Gary Bubly, M.D.
Joo Kim
Josiah D. Rich, M.D., M.P.H.
Ann DeGroot, M.D.

The Miriam Hospital
164 Summit Avenue
Providence, Rhode Island 02906

Denise Bury-Maynard, M.P.H.
Mary Lou DeCiantis, Ph.D.
Paul Loberti, M.P.H.
Barbara A. DeBuono, M.D.

Rhode Island Department of Health
Providence, Rhode Island

Sally Zierler, Ph.D., M.D.
Brown University
Department of Community Health
Providence, Rhode Island

Lenore Normandy, R.N.
Mary Snead, R.N.

Rhode Island Department of Corrections
Adult Corrections Institute
Post Office Box 8274
Cranston, Rhode Island 02920

ACKNOWLEDGEMENTS

The authors express appreciation to Ellen Enderson, Cindy Drake, and Theresa Foley for their tireless efforts in support of the inmates. We thank Finian Murphy, Joe Marocco, and Jeff Laurie of the Department of Corrections for their support; Charles J. Carpenter for manuscript review and unending support; and Connie Arvanites, Pat Schreiber, and Heidi Felice for editorial assistance.

Specialized Medical and Social Service Interventions for Inmates with HIV in Maryland

Newton Kendig, Barbara A. Boyle, and Leslie H. Kummer

The Maryland Division of Correction (DOC) is a State agency whose purpose is to protect the public safety of Maryland by incarcerating men and women committed by the court to the custody of the Commissioner of Correction. The DOC currently houses approximately 19,000 male and 1,000 female offenders in 23 institutions ranging from maximum to prerelease security and spread over four geographic regions of the State. Seroprevalence testing of these inmates for human immunodeficiency virus (HIV) has revealed a nearly constant HIV-positive rate of approximately 8 percent for men and 15 percent for women.

Maryland DOC inmates who are living with HIV have complex medical needs, including primary health care, substance abuse treatment, mental health care, and extensive social support. Furthermore, because many inmates with HIV have not accessed health care prior to incarceration, they encounter barriers to care in the community when they are released. Access to medical services in the community may be impeded by sociological, financial, or logistical obstacles that can compromise the continuation of medical therapies initiated during incarceration. The Maryland DOC has developed a program that provides medical and social services to inmates with HIV and that maintains continuity of care in the community after release or during parole. The program emphasizes medical case management, expeditious medical parole, and clinical trial participation for targeted inmates. It is supported as one of the Special Projects of National Significance (SPNS) through Title II of the Ryan White Care Act.

PROJECT DESCRIPTION

Goals and Objectives

The goals of the Maryland DOC program of specialized medical and social services are to expand medical treatment options for inmates with HIV and to maintain continuity of those services in the community for released inmates. The program goals are accomplished through the following objectives:

- To provide medical case management for all inmates with HIV before they are released;

- To establish community linkages for implementing an aftercare plan for each inmate in the case management program; and

- To expedite medical parole for inmates with endstage AIDS.

Profile of Client Population

An average of 51 percent of men and 61 percent of women entering prison participate in voluntary HIV seroprevalence testing. Of those inmates tested in 1994, approximately 1,600 tested HIV positive. Among inmates with HIV, about 90 percent were African-American men with a median age of 36 years. Over 90 percent of inmates with HIV identified injection drug use (IDU) as their primary risk factor for acquiring HIV infection. During the 1990s, the population with HIV became more symptomatic and more were diagnosed with AIDS; since many inmates were first infected with HIV during the mid- to late 1980s, they are only now developing late-stage complications of their infection. A 1992 survey indicated that 50 percent of Maryland inmates with HIV infection were candidates for antiretroviral therapy and 17 percent were severely immunocompromised with CD4 cell counts of less than 200 cells per mm. During 1994, HIV was the leading cause of deaths among Maryland inmates; 26 inmates died from AIDS, accounting for 39 percent of all inmate deaths. An additional 40 inmates with AIDS were released from DOC to the community through medical parole. Table 1 reflects the characteristics of a sample of inmates living with HIV who are targeted for case management services.

Nature of the Intervention

Seroprevalence Testing. All inmates, at admission to prison, attend a mandatory education session on HIV infection and its prevention. Subsequently, HIV testing is offered to all inmates. Additionally, many inmates receive HIV testing as a component of clinical evaluations. All testing is conducted by staff social workers or nurses trained by the Maryland Department of Health and Mental Hygiene. Testing is voluntary and anonymous and is accompanied by individual pre- and posttest counseling. Inmates are referred to psychologists for trauma counseling if they are very distressed by their HIV-positive status.

Case Management. As soon as an inmate is diagnosed with HIV, case management services at the DOC's social work department begin. Through a confidential infectious disease database, the Maryland DOC Observational Correctional Information System, regional social work supervisors track inmates living with HIV to anticipate release dates and assign them by geographic regions to medical case managers. Case management services become intensive 3-6 months before an inmate's anticipated release, with contact at least every 2-3 weeks and the development of an aftercare plan about 3 months before anticipated release. At release, this plan ensures referral for ongoing health care, financial support,

substance abuse treatment, mental health treatment and counseling, housing, legal aid, and other services as needed. An interagency agreement between the Maryland Department of Human Resources and the DOC has facilitated the submission of entitlement applications prior to release, which expedites financial support for inmates when they are released to the community. Networking with community agencies has resulted in formal and informal interagency agreements that facilitate referrals to primary health care providers, substance abuse treatment centers, home health care, institutional care, and hospice services. Case management staff have also facilitated prison access for hospice volunteers to meet with inmates who are terminally ill with AIDS and are either awaiting medical parole or have been denied parole.

Table 1. Characteristics of DOC Inmates for Case Management

(n=255 inmates)

Gender		CDC Classification	
Men	242	II	15
Women	13	III	98
		IV	20
Race			
African American	234	* A1R	5
Caucasian	21	* A2R	17
		A3	36
Age		B1	3
18-30	64	B2	11
31-40	130	B3	14
40+	61	C1	1
		C2	4
Risk		C3	20
Injection Drug Use	190		
Other	41	Reportable/	
Unknown	24	Class. pending	11
		CD4 Count	
		<200	105
		200-500	80
		>500	66
		Unknown	4

* A1R/A2R = Previously reportable new system A1 or A2.

Medical Parole. An ancillary goal of effective medical case management is to expedite medical parole for inmates who have endstage HIV disease if their condition precludes their compromising public safety. The DOC has developed a medical parole

procedure for this purpose with defined timeframes.* A physician initiates the procedure by completing a medical evaluation for inmates who have been identified as medical parole candidates (i.e., diagnosed with illnesses that have impaired the inmate so that release to the community would not compromise public safety). The medical evaluation is forwarded to the social work and correctional case management departments. A security case management specialist makes a recommendation based solely on public safety considerations. The medical case manager develops an aftercare plan encompassing all the standard case management services; in addition, arrangements are made for special needs such as formal psychological evaluation and clinical treatment and for dealing with anticipated barriers. The medical evaluation, security case management review, and the aftercare plan are collectively forwarded to the warden of the facility for review and approval or disapproval of medical parole. The warden's recommendation is subsequently forwarded to the DOC medical director. The medical director, in consultation with the Director of Social Work and Addiction Services, submits to the Commissioner a recommendation and rationale for or against medical parole approval. If approved by the commissioner, the case is forwarded to the parole commission for a final decision. Once final approval is granted, the medical case manager completes the aftercare plan and ensures its implementation after the inmate is paroled to the community.

Medical Monitoring. Inmates living with HIV are medically monitored in accordance with a DOC medical protocol that is based on recommendations from the medical literature and public health guidelines. Inmates living with HIV are referred for a series of baseline evaluations, including a physical examination by a physician, laboratory studies, and referral for psychosocial assessments when indicated. Followup care for inmates is provided in chronic care clinics at 6-month intervals. The frequency of care depends on the stage of illness. Individuals with later stages of disease are given priority over asymptomatic inmates. Acute medical care is provided to inmates by prison-based infirmaries and by community and university hospitals. The care provided to the population of inmates living with HIV is tracked by regional infection control nurses through a confidential infectious disease database.

Clinical Trials. Additional treatment options have been made available to inmates with HIV through access to federally funded clinical trials. Through a collaborative arrangement with The Johns Hopkins University, university nursing staff enroll inmates in clinical trials, thereby enabling inmates to be treated with experimental drugs for AIDS and related conditions. All clinical trials are approved by The Johns Hopkins University institutional review board, which includes an inmate advocate. Only nonplacebo clinical trials approved by the National Institutes of Health for prisons are considered. None of the clinical trials, however, is exclusive to prisons; that is, the same clinical trial is offered in the community. A benefit of this inclusion of the community is that continuity of care is not

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*State of Maryland Department of Public Safety and Correctional Services, Division of Correction. "Section 190 - Medical Parole," *DCD 130-100: Primary/Specialty Medical Services.* June 9, 1994.

compromised when the inmate is released. University nursing staff administer the clinical trials onsite in Maryland prisons.

Staff

Providing case management and clinical services is labor intensive, requiring staff dedicated to meeting the complex needs of inmates living with HIV. The core staff is composed of two licensed clinical social workers who serve as case managers; a fulltime nurse consultant who reviews clinical records and identifies candidates for case management, medical parole, and clinical trials; and a data manager who collects data from the case managers, processes them, and forwards them to a statewide information system for merging with other HIV-related health and vital statistics.

Funding

A SPNS grant to the Maryland DOC in 1991 provided 3-year funding to develop the case management component of this service delivery system. Additional services are contributed by the agency; these include consultation and supervision from the Directors of Medical Services and Social Work and Addiction Services and the Administrator of Infection Control.

PROJECT SUCCESSES

Case Management and Referrals

It is estimated that 320 inmates (66 percent) have been provided case management services prior to release. The medical case managers have established commitments with a number of agencies to provide services to inmates living with HIV after their release, as shown in the following examples:

- The Chase-Brexton Clinic agreed to provide for primary care needs in the Baltimore area and for mental health needs under Ryan White Title II funding provisions;
- The Chesapeake AIDS Foundation provided financial assistance and creative approaches to case management challenges;
- The Health Education Resource Organization (HERO) agreed to accept 15 referrals for case management services;
- The Prince George's County Health Department agreed to provide comprehensive treatment and support services to inmates who would, after release, reside in Prince George's County;

- The Stella Maris Hospice Care Program agreed to accept DOC referrals for inpatient hospice care, based on available beds; and

- The Maryland Department of Human Resources agreed to permit application of entitlements prior to inmate release.

Medical Parole

Medical parole procedures with definitive timeframes have facilitated medical parole for Maryland inmates. The number of inmates receiving medical parole increased from 8 in 1991 to 42 in 1994. The increase in the number of medically paroled inmates has resulted not only from the structured medical parole procedure but also from increased inmate morbidity, primarily from AIDS. A survey of inmates medically paroled through 1994 indicated that the median time for processing a medical parole was 44 days. Through the end of 1994, *none* of the inmates medically paroled from Maryland prisons has been reincarcerated in Maryland for violent crimes.

Participation in Clinical Trials

The population of inmates living with HIV has enthusiastically endorsed the clinical trials program. The program has been personnel intensive and has required a strong bilateral commitment from both the Maryland DOC and The Johns Hopkins University. Through 1994, six different clinical trials have been offered to inmates and 53 inmates have been enrolled. Continued participation in clinical trials upon release from prison has been excellent.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

Service Gaps

The most significant barriers to effective medical case management reflect gaps in available services. Some of those gaps can be addressed by training the medical staff in custody and security issues as they relate to the performance of clinical duties, training social workers in substance abuse counseling, and training correctional health care providers in palliative care and the provision of hospice services.

Participation in Clinical Trials

Specific barriers must be addressed regarding the enrollment of inmates in HIV clinical trials. The Johns Hopkins University AIDS Clinical Trials Unit (ACTU), funded by the National Institutes of Health, has successfully performed four multicenter clinical trials within the DOC since May 1991. Still, four broad categories of barriers were identified as warranting special attention: accommodation to correctional administrative procedures,

implementation of studies within the correctional health care delivery system, retention, and ethical concerns.

Program administration requires a strong bilateral commitment from the DOC and The Johns Hopkins University because of the cost and labor intensity of implementing satellite trials. A dedicated research team from The Johns Hopkins University provides onsite screening, enrollment, and followup. DOC personnel assist with screening, phlebotomy, and transitional activities associated with release. Also, drug dispensation protocol requires an adaptation of The Johns Hopkins University labeling policies and procedural changes in the DOC that do not compromise security.

Conducting studies within the correctional system also encompasses challenges. For example, additional onsite visits are required to provide ongoing DOC staff education and to assess the clinical condition of study participants. DOC protocols for transporting specimens may be limited because of special processing requirements.

Barriers to retention have been addressed in a variety of ways. Study participants have been retained partially through the 24-hour availability of Johns Hopkins staff. Telephone contact with family members is also available. Newsletters about HIV, greeting cards, and home visits after release are other strategies employed to increase retention. Another service provided is that Johns Hopkins staff facilitate referrals for medical and social services and for substance abuse treatment.

Ethical considerations include study subject confidentiality; involvement of a prisoner advocate on institutional review boards; the use of a database to facilitate identification of inmates as potential clinical trial candidates; and consent forms that clearly state that participation is voluntary, without incentives, and does not affect eligibility for parole.

MAINSTREAM ISSUES

Housing Shortage

At least 60 percent of DOC releases and paroles are to the Baltimore area, which is beset with severe housing shortages for low-income persons. The Federal Government has recently earmarked a large block of funds to help, but the problem is still present; nearly 7,000 persons are on waiting lists for public housing and nearly 8,000 on lists for Section 8 subsidies.

Dearth of Mental Health and Substance Abuse Treatment Services

Of the 77 inmates granted medical paroles from 1991 to 1993, only 5 returned to prison. However, these inmates were not convicted of violent offenses but for activities related to substance abuse and mental health problems for which there were no available services at the time of release. Access to mental health and substance abuse treatment is

problematic in part because of long waiting lists. By the time the substance abuse treatment appointment approaches, the former inmate has relapsed. The mentally ill need more than a once-a-month clinic appointment. Their condition is exacerbated by their physical problems, and they need a level of support across the treatment community that does not exist. Baltimore has no agency whose mission is case management support to exoffenders.

The DOC participates on task forces, planning groups, and interagency meetings. Slowly needs are being addressed but the level of cooperation needed to bring real change has not yet been reached.

EVALUATION METHODS

A key element of the Maryland DOC model is program evaluation. The model is unique in that continuity of care for former inmates will be critically evaluated through the Maryland Department of Health and Mental Hygiene HIV Information System (HIVIS) and using the data collected by the DOC. Outcomes for each kind of intervention—case management, medical parole, and treatment in clinical trials—will be compared to the outcomes of individuals who did not receive an intervention or who participated in clinical trials but were recruited from the community rather than from the prison population. Monthly reports of all inmates with HIV involved in specialized case management are submitted by the clinical social workers to the Director of Social Work and Addiction Services and to the Medical Director. The information tracked is listed in Table 2. Demographic and laboratory data on inmates with reportable disease are also forwarded to the HIVIS, which links information from the Maryland AIDS registry with data extracted from health care claims, institutional records, and death certificates. The data elements that are entered into the HIVIS are listed in Table 2.

By establishing linkage with the HIVIS, the DOC will track the accessibility, utilization, and effectiveness of therapeutic and support services targeted for inmates released into the community. Periodic reports from the Maryland Department of Health and Mental Hygiene will allow the DOC to ascertain whether critical components of health care have been used by released or paroled inmates. Vital statistics will also be monitored to enable the Division to determine if former inmates had access to medical and social services at the time of their deaths. These endpoints will be measured against other data elements such as race, age, DOC institution, address on release, and agencies involved to determine factors that may have compromised continuity of care.

The program for expedited medical parole will be evaluated internally by the nurse consultant by tracking each inmate with HIV who is evaluated for parole and monitoring the data listed in Table 2. The Maryland Parole Commission will provide data on inmates in this program who are returned to the custody of the DOC for violation of parole. As a result of these evaluations, the procedures and criteria for medical parole of inmates with HIV will be refined.

Table 2. Data Elements Collected for Evaluation

Monthly Reports on Inmates In Case Management	Data Entered In the HIVIS	Data Monitored For Medical Parole
Name	Name	Name
Date of birth	Gender	Race
DOC number	Race	Gender
Social security number	Date of birth	Date of birth
Institution	DOC number	DOC number
Date of diagnosis of HIV seropositivity	Social security number	Institution
Date of medical evaluation	Institution	Offense
Date of initial case-management intervention	Date of diagnosis of HIV seropositivity (if known)	Sentence length
Estimated release date	CDC classification	Time served
Completion date	Date of AIDS diagnosis	Date of diagnosis of HIV seropositivity
Completion date of entitlement application	Antiretroviral therapy	Date of change in clinical condition prompting parole consideration
Date of release (if applicable)	Pneumocystis carinii pneumonia (PCP) prophylaxis	CD4+ count
Community referrals	AIDS-related illnesses	AZT usage
	Address upon release	AIDS-related diagnoses
		Karnofsky score (measure of functionality)
		Date of referral for classification review for medical parole eligibility
		Date aftercare plan is completed
		Date parole request is approved or denied
		Anticipated disposition
		Community referrals
		Hospitalization and hospice utilization
		Date of death

The DOC will also use an assessment tool to measure the validity of its program and identify any barriers that have limited inmate access to community therapeutic and support services. The medical, social, or resource issues that can compromise continuity of care will also be applicable to other State and Federal correctional systems, as replicating this model in other systems will depend on such variables as the availability of qualified staff, interagency communication, and quality community resources.

Data concerning the aforementioned variables for 1992 through 1994 have been forwarded to the Maryland Department of Health and Mental Hygiene. Data analysis will be completed in mid-1995.

DISSEMINATION OF THE PROJECT CONCEPT

Information gained from the described model will be disseminated internally within the Maryland DOC and more broadly through local and national conferences and through publication in appropriate journals and information bulletins. The DOC has shared and will further share instructive lessons gained from developing and pursuing the goals and objectives of this model with other correctional systems to enhance the quality of health care for all inmates with HIV infection. For example, the DOC has shared its model for participation in experimental drug trials for inmates with HIV with the New Jersey Department of Corrections through participation in a formal workshop, "Forum on Prisoner Access to Clinical Trials," sponsored by the North Jersey Community Research Initiative. Additionally, the Maryland models for medical parole and clinical trials were presented at the First National AIDS/HIV in Prison Roundtable in San Francisco, California, in October 1993. Informal discussions about establishing a clinical trials program in a State correctional system have been convened with North Carolina and Massachusetts. It is the intention of the Maryland DOC to continue the positions created with the SPNS grants at the end of the funding period in recognition of the project's many successes.

AUTHORS

Newton Kendig, M.D.
Chief Medical Officer

Barbara A. Boyle, L.C.S.W.
Director of Social Work and Addiction Services

Leslie H. Kummer, R.N.
Infection Control Administrator

Maryland Department of Public Safety and Correctional Services
6776 Reistertown Road, Suite 309
Baltimore, Maryland 21215-2342

Cermak Health Services: Linking Pretrial Detainees With HIV/AIDS to Community Services

Tara Howleit and Katie Stauffer

Cermak Health Services provides comprehensive medical, dental, psychiatric, and substance abuse services to the approximately 9,000 detainees at Illinois Cook County Department of Corrections (CCDOC), the largest single-site jail complex in the Nation. Of the approximately 80,000 admissions to the Cook County jail system in 1993, the majority were pretrial detainees.* Detainees experience an average stay of 3-4 months in this facility that has a capacity of 8,661 beds and a recent history of overcrowding.

The prison population is at extremely high risk for acquiring HIV infection; therefore, Cermak's intention is to link individuals who are infected with HIV with health services as early as possible after arrival. In 1994, 3,551 detainees and 12 employees were tested for HIV/AIDS; of these, 227 (6.4 percent) tested HIV-positive. Among those who tested HIV-positive, 32 were confirmed as having AIDS, and 10 were HIV-symptomatic. Through its Health Education and HIV Supportive Services Program, Cermak introduces individuals living with HIV and AIDS to a responsive and caring system of continuing health care and supportive services that emphasizes case management. Staff has an opportunity to begin a comprehensive course of treatment for a clientele that under other circumstances might receive few, if any, services. The HIV program has funding support from Title II and Title IIIb of the Ryan White CARE Act as well as the Cook County Bureau of Health.

PROJECT DESCRIPTION

Goals

Cermak has two goals. The first is to provide the following types of services to detainees and to the health care and correctional staff:

- Educational information about HIV infection and AIDS and other chronic illnesses such as hypertension, lupus, tuberculosis, cancer, and hepatitis;

*Detainees are persons unable to pay bail bonds set by the courts and those whose offenses or criminal records mandate that they be held without bond.

- Training in risk-reduction and behavior-modification techniques, such as safer sex and needle use practices, for the population at risk;
- HIV counseling and testing of individuals living with HIV/AIDS;
- Referrals to case managers for an initial interview and intake to assess the needs of each client testing positive for HIV/AIDS;
- Advocacy services on behalf of detainees living with HIV;
- Discharge planning services for detainees living with HIV;
- Individual mental health counseling services and support groups for detainees living with HIV; and
- Assistance to detainees living with HIV in accessing primary medical services.

The second goal is to help clients meet their needs for ongoing treatment after discharge by directing individuals to appropriate community services and enabling those individuals to continue care in the community.

Profile of the Client Population

Cermak serves an incarcerated adult population of all ages, drawn from communities within Chicago and suburban Cook County. According to the CCDOC's annual statistical data, the average age of adults in the facility is 23 years. The racial breakdown is 75 percent African-American, 15 percent Hispanic, and 10 percent Caucasian. Ninety-five percent of the detainees are men, and 5 percent are women. More than half of the population have less than a high school education with an average reading level of grade six. A majority of persons are unemployed. Their living arrangements vary, but 25 percent of detainees are homeless and 55 percent live with other adults without children.

Client intakes were conducted for 203 of the 221 detainees receiving case management services in 1994. The statistics for the client population vary slightly from the total incarcerated population. Eighty-eight percent of the clients were men, and 12 percent were women. The racial breakdown was 73 percent African-American, 11 percent Hispanic, and 15 percent Caucasian (Figure 1). Most (59 percent) had been living with adults before incarceration, and 19 percent were homeless (Figure 2). The highest risk factor for HIV infection was injection drug use (51 percent), followed by heterosexual transmission (29 percent) (Figure 3). AIDS was confirmed in 16 percent, and 56 percent were HIV-asymptomatic (Figure 4).

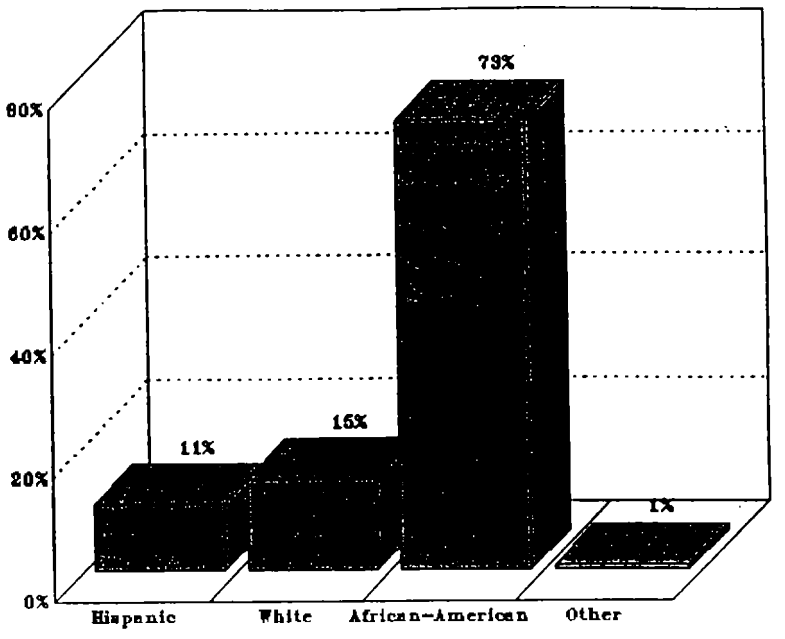

Figure 1. Racial/Ethnic Background of Client Population

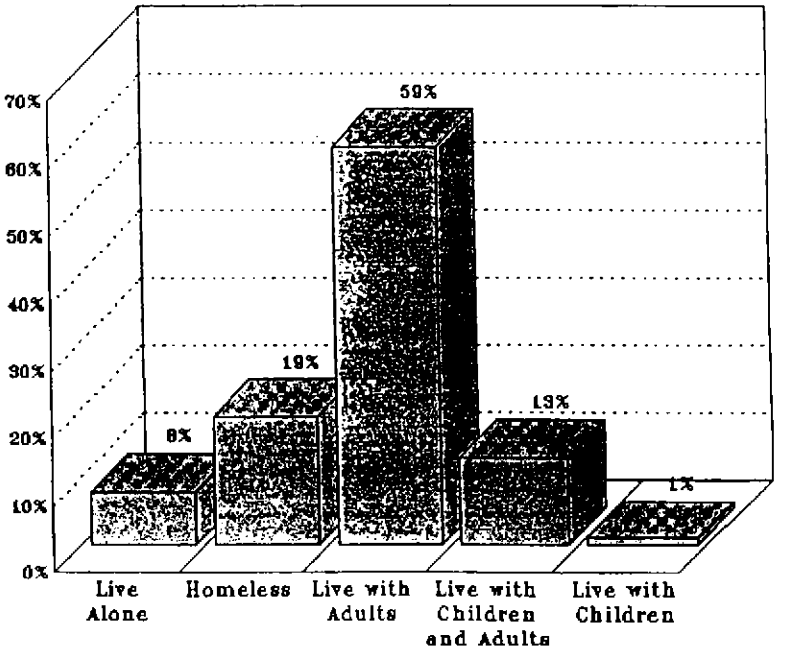

Figure 2. Distribution of Living Arrangements for Client Population

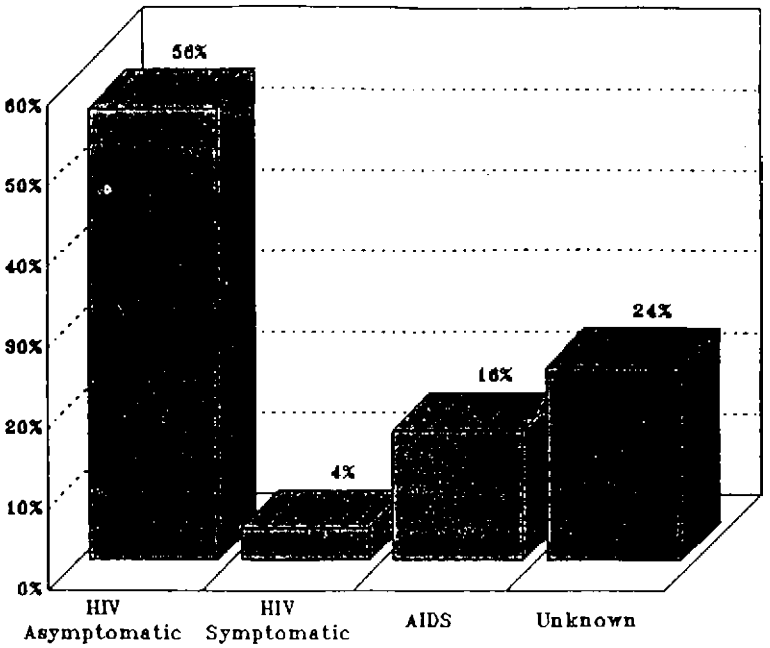

Figure 3. Distribution of Client Population by Health Status

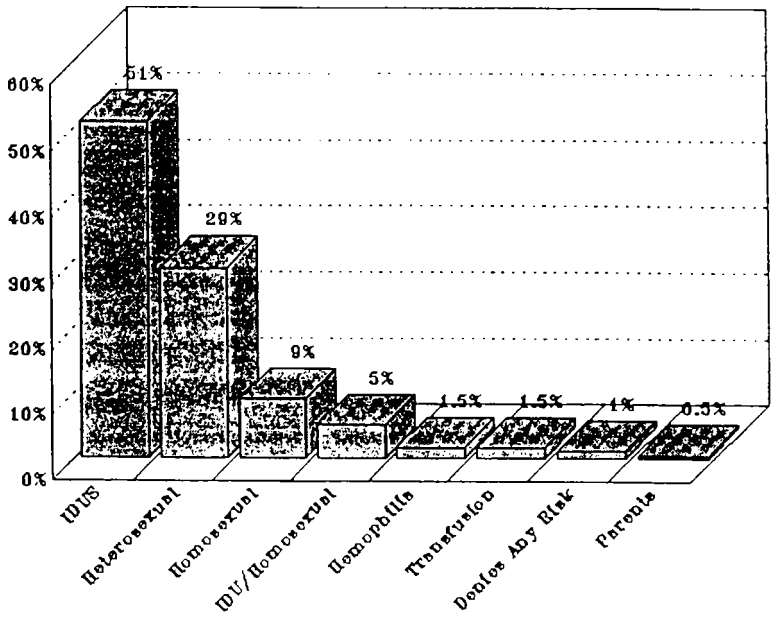

Figure 4. Distribution of Client Population by Risk Behavior

Nature of the Intervention

Enrollment. Client participation in case management services is voluntary and available to all detainees living with HIV throughout their incarceration period. Case management clients can be referred to case managers by health educators or any other clinical staff (doctors, physicians' assistants, nurses, etc.) working throughout the jail complex. Occasionally, case managers receive referrals from outside HIV-related community service agencies. In attempting to locate clients who have missed appointments or who have stopped coming for services, these agencies discover a number of their "lost" clients in the jail system, with ongoing continuity of care requirements.

This program attempts to reach as many detainees as possible by conducting education outreach in the sick call areas, housing tiers, and classrooms. It also provides pre- and posttest counseling for HIV antibody testing. The health educator of each CCDOC unit or division receives requests for HIV testing from detainees themselves, who may volunteer for testing during the education outreach process. The health educator also receives referrals for testing from the doctors, the sexually transmitted disease clinic, the tuberculosis clinic, and the court system (court order for testing). All HIV testing is voluntary, including referrals made for diagnostic reasons.

The Cermak approach is to conduct an initial interview with every detainee diagnosed at or admitted to the CCDOC with a history of HIV infection. The purpose of the initial interview is to provide empathetic support to those individuals who are newly diagnosed and offer supportive services to all detainees living with HIV. Cermak then attempts to engage all of these clients in case management services to link them with necessary services should they be released to the community. For some clients, Cermak is the first experience with any system that provides continuing health care and case management services. Jail provides a continuum of basic services (e.g., food, housing, medical care) that some detainees lack in the community .

Needs Assessment and Treatment Planning. Clients who are interested in case management services are screened to assess their needs and to gather pertinent data. Clients are strongly encouraged to take part in the resolution of their problems; one of Cermak's objectives is to empower clients to better manage their lives, as well as their HIV disease. At this stage, clients are engaged in identifying stress areas to gain an understanding of the client's perception of problem areas. Working with a Cermak case manager, clients develop an informal contract to help the client assess their needs. These needs range from getting out of jail to obtaining adequate health care.

Then, with the support of a case manager, clients set a realistic treatment plan based on the perceived need for change and the existence of services. For example, it is unrealistic to suggest that drug-addicted individuals make drug treatment a priority if they do not feel that the addiction is a problem. Although case managers continue to encourage these clients

to look at the potential hazards of drug use, as well as problematic behavior patterns, some of these clients may give priority to another aspect of their current living situation.

Often it is important to help clients separate the issues they face, because they are often interrelated and overwhelming. Incarcerated individuals who test positive for HIV experience a heightened sense of powerlessness. The case managers work to help their clients recognize the things they can change and to accept those things that are beyond their control. This assessment process is ongoing; therefore the plans can change as priorities change.

Ongoing Support. All case management services are provided on site at CCDOC. After initial screening and treatment planning, clients are seen bimonthly, or more frequently if needed.

Some clients are released from the jail before receiving their HIV antibody test results. The Cermak case manager attempts to locate those clients who test positive by letter. Once located, a meeting is arranged between the health educator, case manager, and client for posttest counseling, and the client is referred to a medical facility in the community. Public transportation tokens are also available for those in need.

On occasion, clients are released from jail prior to a followup visit. In these cases, case managers attempt to locate the clients by telephone and to link them with resources in the community. The case managers act as advocates and liaisons; they interact on behalf of the clients with community agencies, the court system, family members, and internal (jail) systems involved in the clients' overall care. The case manager refers these clients to those services that are available in an appropriate catchment area to meet their individual needs.

Referrals to Community Service Providers. Linkages in the community for Cermak clients and their families include medical centers throughout the Chicago and suburban areas, social service agencies that provide case management and other support, testing sites for partners of clients (Board of Health clinics in the county and city), and substance abuse facilities.

At discharge, most of Cermak's clients are referred to community facilities with case managers, who then become responsible for further followup or for linkages to services. Most of the larger HIV provider agencies have case management services should the need arise. Some clients do not desire case management services in the community, as they are able to access services without the help of an outside provider.

Relevant clinical information about clients is sent to the medical provider with permission. For those clients requiring zidovudine (AZT), Cermak Health Services has a grant that provides a 2-week supply of this anti-retroviral drug so there is no gap in the provision of medication. Those requiring other medications are referred to the Cook County Hospital outpatient clinic, which provides medications free of charge.

Often, Cermak case managers provide clients with the phone number and location of their local social security and public aid offices. Clients are encouraged to seek these services as well as Medicaid. Cermak's clients include patients with advanced AIDS who require acute care or skilled care hospitalization; these clients are sent to Cook County Hospital or Oak Forest Hospital for inpatient care.

Referrals to Prison Alternatives. When appropriate, Cermak case managers work with the court system through the client's attorney to initiate referrals to substance abuse rehabilitation services such as Treatment Alternatives for Special Clients (TASC). A client with a history of substance abuse may qualify for a presentence alternative that permits receipt of the treatment instead of a prison sentence.

TASC is not an option for some. Violent offenders and those who do not demonstrate to the TASC interviewer a serious desire for treatment are denied access. However, if a "violent" offender has a significant need for drug treatment and demonstrates a seriousness about changing his or her behavior, the Cermak case managers and TASC representatives work with the detainee's attorney or public defender to persuade the court to reduce the charge.

Clients accepted to the TASC program go directly from jail into a inpatient treatment program for 3-6 months . The counselors at the drug treatment program become the ongoing support and referral sources for clients.

Linkages to Prison Clients. Pretrial detainees who go to prison before receiving HIV test results are followed by a case manager via a confidential letter to an established referral source in the receiving prison. These clients are then referred to posttest counseling.

Among the Cermak clients who have gone to prison, some have reported a lack of adequate linkage services as they prepare to leave prison. After release from prison, some individuals call Cermak's case managers for referrals in their communities. Case managers provide these linkages in much the same way as they do for detainees when they are being released from the jail facility.

Linkages to Family and Partners. Cermak does not have a formal policy about notifying partners. Officially, case managers do not notify the partners of clients; however, Cermak is establishing a linkage with the Chicago Department of Health to conduct such notifications. Currently, the case managers work with the clients to help them notify family members and partners. In addition, Cermak case managers provide linkages to community services and emotional support for family members and partners of clients living with HIV.

Linkages to family and partners are usually initiated by the clients. Clients may either ask the case manager to call their partners or may ask these individuals to call the case manager. A consent form for release of confidential information is signed by the client prior to discussing or disclosing any information regarding HIV status. Clients are strongly

encouraged to notify as many possible partners they can reach or feel comfortable in telling. Once they disclose their status to their partners, the case manager may provide them with support and information about community services.

Staff

The health education and HIV supportive services team comprises 17 people who bring to Cermak a wide range of backgrounds and experiences. Each has, at a minimum, a bachelor's degree and extensive knowledge about HIV. The positions and their basic duties are as follows:

- 1 program director, who administers the program;
- 11 health educators, who provide health education and information and receive requests for HIV testing, and provide pretest and posttest counseling;
- 3 case managers, who provide individuals living with HIV with linkages to care services and give supportive counseling for behavioral changes;
- 1 medical (HIV) information specialist, who discusses medical care with individuals living with HIV;
- 1 physician's assistant, who facilitates provision of medical care to individuals living with HIV;
- 1 mental health specialist, who provides one-on-one mental health counseling and facilitates in-house support groups;
- 1 support group coordinator (part-time), who coordinates in-house support groups; and
- 1 consulting psychologist, who provides psychological services on an as-needed basis.

All of the above positions are funded through various grants, including funding from Title IIIb and Title II of the Ryan White CARE Act, with the exception of the program director and seven health educators, who are funded by the Cook County Bureau of Health.

PROJECT SUCCESSES

Project success is defined as the delivery of appropriate HIV support services and the establishment of contact by the client to community resources. It includes, ultimately, the achievement of positive behavioral changes, including improvements in safe sex practices and reductions in criminal activity and substance abuse behavior.

Delivery of HIV Support Services

HIV Testing. In 1994, 3,551 inmates and 12 employees were tested for the presence of antibodies to HIV, an increase of 12.5 percent over the total testing in 1993. In an effort to provide HIV testing for all individuals at greatest risk, Cermak established a collaborative agreement with the Chicago Department of Health health workers who are currently assigned to the sexually transmitted disease clinic. In June of 1993, the Department of Health workers, during interview sessions, began offering the HIV antibody test routinely to all patients who tested positive for syphilis. This arrangement allowed Cermak to offer the test to a number of patients who might have been missed otherwise. In 1994, 326 detainees chose to be tested through this arrangement; of those, 16 tested positive (5 percent).

Educational and Counseling Sessions. Health education services are offered to every detainee and employee who requests them. By merging the Health Education Program and the HIV Related Services Program, Cermak was able to eliminate a number of service gaps; 1994 was the first full year in which the two programs operated as a combined effort, providing comprehensive services. Many clients have no idea what to expect from their disease. The addition of an HIV information specialist has filled the void between the point of diagnosis and medical followup. Additionally, the mental health specialist is providing much needed support for clients during this difficult time in their lives. During 1994, 23,574 sessions of health education were delivered; a 5.5-percent increase over 1993. The 1994 breakdown for these encounters is listed in Table 1.

Case Management Services. Once a referral is made, the case manager conducts an initial interview, completes the intake, helps each detainee assess his or her needs, completes followup services, and links the client with an agency that will provide a continuum of care upon release into the community. During the 2 1/2 years since the inception of case management services at CCDOC, the program has been well received by the detainee population seeking help in coping with HIV and with the stress of incarceration. Various community providers and the detainees themselves express their gratitude for the support provided at CCDOC. In 1993, 182 out of 224 clients diagnosed with HIV received case management services at CCDOC; in 1994, 221 of 227 received case management services. Of these 221 clients, 88 percent were men and 12 percent were women.

Data from a random sample of 47 clients interviewed in the first 4 months of 1994 showed the following:

- 37 chose to receive services during the first interview and went through the intake process;
- 7 refused services during the initial interview;
- 2 were repeat clients (received case management services, left jail, and returned to jail, then reconnected with case management services); and

- I asked for time to think about services and scheduled a return visit the following month.

The primary reason for refusal of service was the "fear of others finding out." A few clients reported that they were already linked to services in the community and would rather not focus on HIV while dealing with stresses related to incarceration and their legal cases. For those refusing services during the initial interview, case management services remained an option throughout the period of incarceration.

Table 1. Services Provided in 1994

Case-management services	
75	Initial client interview sessions
949	Follow-up sessions
18	Repeat client sessions
4	Group sessions with participation from 30 HIV-positive detainees
Educational services	
4,261	One-on-one educational/prevention sessions (for detainees)
598	Follow-up sessions
3,431	Pre-test counseling sessions
2,488	Post-test counseling sessions
180	Post-discharge notification sessions
780	Group sessions with participation from 11,861 inmates
101	Staff one-on-one educational/prevention sessions
28	Staff group sessions with participation from 654 employees
Mental health services	
898	One-on-one counseling sessions
88	Group sessions with participation from 68 HIV-positive detainees. These 68 individuals attended an average of 7 sessions each, resulting in a total of 468 units of service.

Mental Health/Support Groups. The first full year in which supportive counseling and HIV support groups were made available for all detainees living with HIV who were in need of such services was 1994. During 1994, a total of 1,366 units of mental health/support group services were provided. Approximately 31 percent of the individuals referred by case managers participated in the HIV support groups. The breakdown for these encounters is listed in Table 1.

Linkage with Community Resources

Initially, the community hesitated to serve those coming out of CCDOC because of their criminal label; however, over time Cermak has established a network of community agencies willing to work with the clients. Some of the agencies belong to a cooperative of agencies under the direction of the AIDS Foundation of Chicago. Cermak invites outside providers to its offices and meets with them in the community to discuss the program. Cermak's staff have attended community meetings and participated in community-based groups and organizations in an effort to establish working relationships with outside providers, as well as to educate others about the program. Cermak continues to establish linkages with outside agencies in order to increase awareness about its services and to encourage other service providers to accept its clients.

In addition, Cermak has been successful in locating clients who have failed to show up for scheduled appointments with outside providers. Community providers call the jail to see if their clients have been incarcerated. The case manager becomes the liaison between client and provider, as well as a resource for meeting the client's needs while he or she is incarcerated. Once the client is released, the provider is notified. This system has enabled Cermak to establish a mutual working relationship with the community providers.

Behavioral Changes

Through program records and interviews with key personnel, as well as with detainees, Cermak has found that many of the program participants have achieved behavioral changes. The current rate of recidivism for the CCDOC is approximately 30 percent.* The recidivism rate for clients receiving case management services is 8 percent. The primary reasons clients state for returning to jail are related to substance abuse and the inability to secure financial stability. Clients have difficulty securing employment because they lack job skills and work histories or because they are "felons." Of course, some clients lack the motivation or desire to seek employment. It is also difficult to get into drug treatment facilities. Waiting lists are long and by the time they can be placed, clients often have become heavily reinvolved in their drug use and are no longer living in the location they indicated on the discharge forms.

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*"Recidivism" at CCDOC denotes individuals who have entered the correctional system previously and have returned to the jail, either by committing another crime or by failing to appear in court after having been released on bond.

The health education staff conduct a followup session with clients to ask whether or not any behavioral changes have been made as a result of the education provided. Additionally, the program director conducts informal interviews with randomly selected clients. These followup sessions and interviews indicate (a) clients' intention to use condoms more frequently, (b) their reduced use of injection drugs, and (c) their intention to avoid the sharing of needles. Many of these behavioral changes may be temporary and due partly to incarceration; however, self-reported changes are viewed as a start to long-term behavior modification and self-empowerment.

Followup

It is difficult to gauge the success of intervention at this early stage. However, given the positive reception clients have received from the community HIV service providers, Cermak is optimistic. Acceptance of clients plays a major role in the overall success of this component of the program. Some clients maintain contact with case managers by calling from time to time to keep them informed or to ask for further assistance. Cermak has established a collaborative effort with some of the outside providers to work toward keeping the client engaged in services. In addition, Cermak staff asks clients questions about the quality of services, the effectiveness of the services, and whether or not the services are adequate.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

Discharge Planning

Due to the uncertain outcome of court cases and the potential for clients to be released unexpectedly on bond, effective discharge planning becomes a unique struggle for case managers working in the jail system. Pretrial detainees are not assigned release dates. The average length of stay for detainees in the HIV program is 4-5 months, but a few have stayed 1-2 years. Furthermore, once detainees are discharged from the Cook County jail, they go to one of numerous locations. Following is a breakdown of the destinations of the 221 detainees who received case management services during 1994:

108 (56 percent) went to prison;

61 (32 percent) went to the community;

16 (8 percent) went to TASC;

2 (1 percent) went to the Dept. of Mental Health;

3 (1.5 percent) died while in jail; and

2 (1 percent) terminated services.

The primary goal of case managers is to link clients with services. Case managers advocate on behalf of clients living with HIV to reduce the waiting time for ancillary services. Cermak refers clients to a significant number of agencies for services, but resources of these agencies are often overwhelmed by the needs they encounter. Long waiting lists, limited placements, and increasing demand for services make it difficult for case managers to establish linkages. In addition, the lack of a definite release date poses problems for scheduling services and for getting financial aid for detainees at release.

Staff Issues

Presently, two case managers staff ten Cermak divisions. Caseloads fluctuate between 30 and 60 clients for each case manager. To prevent staff burnout from these extremely high caseloads, case managers work with the client's family members who may become resources to both them and the client whenever possible. Case managers usually contact family members by telephone, but they do meet with them on occasion. Unfortunately, the lifestyle choices of some clients have alienated them from family members who might otherwise be important sources of support.

A large number of people living with HIV/AIDS pass through jails and prisons. In the beginning of Cermak's program, there was considerable opposition on the part of the security personnel to working with this population. An educational in-service training program was established to lower the anxieties of security personnel. The need for ongoing education is vital as efforts continue to maintain a cohesive working relationship and to respond to the rapidly changing face of HIV/AIDS in corrections.

MAINSTREAM ISSUES

Special Needs of Women

Cermak's staff have found that the needs of their women living with HIV are often greater than those of the men. Two factors for women are involvement with the Department of Children and Family Services (DCFS) and the availability of fewer facility beds for substance abusers. Residential, coed substance abuse facilities are often unable to address the special needs of women that relate to their drug use, including issues of sexuality and victimization. Residential programs specifically designed for women have inadequate numbers of treatment slots.

Women are often the primary caretakers of their children. The involvement of DCFS usually means that the women have to appear in juvenile court as well as criminal court. The stress of "fighting" two cases can be overwhelming. These women have a heightened sense of helplessness as they struggle with the potential loss of children in addition to the possibility of losing their own freedom. Add to this the diagnosis of a potentially life-threatening illness, and the burden facing these women can be enormous.

Limited Community Resources

Other factors influencing outcomes include the clients' inability to access public aid and social security benefits while incarcerated; the staff's inability to place clients in housing on the day of discharge (18 percent of clients are homeless); waiting lists for chemical dependency treatment, mental illness treatment, and HIV treatment; and for some clients, a lack of internal resources and skills necessary to make lifestyle and behavioral changes (e.g., self-esteem, education, and employment). Recognizing that some issues are external to the program, Cermak staff have learned to accept certain limitations and do their best with the available resources.

EVALUATION METHODS

Currently, Cermak is developing a followup questionnaire to assess progress towards its goals of establishing linkages between prisoners living with HIV and community services to address their multiple needs, and to determine whether and how clients are implementing lifestyle and behavioral changes. Behavioral changes of interest are those necessary to deter clients from reentering the CCDOC system, to better manage their medical needs, to address their substance abuse issues, and to make more informed choices about their lives.

Recently, Cermak began tracking the length of jail stay for its clients, the number of referrals that are made to community HIV service providers, and the rate and reason for return to the jail. In addition, Cermak is working with the City of Chicago to establish a referral and tracking system that will help gauge the success of community linkages made for clients. A formal linkage with the City of Chicago was incorporated into the objectives of one of Cermak's recent grants. When Cermak refers clients to city clinics, the clinics respond in writing within a month to indicate whether a referral was successful (the client made the appointment) or whether there was a problem. Cermak and the city work together to reengage the client in services if the initial attempt at linkage proves unsuccessful.

Cermak anticipates revising its statistical reporting format to make better use of the information it is gathering. It expects to conduct a more thorough analysis of services needed or received, risk factors of clients, the effectiveness of the services, client breakdown in terms of testing patterns (i.e., voluntary, diagnostic, court orders, referrals related to sexually transmitted disease, tuberculosis-related referrals, and body fluid exposures), and what happens to clients once they are linked with case management services.

These analyses will be based on followup interviews that are expected to occur at 1-, 3-, and 6-month-intervals after discharge. The 1-month followup interview will be a telephone contact from the Cermak case manager to the former client. The 3-month followup will be a letter sent from the Cermak case manager to the current provider to ensure that the client is receiving services from the agency to which he or she was referred. If the client is no longer receiving services from the referred agency, Cermak will inform the

provider of the reason. The 6-month follow-up will be a letter to the former client to inquire whether the case management services were beneficial, to what degree the linkages were helpful, and whether the linkages were appropriate.

Additionally, Cermak plans to inquire about any suggestions for improvement in the delivery of services. Given the nature of the population, a high response rate is unlikely. However, Cermak is considering an incentive to motivate former clients to respond. The addition of two case managers will reduce the caseload of the current staff to more manageable levels. It will be the responsibility of each case manager to followup on the discharge data for each client after 1, 3, and 6 months. Given that the primary function of Cermak case managers is to provide services to those currently incarcerated, postdischarge tracking methods may be restricted to telephone and mail.

DISSEMINATION OF THE PROJECT CONCEPT

Cermak produces several ongoing publications, including a quarterly newsletter, *Health Watch*, which provides pertinent medical and programmatic information to the detainees and staff at CCDOC. Pamphlets describe the program, available services, and information about contacts for prospective clients and other interested parties. Handouts and videos are available for distribution. Ongoing tours of the facility and interactions with the community increase the network of providers and keep the public informed about activities. Several health educators provided cross-educational coverage for the Healthy Start program.

Cermak's staff has presented its program and results to many organizations, including the AIDS Public Policy and Advocacy Workshop (February 1994, Champaign, Illinois), the Seventh International Conference on AIDS Education (November 1993), the 17th National Conference on Correctional Health Care (September 1993), and the 16th National Conference of Correctional Health Care (September 1992). Several staff members presented workshops at the 18th National Conference on Correctional Health Care: "Diverse Approaches to the Management of HIV in a Correctional Setting," and "Health Education in Corrections: What Works, What Doesn't, and Why?"

AUTHORS

Tara Howleit
Case Manager

Katie Stauffer
Nurse Case Manager

Cermak Health Services
2800 South California Street
Chicago, IL 60600

The Philadelphia Linkage Program

Alicia Beatty and Mary Hale Meyer

By 1991, it was obvious that HIV/AIDS was prevalent and increasing among prison inmates in Philadelphia, Pennsylvania. Studies conducted by the prisons showed a steady increase in the seropositive rates of inmates entering prison; by 1989 7 percent were seropositive, by 1990 10 percent were seropositive, and by the first quarter of 1991 12.8 percent were seropositive. Although individuals living with HIV in Philadelphia received medical care, treatment for drug and alcohol abuse, and mental health counseling through Philadelphia's AIDS Activities Coordinating Office's (AACO) Prison Project, these services stopped at the prison walls. After release there was little if any followup to ensure that a former inmate received either case management or clinical services. Furthermore, the existing prison-based programs did not include either case management or services for the inmates' families.

The Philadelphia Linkage Program was first funded in October 1991 by the Special Projects of National Significance (SPNS) under Title II of the Ryan White CARE Act as the "Inmates and AIDS Intervention Project"; the name was later changed to the Family Linkage Program and then to the Philadelphia Linkage Program. The program was a project of The Circle of Care, a pediatric, adolescent, and family AIDS demonstration project in Philadelphia. The Circle, a program of the Family Planning Council (FPC) of Southeastern Pennsylvania, is funded under Title IV of the Ryan White Care Act and provides family-centered primary and HIV-specific medical care and comprehensive social services in three clinical sites.

The Philadelphia Linkage Program was based on two assumptions: 1) that incarcerated individuals with HIV will be lost to the AIDS service system unless they are linked to appropriate community services *prior to their release*, and 2) that the inmates' families must also be linked to appropriate services *prior to the inmates's release* or they too will be lost to the service system.

Based on these assumptions, the Philadelphia Linkage Program sought to demonstrate that a prerelease intervention would ensure that both the inmate and the inmate's family would receive appropriate care and that this intervention would reduce stress on the inmates, increase their involvement with their families, and reduce the risk of their recidivism. Presumably, through the case management intervention, a case manager could ease the family stress that prison elicits; thus, the earlier the intervention, the greater the opportunity to keep the family intact. Inmates and all their family members were to be linked to The Circle of Care's clinical care, case management, and social services; those without families

were to be linked to community-based clinical services funded by Title I and to case management funded by Title II of the Ryan White Care Act.

PROJECT DESCRIPTION

Goals

The Philadelphia Linkage Program began with two initial goals:

- To link inmates living with HIV to community case management and clinical services before their release, with postrelease followup; and
- For the inmates with families, to link the families to The Circle of Care.

Subsequently, the Philadelphia Linkage Program modified the first goal and made it the primary focus of the program:

- To link incarcerated individuals to community services though case management both before and after their release from prison.

The project proposed to provide these linkages for 480 inmates over a 3-year period. In addition to providing these linkages, the project had an objective of increasing the inmates' involvement with their families through at least one combined health care visit.

Profile of the Client Population

The Philadelphia prison system comprises five short-term institutions. Operated by the city, these institutions confine persons who are 18 years or older. Many persons detained in these prisons are not serving sentences but are awaiting trial or transfer to a State or Federal prison. Those serving sentences are typically confined for less than 2 years. Currently, the total population of the Philadelphia prison system is approximately 5,000: 4,650 men and 350 women. The inmates are predominately young and nonwhite, characterized by low incomes, poor educational background, and poor employability.[1] An overwhelming majority of inmates in Philadelphia prisons use or abuse drugs. In 1989, of men arrested in Philadelphia, 84 percent tested positive for any drug and 76 percent tested positive for cocaine; of women, 79 percent tested positive for any drug and 64 percent for cocaine.[2] HIV seroprevalence data reveal that the seropositivity rate among women equaled that of men: 12.8 percent.

Client data of the Philadelphia Linkage Program mirror those of the larger prison population: of 40 HIV-positive prison inmates enrolled in the program in mid-1994:

- 80 percent (32) were men and 20 percent (8) were women;

- 50 percent were African American, 23 percent were white, and 28 percent Latino/Hispanic;
- 75 percent were 30 to 39 years old; and
- 60 percent acquired HIV by injection drug use.

Nature of the Intervention

The Philadelphia Linkage Program was designed as a collaboration among several Philadelphia-based AIDS service organizations, including 1) The Circle of Care and its parent organization, The Family Planning Council, which developed and implemented the research design; 2) the Philadelphia Health Management Corporation (PHMC), a regional health planning agency, whose staff had considerable experience working with women in prisons; 3) ActionAIDS, the case management agency, which was to coordinate the services to inmates and their families; and 4) the AACO Prison AIDS Project, which was to be the primary source of referrals. The collaborating organizations decided that The Circle would be the lead agency for the linkage program because of its focus on the family. However, because of inmates' reluctance to divulge names of family members, the focus shifted to individual case management, with referrals to medical facilities funded by Title I of the Ryan White CARE Act.

The Circle of Care is a coalition of 13 agencies and institutions formed with both public and private support in 1990 to provide clinical care and supportive services to families, children, and adolescents affected by HIV/AIDS. Programs help prevent the spread of HIV/AIDS through outreach and prevention education. The Circle provides comprehensive, coordinated, family-centered primary medical care and social services to families and children affected by HIV in three family clinics. Two of the clinics are based in Philadelphia's two pediatric hospitals, the Children's Hospital of Philadelphia and St. Christopher's Hospital for Children. The third clinic (which had not opened when the Philadelphia Linkage Program first began), Care Plus, is located in a community-based city-funded health center. Entry into The Circle is available to infants and children with HIV. The children's parents with HIV and uninfected siblings receive health care and a broad array of social services at the same place and at the same time.

Each family has a clinic-based social worker. Approximately 70 families with the most intensive social service needs have an ActionAIDS case manager/homeworker team. ActionAIDS is the largest case management agency in Philadelphia. It was founded in 1986 as an all-volunteer agency that offered a buddy-system program; later, the agency became more structured. ActionAIDS provides services to those affected by HIV; its primary service is case management for adults who are symptomatic, but it also provides case management when a mother or child has HIV and is psychosocially dysfunctional. ActionAIDS began its Family Program in 1989 to provide culturally competent and linguistically appropriate case management to HIV-affected families. Presently, there are two community-based Family

Program sites, one in north Philadelphia near St. Christopher's Hospital for Children, the other in west Philadelphia near the Children's Hospital of Philadelphia. The program has a staff of 16, including 8 homeworkers. The case manager/homeworker teams provide counseling and support for domestic care, medical compliance, and liaisons with physicians to the clients, their families, friends, and caregivers. In 1994 the program had a capacity of 90 families.

In addition to the services provided by The Circle of Care, the Philadelphia Linkage Program provided discharge planning for inmates living with HIV and their families by a team of case manager, nurse, and, for families, a lay homeworker. Prior to release from prison, each inmate with HIV was referred to the Philadelphia Linkage Program case manager and nurse by the AACO Prison AIDS Project. AACO had a staff of eight at the House of Corrections and conducted HIV testing and AIDS education for all incoming prisoners. The Philadelphia Linkage Program case manager and nurse 1) arranged for medical care for the inmate while he or she was still in prison and 2) planned for medical and case management services to be available immediately after release from prison. Referrals were to the closest health facility with Ryan White funds. If for any reason the inmates were denied services—e.g., if they wanted AZT and were not getting it, the team advocated on behalf of them with prison staff. If an inmate had a family, the team sought the inmate's permission to contact them and to enroll them in The Circle of Care prior to the inmate's release. The PHMC had initially planned to conduct an orientation and education program for women inmates, but there were too few women inmates with HIV; instead, the PHMC conducted a needs assessment of a population of women in a residential drug rehabilitation program.

After release from prison, inmates and their families were followed by the case manager for 3-6 months to ensure that they accessed services. The families received the assistance of a homeworker to provide in-home services, to ensure that the families kept clinic appointments, and to give them emotional as well as practical support.

As of August 1994, the Philadelphia Linkage Program had received a cumulative total of 107 referrals; the case load was 40, with 6 pending referrals. The caseload characteristics are shown in Table 1.

The case manager has established relationships with a number of in-prison resources. In addition to AACO's Prison Project and the social workers and drug counselors mentioned above, the case manager receives referrals from the Defenders' Association social workers, the AIDS Law Project, and the prisons' mental health social workers. Each prison has a 10-bed psychiatric unit linked to Hahnemann University Hospital and mental health social workers. Referrals are also received from the prison chaplin. Some prisoners have self-referred. In the 8 months that the current case manager has been with the program, only two people have refused the services: one was mentally disturbed, the other felt he did not need social supports because he had a strong family support system.

The case manager meets with the inmates while they are still incarcerated (usually within two weeks of release) and links them to appropriate social services, including drug rehabilitation. The case manager talks with the admissions person at the referral health facility. The nurse provides medical assessments, makes sure that the prisoners receive adequate medicines, and facilitates care for the inmates when they are sick. The services do not end with the inmate's release. For inmates, transitional planning and support are critical to ensure that they receive needed medical and social services; this is particularly true of substance abusers, who are the clear majority of those served by the Philadelphia Linkage Program. If a connection is not made before release, staff find it difficult to reconnect with the client. In the case management approach, the case manager typically works with her clients for 3 months after release. The case manager provides linkages to financial assistance, other case management and medical services, housing assistance, nursing home placement, HIV education, and general emotional and practical support.

Table 1. Philadelphia Linkage Program: Case Load Characteristics
(n=40)

Characteristic	Percent
Race	
African American	50
Latino	28
White	23
Sex	
Men	80
Women	20
Mode of Transmission	
IV Drug	60
Heterosexual	25
Homosexual/Bisexual Men	8
Transfusion	7

Staff

Three kinds of staff were underwritten by the project: direct service, evaluation, and administrative. Staff of the AACO Prison Project referred inmates to the Philadelphia Linkage Program but were not funded by it. The direct service staff included the family program coordinator, case manager and nurse; the research associate and assistant designed and conducted the evaluation; and the project director and program coordinator administered the project. Table 2 summarizes the roles and responsibilities of the project staff.

Table 2. Project Staffing of the Philadelphia Linkage Program

Referrals (AACO)*	Direct Service (ActionAIDS Family Program)	Evaluation (FPC)	Administration (The Circle)	Needs Assessment (PHMC)
Prison Project Supervisor ♦ A pivotal member of the steering committee; performed liaison and gained entry to the prison Counseling & Testing Staff ♦ Conducted training and orientation of case manage-ment staff re: environment, procedures, and jargon of prison.	Family Program Coordinator ♦ Member of steering committee; coordinated activities with the prison; worked closely with AACO. Case Manager ♦ Responsible for discharge planning; lead contact with inmates Nurse ♦ Performed health assessments of each inmate in the discharge planning process; worked with health services system of the prison; helped inmates understand their health care plan and how to follow through Homeworker ♦ Provided in-home services	Research Associate & Assistant ♦ Managed database; designed and conducted research	Project Director ♦ Oversaw project; interacted with executives of collaborating agencies Program Coordinator ♦ Chaired steering committee; responsible for program implementa-tion	Principal Investigator ♦ Conducted women's needs assessment

* AACO staff was not funded with SPNS funds.

Funding

The Circle of Care, which is under the fiduciary responsibility of the Family Planning Council of Southeastern Pennsylvania, is one of 42 national pediatric AIDS demonstration projects. Major funding for The Circle services come from public and private sources, including Ryan White Titles II, III, and IV; Rhone-Poulenc Rorer; and The Pew Charitable Trusts. The only funding for the Philadelphia Linkage Program was $180,848 annually in Federal SPNS funds to support both research and service delivery.

PROJECT SUCCESSES

Although The Philadelphia Linkage Program was beset with barriers, it had a number of successes.

Steering Committee

An important administrative success was the project's steering committee, established by The Circle of Care's project director in the program's second year. The committee was composed of representatives of all the collaborating organizations, as outlined in Table 3. Initially, all executives and direct service staff were members of the steering committee; later, only direct service staff were members.

Table 3. Steering Committee Composition of the Philadelphia Linkage Program

AACO	ActionAIDS	Research	TCOC	PHMC
Supervisor	Family Program Assistant Director	Research Associate	Project Director	Principal Investigator
Counselor	Program Coordinator	Research Assistant	Program Coordinator	
	Case Manager			

The steering committee which met monthly, ensured that all the players were partners in program planning and implementation. At committee meetings, the members identified problems and brainstormed possible solutions. The steering committee was dissolved when the grant terminated.

Working Relationship with Prison and Staff

Although it took a long time, the Philadelphia Linkage Program staff developed a good relationship with the Philadelphia prison system staff. Part of the credit for the cooperative relationship belongs to the prison system's director of inmate services; part goes to efforts of the program staff to meet with prison staff and develop cooperative relationships with them. For example, at the end of the first year, Philadelphia Linkage Program staff conducted an orientation for prison social workers, which helped them understand that the program staff were not threats to their jobs. Resistance to the program by prison staff diminished when they realized the benefits of discharge planning and continuity of care. At present, Philadelphia Linkage Program received referrals from a number of sources within the prison, including in-prison social workers and drug counselors.

Referral Agreements

Because the Philadelphia Linkage Program had only a few families in its client base, it could not refer clients into The Circle of Care and had to develop referral agreements with

agencies funded by Title I and Title II. The program developed formal agreements with a number of agencies serving Philadelphia's HIV community, including The Circle of Care provider agencies, BEBASHI (Blacks Educating Blacks About Sexual Health Issues) and Congreso de Latinos Unidos.

The Value of the Case Management Approach

Throughout the project, it became clear that once the initial resistance of the prison staff to outsiders was overcome, having outsiders as the intervention team was very important. Their status as outsiders increases their credibility with inmates and helps the team establish trust. Moreover, because they are not part of the system, nonprison staff can advocate more effectively. For instance, both nurse and case manager advocate for inmates to get appropriate medical care in the prison; the nurse has additional credibility because she is medically trained. The lay homeworker is indigenous to the community and is able to move in and out of family homes, often presented as a relative or friend.

BARRIERS ENCOUNTERED AND RECOMMENDATIONS

Before developing this paper, The Circle of Care circulated a questionnaire to project staff. Questions were asked about proposal development, project implementation, project administration, and program evaluation. Most of the responses concerned the first two areas. Eleven people responded to the survey. Of these, seven felt they had been involved in the program long enough to answer the survey in depth. The following discussion of barriers draws heavily on both the questionnaires and on the project's periodic progress reports.

Project Planning

Many of the issues encountered in implementing the Philadelphia Linkage Program began with the project planning process. Table 4 summarizes what the survey respondents indicated to be the greatest obstacles during the planning process.

One concern was that the people who developed the project plan did not interact with The Circle of Care's own Board of Directors, which had great difficulty understanding how this project would fit with The Circle's mission. Many board members declined to write support letters for the project.

Problems with the prison system can be avoided by making the appropriate contacts during project planning and early implementation. When the Philadelphia Linkage Program contacted the director of the prison system for assistance, the program director referred to the director of inmate services, whose job it was to ease the way for outside groups to work within the prison system. His assistance was invaluable in helping the Philadelphia Linkage

Program staff learn the prison system and cut through the red tape. Responding to the lack of inclusion of the prison staff in the planning, one survey respondent said:

> "If [the prison staff] had been brought into the program,it could have eliminated turf and culture issues.. They would have offered a broader perspective [and] advocated for the program rather than be threatened by it."

Table 4. Obstacles to the Success of the Planning Process

	Number of Respondents (n=11)
Key players not involved in planning	
♦ Prison staff and administration	5
♦ Other agencies doing prison work (Defenders Association., Hahnemann Mental Health Unit)	2
♦ ActionAIDS direct service staff	3
Lack of information about prisons	
♦ AACO withheld information	2
♦ Little understanding of how difficult it was to retain staff in this setting	2
♦ Limited knowledge of relationship of many inmates to their families; thus eligibility criteria for program too narrow	1
Other	
♦ Proposal objectives stretched to fit The Circle's mission	1
♦ Planning rushed because of proposal deadline	2

The director of inmate services also was instrumental in expanding the program's referral base by convening a meeting of the special service staff of all the prisons. At a meeting of 60 prison employees, the Philadelphia Linkage Program staff presented its program and secured cooperation from the social service staff, drug and alcohol programs, the mental health unit, the social work staff, and others.

Project Implementation

The limitations in the planning process revealed themselves during project implementation. A key barrier was the project staff's lack of knowledge about the prison system and about the difficulties in working with an inmate population. Additional obstacles to implementation included an insufficient number of client referrals, insufficient time to build trust, the changing name of the project, and high turnover of case management staff.

Mistrust of the Program. The prison's internal social work staff was suspicious of the program and its staff and feared the Philadelphia Linkage Project staff would replace them, particularly in the face of a municipal workers' strike. Distrust of the Philadelphia Linkage Program staff by the prison staff was intensified by the city's budget crisis and the city administration's threats to privatize city services to save money.

Some project staff and prison social workers may not have had an adequate understanding of the project's goals and criteria. The lack of knowledge about the prison system hampered the startup in practical ways as well; case managers did not have clearance to enter the prison, staff did not have identification badges, and there was no confidential work space or telephone.

In addition, the initial budget funneled all funds to direct services and evaluation, with no funds available for coordination. During the first 2 years of the project, as elements clearly were not going well, there was an undercurrent of distrust and blame among the project staff. Finally, all staff met with the coordinator of client services at ActionAIDS and the director of Philadelphia's AIDS Activities Coordinating Office to clarify roles and responsibilities.

Insufficient Number of Clients. Too few clients was an ongoing problem. Because the project developers lacked knowledge of the prison system, they relied on the AACO Prison Project for guidance and for referrals. Consequently, the Philadelphia Linkage Program did not reach inmates who had been tested prior to incarceration or inmates who were tested by a provider other than AACO. Also, most client referrals were not family connected possibly because inmates were not willing to admit to children that they would not be reuniting with their families or because they feared facing a child support detainer upon release. The steering committee and staff studied the low number of referrals and decided to implement two suggestions: 1) seek referrals from prison social workers and health services staff; and 2) encourage the case manager to spend more time with each inmate. At the request of the steering committee, a meeting of project participants provided an opportunity for networking and information exchange among the project participants.

Insufficient Time to Build Trust. The original program plan called for the case management team to meet once with an inmate prior to release from prison. Planners assumed that the nurse and case manager could build trust with a client in one meeting. When it was realized that trust takes more time, the program timetable was revised to include

more than one in-prison visit. However, because prison terms are usually short and release dates unpredictable, keeping to the timetable proved difficult.

The Project Name and Focus. The project's names were a major barrier to inmate enrollment in the program. Its original name, "Inmates and AIDS Intervention Program," deterred prisoners from self-referring because of the word "AIDS." A woman inmate who missed several appointments with her case manager said that such a meeting might let other inmates know that she was living with HIV and she feared being ostracized.

Distributing flyers with the project's name as a form of outreach proved to be counterproductive as well because of the AIDS identification. Inmates would not take these flyers to their cell blocks for fear of stigma. Subsequently, focus group results revealed the extent to which the prisoners feared exposure and knew, better than did the program planners, how little confidentiality there is in a prison. In the second year, therefore, The Circle of Care changed the project's name to "The Family Linkage Program."

This name better fitted the original purpose to link inmates and their families with appropriate services, and it better reflected the mission of The Circle of Care. However, the new name proved to be a barrier to referrals. Although many of the inmates have children and families, contact with their families is sporadic. Two focus groups conducted by the Family Planning Council Research Department probed family relationships. When asked about their relationships with their families since incarceration, the majority of the men said that their relationships have been strained since their sentencing. Only one man reported regular contact with his family; most have older children "out on their own" who do not visit often. While ten of the women in the focus group reported having children and having been responsible for the children's health care prior to incarceration, these women were unsure what would happen when they were released. Some barely knew their children; others expected that the State would take custody.

As the program evolved it also became clear that few of the inmates living with HIV who were in contact with their families had disclosed their HIV status. Like many people with HIV, inmates fear the consequences of disclosure. Disclosure to family members might have even more devastating consequences for people in prison than for people "outside." Families are an inmate's link with the world; they bring money, cigarettes, and other gifts. Disclosure might break that link.

Finally, The Circle of Care renamed the program to "The Philadelphia Linkage Program." This name and the revised goal of working with inmates living with HIV whether or not they wished to identify families greatly increased the program's chances of success. It also helped to increase the number of participating clients.

Turnover in Case Management Staff. Undoubtedly, the greatest obstacle to the ability of the program to meet its goals was the high turnover in case management staff (five case managers in 2.5 years). Each resignation or firing resulted from issues of personality

conflicts and private quarrels. The turnover impeded progress and affected the program's ability to develop relationships with inmates and to provide meaningful followup after discharge. Furthermore, the instability of the staff affected relationships among organizations cooperating on the project. As a representative of AACO wrote in his survey:

> "The staff turnover and [subsequent] lack of coverage and continuity made it difficult for [our] staff to see the case manager as more than a drain on services and not a support to existing services."

The position of case manager was a demanding one and was vital to the success of the project. It required a professional with flexibility, resourcefulness, empathy, compassion, persistence, enthusiasm, and the ability to work with all parties. The case management staff stabilized in the winter of 1994; thereafter, the program began to move forward.

MAINSTREAM ISSUES

Understanding the System

A mainstream issue for any program providing service linkages to prisoners is cooperation from the prison system. Perhaps no one connected with the project with the possible exception of AACO staff understood the difficulty an outside organization encounters in becoming accepted by inmates and staff of a prison system.

Events in the prison system also interfered with program implementation. Often, there was an inordinate period between the time an inmate was called to be interviewed and the time the inmate actually arrived. There were many reasons for this delay, including a lock down and a prison count. Frequently, inmates did not hear their call because they were asleep, in the yard, at meals, or in the infirmary and no one bothered to find them.

Understanding the Population

A clear understanding of the characteristics of the clients to be served is critical to the success of a program like the Philadelphia Linkage Program. HIV disease may not be an inmate's greatest concern; in fact, practical needs at the time of release most likely overshadow, if not overwhelm, the client's ability to seek HIV-related services. The ideal approach would be to gather data and profile the population to be served by the intervention.

The Philadelphia Linkage Program was not able to survey the Philadelphia prison population, but observations from a study of 66 women in a voluntary residential drug rehabilitation program in Philadelphia assisted in program planning.[3] The findings from the study must be interpreted conservatively for several reasons: the small sample size, the potential bias of sampling only women in a drug treatment program, and the limitations of a self-administered questionnaire. However, the characteristics and life situations of the study participants were similar to those of the larger population in Philadelphia prisons (Table 5).

Table 5. Characteristics of Women in Voluntary Drug Rehabilitation Program Study (n=66)

Age	30.8
Mean in years	(18-64)
(Range)	(18-64)
	%
Race/Ethnicity	
African American	61
White	23
Latino	15
Other	2
Marital status	
Single	73
Divorced/Separated	12
Married	9
Widowed	6
Children	
Yes	82
No	18
Lived with children before incarceration?	
Yes	32
No	68
Education	
Did not complete high school	73
Completed high school	27
Ever homeless?	
Never	58
At some time	42
Ever worked?	
Yes	75
No	25
Drug use	
Alcohol	83
Cocaine	80
HIV status (n=65)	
Positive	77
Don't know/not sure	20
Negative	3

A majority of the women did not complete high school, and 42 percent had been homeless. The majority of women (77 percent) were living with HIV. The high percentages of women using alcohol and cocaine indicate that most women used both substances. A high percentage (68 percent) of women had not lived with their children prior to incarceration, even though 82 percent of the women had children. The study reported that many women had few close relationships, although one-third reported having a close relationship with a grandmother and one-fourth reported regular visits from a parent; one-fourth reported no visits.

The women reported emotional and physical distances that were rooted in many issues, including drug addiction. Drug addiction was termed "one of the toughest challenges" facing a provider working with incarcerated women. Often, women in prison are drug free for the first time in many months, or even years. The majority of the study participants... identified drug addiction as the number one issue they needed help with, presently and in the future, when they leave prison. Programs such as the Philadelphia Linkage Program must place a strong emphasis on linking women in the prison system to intensive drug rehabilitation programs. Otherwise, the impact of the program will be limited, if not lost.

The study underscores what providers need to know about women living with HIV and women affected by HIV, i.e., that such women have multiple needs that must be met in a coordinated fashion within a fragmented system. Furthermore, the study notes that since it is easy to lose track of women once they are released from prison, a program like the Philadelphia Linkage Program which builds a trusting relationship with women is "key to maintaining a relationship following [these women's] release into the community."

EVALUATION METHODS

The program's evaluation was designed 1) to provide an ongoing assessment of project components to monitor the implementation of project activities and 2) to assess the project's effectiveness in meeting its goals. The evaluation instruments included:

- ***Focus groups*** with men and women to probe their issues, attitudes, perceptions, and feelings so that the needs of inmates living with HIV and their families could be better addressed once the prisoners are released.

- ***A longitudinal survey*** to assess the program's effectiveness in providing support to clients. The survey was to be administered before an inmate's release and at 3 months after release.

- ***Comparison group*** of families enrolled in The Circle of Care to compare the service needs of referrals, the use of services, and aggregate demographics of individuals with HIV and HIV-affected families with and without a history of incarceration.

Focus Groups

Family Planning Council Research Department staff conducted two focus groups in the Philadelphia prison system, one with 11 men and one with 14 women, on May 11, 1992, and October 28, 1992, respectively. The participants were not necessarily living with HIV. Table 6 lists the characteristics of these inmates. Although participants in both focus groups showed a general lack of knowledge about the transmission of AIDS, the men were much more reluctant than the women to talk about AIDS and other sexually transmitted diseases. Among the men there was a high degree of homophobia. Of the two groups, women had closer ties with their families than men, although it was unclear how many would regain custody of their children after being released. Men and women wanted separate facilities for inmates with HIV, but for different reasons: the men wanted separate facilities to prevent transmission while the women wanted a place where they could express their feelings openly in support groups. In addition, participants said they preferred the staff to be people from outside the prison system.

Longitudinal Survey

The longitudinal survey was designed to measure the following:

- Inmates' perceived medical and social service needs (both HIV- and non-HIV-related) during and after incarceration;
- Perceived medical and social service needs (both HIV- and non-HIV-related) of the inmates' families; and
- Inmates' sexual risk behaviors, condom use, and injection drug use before and after incarceration.

In addition, the evaluation team planned a "linkage monitoring system"—an instrument designed to track individuals and families for 3 months after the inmates' release to document the number and demographics of Philadelphia Linkage Program clients, their needs, referrals made for them, and their use of services. The linkage monitoring system was designed to gather the following information:

- Communication by inmates to prison staff, Philadelphia Linkage Program staff, and families regarding HIV/AIDS and prison issues;
- Pregnancy status, birth control history, and intentions to give birth of women inmates living with HIV;

- Emotional well-being and stress levels of inmates; and
- Demographic characteristics of inmates living with HIV.

Table 6. Characteristics of Focus Group Participants

	Total (n=25)		Men (n=11)		Women (n=14)	
	%	#	%	#	%	#
Race/Ethnicity						
African American	80	20	81	9	79	11
Latino	4	1	-	0	7	1
White	8	2	18	2	-	0
Other	8	2	-	0	14	2
Marital Status						
Single	60	15	64	7	57	8
Married	20	5	27	0	14	2
Separated	8	2	-	0	14	2
Divorced	8	2	9	1	7	1
Widowed	4	1	-	0	7	1
Age						
Mean in Years	29		28		30	
(Range)	(18-46)		(18-46)		(21-42)	
Education						
Mean in Years	10.0		10.0		10.0	
(Range)	(5-12)		(6-12)		(5-12)	
Number of Children						
Mean	1.5		1.0		2.0	
(Range)	(0-9)		(0-6)		(0-9)	
Number of Jail Terms						
Mean in Months	2.5		3.0		2.0	
(Range)	(1-10)		(1-10)		(1-10)	
Length of Current Sentence						
Mean in Months	8.2		6.5		10.0	
(Range)	(.5-24)		(2-12)		(.5-24)	

Unfortunately, the database never became operational because of the turnover in case management staff.

While the study was designed to compare inmates' needs during incarceration and after release, as of September 1994 only two inmates were eligible for the followup survey; therefore, the study was limited to a cross-sectional description of the prison population. Surveys were obtained between March and June of 1994 from a convenience sample of 13 inmates in the Philadelphia Linkage Program. The demographics of those surveyed were similar to those of the prison population and of participants in the program. Eleven were men and two were women; five were African American, three Hispanic, three white, and two "other." They ranged in age from 23 to 50. Eight were single, two were widowed, two had long-term relationships with a partner, and one was divorced.

The survey covered a number of issues. One of the most positive findings was the inmates' response to the questions regarding to whom, inside and outside of prison, they could talk about their concerns about HIV and the prison. *All* the respondents said they could talk to their case manager or nurse about HIV and all but one said they could talk to the case manager or nurse about the prison. In contrast, only 39 percent said they could talk to the prison social worker about HIV; 46 percent said they could talk to the social worker about prison issues.

Comparison Group

A component of the comparison group analysis was the stress scale, designed to measure how inmates were functioning, in general and with regard to their HIV status. The results of the scale were compared to the results of a similar survey with family caretakers living with HIV enrolled in The Circle of Care. The results show that inmates living with HIV experienced a greater degree of stress than did the families affected by HIV enrolled in The Circle of Care. These results were statistically significant ($p \leq .05$). The original aim of the comparison group analysis was to compare the levels of stress of the inmate before and after incarceration, to see if case management support alleviated the stress and to see how this compared with families enrolled in The Circle of Care. To date, the staff have not been able to interview inmates released from prison.

DISSEMINATION OF THE PROJECT CONCEPT

Staff felt that the program, including the obstacles it faced and overcame, provides valuable lessons for other organizations seeking to provide case management and related services to incarcerated men and women. Findings from the survey, the numbers currently reported by the case management staff, and the insights from the "Women in Prison" study suggest that The Philadelphia Linkage Program is on the right track. Prerelease case management for incarcerated men and women with HIV is crucial if these individuals are to be linked to medical care and social services upon their release. The program, in a limited form (without a nurse or homeworker), will continue for at least another year with funding

for case management supplied by the Philadelphia Department of Public Health's AIDS Activities Coordinating Office.

The Philadelphia Linkage program has been disseminated in a number of forums. The program was presented at the 1993 American Public Health Association meeting; at the African American Summit in Gabon, Africa; and at the SPNS Annual Meeting.

NOTES

1. The Philadelphia Regional Comprehensive Plan. This is the planning document of The Philadelphia AIDS Consortium (TPAC), the Ryan White Planning Council for the Philadelphia EMA.

2. National Institute of Drug Abuse Forecasting System.

3. Women, AIDS and Prison: Findings from a 1993 Survey of Women in Prison in Philadelphia, by Lisa Bond. Philadelphia Health Management Corporation, 1993.

AUTHORS

Alicia Beatty
Director

Mary Hale Meyer, M.A., M.Ed.
Coordinator of Program Planning and Development

Circle of Care
260 Broad Street
Suite 1510
Philadelphia, Pennsylvania 19102