



Behind the Wall

Collaborative Responses in
Massachusetts and Michigan
to Address HIV/AIDS Among
Incarcerated Populations



Association of State and Territorial Health Officials

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Executive Summary

The rate of confirmed AIDS cases in U.S. prison systems at year-end 1997 was 2.1 percent, approximately five times greater than that of the general population.¹ The 1.9 million individuals in U.S. correctional facilities represent a population at high risk for and with high rates of HIV/AIDS and other infectious diseases. Moreover, demographic shifts in the nation's HIV/AIDS epidemic among African Americans, Latinos/Hispanics, and women are paralleled in correctional facilities.

The Association of State and Territorial Health Officials (ASTHO) developed the ASTHO Prison Project to focus attention on appropriate strategies and models for prevention of HIV/AIDS and other infectious diseases prevalent among incarcerated populations. The goal of this report is to document the process of program implementation and to describe the challenges and strategies utilized to forge new collaborations based upon the experiences of Massachusetts and Michigan. States in any stage of HIV/AIDS program formation can look to the collaborations in Massachusetts county correctional facilities and Michigan state prisons to better understand the partners needed, the growing pains, and the potential program success associated with implementing such programs.

Massachusetts and Michigan recognized the importance of providing HIV/AIDS interventions in correctional facilities as a method of improving overall community health and preventing disease transmission at the community level. The vast majority of individuals in correctional facilities are detained for relatively short periods of time and then returned to the community. For inmates* and released individuals with HIV infection, assuring access to appropriate medical care, treatment, and support services is critical to keeping their infection under control and reducing the potential for transmission to their sexual and needle-sharing partners and others in the community.

Massachusetts and Michigan utilize a collaborative approach involving multiple partners. To implement their HIV/AIDS programs for inmate populations, Massachusetts and Michigan utilize a collaborative approach involving multiple partners. The partners in the collaboration include state and local health departments, correctional agencies, and community-based organizations (CBOs). The two programs described in this report have led to better medical and aftercare services for inmates, program expertise, staff commitment, dedicated funding and community resources, and, it is hoped, improved community health.

The approaches these states took to collaboration are similar yet different, as they were created within the realities of two different testing policies. Massachusetts county correctional facilities have voluntary HIV testing and counseling for inmates, while the Michigan Department of Corrections has mandatory HIV testing and counseling for inmates at intake.

The following observations emerged throughout the course of interviews and site visits to HIV/AIDS programs administered in Massachusetts and Michigan correctional facilities. These observations should be considered by any jurisdiction considering implementing public health programs for inmates infected with or at risk for HIV.

Collaborations among public health, correctional agencies, and community-based organizations can be effective in addressing HIV/AIDS among incarcerated populations, especially if comprised of a shared mission, executive staff support, and dedicated program funding.

While such collaborations can be effective, a number of steps need to be in place to ensure success. These steps include a commitment by the collaborative partners (e.g., public health and public safety agencies) to strive to understand and be sensitive to the needs of the others. When involved agencies understand each other's mission and obligations, roles and accountability, collaboration has a better chance at success. Also needed is the support of the policymakers who set the agenda for their respective agencies and a commitment to both the issues and program sustainability.

* For the sake of clarity, this report will refer to incarcerated individuals as "inmates." It is noted that individuals in jails are usually referred to as "detainees," noting their pretrial or presentence status.

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Effective HIV/AIDS programs address the issues of stigma and discrimination, as well as the need for privacy and confidentiality associated with HIV/AIDS in corrections.

An intense HIV/AIDS stigma often exists behind bars and is exacerbated through inmate and staff attitudes and behaviors regarding HIV. The fear of disease disclosure and the sense of isolation experienced by inmates with HIV/AIDS should never be ignored when developing an HIV/AIDS program in this setting.

Effective HIV/AIDS programs in correctional facilities have multiple components and support a continuum of care following discharge.

Multifaceted HIV/AIDS programs in correctional facilities include components such as HIV/AIDS prevention and education, case management, discharge planning, and psychosocial services. The overall goal of continuity of care for inmates with HIV/AIDS involves providing care and treatment from their first day in the facility all the way through to their return to the community. Discharge planning should begin early in the process in order to ensure that the individual has continuity of care and continued access to appropriate treatments and other critical services. By providing such services, these individuals have a better chance of staying connected with appropriate care, and perhaps preventing HIV transmission at the community level.

HIV/AIDS programs within a correctional facility must educate inmates and correctional staff about the disease.

Fear of HIV transmission is commonplace among inmates and correctional staff. Correctional officers' attitudes toward HIV affect the way they relate to HIV-positive inmates, as well as their response to educational programs offered to inmates, and the related public health issues. Therefore, educational efforts must be directed to both inmates and correctional staff to ensure that they are knowledgeable about HIV, modes of transmission, and other factors. Educational programs that are directed to both inmates and correctional staff lead to more internal support and enhanced service delivery.

Peer-led education and prevention efforts in prisons and jails can be an effective teaching method for inmates.

Peer educators who are carefully selected and trained are viewed by inmates as more credible and approachable sources of information than correctional personnel, and are more likely to use terms that are relevant and understandable to the inmates. The use of peer-led education and prevention can increase the effectiveness of educational sessions and the levels of acceptance for such programs among inmates.

Measurable outcomes of program success and client health are still being developed and evaluated.

Measures of success associated with HIV/AIDS programs in correctional settings continue to evolve. Thus far, these measures have included variables such as reduced recidivism rates, increased inmate requests for HIV testing and counseling, medical/case management appointments kept upon release from a facility, decreased rates of post release hospitalization, and lower rates of opportunistic infections and emergency room visits. Additional evaluation components are being developed. A new correctional health initiative established by the Centers for Disease Control and Prevention and the Health Resources Services Administration will yield insights on factors related to engagement of medical care by released individuals with HIV/AIDS as well as examples of successful program models that can be replicated in other locales.² The dissemination of data findings and evaluation recommendations resulting from this process will ultimately be made available to the public.

EXECUTIVE SUMMARY

In closing, individuals sentenced to correctional facilities remain members of outside communities despite their time behind bars. In most instances, they are released from detention and returned to the community after relatively short periods of time. HIV/AIDS education and prevention, treatment, and transitional services must be made available in the facilities where they serve their time in order to prevent the cycle of risk that is associated with contracting and transmitting HIV infection. HIV-infected inmates who are not provided adequate medical care while incarcerated can impose an additional burden on the health delivery system upon release. Moreover, without proper interventions, inmate and formerly incarcerated individuals may continue to engage in high-risk behaviors, thereby increasing the possibility of new transmissions within the community. Through their collaborative efforts, the Massachusetts and Michigan programs reflect a new model for addressing HIV/AIDS among incarcerated populations. This model supercedes traditional barriers and blends together public health and public safety approaches, methodologies, cultures, and funding streams.

“General health education and planning for continuity of care after discharge for inmates with chronic diseases can help reduce inappropriate use of emergency medical facilities, help these persons maintain health gains, and lower the likelihood of recidivism. Cumulatively, the above changes can pose a significant financial and social benefit to the community.”

—American Journal of Public Health³

II. Introduction

Introduction

Incarcerated individuals represent a population at higher risk for and with higher rates of HIV/AIDS. At year-end 1997, 2.1 percent of all persons incarcerated in the United States were HIV positive.⁴ Inmates' higher rates of HIV and AIDS are related to high-risk behavioral factors such as injection-drug use and the sharing of needles and other drug-injection equipment, high-risk sexual behavior, and drug and alcohol abuse.

Correctional facilities, which are fast becoming a major provider of health care and mental health services, are critical settings for implementing strategies to prevent and treat HIV/AIDS and other infectious diseases. These settings can provide a structured environment in which inmates can learn their HIV serostatus and make behavioral changes associated with decreasing their risk of infection.

Incarceration may represent a time when an individual abstains from substance use and may provide an opportunity to examine the realities of life. "Entering prison is often when someone 'hits bottom,' when the opportunity is greatest to educate, rehabilitate, treat addiction and change destructive patterns."⁵ Strategies such as comprehensive HIV/AIDS education, infection control practices, early disease detection, and alcohol and drug treatment programs are urgently needed to reduce rates of HIV infection both within and outside the correctional facility setting.

Collaboration between public health and correctional agencies and community partners is an effective strategy for addressing HIV/AIDS and other infectious diseases among inmates. Public health offers clinical and programmatic expertise in disease prevention and control. Correctional facilities provide a population in need of services and staff expertise related to the target population. Community partners, which may include CBOs, AIDS service organizations,* and community health centers, provide HIV/AIDS services and social service links for released individuals. Such collaborations are not without challenges — program professionals often have different priorities, methodologies, philosophies, and professional cultures. Yet collaboration can increase program effectiveness, generate financial savings, and increase public safety.

Individuals who are at risk of HIV exposure or are HIV positive may be among those cycling in and out of corrections. Correctional facilities are housing more people and seeing them more frequently due to recidivism, but still returning them to society within a short period of time. The average time served in a state prison in 1998 was twenty-eight months.⁶ The average stay in short-term correctional facilities (e.g., jails and houses of correction) was under nine months in 1996.⁷ Not included in that statistic are the hundreds of thousands of arrested individuals who pass through jails and are either sentenced to short-term correctional facilities, receive probation, have their cases dropped, or are found not guilty and released. With this revolving door of incarceration, release, and potential reincarceration, it is important for correctional facilities, with public health support, to practice primary and secondary disease prevention.

* An AIDS service organization is a community-based organization facilitating support services and advocacy for patients with HIV/AIDS and education for the community.

Introduction

This report was written in an effort to draw attention to the need for public health intervention in short and long-term correctional facilities and to assist public health agencies in implementing health strategies that address the needs of inmates who are HIV-positive or at risk for exposure. This report provides a detailed description of collaborative HIV/AIDS programs taking place in selected correctional facilities and the resources needed to develop these collaborations. These collaborations represent multiple agencies and individuals working together to address HIV/AIDS among incarcerated populations through programs in correctional facilities. Also discussed are the efforts needed to ensure quality, sustainability, and program evaluation. *Behind the Wall: Collaborative Responses in Massachusetts and Michigan to Address HIV/AIDS Among Incarcerated Populations* provides insights about developing and managing an HIV/AIDS public health–corrections–community partnership. Massachusetts and Michigan were selected as case examples because of their early insight and long-standing activities addressing HIV/AIDS among their incarcerated populations. Clearly, success stories exist in other states as well.

The report is compiled in three key sections. The first section, **HIV/AIDS and Other Infectious Diseases Among Incarcerated Populations**, illustrates the high rates of HIV/AIDS and infectious diseases among incarcerated populations and describes some of the challenges to addressing those diseases in correctional settings. The second section, **Program Overview**, describes the programs in Massachusetts and Michigan, including the development and aspects of program components and funding. The final section, **Key Findings**, outlines conclusions drawn from the experiences of these states and uses program details to further elaborate on important policy issues.

III. HIV/AIDS and Other Infectious Diseases Among Incarcerated Populations

HIV/AIDS is a disease that carries tremendous stigma, isolation, and fear in correctional facilities. Terms used to describe HIV in correctional facilities (such as “the bug”, “el monstro”, “the ninja”, and the “dog/el perro”) illustrate the negative attitude some individuals have about this disease.

While the focus of this report is on HIV/AIDS, it is important to note that many risk behaviors associated with HIV transmission also increase the chance of contagion with other infectious diseases, such as viral hepatitis, sexually transmitted diseases (STDs), and tuberculosis (TB). Viral hepatitis infections are spread through blood-to-blood and sexual contact. Engaging in unprotected sex and having multiple sexual partners can increase the risk of exposure to certain STDs. HIV infection can activate latent TB infection and accelerate the course of the disease.

A significant common denominator underlying the risk of some infectious diseases among incarcerated persons is drug and alcohol abuse. Drug and alcohol abuse, and in particular injection-drug use, increase the risk of contracting HIV/AIDS and hepatitis C (HCV) through the sharing of needles and by engaging in the high-risk sexual activity commonly associated with illicit drug use such as trading sex for drugs. The National Center on Addiction and Substance Abuse at Columbia University reports that “Drugs and alcohol abuse and addiction are implicated in the crimes and incarceration of 80 percent [of] men and women behind bars in America.”⁷⁸ Massachusetts and Michigan have responded to that reality because a disproportionate percentage of their HIV/AIDS cases among inmates are

linked to alcohol and drug use. Moreover, both states have seen the need to address another blood-borne pathogen prevalent among this same population—HCV.

Correlating factors associated with inmates’ poor health prospects and the increased risk of infectious disease include an array of psychosocial problems that pose added challenges for agencies involved in providing health care and social services to this population.

Creating an HIV/AIDS program for implementation in a correctional facility involves taking into consideration many realities and nuances. It involves an understanding of the demographics and dynamics of HIV/AIDS among inmates and the divergent missions of public health and corrections. Typically, the approaches taken by disease control programs vary based on differences in culture, organization, and correctional facility policies. Short-term facilities, such as jails, typically process and release individuals in short amounts of time, whereas houses of correction incarcerated inmates usually serve less than one year for nonviolent crimes. In long-term facilities such as prisons, inmates serve longer sentences for more serious crimes. Regardless of the setting, primary care for an inmate with HIV/AIDS includes clinical case management through regular visits with infectious disease specialists, routine testing to ascertain disease markers (e.g., CD4 T cell count),* medication monitoring (e.g., viral load testing),** and emergency treatment when necessary. Clinical case management consists of ensuring that standard HIV treatment protocols are utilized.

* The number of CD4 positive cells in a milliliter of blood. These cells (white blood cells within the immune system) are constantly measured in HIV-positive infected clients because their number reflects overall health of the immune system.

** Viral load is the quantity of HIV, measured as viral particles per milliliter of blood or any other tissue.

HIV/AIDS Among Incarcerated Populations in the United States

- **A significant number of people pass through the U.S. criminal justice system.** At mid-year 1999, more than 1.8 million people were in U.S. prisons and jails.⁹ In 1993, there were approximately 13.2 million total admissions to local jails (that total includes multiple admissions and readmissions of some of the same individuals),¹⁰ and in 1997, more than 500,000 total admissions to state prisons.¹¹
- **The prevalence of confirmed AIDS cases among inmates was more than five times greater than in the U.S. general population (0.55 and 0.10 percent, respectively) in 1997.**¹² In 1997, it was estimated that 3.5 percent of female inmates and 2.3 percent of male inmates in state prisons were HIV positive.¹³
- **HIV/AIDS is more prevalent among incarcerated African Americans and Latinos than incarcerated Caucasians.**¹⁴ African Americans in state prisons are twice as likely as Caucasians to test HIV positive.¹⁵ In jail settings, Hispanic males have the highest rate of all inmates testing positive for HIV (3.5 percent).¹⁶

IV. Program Overview

Site visits by ASTHO staff to Massachusetts (October 1999) and Michigan (January 2000) were conducted during the course of research for this report. In Massachusetts, site visits were conducted at the Berkshire, Bristol, Essex, and Hampden County houses of correction,* MCI-Framingham (female state prison), and the Nashua Street Jail (Suffolk County). In Michigan, the Robert Scott Correctional Facility and the Ionia Temporary Correctional Facility for adults were visited.

During site visits, interviews were conducted with state health department staff; correctional facility staff in health care, programs, and administration; and inmates who serve as HIV/AIDS peer educators. In addition, HIV/AIDS educational classes and an HIV-positive inmate support group were observed.

The purpose of the site visits was to become familiar with the components of both states' HIV/AIDS programs for incarcerated populations, the innovative models/practices employed, and sources used to support these efforts.

The programs described do not represent all HIV/AIDS activities for inmates in Massachusetts and Michigan, and this report should not serve as a qualitative comparison between the states. Each program is couched in a unique set of circumstances and is based on assessment of state needs, HIV/AIDS laws and policies, and respective agency funding and support. Also, it is important to note that the Massachusetts case examples reflect voluntary HIV testing policies and the Michigan case examples reflect mandatory HIV testing policies.

Massachusetts

The Massachusetts HIV/AIDS programs described in this report involve the county sheriffs' departments and their respective correctional facilities; the Massachusetts Department of Public Health (MA-DPH); and CBOs, including community health centers. The average daily HIV/AIDS census in Massachusetts county facilities ranges

from less than one percent to approximately 10 percent (T. Gagnon, personal correspondence, 1999).

The county sheriffs' departments operate short-term county facilities such as jails and houses of correction. In Massachusetts, individuals held in jails are most likely postarrest, pretrial, or awaiting sentencing. Some have been charged (but not convicted) with a felony crime such as rape, armed robbery or murder and, because of the nature of these charges, are held in jail pending trial. Adults who are tried, found guilty, and sentenced in Massachusetts (nonfederal) can serve their time in a Massachusetts house of correction or state prison facility.**

In Massachusetts, recognition of the need to address HIV/AIDS issues among inmates began more than a decade ago. At that time, HIV/AIDS activities, such as education for inmates and staff, and facility contracts with CBOs to provide HIV testing, counseling, and case management were occurring in some county correctional facilities. But these initiatives were not necessarily comprehensive in scope and offered in all facilities.

In 1990, MA-DPH conducted a blinded HIV-serostatus study*** in three state prisons (Concord, Cedar Junction, and Framingham) and found that 8 percent of males and 12 percent of females were HIV positive.¹⁷ These data, plus the belief in the benefits of a coordinated approach to HIV/AIDS, led to the development of a more comprehensive pilot program in facilities operated by the Hampden County Sheriff's Department.

The pilot program was launched in 1992 with approximately \$70,000 provided by MA-DPH (T. Gagnon, personal correspondence, 1999). Previous HIV/AIDS activities in Hampden County correctional facilities were limited to contracting with CBOs and community health centers to provide HIV testing and counseling and case management in the facility. The pilot program funding supported HIV/AIDS peer education, enrollment of inmates in the Massachusetts HIV Drug Assistance Program (HDAP, a program to make

* In general, houses of correction are considered short-term county correctional facilities. Unlike jails, individuals in a house of correction have been found guilty of a charge and sentenced. In Massachusetts, houses of correction hold individuals serving a sentence of less than two and a half years.

**The majority of postarrest pretrial individuals found guilty will be sentenced to a state facility because of the severity of their crimes, according to Mariellen Fidrych, Executive Director of the Massachusetts Sheriffs' Association. However, individuals with a sentence of less than two and a half years will serve their time in a Massachusetts house of correction.

medications available to HIV-positive individuals with little or no coverage from private insurance or Medicaid), and a part-time, on-site infectious disease doctor. With this new comprehensive package of HIV/AIDS education and services for inmates and an unrelated increase in the total number of inmates, there was an increase in the number and percent of inmates requesting HIV tests and counseling. In addition, more HIV-positive inmates disclosed their infections and requested treatment and additional services such as case management.

The health department visited sheriffs' departments to discuss expansion of the pilot program with sheriffs and their staffs. Discussions focused on the types of HIV/AIDS services and components each facility needed and concerns about housing such a program. These conversations were critical to establishing trust between the public health and correctional authorities and identifying issues of concern.

Through these meetings, health departments and sheriffs' departments created a shared mission about HIV services for inmates. Parallels were drawn between the public safety threat caused by a violent individual on the street and the

public health threat of an inmate who is unaware of his HIV status or unable to access proper treatment and care when released back to the community. These discussions were also instrumental in helping to identify the logical partners for this response, which included public health organizations, correctional facilities, and CBOs.

Based on the experience gained from previous collaborative efforts and the pilot program, the state health department created the Massachusetts County Sheriffs' Department HIV/AIDS Program (hereafter referred to as the MC Program) and launched it through the release of a request for applications (RFA) in 1994. The RFA was extended to county sheriffs' departments. Nine of the thirteen applicable sheriffs' departments with correctional facilities applied for funding and all were awarded funding that totaled \$600,000 per year for four years. In 1998, the RFA was rereleased and thirteen sheriffs' departments received funding totaling \$1.2 million each year for four years (T. Gagnon, personal correspondence, 1999).

Currently, twelve counties in Massachusetts with a jail and house of correction are part of the MC Program. The MA-

Massachusetts County Correctional Facilities and HIV/AIDS

- **County correctional facilities have numerous admissions a year.** In 1998, there were 18,748 commitments to Massachusetts county correctional facilities²⁰ compared to 2,856 commitments to the Massachusetts Department of Corrections.²¹ The average length of stay in Massachusetts county correctional facilities was approximately six months.²²
- **A 1995 blinded sero-status study at three Massachusetts county facilities (Hampden, Middlesex, and Worcester) revealed HIV antibodies in 5.4, 5.6, and 2.3 percent, respectively, of the samples tested.**²³
- **In 1995, 5,721 inmates voluntarily opted to be tested for HIV in Massachusetts county jails, many of whom had never been tested.** Close to a quarter of all inmates tested HIV positive and 75 percent of inmates testing HIV positive were racial/ethnic minorities. Female inmates made up 11 percent of inmates who tested positive.²⁴
- **Following the commencement of the MC Program, more inmates requested HIV counseling and testing.** In 1994, the MC Program was implemented in nine Massachusetts county sheriffs' departments. By 1995, almost twice the number of inmates requested HIV counseling and testing compared to 1994.²⁵ Among those inmates who tested HIV positive in 1995, injection-drug use was the most prevalent risk factor (44 percent), followed by having sex with a person with HIV or AIDS (17 percent).²⁶

*** Blinded seroprevalence surveys involve collecting samples of blood specimens for HIV antibody testing. All personal identifiers are removed before the samples are screened for HIV antibody testing, thus making the testing anonymous.

Program Overview

DPH's AIDS Bureau manages the contract for the program and supplies the majority of funding. The AIDS Bureau's general mission promotes programs like the MC Program through its belief in effective prevention; the importance of partnerships to maximize accessibility to health care; the desire to protect, preserve, and improve the health of Massachusetts residents; and dedication to those most in need.¹⁸

The HIV/AIDS treatment, care, and prevention components of the MC Program involve program coordination, voluntary HIV testing and counseling, partner notification services,^{****} HIV/AIDS peer education for inmates and staff, on-site infectious disease specialists, HIV/AIDS case management and discharge planning, and enrollment in HDAP.¹⁹

Each facility under contract with the MC Program has an on-site program coordinator. This position is equally funded by the MC Program contract and the individual county sheriff's department. The coordinator, an employee of the sheriff's department, regularly interacts with individuals from the correctional facility, the CBOs, and the other agencies in order to carry out the other elements of the program. The arrangement establishes one contact person for the program, thus decreasing miscommunications and lapses in HIV/AIDS services. The MC Program coordinators meet once a month with the MC Program contract manager in order to keep the contract manager and others apprised of administrative issues and activities within the facilities.

Under the terms of the MC Program, voluntary confidential HIV counseling and testing must be made available to all inmates in county facilities and Spanish-speaking counselors must be available for Spanish-speaking inmates. In addition, by 2000, all county facilities contracted under the MC Program must provide peer-led education to their inmates. The MC Program coordinator, or a staff member from a CBO, provides training to potential peer educators and remains present during peer-led classes as required under facility rules.

Infectious disease specialists are funded through subcon-

tracts to provide care and treatment to inmates at the facilities. These specialists are sometimes obtained through medical schools and because of this affiliation, schools learn of the health initiatives taking place in correctional facilities and sometimes formally join the partnership. An on-site medical visit is less complicated and less costly to the correctional facility because it frequently eliminates the need to escort inmates to secured off-site medical centers. Massachusetts county correctional facilities found that when infectious disease specialists are not part of the facility's health services staff, inmates are more likely to require transportation to outside medical facilities (i.e., to hospitals with secure wards). Transporting inmates under these circumstances is expensive because of added security costs.

Within Massachusetts county correctional facilities, various CBOs and AIDS service organizations provide a multitude of HIV/AIDS services such as testing, counseling, treatment, case management, and referrals to other agencies under the MC Program contract. In addition, some forty-six Massachusetts community health centers provide critical high-quality care to those who lack access to traditional medical systems. CBOs and community health centers are pivotal to the success of the program because they provide a vital link to the community and also assist with critical services provided upon an inmate's release.

Facilities that are funded under the MC Program contract are also eligible to participate in the Massachusetts HIV Drug Assistance Program (HDAP). Under Title II of the Ryan White CARE Act (a federal AIDS program that provides health and social services to people infected with HIV), funds are allocated to states to make medications available to individuals who have HIV/AIDS and little or no coverage from private insurance or Medicaid. This federal funding is referred to as the AIDS Drug Assistance Program (ADAP). The Massachusetts HDAP program is made up of the federal ADAP contribution and state funds. Federal law mandates that the federal portion of the HDAP cannot be used to pay for HIV/AIDS medications for inmates; however, Massachusetts

^{****} Partner notification is a process by which public health agencies identify sexual or other high-risk contacts of a person with a sexually transmitted disease.

has made state funding available to inmates of county correctional facilities for this purpose. This cost savings for AIDS medications has provided a financial incentive for county facilities to participate in the MC Program.

If an inmate in a county facility has HIV/AIDS, he or she can enroll in HDAP and the facility will receive reimbursement for the HIV/AIDS medication costs through state HDAP funds. The Massachusetts HDAP has a liberal drug formulary and new drugs are almost always added to the list. HDAP reimbursement to a facility supplements MC Program contract funding, and in some instances, the reimbursement will exceed the MC Program funding a sheriff's department receives.

Michigan

The Michigan Department of Community Health, the Michigan Department of Corrections (MI-DOC), and CBOs are involved in a collaborative effort to address HIV/AIDS and HCV in Michigan state prison populations. The Michigan HIV/AIDS program in state prisons strives to reach a population at risk for infectious diseases and improve the health of the community. The 1999 report of HIV/AIDS cases among adult inmates in Michigan state prisons revealed an infection rate of 1.2 percent.²⁷

The MI-DOC oversees forty-four state prisons, fourteen camps, and four reception centers. According to the 1999 MI-DOC annual report, adults convicted of felonies where the statutory maximum exceeds a year are sentenced to the state prison system. In 1999, there were 8,810 commitments to MI-DOC facilities.²⁸

The HIV/AIDS program in Michigan has evolved over time and currently involves HIV/AIDS and HCV peer education at state prison reception centers,* mandatory HIV testing and counseling, partner notification, the availability of written and audiovisual HIV/AIDS materials, and HIV/AIDS case management and discharge planning. Inmates also gain membership in the MI-DOC Ryan White CARE Act Consortium (designed to provide a “continuum of care” to those affected by HIV disease in those areas most heavily affected by the epidemic) if they request it and are eligible. (See page 19 for additional information about the Michigan consortium.)

The Michigan program resulted from state laws whose implementation highlighted gaps in HIV/AIDS services such as discharge planning for inmates. In 1988, the state enacted a partner notification law that ultimately resulted in the Michigan HIV prison partner notification program and a law mandating that all individuals (i.e., inmates) entering state correctional facilities must receive HIV testing and

Michigan State Prisons and HIV/AIDS

- In 1999, approximately 8,810 people entered the Michigan Department of Corrections system.³⁰
- At intake, approximately 63 percent of male and 71 percent of female prisoners in Michigan reported a history of substance abuse.³¹
- Of the 14,780 Michigan state prisoners tested and counseled for HIV in 1999, approximately one percent tested HIV positive.³² Close to a third of those who tested HIV positive attributed their infection to injection-drug use (IDU), followed by trading sex for drugs or money (19 percent), sex while using drugs (19 percent), male-male sex (13 percent), male-female sex (11 percent), male-male sex/injection-drug use (3 percent), and exposure to blood products (1 percent).³³
- HIV infection rates disproportionately affect racial/ethnic minorities in the MI-DOC system. Of those inmates testing HIV positive in Michigan from 1989 to 1999, at least 75 percent in any given year were African American.³⁴

* Individuals who have been sentenced to MI-DOC are processed through MI-DOC reception centers. While in the reception center, an inmate will undergo a physical and mental evaluation and mandatory HIV testing and counseling. After the evaluations and security classification, an inmate will be transferred to a MI-DOC state prison facility.

Program Overview

counseling upon entry into MI-DOC.²⁹ In 1998, MI-DOC instituted a multimedia presentation on HIV education and prevention, partner notification, and case management and discharge planning.

Individuals entering the MI-DOC system are processed through one of four reception centers. Here inmates receive mandatory HIV counseling and testing, HIV/AIDS peer education, health and mental health screening, and security clarification. An inmate spends approximately thirty days in a reception center until transferred to a state prison.

Within the facilities, correctional health care staff provide discharge planning, support services to inmates, and links to CBOs in the geographic area a person may go upon release (i.e., some individuals released from MI-DOC facilities are prohibited from returning to certain geographical areas). Michigan is a large state and individuals are often incarcerated far from home or from where they plan to locate upon release. Because of these distance restrictions, it is usually the staff of the prison's health care services who initiate an inmate's contact with a CBO for discharge planning.

Each state prison in the MI-DOC system has an ambulatory and HIV chronic care clinic. In a nonacute situation, inmates are assured a visit to the chronic care clinic every six months that involves an encounter with a physician or a nurse. All of the health clinics in the MI-DOC system have access to HIV/AIDS education material for inmates.

All individuals entering or reentering the MI-DOC system are required to attend an HIV/AIDS and HCV peer-led education session and receive HIV counseling and testing. HIV/AIDS and HCV peer education in state prisons was launched in 1990 at the Jackson Reception and Guidance Center; it has since been expanded to three other reception centers. Inmates who want to be peer educators participate in a four-five day training program certified by the Michigan Department of Community Health. These inmates must successfully pass a certification test before they can serve as peer educators. The prison partner notification coordinator

screens and trains potential educators at the four reception centers. In all but one of these centers, the peer-led HIV/AIDS education sessions take place five days a week. At each reception center there are four active peer educators and one to three persons on standby. The peer education position is funded by MI-DOC and pays \$1.31 a day. Those inmates chosen as peer educators and approved by the facility's administrative staff are placed on permanent "temporary hold" at their respective reception center. Unless the inmate is transferred or security becomes an issue, a peer educator will remain at the reception center to conduct HIV/AIDS education sessions. The same HIV/AIDS curriculum is used at all MI-DOC reception centers with modifications when appropriate (i.e., gender differences).

HIV/AIDS case management is offered to HIV-infected inmates in Michigan state prisons. Under the MI-DOC case management program, inmates with HIV/AIDS are regularly informed of the services available to them under this program, such as an assessment of the services they will need upon release and HIV/AIDS services available in the geographic area where they plan to locate. Facility nurses will ask inmates whether they are interested in HIV/AIDS case management and discharge planning. Those inmates wanting HIV/AIDS case management/discharge planning services sign a consent form allowing for the release of their medical records to a case management agency. When distance allows, CBO case managers will visit the inmate or talk to the inmate by telephone. Ideally, HIV/AIDS case management is initiated thirty-sixty days prior to release. As is the case in facilities throughout the country, an inmate's release date is often indeterminate. At the time of release, inmates with HIV/AIDS receive a thirty-day supply of medication, a sealed envelope containing a copy of portions of their health record and case management discharge assessment, an HIV/AIDS information booklet, and condoms. Also, a brief patient education session is provided by a nurse.

Various individuals are responsible for coordinating efforts under the Michigan program. For example, the prison

partner notification coordinator of the Michigan Department of Community Health is responsible for both HIV partner notification and the peer education program at the reception centers. This person has a counterpart at each of the MI-DOC reception centers who provides program continuity when they are off-site.

A MI-DOC employee serves as the HIV case management coordinator and the coordinator of the MI-DOC Ryan White Consortium. Because a portion of these activities are funded by Ryan White CARE Act funds, this employee is careful to document that Ryan White CARE Act funds are not being used for health care services that inmates are constitutionally mandated to receive.

Unique to the Michigan collaboration is the existence of the MI-DOC Ryan White CARE consortium, which is a member of the Michigan Title II care consortia.** Under the Ryan White CARE Act, a portion of the Title II funds are designated to establishing such consortia, which provide a “continuum of care” to those affected by HIV disease in those areas most heavily affected by the epidemic. The MI-DOC consortium is a member of the Michigan consortia and is made up of inmates from any of the state’s 44 prisons. The Title II funds MI-DOC receives for this activity serve only to support the salary of the MI-DOC’s consortium coordinator and not to provide services for the inmates. The MI-DOC Ryan White CARE Act consortium does not participate in funding decisions, as do other Michigan consortia, but

provides insights on the HIV/AIDS-related needs of incarcerated individuals. Inmates figuratively “at the table” of the Michigan consortia reflects the fact that the state consortia should represent the needs of all individuals with HIV/AIDS.

The MI-DOC consortium meetings consist of a female and a male group (meeting separately) of inmates that meet approximately once a month. This meeting is coordinated by the MI-DOC case management/consortium coordinator. Those inmates who are part of the consortium are either already in or transported to a MI-DOC facility with telemedicine capability. In this capacity, inmates from different facilities are audiovisually linked to one another. Activities of the MI-DOC consortium include creating a mission statement; developing needs assessment tools that identify the needs of Michigan state prison inmates with HIV/AIDS during incarceration and upon release; identifying ways in which the needs of individuals vary based on length of incarceration; and participating in focus groups. Because they are a member of the Michigan Regional HIV/AIDS Council, the HIV/AIDS needs of Michigan’s state prison inmates receive attention at the statewide level, which has resulted in recognition of inmate needs by other Michigan HIV/AIDS agencies and task forces. Since formulation of the MI-DOC consortium, other HIV/AIDS agencies and organizations have developed an interest in the HIV/AIDS issues of inmates, thus creating awareness in the outside community.

** A consortia is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV disease. (Health Resources and Services Administration. HIV/AIDS Bureau factsheets: Title II. Rockville, MD Retrieved November 1, 2000 from the World Wide Web: <http://hab.hrsa.gov/publications.html>)

V. Key Findings

Key Findings

Key Finding 1. Collaborations among public health, correctional agencies, and community-based organizations are effective in addressing HIV/AIDS among incarcerated populations, especially if comprised of a shared mission, executive staff support, and designated program funding.

The first stage of collaboration involves dialogue among prospective partners and it can take many forms. Who approaches whom and the types of HIV/AIDS activities already taking place in a correctional facility may vary. The initiative for the development of this type of HIV/AIDS program is most likely to come from departments or divisions within public health (e.g., HIV/STD division) or corrections (e.g., program departments or health services), which regularly address and treat infectious disease among this population. In addition, such efforts are also spurred by community advocates and activities of community organizations.

Traditionally, state public health departments and correctional facilities do not share a common mission. These differences can result in a lack of interagency dialogue, suspicion, and confusion. A definition of public health's mission is likely to encompass themes of community health promotion and disease prevention. Sheriffs' departments and state departments of corrections' missions generally include safe custody, public safety, and security. By assuring that all involved agencies understand the mission and obligations of the other partners, the various agency roles, and accountability, collaboration has a better chance at success.

Also key to gaining support for this collaborative effort is the availability of data that document the burden of disease. Based on the experiences in Michigan and Massachusetts, needs assessments that include the use of valid sampling techniques can provide information about disease incidence and the needs of inmates with or at risk for HIV. Collecting

these data can be a first step in identifying the appropriate partners for the collaborative effort. Unfortunately, such data are not always available prior to the launch of a formal collaboration. Often it is only after a collaboration has been formed that the partners are better able to properly assess the burden of HIV/AIDS among inmates and the needs of the facilities that house and provide medical treatment for them.

Collaborative initiatives ultimately require the support of the policymakers who set the agenda for their respective agencies, targeted funding, dedicated staff, and a commitment to staff education and program sustainability. Discussions between senior officials (i.e., the state public health commissioner and his or her respective counterpart in corrections such as the sheriff or superintendent) can lead to cross-agency support of a program, dedication of funding, and staff to implement and maintain the program, and the provision of a full range of services.

The HIV/AIDS programs in Massachusetts county correctional facilities and Michigan state prisons are the result of funding from public health, correctional agencies, and in some instances private foundations. It is highly unlikely that any one agency can afford to support an entire HIV/AIDS program in a facility. In both Massachusetts and Michigan, the majority of the program funding comes from the state health department in the form of state and federal dollars. State funds support program components such as the Massachusetts HDAP for county inmates, and federal Ryan White Title II money supports the salary of the MI-DOC HIV/AIDS consortium coordinator. As was observed in both states, no one funding formula will work in all states and jurisdictions. Massachusetts and Michigan have been creative in locating resources from multiple sources based on availability, political will, agency support, and legal restrictions.

Key Finding 2. Effective HIV/AIDS programs must address the issues of stigma and discrimination as well as the need for privacy and confidentiality associated with HIV/AIDS in corrections.

HIV/AIDS remains for many a disease shrouded in fear, anger, and shame. Homophobia and negative attitudes toward individuals with HIV/AIDS have long played a part in feeding

According to one Massachusetts program coordinator, “The loneliness is one of the biggest realities for these guys ... It may be a generalization, but it’s not so much the fear about what other people think about them having HIV so much as feeling lonely, never being able to have children or at least feeling like they can’t have children, or never having a relationship.”

the disease’s secrecy and denial. While rates of HIV/AIDS among correctional facility inmates are often disproportionately higher than rates outside corrections, this does not necessarily mean there is less stigma, discrimination, or ignorance associated with the disease. An inmate identified (not always accurately) as having HIV/AIDS by other inmates and/or staff is likely to face negative reactions from those who do not understand the disease. Some inmates fear bunking in a cell with someone who is HIV positive or has AIDS. Due to a lack of education, misinformation, and a fear of AIDS,

some correctional staff inappropriately react to exposures of saliva and other fluid that do not carry a risk for disease transmission. In addition, some correctional staff may not respect or understand the need to protect the confidentiality of an individual’s HIV status. They may believe that they have a right to know an inmate’s HIV status because of the nature of their job. Observing and experiencing negative reactions to HIV/AIDS can lead an inmate to refrain from being tested in a facility with voluntary testing policies, and for those inmates who know they are positive, negative reactions may result in their not seeking medical treatment out of a desire to keep their status a secret.

Even in a facility where the presence of an HIV/AIDS program has increased the level of knowledge and disease acceptance by inmates and staff, a type of isolation prevails for many inmates with the disease. To increase the number of inmates who want to know their HIV status and seek treatment and services, programs must develop activities that provide inmates with the highest possible degree of privacy and confidentiality allowable. Both Massachusetts and Michigan developed their HIV/AIDS programs while taking these issues into consideration.

Several of the Massachusetts houses of correction hold monthly support group meetings for inmates with HIV/AIDS. As with many activities at the facility, inmates are escorted by correctional officers to the appropriate building for the activity. The name of the support group does not contain the term “HIV/AIDS” so that when the correctional officer appears at the housing unit to escort the inmate, the inmate is seen as going to a particular building to receive counseling on a generic health issue. Under this scenario it is not obvious that the particular inmate is taking part in an HIV/AIDS activity.

Michigan also recognizes the importance for HIV/AIDS program activities to be discrete, and has extended this approach to the development of printed material about HIV/AIDS. The MI-DOC HIV/AIDS case management brochure does not use the terms “HIV” or “AIDS” or other words that would reveal the disease associated with the service. In designing the pamphlet, the case management coordinator acknowledged that it would be unlikely that any inmate would take written material back to his or her cell that was identified as AIDS-related. Under the “How Does a Case Manager Help?” section of the MI-DOC case management brochure, it reads:

The relationship between you and your Case Manager begins with an interview to find out about your current situation. He/She will ask you questions about your health status, who you are already receiving services from, your financial situation, your living situation, or any other

Key Findings

*information that might help direct you to the services you may need.*³⁵

Inmates often want to know who will be informed about their test results should they test positive for HIV. Under the Michigan and Massachusetts programs, facility health staff can have knowledge of an inmate's status because it is reflected in their medical chart, but the test result is not given to any non-health-related staff (e.g., sheriffs, superintendents, or correctional officers). In Massachusetts, additional staff that know an inmate's status are the MC Program coordinator and the HIV/AIDS case manager. In Michigan, the prison partner notification coordinator is also informed of positive results, as required by law.

Confidentiality is imperative to the success of both programs, with an additional twist in Massachusetts because of voluntary HIV testing and counseling in county and state facilities. In these facilities, any suspicion surrounding the confidentiality of HIV test results could impact inmates' requests for testing and services. Programs that are not mindful of stigma when developing classes, written materials, support groups, and case management and discharge planning services may not have an active inmate response.

Key Finding 3. Effective HIV/AIDS programs in correctional facilities have multiple components and support a continuum of care following discharge.

A report by the National Institute of Justice noted that “an integrated continuum of care with continuity of providers is the best model for addressing the multiplicity of medical and psychosocial problems of inmates both within correctional facilities and following their return to the community,” making for “optimal clinical and psychosocial outcomes for inmates with HIV disease.”³⁶ A model of an integrated continuum of care contains the following key elements: screening and identification of medical and psychosocial problems, psychosocial support services, hospice care, substance abuse treatment, case

management, discharge planning, and continuity of care and community linkages.³⁷

Effective HIV/AIDS programs in correctional facilities address the needs of inmates who are incarcerated as well as those inmates poised for release. This report has described many of the components of a multicategorical HIV/AIDS program in a correctional facility (i.e., HIV/AIDS education, availability of HIV testing and counseling for inmates, HIV/AIDS primary treatment and care, and program coordination). Two additional components that play a key role in the continuum of care are HIV/AIDS case management and discharge planning. Although case management and discharge planning services may overlap at times, they may be comprised of a variety of different activities. Case management for the HIV-positive inmate involves disease management while the person is incarcerated. Disease management entails many activities such as familiarizing the client with the medications they will take, discussing the importance of doses, filling out a weekly medication time table, and enlisting clients to actively participate in their own care. Case management also includes support of HIV/AIDS medication adherence, disease management, connecting the inmate with mental health services, and family reunification services.

HIV/AIDS case management can blend into discharge planning at anytime during one's period of incarceration. Discharge planning prepares the inmate for release and includes making appointments with HIV/AIDS case managers and/or infectious disease specialists in the community, starting the AIDS drug assistance program (ADAP) application process, and making appropriate housing and substance abuse treatment arrangements. Establishing these connections and appointments prior to release is vital because it can be quite difficult to locate an individual following release. Discharge planning not only offers assistance to the soon-to-be-released inmate, (thus affording a greater chance of proper disease maintenance), but the process itself also provides an opportunity for trust

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According to Joseph Ouellette, HIV Coordinator of the Massachusetts Essex County Correctional Facility and Sheriff's Department.

[Inmates] at least know that when they leave here they don't have to go to the corner and grab and shoot dope or smoke crack cocaine because they don't want to have to deal with the feelings. We essentially hand-hold them out and bring them to the community and hook them up with all of the services out there—housing, medication, appointments with social security, job hunting, mental health issues with family and family reintegration. For those who request [HIV/AIDS] discharge planning services, they now really trust that those services are going to happen.”

to develop between the HIV/AIDS program staff and the inmate. Considering the perceived stigma of HIV/AIDS and the value of trust behind bars, this is no small feat.

Discharge/aftercare planning must be tailored to fit the incarceration setting and the inmate's characteristics. Short-term facilities usually house inmates in the community where the inmate used to live and will return upon release. However, inmates in long-term facilities such as state prisons may be transferred from one state prison to another throughout their incarceration. They may serve the majority of their sentence hundreds of miles from home and be released at this distant location. Extra effort is then required to link inmates to services within the community where they intend to reside following release.

While facility computer systems attempt to keep track of this type of movement, inmates are often released with little notice. In jails, the turnaround is so rapid that an inmate can be released before their HIV test results are returned from the lab. A person may also be released at a time of day when public transportation is not available. In Massachusetts's county facilities and Michigan state

prisons, case management and discharge planning commences the day an individual enters the facility. This approach is especially valuable in jails, where many individuals may be released within forty-eight hours.

Under the best circumstances, discharge-planning services should be available to all HIV-positive inmates who request it, and these services should begin as early as possible.

Key Finding 4. HIV/AIDS programs within correctional facilities must educate inmates and correctional staff about HIV disease.

Appropriate HIV/AIDS education programs for inmates and education efforts specifically targeted to correctional staff are needed to teach them about the disease and address their concerns.

The National Commission on Correctional Health Care states that “[HIV/AIDS] education programs should include culturally sensitive and scientifically accurate health information that provides clear and easily understood explanations of practices that reduce the risk of becoming infected or transmitting HIV. It is highly recommended that information on the psychosocial implications of HIV infection as well as resources available to the infected person be included as well.”³⁸

Both Michigan and Massachusetts supplement their educational sessions with materials that are available for inmates to take to their cell or access in the library. In addition, MI-DOC inmates can access written materials and videos on HIV/AIDS in most facility health care units. In the MC Program, educational materials are available in English and Spanish. Currently, the Michigan program materials are in English only and HIV/AIDS educational videotapes are available at non-reception center state prisons. Before inmates are transferred to Michigan state prisons, they have already gone through a face-to-face HIV/AIDS education session at the reception center as well as HIV counseling and testing.

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While occupational exposure to HIV is rare, fear of transmission among correctional officers is commonplace. Therefore the MC Program and the Michigan program staff also provide HIV prevention and education to correctional staff.

In both states, HIV/AIDS education sessions for correctional staff are conducted by facility staff and/or outside organizations. Educational sessions for both inmates and staff address topics such as disease prevention and modes of HIV transmission, universal precautions, HIV/AIDS treatment options, HIV/AIDS services available at the facility, and HIV/AIDS laws and facility policies such as those concerning confidentiality.

According to the book *Prisons and AIDS: A Public Health Challenge*:

“Officers may be especially concerned about the risk of HIV infection from being bitten, spit upon, struck with sharp objects, or from coming into contact with inmates’ urine, feces, or blood. Fear of AIDS contagion among officers may even influence the health care of HIV-infected inmates, as correctional officers are often the link between inmates and health care providers ... their [correctional officers’] attitudes towards HIV will directly affect the way they treat HIV-positive inmates, educational programs offered to inmates, and related public health issues ... [Therefore] having detailed information about HIV enhances educational programs for inmates and prison staff. More-informed prison officials can become HIV educators as well as client advocates, contributing much more to public health in preventing the spread of HIV.”³⁹

Key Finding 5. Peer-led education and prevention efforts in prisons and jails can be an effective teaching method for inmates.

Peer-led HIV/AIDS education and prevention efforts can help reduce stigma and increase the credibility of a facility’s HIV/AIDS program. Peer education is a teaching model where individuals of the target audience/population are trained to educate that same audience/population on a given topic. In this case, inmates are trained to instruct other inmates on various HIV/AIDS-related topics, such as modes of virus transmission, safer sex and injection-drug practices, the implications of HIV testing in their particular facility (i.e., who will know their status should they test positive), and what HIV/AIDS services are available to the inmates.

Peer educators who are carefully selected and trained are seen as more credible sources of information and are more likely to use terms that are relevant and understandable to the inmates. In addition, peer educators are also able to conduct informal one-on-one outreach and support in a variety of different areas of a facility in addition to conducting formal education sessions. Peer educators may provide a level of trust the inmate needs to be comfortable in seeking an HIV test and/or treatment, social support, and discharge planning.

These HIV/AIDS peer educators also may take on a variety of infectious disease topics with appropriate training. In both the Massachusetts and Michigan program, the peer educators are already fielding questions on HCV and developing teaching modules. Peer-led HIV/AIDS education and prevention programs for inmates can be maintained at little cost to the correctional system, since the inmates themselves provide much of the labor themselves for free or at a low daily pay rate.

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Peer education offers job training and may increase the level of self-esteem of inmates serving in this capacity. According to staff involved in the Massachusetts and Michigan collaborations, certification as a peer educator is, for many inmates, the first time they have “earned” any type of professional recognition or been entrusted with this level of responsibility. A few peer educators from the programs have continued their outreach-education work upon release. In Massachusetts, HIV/AIDS peer educators formerly housed in county facilities and state prisons provide education sessions in some Office of Community Corrections centers. These peer educators receive a stipend for their work from community organizations funded to provide such services.

The dynamics of peer education vary between these two states because of their differing HIV testing policies. In a facility with voluntary testing, peer education can result in an increase in the number of HIV tests requested by inmates. In a facility with mandatory HIV testing, a peer education session informs inmates about the consequences of a positive test and what HIV/AIDS services the facility provides. By knowing that there are services in place and staff trained to deal with the disease, inmates may be more likely to be active participants in their own care.

Selling the concept of an HIV/AIDS peer education program in a correctional facility to staff is not always easy even with the support of the superintendent or sheriff. Anecdotally, not all correctional staff support the concept of inmates leading a class. If time passes without incident and appropriate peer educator conduct, many staff will come to support this method of HIV/AIDS education for inmates.

With the distinction of being an inmate-led program comes the reality that any peer educator who does not follow the rules can alter the program's status. In both Michigan and Massachusetts there is a rigid application, selection, and supervision process for peer educators. “Potential peer educators go through a strenuous training program. They are given oral drills on program content, and evaluated for their ability to handle confrontational situations. Peer educators must be thoroughly screened for any behaviors that could result in injury to themselves or others. This is probably the most difficult to assess, and requires many hours of supervisory observation and interaction with their peers and staff. The peer educator must effectively communicate to all prisoners in a style that is non-threatening, and conducive to learning. They must be able to diffuse aggressive behavior, without placing themselves in a

“The success of the Massachusetts Bristol County Sheriff’s Office HIV/AIDS program is “because of the dedication, commitment and training of our staff and the involvement of inmates as peer educators,”

—Sheriff Thomas M. Hodgson

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potentially dangerous situation,” reports Ray Cotton, RN, Michigan Department of Community Health, prison partner notification coordinator and peer education trainer for state prisons. Inmates who are serving time for certain offenses or have committed specific infractions while in the facility are not permitted to serve as peer educators. Referrals from facility programs such as GED and Lifeskills can lead to strong HIV/AIDS peer educator candidates.

Key Finding 6. Measurable outcomes of program success and client health are still being developed and evaluated.

A Department of Justice report concluded that HIV/AIDS program models in corrections “have not been rigorously evaluated yet probably warrant replication based on anecdotal evidence.”⁴⁰ While measures of program success and efficacy are being developed and evaluated, some programs are measuring success through readily available data. Massachusetts tracks the number of inmates voluntarily requesting HIV testing. Both states track the number of inmates requesting HIV/AIDS case management and discharge planning, and recidivism rates as outcomes of success and efficacy.

Documentation of disease burden in the setting can be used to secure support and funding for collaborative HIV/AIDS programs. For example, data secured by the Rhode Island Department of Health and Rhode Island Department of Corrections demonstrated that 42 percent of the state’s new HIV infections were identified in their correctional facilities.⁴¹

In 1999, the Centers for Disease Control and Prevention and the Health Resources Services Administration awarded \$7

million to seven state and city health departments for the implementation of comprehensive HIV/AIDS intervention in correctional facilities. The funded sites developed models of public health and correctional collaborations for the delivery of HIV/AIDS education, testing, prevention, and transitional planning in prisons and jails.

Abt Associations, Inc. (headquartered in Cambridge, Massachusetts) and the Evaluation and Program Support Center (located at Emory University’s Rollins School of Public Health) will evaluate the data collected from the grantees. The purpose of the evaluation component is to “document the process of program implementation, and to describe challenges and strategies [of program implementation], and determine whether the interventions are building on existing programs or forging new collaborations.”⁴² This process includes the collection of aggregate and client-level data regarding services such as discharge planning, HIV prevention, and staff training. According to Ellen Bentz of the National Minority AIDS Council, (one of the three agencies providing technical assistance on the project), the collection of this type of data will enable the evaluators to measure the effectiveness of objectives established for the initiative. The objectives examined will include insights about factors that influence engagement and maintenance of medical care by released individuals with HIV/AIDS, outcome data to use for advocacy activities, and examples of successful program models that can be replicated in other locales.⁴³ The dissemination of findings and recommendations resulting from this process will be distributed through a protocol that is being developed.

VI. Conclusion

ASTHO developed its Prison Project to focus attention on public health issues such as HIV/AIDS and other infectious and communicable diseases prevalent among incarcerated populations. ASTHO hopes that through efforts such as this report, there will be increased recognition that health interventions directed to inmate populations improve the health of entire communities. The goal of this report has been to document the process of program implementation and to describe the challenges and strategies utilized to forge new collaborations.

States and jurisdictions throughout the United States are, to varying degrees involved in addressing HIV/AIDS in incarcerated populations. Some states are in the early stages of collaboration development, while other states have not yet begun discussions. States in any stage of program formation can look to collaborations in Massachusetts and Michigan to better understand the essential elements of partnerships and collaboration and the growing pains and potential program success associated with implementing an HIV/AIDS program in a correctional facility.

In reaction to the often-daunting task of housing individuals with serious health problems, the correctional and public

health agencies and their community partners in Massachusetts and Michigan have created partnerships to address the high risk for and high rates of HIV/AIDS among incarcerated populations. The individuals involved in these collaborative efforts include the program, medical, and custody staff of the correctional facility; employees and contractors of health departments; CBOs; and inmate HIV/AIDS peer educators. Their work supports the challenging public health–corrections–community goal of promoting the health of the entire community, including incarcerated individuals.

Site visits and interviews conducted for this report marked the uniqueness and similarities of the Massachusetts and Michigan collaborations to address HIV/AIDS among incarcerated populations. While there are specific collaboration details that do not necessarily translate to all states or different types of correctional facilities, these details echo overarching goals and themes associated with this type of work. ASTHO is hopeful that this information aids other states and locales in the initiation or enhancement of activities addressing HIV/AIDS among incarcerated populations.

References

References

1. U.S. Department of Justice. (1999, August). Bureau of Justice statistics bulletin: Prisoners in 1998 (NCJ 175687). Washington, DC: Author.
2. Jacob Arriola, K.R. (2000, September). CDC/HRSA HIV prevention and treatment initiatives for incarcerated populations. Presentation made at the U.S. Conference on AIDS in Atlanta, Georgia.
3. Conklin, T. J., Lincoln, T., & Tuthill, R. W. (2000). Self-reported health and prior health behaviors of newly admitted correctional inmates. *American Journal of Public Health*, 90(12), 1939-1941.
4. Ibid.
5. Strub, S. (1998, November). S.O.S.: Prison work is the loneliest field of AIDS activism. *POZ*, 18.
6. U.S. Department of Justice. (2000, August). Bureau of Justice statistics Bulletin: Prisoners in 1999 (NCJ 183476). Washington, DC: Author.
7. U.S. Department of Justice. (1998, April). Bureau of Justice statistics Special Report: Profile of jail inmates 1996 (NCJ 164620). Washington, DC: Author.
8. National Center on Addiction and Substance Abuse at Columbia University. (1998, January). *Behind bars: Substance abuse and America's prison population*. New York: Author.
9. U.S. Department of Justice. (2000, April). Bureau of Justice statistics Bulletin: Prison and jail inmates at midyear 1999 (NCJ 181643). Washington, DC: Author.
10. U. S. Department of Justice. (1995, April). Census of jails and annual survey of jails: Jails and jail inmates 1993-94 (NCJ 151651). Washington, DC: Author.
11. U.S. Department of Justice (1999, August). Bureau of Justice Statistics bulletin: Prisoners in 1998 (NCJ 175687). Washington, DC: Author.
12. U.S. Department of Justice. (1999, November). Bureau of Justice statistics bulletin: HIV in prisons 1997 (NCJ 178284). Washington, DC: Author.
13. Ibid.
14. Hammett, T. M., & Maruschak, L. M. (1999, July). 1996–1997 update: HIV/AIDS, STDs, and TB in correctional facilities (NCJ 176344). Washington, DC: National Institute of Justice, U.S. Department of Justice.
15. Ibid.
16. Ibid.
17. Massachusetts Department of Public Health. (1997, April). Unlinked (blinded) HIV seroprevalence studies: Massachusetts correctional facilities. Jamaica Plain, MA: Massachusetts Department of Public Health State Laboratory, Infectious Disease Lab Division.
18. Massachusetts Department of Public Health. Massachusetts Department of Public Health mission. Boston, MA: Author. Retrieved November 1, 2000, from the World Wide Web: <http://www.magnet.state.ma.us/dph/dphhome.htm>
19. Massachusetts Department of Public Health, AIDS Bureau. (1998, March 6). Request for applications: Massachusetts County Sheriffs Department HIV/AIDS Program. Boston, MA: Author.
20. Massachusetts Department of Corrections. (1999, September). New court commitments to Massachusetts county correctional facilities during 1998. Milford, MA: Author.
21. Massachusetts Department of Corrections. (1999, November). A statistical description of releases from institutions and jurisdiction of the Massachusetts Department of Corrections during 1998. Milford, MA: Author.

References

22. Massachusetts Department of Corrections. (1999, September). New court commitments to Massachusetts county correctional facilities during 1998. Milford, MA: Author.
23. Massachusetts Department of Public Health. (1997, April). Unlinked (blinded) HIV seroprevalence studies: Massachusetts correctional facilities. Jamaica Plain, MA: Massachusetts Department of Public Health State Laboratory, Infectious Disease Lab Division.
24. Massachusetts Sheriffs' Association Task Force. (1997, February). HIV/AIDS in the Massachusetts county correctional system 1995. Boston, MA: Author.
25. Ibid.
26. Ibid.
27. Michigan Department of Community Health. (2000, January). Michigan HIV prison partner notification program: Analysis of 1999 data. Lansing, MI: Author.
28. Michigan Department of Corrections. (1999, April). 1999 annual report: Reaching out to serve the public. Lansing, MI: Author.
29. Michigan Department of Community Health, HIV/AIDS Prevention & Intervention Section. (1995, November). Michigan HIV laws: How they affect physicians and other health care providers. Lansing, MI: Author.
30. Michigan Department of Corrections. (1999, April). 1999 annual report: Reaching out to serve the public. Lansing, MI: Author.
31. Ibid.
32. Michigan Department of Community Health. (2000, January). Michigan HIV prison partner notification program: Analysis of 1999 data. Lansing, MI: Author.
33. Ibid.
34. Ibid.
35. Michigan Department of Corrections. (1999, June). What is case management: Commonly asked questions [brochure]. Lansing, MI: Author.
36. Hammett, T. M., & Maruschak, L. M. (1999, July). 1996–1997 update: HIV/AIDS, STDs, and TB in correctional facilities (NCJ 176344). Washington, DC: National Institute of Justice, U.S. Department of Justice.
37. Ibid.
38. National Commission on Correctional Health Care. (1994, September). Position statement: Administrative management of HIV in corrections. Found at <http://www.ncchc.org/statements/hiv.html>.
39. Braithwaite, R. L., Hammett, T. M., & Mayberry, R. M. (1996). Prisons and AIDS: A public health challenge. San Francisco, CA: Jossey-Bass.
40. Hammett, T. M., & Maruschak, L. M. (1999, July). 1996–1997 update: HIV/AIDS, STDs, and TB in correctional facilities (NCJ 176344). Washington, DC: National Institute of Justice, U.S. Department of Justice.
41. Ibid.
42. Federal funding for HIV in corrections : One year later. (2000, October). HEPP News, 3, p. 7.
43. Jacob Arriola, K. R. (2000, September). CDC/HRSA HIV prevention and treatment initiatives for incarcerated populations. Presentation made at the U.S. Conference on AIDS in Atlanta, Georgia.



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