

HIV Prevention Education In Correctional Settings

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The appalling health status of those in the correctional setting is a serious statement of the breakdown of our community health and social service systems. The medical, health and social issues that are not addressed in the community often find their way into the criminal justice system. HIV is but one of these issues. If we do not confront the lack of community mental health centers, barriers to substance abuse treatment, and lack of safe and affordable housing in our communities, then it is just a matter of time before those impacted by these disparities will be involved in the correctional system.

There is a strong association between mental health and substance use; there is a strong association between homelessness and lack of medical care; there is a strong association between mental health and self-medication. All of these issues can be prevented, especially before the criminal justice system gets involved. We need to prioritize prevention...this is what Prevention Justice is all about.

The following brief will give an overview of evidence-based HIV prevention education programs for correctional settings, core components of effective prevention programs, and a list of recommendations toward a comprehensive approach to HIV prevention in correctional settings.

The Link Between Community and Correctional Health

There are too many people incarcerated in the United States today, the highest rate in the world. The burden of disease among people who are incarcerated is many times greater than the community. But people on the inside today were on the outside not too long ago. The health status of people who are incarcerated is more of an indicator of community health than correctional health. People are far more likely to have brought a disease from the community into the correctional system when they arrive, than they are to have picked something up while incarcerated that they are taking back out to the community when they are released.

Incarcerated men have been blamed for increasing rates of HIV and STI in the community. A recent editorial (Fullilove, et al. 2008) articulated how imprisonment does impact HIV and STI rates in the community. It is a result however, of how incarceration decreases the number of men in the community (i.e. it changes the male-female ratio) and that impacts sexual concurrent partnerships within the community. It is not from men getting HIV on the inside and bringing it out to their female sexual partners once they are released.

We cannot expect corrections to tackle these major public health issues on their own. Nor can we expect public health to take on the issues of public safety and correctional custody issues. We have to work together to collaborate. The authors have been working within this collaborative structure for over 30 years, and can attest that though it is not easy, it is both doable and feasible. The worlds of public health and corrections have different cultures and priorities. But the mutually beneficial goals of public health and public safety can and should bring these worlds together.

Overview of Evidence-Based Prevention Programs

Despite the long-standing recognized need for both primary and secondary HIV prevention within the correctional system, there have been few quantitative evaluations of HIV prevention interventions with incarcerated populations. In 2006, Bryan and colleagues reviewed this literature and found seven total studies published since 1991, only five of which were found to be effective (El-Bassel, Ivanoff et al. 1995; Grinstead, Faigeles et al. 1997; St Lawrence, Eldridge et al. 1997; Grinstead, Zack et al. 2001, Bryan, et. al, 2006). There are at least four additional published prevention interventions that have shown significant effects (Grinstead, et al. 1999; Bauserman, et al. 2003; Ross, et al. 2006; Wolitski, 2006) resulting in a total of nine known effective HIV prevention interventions involving people in the correctional setting. Only one of these interventions was limited to HIV+ participants (Grinstead, Zack, and Faigeles, 2001; Zack, Grinstead et al. 2004).

It is important to note that the two individual level interventions that showed reductions in risk behavior were not exclusively disease or health focused, but instead emphasized individualized planning for housing, employment and education within the context of disease prevention (Grinstead, Zack et al. 1999; Wolitski R 2006). Most recently, Wolitski (2006) showed a significant difference in risk behavior at 6 months post-release as a result of a program (Project START) based on prevention case management and risk reduction counseling, in which the participant and program staff created an individualized prevention plan for the post-release period. Myers and colleagues (2005) also documented that pre- and post-release case management support can facilitate healthy behaviors.

Despite the variety of approaches, the evidence suggests that both HIV-related risk behavior and factors known to be related to these risk behaviors can be reduced as a result of prevention programs in these populations. Furthermore, though far from conclusive, there is evidence that prevention programs should not be “disease specific,” but rather, should focus on multiple health issues and the factors that directly impact an individual’s ability to enact prevention behaviors. In other words, comprehensiveness increases effectiveness.

Other than the published data, there are numerous community-based organizations, departments of corrections and county jails who are implementing programs that address these issues. Since most of these programs are not evaluated and/or published in the public health or criminal justice literature, we remain at a disadvantage in neither being able to summarize their methodologies nor being able to identify their potential effective outcomes.

With only nine studies which show evidence of effectiveness in the past 20 years, we need to simultaneously replicate evidence-based interventions in the field while at the same time

incorporate innovative community-based intervention strategies that show great promise but which have not yet been tested or evaluated.

Core Components of Behavioral Interventions

The following set of core components is an attempt to combine both lessons from the literature and from the field. HIV prevention program development and implementation in the correctional setting require that four distinct components to be taken into consideration: 1) the type of intervention; 2) the timing of the program; 3) the content; and 4) the messenger.

Type of Intervention

There are multiple vehicles to intervene with this community. Some correctional facilities put up posters or distribute brochures and call it, “education,” when in reality it is solely “information sharing.” To be effective, education goes beyond simply sharing of information. Education should be initiated through both individual and group programming. Peer facilitated, multi-session group or individual sessions that are comprehensive and client-centered are most effective. Different learning and literacy capacities should be taken into consideration, as should cultural issues, so that the content and delivery is intellectually appropriate for those receiving it.

Additionally, the more that HIV prevention can be integrated into other health and related programs, the more effective it will be. HIV-specific programming can be counter-productive, as attendance and engagement are affected by stigma, perception of risk, and competing life priorities of the incarcerated population. Often times, staff are identified by their program involvement, the HIV program coordinator becomes the “AIDS person” and everyone interacting with him or her becomes suspect. This association has been shown to prevent individuals from approaching program staff with questions or concerns. By expanding the scope of the program, the staff could be identified as the “health person.” This wider association can increase the degree of accessibility and effectiveness of the prevention program.

Timing

Optimally, prevention education should be initiated at the onset of incarceration, be reinforced during incarceration, strongly emphasized during pre-release planning, and continued upon release. Prevention education must occur upon entry into the correctional facility to inform those coming into the system of ‘risks inside,’ as well as including the department policies about both behavior risks and screening or testing procedures. Education and skills building programs should be made available to the general incarcerated population to reinforce messages given at entry. Programs should also give access to resources and information for individuals to practice risk reduction strategies while incarcerated as best as they are able. Equally, if not more important, is the pre-release period. It is well documented that high-risk behavior occurs at the time period immediately following release (Zack, Flanigan et al. 2000). Thus, there is a strong need for pre-release programs that continue after release, such as transitional case management or risk reduction counseling programs.

Content

Just as the HIV epidemic is not equally distributed throughout the country, neither is the basic knowledge or skills necessary to prevent HIV. For some, basic HIV information is (still) required before a more in-depth program can be initiated. If the basic information is not there, the

perception of risk is non-existent and the program itself is less likely to be approved or accepted by the facility or by those who are incarcerated.

Once there is a common knowledge base, the next phase of education includes increasing one's perception of risk and skills specifically around risk behaviors (sexual, injection drug and other blood to blood risk behaviors). Increased perception of risk is achieved by the participant examining his or her own behaviors and understanding the risks involved. Skill development usually focuses on the proper use of condoms, strategies for encouraging condom use with partners, understanding and practicing syringe hygiene, increasing awareness of needle exchange programs, and other methods of prevention activities (including not sharing tattooing equipment).

The Messenger

The "messenger" of the HIV prevention message is critical in this environment. Examples of messengers include staff from correctional medical departments, local health departments or community agencies. Mistrust is pervasive in many correctional facilities. This mistrust is rooted in differing priorities between those doing time, correctional custody staff, and other correctional support staff. Therefore, a messenger who is viewed as neutral and trustworthy is critical.

Over the past ten years, peer education has increased in both acceptability and effectiveness. By using a peer educator, the language is more relevant, trustworthiness is increased, and, as a result, the messages are more easily communicated and more likely to be considered. There are varying working definitions of "peers." Some programs are staffed with currently incarcerated individuals while others utilize staff or volunteers from local community groups who have a history of incarceration. There are many current peer education curricula that were developed specifically for correctional-based programs. Examples of these curricula include: Bedford Hills Women's Prison, ACE: AIDS Counseling and Education, (Boudin K, et. al. 1999), Canadian Federal Penitentiary Model, CAN: Con AIDS Network (Ploem C, Toepell A. 1996), Centerforce, Reach One Teach One, (Kramer, K., Zack, B., Heft, L., 2000) and the AIDS Foundation Houston, Wall Talk (Ross, et. al., 2006).

Other Important Opportunities for HIV Prevention

The focus of this brief is on educational prevention programs as a method of HIV Prevention. Other opportunities are presented below. Each one of these options is also a documented and important form of HIV prevention.

Counseling and Testing:

Counseling and testing works. When people learn of their HIV status, their behavior changes. If people test negative, we need to support their efforts to stay negative. If people test positive, we need to provide comprehensive prevention and treatment services that will support their efforts to live productive lives and reduce their risk of transmitting HIV to others.

HIV testing within a correctional setting may have many implications for the individual. For example, if someone tests positive, he or she may be housed in a different location in the facility or be transferred to an entirely different facility. This new correctional facility may be further

away from friends and family and thus may affect the number of visits someone receives while incarcerated. Additionally, receiving a positive result while incarcerated may alienate someone from other incarcerated individuals due to stigma and fear. This isolation can exacerbate feelings of depression and anxiety for a newly diagnosed individual. On the other hand, if someone tests positive, he or she may have access to treatment opportunities while incarcerated as well as be linked to support and other community resources upon release that he or she may not otherwise have known about.

Thus, it is very important for any correctional facility that is conducting HIV testing to have a strong pre- and post-test counseling program that: 1) clearly educates individuals on the facility's testing policy (routine, mandatory, voluntary, opt-out); 2) delineates the implication of having an HIV+ diagnosis within the correctional system (i.e. housing policies, medical access and utilization procedures); 3) provides support for newly diagnosed individuals; and 4) links HIV+ individuals to a system of care and community resources both during incarceration and after release.

Condom distribution and/or availability

It is well documented that with consistent and proper condom use, HIV transmission can be prevented (National Institute of Health 2001; Hearst 2004; Holmes 2004). Yet, as of February 2007, condoms are banned or unavailable in over 99% percent of U.S. prisons and jails. This ban is based on security concerns of misuse and strict interpretations of policies that prohibit sexual behaviors inside correctional facilities. But, no correctional system that has implemented a condom availability program (in either the United States or in the world) has been required to discontinue the program as a result of a security or custody issue (Dolan K 2003). Thus, denying condoms to people who are incarcerated cannot be justified on public safety grounds.

There have been legislative efforts to pass condom availability programs for correctional settings. Many in the public and correctional health communities have advocated for such distribution programs. The WHO and UNAIDS have recommended for more than a decade that condoms be made available to people who are incarcerated. Currently, the state prisons in Mississippi and Vermont make condoms available, as do county jails in New York City, Philadelphia, Washington, D.C., San Francisco and Los Angeles. In both Los Angeles and San Francisco County Jails, the Center for Health Justice (CHJ) is evaluating their condom availability programs. The California Department of Corrections and Rehabilitation in collaboration with the California Department of Public Health and CHJ will soon start a pilot condom distribution project in one California prison.

Access to clean injection equipment

Though there are no sanctioned in-prison/jail syringe exchange programs in the United States, it is well documented that 1) injection drug use occurs in the correctional setting; 2) sterile IDU paraphernalia is extremely difficult to obtain; and 3) as with sexual activity, the risk is greater on the inside as a result of higher prevalence of HIV. An evaluation of correctional-based programs in Switzerland, Spain, and Germany that provide sterile needles and syringes found “no increase in drug use, a dramatic decrease in needle sharing, no new cases of infection of HIV or Hep B or C, and no reported instances of needles being used as weapons.” (Dolan K 2003; Okie 2007). Thus, we need to be discussing how to make this work in the United States.

If a safe syringe/needle exchange program is not legal or feasible, both the World Health Organization and the U.S. Centers for Disease Control and Prevention are on record as stating that other measures should be made available to prevent further transmission. WHO states that the provision of other cleaning techniques (e.g. bleach) should be used “where there is implacable opposition to NSP (Needle Syringe Programs).” The Centers for Disease Control and Prevention states that bleach should be made available “where no other safer options are available.” The WHO and UNAIDS also recommend that drug-dependence treatment and methadone maintenance programs be offered in correctional settings if they are provided in the community, and that needle-exchange programs be considered (Okie 2007).

HIV and STI Treatment as Prevention

Treatment of STIs can be a method of HIV prevention (Fleming and Wasserheit 1999). The presence of an STI can increase susceptibility of HIV infection. Thus, by treating these STIs, the risk of HIV infection is decreased. The same can be said about HIV treatment. By suppressing viral load, HIV treatment helps reduce the risk of HIV transmission (Porco 2004).

Treatment of Substance Use

There is a strong relationship between substance use and sexual risk behavior. Given the high percent of substance use of those in the criminal justice system (Bureau of Justice Statistics 1997), substance abuse treatment is HIV prevention (Rich, Holmes et al. 2001; Fiscella K. et al. 2004; World Health Organization 2005; Okie 2007).

Mental Health Treatment

A 2006 Bureau of Justice Statistics report documented the quadrupling of the number of mentally ill who are incarcerated in the past six years. Mental health disorders among those in state prison are five times higher than the community rates (Bureau of Justice Statistics 2006). People with undiagnosed or non - managed mental health disorders are less apt to have the cognitive capacity to enact traditional HIV prevention methods such as negotiating safer sex practices and cleaning syringes. Thus, increasing mental health treatment increases the success of HIV prevention.

Expanded Prevention Outcome Measurements

Different educational HIV prevention efforts have measured their successes with different outcomes. Though the bottom line outcome is not getting infected, there are a myriad of other outcomes that indirectly impact HIV incidence. Other outcomes that should be considered for evaluation of programs include:

- Condom use both inside and after release
- Use of sterile injection equipment both inside and after release
- Decreased alcohol/drug use with sexual activity
- Use of needle exchange programs (if available)
- Access and utilization of substance abuse and mental health treatment
- Access and utilization of community health services

- Access and utilization of community case management programs
- Complying with parole and probation conditions
- Staying out of the criminal justice system (and/or staying out for longer periods of time)
- Family/support system involvement both during incarceration and after release

Conclusion and Recommendations

To have the greatest impact on the HIV/STI/hepatitis rates of the incarcerated, those formerly incarcerated, and the communities to which they are released, we should strive to make our prevention programs as comprehensive as possible. To stem the tide of this epidemic, prevention programs, whether focused on HIV, STIs, hepatitis, or any other health issues, must address the issues of housing, employment, health care access (including access to substance abuse and mental health treatment), and education. Without intervening upon the contextual factors that directly impact HIV risk behavior, we cannot hope to have a long-term impact on the incidence of this disease.

Most HIV prevention programs focus on encouraging the individual to make behavior changes (i.e., the person engaging in high risk behavior). This is but one strategy for prevention. Other strategies include structural interventions (e.g., a comprehensive community health system), environmental interventions (condom and syringe availability), and policy level (sentencing reform) interventions. It will take a multi-strategy approach to truly impact HIV rates in our communities. Effective prevention programs for individuals in the correctional setting are multi-strategy approaches with results that are felt not only by the individual program participant or client, but also by other incarcerated individuals (through diffusion), by correctional staff (either through observing the program for security reasons or through osmosis), by family visitors, and by community volunteers.

Within the context of a multi-strategy approach, the following recommendations are based on the aforementioned review of the literature, current prevention research efforts, and the authors' many years of program experience and behavioral research in the correctional setting:

1. Comprehensive prevention education should be available to all those incarcerated, whenever and wherever possible. This education should be integrated into existing educational programs throughout the entire time of ones' incarceration (e.g. upon entry, at correctional facility transfer, during the course of incarceration and - with an added emphasis- in the immediate pre-release period).
2. Counseling (both pre- and post-test) and testing should be voluntary only, requiring opt-in consent with an additional component to allow the individual to understand the ramifications of testing (either positive or negative) in the correctional setting.
3. Policies should be adopted that will allow for preventive practices and disease prevention for individuals while they are incarcerated (condom availability, syringe exchange and tattoo cleaning).
4. Comprehensive treatment for HIV and STIs should be available that includes ongoing monitoring of health status including medication adherence.

5. Substance abuse, alcohol and mental health treatment must be primary, secondary and tertiary prevention effort priorities.
6. Comprehensive pre- and post-release transitional support must be offered to all those getting out that includes: a) continuity of any and all treatment; b) support with housing, employment and education; c) family and social support; d) ‘plugging’ into the community service network; and e) working with community law enforcement (e.g. parole and/or probation) to understand conditions of one’s release.

It is clear that providing effective disease prevention programs to those who are incarcerated would not only help protect them, but also would likely have a synergistic impact on HIV rates in our communities. If departments of corrections were to adopt evidence-based prevention measures, people in the correctional settings would be returning from incarceration equipped with the knowledge and skills necessary to play an important role in reversing the current epidemic trends. When public health becomes a priority, both the correctional and community populations will benefit with healthier outcomes.

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Since 1986, Mr. Zack has engaged at every level of public health programming and research in the prison/jail setting, from Jail Outreach Worker to Executive Director of Centerforce, one of the nation's leading non-governmental organizations working with people who are incarcerated, their families and others impacted by incarceration. He has also served as the Principal Investigator of multiple national research studies. Mr. Zack is currently a Principal Consultant with The Bridging Group as well as an Associate Clinical Professor at the University of California, San Francisco, in the Department of Community Health Systems.

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Ms. Kramer has been designing and providing social services since 1990. For the past 15 years, she has focused on the development, implementation, and evaluation of social service and health programs that serve individuals, families and communities impacted by incarceration. She is an experienced agency manager with comprehensive knowledge in program oversight, agency policy development, grant writing and staff supervision. She has experience as a clinical social worker providing direct service for clients and clinical supervision for direct-line staff. Ms. Kramer is also a professional trainer and curriculum developer with over 15 years experience in the creation and facilitation of skills-based training. Ms. Kramer is currently a Principal Consultant with The Bridging Group, located in Oakland, California.

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