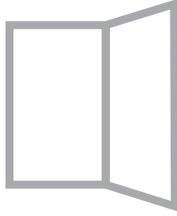


OPENING DOORS

THE HRSA-CDC CORRECTIONS
DEMONSTRATION PROJECT FOR
PEOPLE LIVING WITH HIV/AIDS



U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration



OPENING DOORS

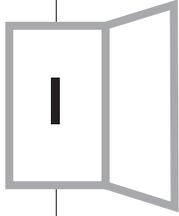
**The HRSA-CDC Corrections Demonstration Project
For People Living With HIV/AIDS**

**U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau**

December 2007

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INTRODUCTION

In 1997 more than 1.75 million people were incarcerated in jails or prison in the United States—almost 1 percent of the Nation’s population.¹ This dramatic increase in the number of prisoners has been fueled since the 1980s by the “War on Drugs.” By 1998, nearly 60 percent of incarcerated people were drug offenders, compared with only 29 percent in the mid-1980s.² By early 1999, an estimated 2 million people were incarcerated, an increase of about 500 percent over the 325,400 who were incarcerated in 1970.³ During the 1990s, the United States experienced its highest incarceration rate ever, which created a strain on the resources of corrections systems, particularly in the area of health care.⁴

Inmates suffer disproportionately from infectious diseases, substance abuse, and a constellation of problems related to socioeconomic status.⁵ Most people who are incarcerated come from impoverished, medically underserved environments; they have engaged in a variety of high-risk and often violent behaviors. Those behaviors and high-risk lifestyles make them vulnerable to serious health problems and increase the prevalence of infectious diseases, such as HIV/AIDS, tuberculosis (TB), sexually transmitted infections (STIs), and hepatitis. Factors such as drug addiction, lack of access to health care, poverty, substandard nutrition, poor housing conditions, and homelessness contribute to increased risk for not only infectious diseases but also chronic conditions such as hypertension, cardiovascular disease, skin conditions, gastrointestinal disease, diabetes, and asthma. For many people, incarceration may be their first contact with health care. It is estimated that up to 80 percent of chronically ill inmates have not received medical care prior to incarceration and may have been using the local hospital emergency room as their primary care provider.⁶⁻⁸

As a group, inmates report higher rates of disabling conditions, have poorer perceptions of their health status, and have lower utilization of primary health care services than the general population. In the United States, 20 to 26 percent of people living with HIV/AIDS (PLWHA), 29 to 43 percent of those infected with the hepatitis C virus, and 40 percent of those who have TB passed through

correctional facilities during 1997.⁹ Physical and mental illness and the range of psychosocial problems encountered in correctional facilities reflect the health disparities within the larger community.

The correctional population is most in need of care, as outlined in the Surgeon General's list of priorities for the Nation's health care.¹⁰ Although the focus of correctional health care is generally on the people who are incarcerated, benefits accrue to corrections staff, their families, and the neighborhoods from which inmates come and to which they return. In this way, correctional settings, although self-contained, are linked to our Nation's communities.^{11,12}

The huge growth in incarceration over the past two decades has led to similar growth in the numbers of people released. Nearly 700,000 people from State and Federal prisons were released to return to their communities in 2005, more than four times the 170,000 released in 1980.¹³ This figure, however, does not include the additional 12

opportunity within corrections and the potential to benefit the community through reduced illness rates, financial savings, improved public safety, and better use of the existing health care system and resources. More inmates are returning home, having spent longer and more frequent terms behind bars; they are less prepared for life on the outside and have less help and fewer resources available to assist in their reintegration. They will have difficulty reconnecting with jobs, housing, and families when they return and will have to deal with substance abuse and health problems. Many will be rearrested, and many will be returned to prison or jail for new crimes or parole violations. This cycle of removal and return, which is occurring mostly among men, is increasingly concentrated in communities that are already disproportionately affected by social and economic disparities.¹⁷

From a policy perspective, inmates' health care and reintegration back into the community began to take on new importance with the increasing number of HIV/AIDS cases identified in correctional

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IN JAILS OR PRISONS IN THE UNITED STATES—ALMOST 1 PERCENT
OF THE NATION'S POPULATION.**

million who are incarcerated in local or county jails for short periods, ranging from only a few hours to up to a year, and are subsequently released. Local officials and community leaders are starting to ask questions about how the flow of inmates back into communities affects public safety, how corrections systems prepare prisoners for release, and what communities can do to successfully absorb and reintegrate inmates into community life.¹⁴⁻¹⁶

Because most inmates are eventually released back to their communities, public health officials have begun to recognize the tremendous public health

settings. By the late 1990s, public health and corrections officials had begun to recognize that a comprehensive approach, including early detection and assessment, health education, prevention and treatment, and continuity of care, was critical to reducing the incidence and prevalence of disease in correctional facilities and communities.¹⁸ Given this realization, collaborations among corrections, community, and public health programs at both the Federal and State levels have increasingly been developed to take advantage of the incarceration episode to decrease the burden of illness on inmates and the greater community.^{19,20}

Although the costs of prisoner reintegration are great, opportunities to enhance the health and safety of the community are gaining in importance. By the mid-1990s, public health workers in communities with high rates of HIV and STIs had begun to recognize the strong relationship among disease, drug use, and periods of incarceration in jails and prison among PLWHA. Those relationships were especially pronounced among injection drug users (IDUs).

Despite high disease rates and risk behaviors among prisoners and releasees, initial Centers for Disease Control and Prevention (CDC) studies documented that correctional health and community-based primary health care systems had not forged the relationships to link and deliver surveillance, prevention, and treatment, including substance abuse treatment and social services. This lack of comprehensive approaches and the poor organizational framework to support continuity of care were contributing to significant, preventable disease and morbidity among people at high risk for HIV/AIDS, TB, STIs, hepatitis, and other health problems.^{21,22}

People moving into or out of incarceration must negotiate differences in access as well as structural and procedural differences between correctional and community-based care systems. The barriers also may make it more difficult for clients to benefit from public health efforts to promote behaviors that aid in prevention and treatment.^{23,24}

The Health Resources and Services Administration's (HRSA's) Special Projects of National Significance (SPNS) initiatives, which targeted incarcerated populations during the mid-1990s, found that continuity of care was a significant problem for recently released inmates with HIV disease for whom effective clinical management and ongoing treatment were essential to prevent further HIV transmission. SPNS also found that program models that integrate correctional and community-based prevention, primary care, and other supportive

services were effective at helping clients maintain continuity of care and reduce risk behaviors.²⁵

Better coordination of services for returning inmates can reduce criminal behavior, which in turn can translate into fewer crimes committed and fewer returns to jail or prison. This approach has potential benefits for the families and communities most affected by prisoner reentry as well as for the former prisoner.

The costs and opportunities associated with reentry and long-term reintegration of former prisoners raise important questions that need to be addressed:

- * How can corrections and communities work together to build a successful framework for reentry that addresses both the needs of the prisoner and those of the community to prepare for the return home?²⁶⁻²⁸
- * How can public resources be allocated to improve public safety and reduce or prevent reoffending?
- * How can corrections and communities work together to develop strategies and programs to support successful reentry into society?
- * And, most important, what types of policies can be realistically implemented to make a difference using current resources?^{29,30}

Collaborations between public health and correctional agencies have evolved and are now an important venue for addressing gaps in health care services for inmates. Public health departments are mandated to prevent illness—particularly environmental and communicable diseases—in the general population. Public health departments have the funds, staff, expertise, and other resources to help correctional facilities address the serious health needs of inmates and thereby advance the cause of public health in their communities.^{31,32}

The same can be said for public health's interactions with community-based organizations (CBOs). Corrections agencies and CBOs, in turn, need to collaborate because they share the same clients (although traditionally at different times) and families and because each entity has the necessary expertise and experience to address the issues. Many types of collaborations exist between corrections and public health at Federal, State, and local levels, although State departments of corrections collaborate most often with State-level public health agencies. Most collaborations at all levels are limited and focus only on correctional populations

that are HIV infected or mentally ill. Although correctional systems value the collaborations, vast areas for improvement remain.^{33,34}

Recognizing this need and opportunity, HRSA and the CDC developed a partnership in 1999 to provide funding "to support demonstration projects within correctional facilities and communities that develop models of comprehensive surveillance, prevention, and health care activities for HIV, STIs, TB, substance abuse, and hepatitis."³⁵ This report describes the initiative; its intent, development, and implementation; and lessons learned.

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THE CORRECTIONS INITIATIVE

From 1999 to 2004, HRSA and the CDC jointly funded a national corrections demonstration project in seven States (California, Florida, Georgia, Illinois, Massachusetts, New York, and New Jersey). The HIV/AIDS Intervention, Prevention, and Continuity of Care Demonstration Project for Incarcerated Individuals Within Correctional Settings and the Community, known nationally as simply the Corrections Demonstration Project (CDP), involved jail, prison, and juvenile settings. The program targeted inmates with HIV/AIDS, hepatitis B and C, TB, substance abuse, and STIs. It supported an array of services that included treatment for HIV and other diseases in correctional facilities; discharge planning; case management to link clients to services following release; and, in two States (California and New Jersey), prevention case management for high-risk, HIV-negative releasees.

The CDP was an effort to develop effective collaborations with corrections systems, the community, and public health systems. It promoted partnerships among State and local health departments and CBOs and AIDS service organizations that were contracted by the grantee to provide services. The project provided services to thousands of inmates and generated a tremendous amount of data and information. That information is now being used to develop collaborative efforts in other parts of the country.

The goal of the CDP was to increase access to health care and improve the health status of incarcerated and at-risk populations, especially African-Americans and other racial minorities disproportionately affected by the HIV/AIDS epidemic. Major objectives were as follows:

- * Increase access to HIV/AIDS primary health care and prevention services
- * Improve HIV transitional services between corrections and the community
- * Develop organizational supports and linked networks of comprehensive HIV health and social services.

The initiative targeted people in correctional settings; the primary objective was to extend inmates' medical care and support services to the community to which they were returning upon release. Correctional settings included prisons, jails, detention centers, and transitional halfway houses. The target population included African-Americans detained in the criminal justice system, especially jails and juvenile detention facilities. Projects were to develop collaborations between correctional settings and community-based health care and support service providers that would support continuity of health care and provide ancillary and supportive services to effect positive behavioral change, increase health care access, and improve health status.

Models of linked networks of health services, including prevention and treatment of HIV/AIDS, STIs, TB, hepatitis, and substance abuse during and after incarceration, were to be developed and evaluated for replication by other primary care, prevention, criminal justice, and community service organizations. The CDP sought to create a combination of services, including surveillance, medical and behavioral screening and assessment, prevention education and counseling, primary health care, and referral linkages. Its multitiered focus included providing services in jails, prisons, juvenile detention centers, and transitional halfway houses; working within correctional and community-based systems of care; and implementing long-term, systemic change. Special emphasis was placed on working with jails and juvenile detention facilities because of their direct linkages to the community.

This initiative was a competition limited to 11 States (California, Connecticut, Florida, Georgia, Illinois, Maryland, Massachusetts, New Jersey, New York, Pennsylvania, and Texas) and the District of Columbia.

These locations were identified as priority areas because they represented

- * 56.2 percent (635,483) of the total prison population for 1997,
- * 74.7 percent (76,679) of all AIDS cases among African-Americans for 1997,
- * 82.7 percent (19,361) of all HIV-positive inmates in State prisons, and
- * 26 of the 30 Metropolitan Statistical Areas where AIDS had the greatest impact on African-Americans.

Funding priority was given to applicants that offered the greatest potential to increase access to prevention and primary health care and improve the health status of incarcerated and at-risk African-Americans and other racial and ethnic minorities. The funds were part of a larger pool of resources targeting the AIDS epidemic that was made available as a result of activities initiated by the Congressional Black Caucus in response to a state of emergency issued in 1998 by the caucus and CDC. Approximately \$7 million was available to fund five to eight demonstrations for a project period of 3 years. This period was later expanded to 5 years. The application stipulated that at least 40 percent of the provided funds be directed to community-based prevention, primary care, and other ancillary service providers to support and develop models of linked networks of health services. Services would include prevention and treatment of HIV/AIDS, STIs, TB, hepatitis, and substance abuse during and after incarceration.

HRSA and CDC provided technical assistance, staff development, and onsite evaluation consultants to ensure that the projects would have the technical support and assistance needed to undertake the outlined activities. To ensure the definition and measurement of appropriate project outcome

THE GOAL OF THE CORRECTIONS DEMONSTRATION PROJECT WAS TO INCREASE ACCESS TO HEALTH CARE AND IMPROVE THE HEALTH STATUS OF INCARCERATED AND AT-RISK POPULATIONS.

measures, HRSA and CDC issued a separate request for proposals to identify and select an evaluation support center (ESC). The role of the ESC was to work collaboratively with the projects to develop a data collection plan that included data collection instruments and procedures. The ESC was to produce a series of formative cross-program evaluations to identify and describe (1) program components critical to health-seeking behaviors among previously incarcerated people, (2) the costs associated with program interventions in and outside correctional settings, and (3) lessons learned (issues of local governance, management strategies, development and implementation of intervention models, etc.). Each project would analyze its own outcome indicators to monitor and support program management and evaluation.

Health departments from six States (California, Florida, Georgia, Massachusetts, New Jersey, and New York) and one city (Chicago) were awarded funding from CDC to implement their projects in prisons, jails, juvenile facilities, and related correctional settings. HRSA's SPNS program funded the Emory University Rollins School of Public Health (Atlanta, GA) and its collaborator, Abt Associates (Cambridge, MA), to coordinate the evaluation of the initiative. Three additional organizations were funded by HRSA and CDC as technical assistance providers for the grantees and their subgrantees or contractors: the National Minority AIDS Council (Washington, DC), the Southeastern AIDS Training and Educational Center (Atlanta) and the Hampden

County Correctional Facility (Public Health Model of Correctional Care; Ludlow, MA). Funds were awarded at the end of September 1999, and the project began that October.

Each of the seven CDP grantees received approximately \$1 million per year to conduct continuity-of-care service activities for HIV/AIDS. A few sites' existing activities were enhanced by CDP funding, whereas others were able to implement new services within correctional settings. By early 2001, an assessment compiled for the annual grantee meeting revealed that services were being provided in 24 jails, 48 prisons, more than 100 juvenile justice facilities, and 26 community corrections settings. The cross-site activities fell into eight categories:

- * HIV/AIDS clinical evaluation and treatment
- * HIV/AIDS prevention education
- * Peer education
- * Disease screening, counseling, and testing
- * Staff development and training
- * Discharge planning
- * Continuity-of-care case management
- * Prevention case management.

Considerable variability existed within each category and within each correctional setting.

The CDP grantees provided ample resources and technical support, but local political environments, the lack of trust between corrections and public

health, and cumbersome fiscal and management policies plagued all projects to some extent during the first year. As a result, it was not until mid-2000 that basic services were sufficiently in place to begin quantitative data collection on critical process indicators.

The following section provides aggregate data from all CDP grantees according to service category and facility type. The data reflect the services supported

by the CDP and tracked by the ESC; they do not reflect the comprehensive array of services that each grantee provided in participating correctional facilities. Many grantees saw this initiative as an enhancement of existing services, whereas others used CDP resources to plan and implement services where none were previously available. As a result, cross-site evaluation data do not reflect the true extent of efforts that were provided during the duration of the project.

3

AGGREGATE FINDINGS

During 5 years of prevention and case service delivery, the CDP provided HIV, STI, and hepatitis prevention education to more than 123,000 people, disease-screening services to more than 41,000 clients, and discharge-planning and community case management services to nearly 7,000 PLWHA (Tables 1 and 2).

HIV, STI, and hepatitis prevention education was offered in juvenile detention, local jail, and State prison settings. In some areas, staff in those institutions also were offered prevention education. Nearly everyone who received prevention education was located in a State prison setting; far fewer people in local jails and juvenile detention centers received prevention education.

Disease screening was offered in most of the settings in which prevention education was presented, often as a follow-up to the classes. The number of tests carried out for particular diseases is known; however, clients may have been tested more than once. Among juveniles, chlamydia and gonorrhea were the most frequently screened diseases (13,655 tests each), followed by HIV infection (1,205 tests). Chlamydia was the most often identified infection (7.93 percent of tests were positive), and HIV was quite rare (0.17 percent of tests were positive) among juveniles (Table 2).

Adults who were screened in county jail settings revealed a similar pattern of disease prevalence. Chlamydia was the most frequently recorded test ($N = 27,760$) and displayed the highest positive rate (7.36 percent, almost identical to the rate for juveniles), followed by gonorrhea ($N = 22,166$; 3.36 percent positive). Although fewer HIV tests than other types of STI screens were conducted ($N = 14,450$), the percentage positive (3.45 percent) was slightly higher than the percentage of positive gonorrhea tests. Syphilis tests were the least frequently reported among the jails and had a positive rate of 3.86 percent. Rates of HIV and syphilis are higher among adults primarily because of the additional risk factors

TABLE 1. NUMBER OF CLIENTS SERVED, BY SETTING, HRSA/CDC CDP, 1999–2004

No. Sessions	Juvenile Detention Facilities	Jails	Prisons	Staff (variety of correctional settings)	Total
Single Session	5,082	16,910	76,764	2,585	101,341
Multiple Sessions	3,443	1,159	16,396	1,118	22,116
Total	8,525	18,069	93,160	3,703	123,457

TABLE 2. DISEASE SCREENING RESULTS, HRSA/CDC CDP, 1999–2000

Disease Screened	Juvenile Detention Facilities (N)	% Positive	Jails (N)	% Positive	Prisons (N)	% Positive	Total Screened (N)
Chlamydia	13,665	7.93	27,760	7.36	N/A	N/A	41,425
Gonorrhea	13,665	2.77	22,166	3.36	N/A	N/A	35,831
HIV	1,205	0.17	14,450	3.45	12,861	1.39	28,516
Syphilis	N/A	N/A	12,166	3.86	N/A	N/A	12,166

TABLE 3. PERSONS RECEIVING DISCHARGE-PLANNING SERVICES, HRSA/CDC CDP, 1999–2004

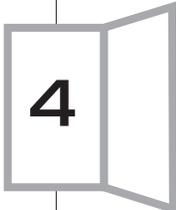
Discharge Services	Juvenile Detention Facilities (N)	Jails (N)	Prisons (N)	Total
Plan Developed	167 (2)	3,789 (55)	2,342 (34)	6,298
Discharged	122 (2)	3,254 (63)	1,810 (35)	5,186
Received services in community	54 (2)	2,298 (64)	1,216 (3)	3,568

associated with substance abuse that are not as predominate among juveniles.

State prisons tested only for HIV, perhaps because of the probability that other STIs would have been detected and treated in county jails, through which most State prisoners pass prior to coming to prison. Over the course of the project, participating prisons conducted 12,861 HIV tests. Only 1.39 percent of the prison tests were positive. The rate is much lower for prison populations than jail populations because prisons have a more stable population that should have already been medically evaluated and treated for most infectious diseases prior to admission. Jails, however, represent the community, and the flow of people in and out results in a

much higher rate of positive tests because of behavioral risk factors.

The CDP focused primarily on linking prisoners living with HIV to services inside the correctional setting, discharge-planning services, and community case management services after release. Table 3 shows that 6,298 prisoners had discharge plans prepared by project staff (mostly CBO staff). Most prisoners for whom discharge plans were developed (55 percent) were in jail settings. Nearly 75 percent (5,186) of the inmates for whom plans were developed were released back into the community during the CDP. Of those, 69 percent (3,568) received at least one service from CDP providers in the community.



4

PARTICIPATING PROJECTS

California Department of Health

Partners and Collaborators

The State of California partnered with the San Francisco Department of Public Health, CBOs, and correctional facilities to serve HIV-positive and high-risk inmates. The Office of AIDS also used its own resources to include the Los Angeles County Health Department and Los Angeles County Jail as separate components to address internal programmatic and political concerns. Centerforce, a CBO in San Quentin, California, was funded by the CDP to provide services for men and women at three State prisons in four core program areas: peer health education, prerelease health education, individual and group outreach, and prevention case management. The Forensic AIDS Project (FAP), part of the San Francisco Department of Public Health, and Continuum, part of Tenderloin Cares (a consortium of providers), were funded to provide case management services and housing placement to HIV-positive inmates in San Francisco County jails following their release to the community.

The CDP funded Continuum to expand existing services for HIV-positive men and women at the San Francisco County Jail to create a more comprehensive program that supported successful transition back into the community. Program components included health education, substance use counseling, transitional housing, money management, transitional case management, medical care, and mental health counseling. To provide those services, several infrastructure and capacity enhancements were implemented within jail facilities and the community.

Linkages were strengthened between Continuum and the San Francisco County Jail/FAP, the Positive Health Practice at the University of California, San Francisco (UCSF), the Tenderloin Neighborhood Development Corporation, the Northern California Psychiatric Foundation, and the City College of San Francisco. These linkages allowed a much large number of community agencies to market their services to jail inmates during community health resource fairs. During the final

year of the CDP, Continuum collaborated with Centerforce to develop the Continuum Learning Institute so that lessons learned throughout the CDP could be widely disseminated in California.

Model

The State of California developed an integrated service model to deliver prerelease and postrelease HIV and STI prevention and treatment services to high-risk and at-risk incarcerated populations. The model enhanced the limited HIV/STI services that were previously available to California State prison and San Francisco County and Los Angeles County jail populations. Data from Los Angeles County are not included in the cross-site evaluation but were used to help inform and focus case management for inmates being released from

prison back to Los Angeles County. The California service model emphasized prerelease education and prevention; transitional case management, including individualized needs assessment, service plans, and community service referrals; and postrelease follow-up, support, and incentives to promote and maximize client access to community care services.

California considered the CDP an enhancement to existing correctional program initiatives and chose not to participate in the ESC's client-specific cross-site evaluation. It did, however, contribute to aggregate service data and conducted its own internal evaluation in conjunction with the San Francisco Department of Health and UCSF. The project participated in a separate HRSA-sponsored cost analysis.

LESSONS LEARNED: CALIFORNIA DEPARTMENT OF HEALTH

Developing and maintaining relationships with correctional officials and administrative departments were critical steps to the delivery of correctional health and prevention services. Lack of communication and the rapid turnover of correctional staff presented many barriers, such as delays in access; inability to gain access to program participants and, in some cases, not being permitted to work in some institutions; and difficulty with the basic logistics of providing programs in a secure environment. Prisons and jail systems participating in the project recognized the need to develop strong mutual relationships around existing services and to embrace institutional priorities of safety and security and incorporate them into program priorities. Finally, adding value to correctional programs by providing resources and services outside the corrections budget helped foster strong partnerships.

The California CDP was able to overcome some formidable challenges and has gained wide acceptance of its programs throughout the State. Although resources have been severely reduced, both programs have implemented plans to sustain operations and continue to provide services.

LESSONS LEARNED: CALIFORNIA DEPARTMENT OF HEALTH (CONT'D)

The following recommendations are based on lessons learned.

Case managers must foster trust and facilitate insight into the client's behavior patterns that lead to reincarceration and medical noncompliance.

- * Case managers should be trained professionals with mental health training.
- * Use the same case managers for pre- and postrelease case management.
- * Implement comprehensive case management during and after incarceration.
- * Case managers should identify and assess the client's strengths and challenges with the client.
- * Benefits enrollment, including AIDS Drug Assistance Program, and other clear medical plans should be made prior to the inmate's release.

Ensure clients' ownership in developing their discharge plan and their transition.

- * Have clients develop their own goals and step-by-step plan.
- * Ensure that clients understand the need for transitional housing, especially on the first night out.
- * Set up face-to-face meetings with personnel from community resources before release. Face-to-face meetings with community resource staff should be tailored to address the needs of the client with the resources available to them in the county of their release. Inmates from State and Federal institutions are released back to their home county, which may be hundreds of miles away, and efforts must be made to link them with services that will actually be available.
- * Provide training in life skills, including anger management.

Offer clients practical assistance in stabilizing their lives and attaining identified goals.

- * Provide transitional housing opportunities; use a community liaison to meet the client at release and escort him or her to approved housing.
- * Provide a structured living environment.
- * Provide vocational training and job assistance.
- * Assist or accompany clients to court appearances, medical appointments, and parole officer check-ins.
- * Provide a life skills class covering everything from budgeting to cooking, laundry, public transportation, and money management.

Florida Department of Health

Partners and Collaborators

The CDP funded the Florida Department of Health (FDOH), Bureau of HIV/AIDS, Early Intervention Program. The grant included funds for the Linking Inmates Needing Care (LINC) project, which began in February 2000. During this period, the FDOH had in place a peer education program for HIV prevention in three north-east Florida prisons and the Pre-Release Planning Program in collaboration with the State Department of Corrections (DC). The LINC project was implemented in both short- and long-term Florida correctional facilities. Implementation sites included the Jacksonville-Duval County Jail in north-eastern Florida, the Central Florida Reception Center (CFRC) in Orlando, and seven satellite prisons throughout the State.

The Jacksonville/Duval County Jail, in the north-eastern corner of Florida, housed the Jail LINC project. The local county health department managed the project and established contractual linkages with the Jacksonville/Duval County Jail and four community-based agencies: Lutheran Social Services, for case management; River Region Mental Health Services, for mental health and drug treatment; the Rainbow Center, for maternal and infant primary care; and the Northeast Florida Health Planning Council, for data management.

The services provided by Jail LINC staff included screening for HIV, STIs, TB, and hepatitis; HIV prevention education for inmates and corrections staff; prerelease planning; and follow-up in the community for at least 6 months. During intake, all inmates received HIV prevention education and were offered HIV/STI testing prior to the jail medical examination.

The Florida Department of Corrections operates 62 correctional facilities. Twenty-two are “HIV cluster prisons,” housing most of the HIV-infected inmates to allow for the concentrated and intensive medical care such inmates need. To implement the

LINC Project, the DC contracted with the University of Miami to provide LINC services in seven correctional facilities in central Florida: Hernando Correctional Institution (CI); Lowell CI, a women’s facility in Marion County; Lake CI; Tomoka CI; Brevard CI; the Kissimmee Work Release Program; and Zephyrhills CI. The CFRC served as the hub for LINC services for inmates of the CFRC and the seven satellite facilities.

The prison network established informal, collaborative relationships with 45 case management and support service agencies around the State. The agencies were located in 13 counties, most of which were part of Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Eligible Metropolitan Areas in south central and south Florida.

Unlike the jail component, DC prison facilities release inmates from all over the State and sometimes to other States. As a result, formal agreements were not made with local community-based agencies for case management, and those agencies were not reimbursed through the LINC project. To determine what resources were available on a statewide basis, the FDOH established the Community Agencies Providing Resources for Ex-Offenders (CARE) Network, which was a network of CBOs, advocates, former inmates, and county health department and corrections staff who serve HIV-infected ex-offenders. The CARE Network continues to function as a forum for agencies and individuals serving HIV-infected ex-offenders.

The Prison LINC project provided screening and counseling and testing for HIV, HIV prevention education for inmates and staff, prerelease planning for releasees, and follow-up in the community for at least 6 months. The project began in the Lowell CI and expanded into the others.

The case management program followed releasees for a minimum of 6 months postrelease. Case managers identified clients’ needs, developed a case management plan, referred clients to both a case

management program and a primary care clinic, and maintained oversight management with each client. The case managers also maintained contact with the clients' community service providers. Case management plans were developed prior to release and were updated as needed postrelease. A major effort was made to identify community agencies by county to meet the needs of releasees.

The disease-screening component of the project was linked to HIV prevention and education. HIV screening and counseling were offered following all prevention education sessions. Quarterly, intensive, in-depth, and interactive training sessions were provided to correctional medical staff through the LINC mini-residency program and CFRC. At the end of the project, no funds were available to sustain the Prison LINC project.

Model

The goal of the LINC Project was to identify inmates with HIV, STIs, TB, and hepatitis; assist in planning for their release; and provide follow-up to determine whether project interventions made a difference. Before the CDP, limited HIV screening, counseling and testing, and linkages were provided in Florida's correctional facilities. Some HIV prevention services were provided, but not on a large scale. Under CDP, HIV and STI disease screening, as well as discharge-planning and case management services, was enhanced and provided on a much broader scale. A supplemental hepatitis screening and vaccination program component was developed in the jail project as an ancillary service using other resources. An HIV/AIDS secondary prevention program and a major staff training initiative were implemented within the CDP.

LESSONS LEARNED: FLORIDA DEPARTMENT OF HEALTH

The Prison LINC project case managers found that releasees who had been in prison for more than 5 years needed special support to adjust to living outside the structured prison environment. They implemented a "Life Skills Training for DC Clients" program. This program enabled inmates to develop an understanding of the barriers they would face following prison, including treatment compliance, substance abuse, unsafe sex, family dysfunction, and the lack of marketable skills.

The most overriding of the lessons learned from the LINC Project during the 5-year CDP was that public health and corrections programs can successfully work together to provide services to HIV-infected inmates within the confines of a secured environment. The burden is on public health providers to work around the security issues that dominate the corrections environment. As long as public health providers understand how to work within the constraints of correctional facilities, public health programs can flourish.

Public health providers strive to provide services without disrupting the routine of the correctional facility and without putting an extra burden on security and correctional medical staff. It also is important for security and correctional medical staff, to the extent possible, to create an atmosphere conducive to the provision of public health services.

LESSONS LEARNED: FLORIDA DEPARTMENT OF HEALTH (CONT'D)

Providing discharge planning and follow-up in a statewide system requires the development of a statewide network of agencies, such as the Florida CARE Network. Because it was difficult to fund contracts with agencies to provide support services to ex-offenders on a statewide basis, it was essential to provide a forum for those agencies to communicate regularly, share information, and receive the latest information about HIV prevention and education. The FDOH provided staff support for the CARE Network and for the departmental Correctional Infections Workgroup, a group of administrators at headquarters level representing key FDOH and DC programs.

Georgia Department of Human Resources

Partners and Collaborators

Funding was provided to the Georgia Department of Human Resources, Division of Public Health, Prevention Services Branch. The program was administered by the Sexually Transmitted Disease section. The Georgia demonstration project system included prison, jail, and juvenile components that serve the Atlanta area, including Fulton and DeKalb counties. An adult program that included the Metro State Prison (a women's facility in Atlanta) provided discharge planning and in-prison case management. In addition, the Fulton County Jail provided case management, disease screening, and staff training at the jail facility. The juvenile component included the Metro Regional Detention Center, which provided HIV prevention, disease screening, and staff training; the DeKalb County Juvenile Court provided HIV prevention services for youth.

The Georgia CDP (GCDP) also contracted with three CBOs to provide services to clients who were either incarcerated or released:

- * AID Atlanta provided transitional planning and case management for Fulton County Jail

inmates with HIV during and after incarceration. AID Atlanta's Correctional Transition Program was designed to ensure that HIV-positive inmates received case management services and discharge planning to assist them with obtaining access to health care, medications, substance abuse treatment, and other community services prior to and after release. Outreach, Inc., was subcontracted through AID Atlanta to provide substance abuse counseling, education, and treatment referral for inmates at the Fulton County Jail. Counseling groups were held in conjunction with Fulton County Jail substance abuse and HIV education programs.

- * The Wholistic Stress Control Institute provided HIV/AIDS and other STI prevention education to inmates at the Fulton County Jail, the Jimmy Helms Diversion Center, the Metro Transitional Center for Women, and the Metro Regional Youth Detention Center (MRYDC) and DeKalb Regional Youth Detention Center.
- * The Southeast AIDS Education and Training Center at Emory University provided training sessions and technical assistance for the CBOs involved in the CDP as well as medical staff and correctional staff at the Fulton County Jail and the MRYDC.

Model

The goal of the Georgia CDP was to improve health among incarcerated populations as related to HIV, STIs, TB, hepatitis, and substance abuse during incarceration and after release, using a range of primary health care and prevention strategies. The strategies centered on disease screening, treatment, and counseling; HIV and STI prevention education; case management, prevention case management, and discharge planning; and staff training and technical assistance. Participating correctional facilities also provided the following services:

- * The Fulton County Jail participated in transitional planning and case management, STI screening, and prevention education projects.
- * The MRYDC participated in chlamydia and gonorrhea screening and prevention for female youth. The center provides temporary secure care and supervision for youth who are charged with crimes or who have been found guilty of crimes and are awaiting disposition of their cases by a juvenile court.
- * The DeKalb Regional Youth Detention Center in Decatur and the Jimmy Helms Diversion Center participated in prevention education for male youth and adult men, respectively.
- * The Metro Transitional Center for Women participated in the prevention education project, helping residents make the transition into the community using therapeutic counseling and social and employment skills training.

LESSONS LEARNED: GEORGIA DEPARTMENT OF HUMAN RESOURCES

The Georgia CDP divided its recommendations into four general dimensions:

Project Design

- * Establish theoretical, structural, and systematic integration of services prior to project implementation.
- * Goals must be manageable and meaningful.
- * Obtain “buy-in” from all affiliates and partners and ensure that agreements are in place to maximize continuity of care.

Program Operations

- * Establish operational protocols and tools for service delivery and test those protocols before project implementation.
- * Establish clear definitions of the deliverables.
- * Establish formal memoranda of understanding with all partners and facilities and regular means for communication and dissemination of information.

Program Assessment and Evaluation

- * Develop a complete and comprehensive evaluation plan that includes all measures, assessment instruments, data sources, collection methodologies, and evaluation questions before the start of the project.

Program Sustainability

- * Sustainability should be part of program design and a key program objective.

Illinois: Chicago Department of Public Health

Partners and Collaborators

Funding was provided to the Chicago Department of Public Health, Division of STD/HIV Prevention and Core Programs, to develop and administer the Illinois Public Health Corrections and Community Initiative (IPHCCI). The IPHCCI was charged with the development, implementation, and evaluation of a comprehensive and continuous care system for PLWHA recently released from the Cook County Department of Corrections (CCDOC) and Illinois Department of Corrections (IDOC).

Before the inception of the IPHCCI, known internally as the HIV Continuity of Care Project, no formal partnership existed between the Chicago Department of Public Health and other organizations. The following Chicago agencies formed new partnerships in the Continuity of Care Project and provided services:

- * The Chicago Department of Public Health Adolescent Team, in addition to serving as project coordinator, provided HIV/AIDS, STI, and pregnancy prevention education to female detainees ages 13 to 17 at the Cook County Juvenile Temporary Detention Center and the Illinois Youth Center of Chicago. Each detainee received 12 weeks of instruction, 6 weeks of which were drawn from the “Making Proud Choices” curriculum.
- * The CCDOC Juvenile Temporary Detention Center focused on providing health education to detained adolescents at the detention center in Cook County.
- * The Ruth Rothstein CORE Center provided HIV primary health care for all clients in IPHCCI in addition to client tracking. The Core Center corrections clinic (held weekly) was a vital component of the initiative because it was the one place where case managers were able to locate their clients in the event contact was lost.
- * Cermak Health Services and the CCDOC provided internal case management, discharge planning, and linkages to the CORE Center and Haymarket Center. A key aspect of the IPHCCI was linking incarcerated clients at the Cook County Jail to their external case managers. Cermak Health Services provided the link between internal and external case managers so that inmates could receive continuity of care and develop a work plan before their release. Cermak also provided HIV primary health care using the same physician and medical assistant who provided HIV care at the Corrections Clinic at the CORE Center. This structure promoted client adherence to scheduled appointments and medication regimens.
- * The Illinois Youth Center of Chicago was added during the second year of the project. The program focused on providing HIV prevention services through HIV testing, counseling, and educational sessions.
- * AIDS Foundation of Chicago (AFC) provided intensive community case management for the project and coordinated projectwide case management services through its corrections coordinator. The coordinator provided technical assistance and consultation to case managers via telephone, e-mail, faxes, and bimonthly case management meetings and site visits.
- * New Beginning Recovery Homes, Inc. (NBRHI) provided housing and employment training for IPHCCI clients. NBRHI successfully provided emergency and transitional housing to homeless ex-offenders, clients with HIV/AIDS, and clients with mental illness. NBRHI was staffed with paraprofessionals on a 24-hour basis, and the organization hired ex-offenders as staff members and offered an extensive developmental and supportive skills program. NBRHI served more than 2,064 ex-offenders during the project; 200 of those clients were male HIV-positive residents.

- * The Safer Foundation provided employment readiness and placement to recently released ex-offenders. The foundation focused on reducing recidivism by providing a full spectrum of employment and training services to ex-offenders.
- * Community Supportive Living Systems provided housing and case management for homeless, HIV-positive clients (and their families) who were recently released from jail or prison and were enrolled in the IPHCCI. Services included comprehensive life skills training, disease treatment and follow-up, discharge planning, an accountable and supportive client-level case management model, and identification of community-based supportive resources.
- * For Action in Togetherness Hold Fast (F.A.I.T.H.) Inc. provided assistance to IPHCCI clients in obtaining identification and other documents, including State identification cards, birth certificates, high school transcripts, voter registration cards, and Social Security cards, upon release from correctional facilities. During the project, F.A.I.T.H. helped thousands of ex-offenders obtain State ID cards and provided transportation to various facilities by distributing public transportation farecards.
- * Haymarket Centers (HM), providers of mental health and substance abuse treatment and primary health care, became integral elements of IPHCCI's comprehensive continuity-of-care system. HM provided onsite nonmedical detoxification services, residential and outpatient substance abuse treatment, mental health services, and primary medical care. In addition to accepting large numbers of project clients, HM

provided a court liaison to conduct substance abuse assessments with potential clients at the Cook County Jail who requested treatment. By becoming a full partner in the IPHCCI, HM maximized treatment slots for releasees who were living with HIV and seeking treatment.

- * IDOC and the Chicago Center for Health Systems Development also played an important role in strengthening the depth of projects in enhancing continuity of care.
- * The Community Mental Health Council was added to the project as an additional mental health component of the IPHCCI's comprehensive continuity-of-care system.

Model

Clients who were identified as HIV positive through voluntary testing while incarcerated were provided with medical services. As a priority for discharge planning, HIV-positive inmates were referred to the IPHCCI intensive case management services. Clients and IPHCCI case managers (ICMs) were linked before release. Unlike traditional Ryan White case management, ICMs provided intensive services, which included individualized treatment plans addressing client needs through partners in the initiative and frequent contacts inside and outside correctional facilities.

The IPHCCI provided services that were vital to a high-risk population with a multitude of health and social needs. It became a nationally recognized model of community-based continuity of care for HIV-positive releasees. The CDP provided significant benefits to communities of color throughout the city of Chicago, where many releasees returned to live.

LESSONS LEARNED: CHICAGO DEPARTMENT OF PUBLIC HEALTH

IPHCCI partners faced the following challenges and barriers in program development and implementation:

- * Reductions in funding that limited the ability to provide comprehensive services
- * Lack of low-income housing and substance abuse treatment beds
- * Inability to fully staff the project with sufficient case managers to meet the demand of all clients released from CCDOC and IDOC
- * Limited role from IDOC in support of continuity of care in the community
- * Lack of comprehensive transition planning by social workers and weak linkages between correctional staff and community referral agencies
- * Lack of trust among service providers in meeting client needs
- * Breakdowns in communications with case managers not directly affiliated with the IPHCCI
- * Difficulties associated with identifying jobs for clients with criminal backgrounds
- * Inability to provide vaccinations to juveniles without parental consent (It was difficult to find a parent or guardian to sign consent, especially for incarcerated juveniles; many parents wanted nothing to do with them.)
- * Limitations in access to school immunization records for juveniles.

Equally important, recommendations resulting from those barriers were as follows:

- * The system was most effective when individual staff members were committed to providing the best services for their clients, when they were supported by agency and project administration, and when open communication occurred.
- * The success of this collaborative initiative was tied to individual staff members' commitment. Agency buy-in is crucial, however: Even the most supportive agency will not benefit the project if staff do not collaborate within the multidisciplinary team.
- * Effective communication and training are essential to assist diverse service providers with working toward a common goal.
- * Routine AFC coordination and face-to-face meetings of case managers increased the number of formal linkages with community service providers.
- * Ongoing communication between project administration and project partners can be affected as new programs with new priorities are implemented by partner organizations.

The Chicago Department of Public Health and the IPHCCI partners are committed to continuing the work of the initiative and have sought and received funding from the Illinois Department of Public Health to continue the project on a statewide basis.

Massachusetts Department of Public Health

Partners and Collaborators

Funding was provided to the Massachusetts Department of Public Health, HIV/AIDS Bureau (HAB), which implemented the Transitional Intervention Project (TIP), a statewide public-private partnership that provided intensive case management services to support the reintegration of inmates living with HIV/AIDS back into the community. The project built on HIV-related services that were already in place in correctional facilities and supported by HAB, such as prevention and education, counseling and testing, and case management. The State was divided into six regions for delivery of services. HAB provided management oversight, training and technical assistance, and evaluation support to a contracted CBO in each of the six service regions, as follows:

- * SPAN (Boston and mid-central Massachusetts)
- * Ruah Breath of Life (Boston region)
- * Great Brook Valley Health Center (central region)
- * South Shore AIDS Project (southeast region)
- * Health and Education Services (northwest region)
- * Brightwood Health Center (western region).

A comprehensive array of services existed in Massachusetts prior to the CDP, and the services continued during the demonstration project. County jails and State prisons provided primary medical care; HIV prevention and education (inmates and staff); HIV counseling and testing; and case management, including mental health services, support groups, and discharge planning. The Offices of Community Corrections offered peer-led HIV, STI, TB, and hepatitis prevention and education services and an extensive system of community service linkages. The Department of Youth Services (DYS) provided HIV prevention and education services; primary medical care; HIV counseling and testing; and a wide range of case

management, psychological, and structured recreation services.

Supplementary components of TIP were a chlamydia screening program for male arrestees at the Nashua Street Jail in Boston, a peer-based HIV education and prevention program at all Offices of Community Corrections, and HIV counseling and testing in juvenile corrections facilities.

Model

Upon implementation of the TIP project, the prevalence of HIV/AIDS, substance abuse, and hepatitis C in the prison population was high and was a major concern among program planners and officials, especially with regard to the female population. TIP sought to determine the extent of inmates' service needs for transition and reintegration into their home communities upon release, focusing on the following activities:

- * Intensive, community-based transitional case management for all HIV-positive inmates released from all 19 State prisons, all 13 county jails, and all 62 DYS facilities
- * Creation of a bridge between HIV services "behind the wall" and existing HIV services in the community to improve the quality of life and reduce morbidity and mortality for incarcerated and recently released HIV-positive inmates
- * Evaluation of the utility and feasibility of the TIP reintegration model
- * Provision of and improvements to chlamydia surveillance and treatment to reduce the incidence of STIs, including HIV, in jail settings.
- * A comprehensive, peer-led prevention and education program focusing on HIV, STIs, TB, and hepatitis in 22 community correction center sites, including evaluation of the utility and feasibility of the model
- * HIV counseling and testing in the 62 juvenile corrections facilities and referrals to appropriate community HIV services, including TIP.

Through participating CBOs, HAB funded eight TIP teams. The teams, which comprised jail coordinators, infectious disease nurses, and case managers in prisons along with other correctional facility staff, referred clients to TIP during incarceration (preferably 6 months prior to release). Teams then focused on the frontline reintegration work of establishing rapport with the clients before release so that relationships could be maintained post-release and during the follow-up period. TIP case managers from clients' home regions worked with them during incarceration to assess their release needs. When released, TIP staff implemented a client-specific service plan.

In jails and prisons, clients usually learned about TIP through HIV coordinators and HIV nurses. TIP services during incarceration included helping clients focus on what they wanted to do after release, assistance completing forms and applications, finding and arranging appropriate housing, discussing and setting up postrelease medical treatment and other appointments, and building a trusting relationship between client and case managers.

Postrelease services included assistance with acquiring health insurance and other benefits, finding a primary care physician skilled in HIV care, counseling on HIV treatment adherence, locating mental health and substance abuse treatment services and other community services, and obtaining transportation and safe housing. After 6 months of intensive case management, it was hoped that clients would have developed the capacity to function on their own.

TIP functioned under the premise that successful client transition and reintegration into the community would decrease the likelihood of substance abuse relapse, return to high-risk behaviors, reincarceration, AIDS morbidity and mortality, and potential for AIDS transmission. The result would be healthier and safer communities.

An evaluation component was included to apprise project management and case managers of what worked, identify emerging client issues and needs, and redirect program activities and resources to maximize client participation.

LESSONS LEARNED: MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Barriers to utilization of TIP were as follows:

- * Lack of privacy in utilizing TIP services during incarceration
- * The complexities associated with helping clients stay on their mental health medications and off drugs
- * Fear of being "outed" and the repercussion of stigma and rejection by other inmates and corrections officers
- * Underutilization of services and difficulty with retention in TIP as a result of substance abuse relapse
- * Territorial issues between community programs

LESSONS LEARNED: MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH (CONT'D)

Recommendations for continued success were as follows:

- * Transitional case management is effective in helping inmates living with HIV meet multiple needs to ensure successful transition to the community. Clients believed that they would be worse off without TIP.
- * Accessibility of case managers is important: Efforts must be made to ensure that clients have open access to their case manager.
- * Program flexibility reinforced client retention and continuity.
- * Inmates returning to the community have significant medical, mental, and substance abuse needs that can undermine the quality of life and support available within the community.
- * Transitional case management can reduce recidivism.
- * TIP services must be “one stop” and address multiple needs. Persistent and consistent efforts should be made to help releasees stay healthy and practice safe behaviors.
- * Gaps in services are a barrier and result in loss of clients.
- * Inmates with substance abuse issues require longer, more intensive case management.
- * Because of high prison staff turnover, ongoing education of staff is necessary.
- * Participation and support from parole officers is needed to explain the role of TIP case managers among inmates.
- * It is important to sustain linkages with service providers within correctional settings and the community.
- * Attention must be paid to the emotional and support needs of case managers.
- * Special attention needs to be given to retaining case managers who are non-judgmental and respectful of their clients. According to clients, those issues, along with accessibility, were important to the success of the program.
- * The need for a particular service did not change appreciably between intake assessment, monitoring events, and case review.

New Jersey Department of Health and Senior Services

Partners and Collaborators

Funding was provided to the New Jersey Department of Health and Senior Services, Division of HIV/AIDS Services (DHAS), to develop a program with a broad array of intervention services in

prison, jail, and juvenile settings. The State Department of Corrections (DOC) is responsible for inmate health care, including HIV medications. Services beyond basic acute health care, however, were not legally required and were limited because of a lack of resources. Services not provided included programs for HIV prevention during incarceration and HIV postrelease transitional services.

Through contracts with outside agencies, the DOC was able to provide some HIV/AIDS services, but they varied across facilities. All facilities provided HIV testing and test results, but none offered posttest counseling. All testing of inmates had to be physician initiated; inmates could not request testing. The Juvenile Justice Commission (JJC) had oversight of the State's youth correctional facilities. The contracted medical care company provided medical services to all State facilities. Discharge planning was limited or not provided at all.

DHAS contracted with eight CBOs to provide services to 13 correctional facilities: seven men's prisons; two discharge assessment facilities for men; one women's prison; one jail; one juvenile facility; and the Central Reception Assignment Facility (CRAF), which served adult men. The CRAF is the intake facility for all adult prisoners; it provides intake exams, medical and dental education, and psychological evaluations. Services were phased into these facilities over a 2-year period. Additional funding to enhance and complement services was secured through the State's Ryan White Title II funding, other CDC funds, and State resources.

Listed below are CBOs, their assigned correctional facilities, and the year services were initiated:

- * AIDS Coalition of Southern New Jersey: Riverfront State Prison—men's prison, Camden (2000)
- * Henry J. Austin Health Center: Albert "Bo" Robinson Treatment Center—discharge assessment facility for men, Trenton (2002)
- * Hyacinth AIDS Foundation: Edna Mahan State Prison—women's prison, Clinton (2000); and East Jersey State Prison—men's prison, Rahway (2001)
- * North Jersey AIDS Alliance: Northern State Prison—men's prison, Newark (2001)
- * South Jersey AIDS Alliance: South Woods State Prison—men's prison, Bridgeton (2001); Southern State Correctional Facility—men's prison, Delmont (2001); Bayside State Prison—men's prison, Leesburg (2001)

- * The New Jersey Association on Corrections: Midstate Correctional Facility—men's prison, Wrightstown (includes CRAF) (2002); Talbot Hall—discharge assessment facility for men, Hackensack (2000)
- * Visiting Nurse Association of New Jersey: Monmouth County Correctional Institute—county jail, men and women, Freehold (2000)
- * University of Medicine and Dentistry of New Jersey, Division of Youth and Young Adult Medicine: New Jersey Training School for Boys—juvenile, Jamesburg (2000)

The Monmouth County Correctional Institution was the only correctional facility with educational programs in place prior to the CDP. The Visiting Nurse Association of Central New Jersey provided health education, risk-reduction counseling, and support groups. The other 12 facilities did not have anything in place at the start of the project.

Staff at the CBOs and correctional facilities were trained in HIV education, counseling and testing, and prevention education along with a variety of other health promotion and risk-reduction topics. Staff training and peer education on HIV were integral components of the CDP. Each contracted CBO hired and assigned a minimum of one HIV care coordinator and one outreach specialist to each prison facility to provide the HIV prevention, intervention, care, and discharge-planning services. An HIV specialist also was hired at each CBO. Coverage was expanded by use of peer inmate counselors trained through a curriculum developed by the National College of Wisconsin, Center for AIDS. The inmate counselors acted as peer resources within the community culture of each facility; they disseminated HIV prevention and health promotion information and encouraged inmates to get tested.

Discharge planning and case management were vital to facilitating continuity of care before and after release. Prior to release, each inmate's needs were assessed and appointments and referrals for services were made in the community. The New

Jersey protocol called for client enrollment 6 months before release and follow-up for 6 months postrelease.

Model

Formalized linkages were developed among the correctional facilities, community health centers, early intervention programs, drug treatment programs, STI and TB clinics, mental health providers, Ryan White and HIV prevention planning groups, and infectious disease physician organizations to ensure a coordinated statewide network of continuous care for inmates postrelease. Each participating agency had primary responsibility for its assigned institution, but agencies assisted each other when inmates were transferred or released to different parts of the State.

The New Jersey CDP was designed to fit the existing layout of each facility. Services involved ongoing meetings for staff and inmates, HIV education, health education and risk-reduction classes, networking, communications of various types, case management for HIV-positive inmates, and discharge planning for all inmates who enrolled in the CDP. CDP recruitment efforts included presentations at weekly orientations, parole points for health education/risk reduction (HE/RR) class

attendance, the influence of other inmates, discharge-planning and HIV-related services, classes for all inmates, and the independence of the community services from the correctional system once the inmate was released.

The DOC was a strong supporter of the CDP, but even with its support and participation, the project took time to implement. Relationships had to be developed with correctional staff and administration. The development of procedures for civilian entry into the prisons and access to inmates was a critical first step. Space, especially private space, and confidentiality were concerns in many facilities. Institutional differences existed between CBO and correctional staff (helping focus vs. security focus), and CBO staff experienced a definite distrust of “outsiders” at first. The biggest challenge in the juvenile facility involved the medical provider: The CBO could not get the provider to increase the number of HIV tests because the provider did not want to increase its costs for treatment and care.

The number of correctional facilities offering the CDP services grew from 5 at the start of service implementation in 2000 to 13 by 2003. In addition, the JJC requested that the CBO expand CDP-like services to all JJC facilities.

LESSONS LEARNED: NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

The CBOs indicated that client health status either stayed stable or improved with community case management. The availability and comprehensiveness of services within the community were major predictors of retention of ex-offenders in case management, and utilization of services tended to improve releasees’ health status. The number and types of services increased in all communities. Releasees used services including housing resources, assistance with applying for entitlements, ex-offender agencies, food banks, mental health counseling, substance abuse treatment centers, peer mentoring, outreach, prevention case management, employment assistance, drop-in and day centers, transportation services,

LESSONS LEARNED: NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES (CONT'D)

medical care, and vocational rehabilitation. Utilization of mental health, substance abuse, housing, and employment services increased. Linkages to services were strengthened, making it easier to refer clients to needed services.

The following points summarize key lessons from the New Jersey CDP:

- * Developing working relationships among the various State departments, community agencies, and correctional facility administration and staff was essential to the implementation and operation of the CDP.
- * Education of corrections administrators and staff about the CDP and the topics covered in inmate prevention education was important in establishing working relationships.
- * Use of peer educators helped recruit and retain inmates in the CDP.
- * One of the most significant factors in clients' adherence to the CDP was a strong support network.
- * Intensive case management and development of close relationships between the case managers and CDP clients during incarceration was a factor in their participation in the CDP after release.
- * Inmates should be met at the gate by a case manager who serves as a "navigator" from the CBO and provides linkages to basic supports.
- * Ex-offenders should be escorted to their first appointments to help them access the system; the oversight aids in their retention and compliance.
- * Basic needs, such as food, clothing, housing, and employment, must be addressed in addition to mental and physical health needs.
- * Access to substance abuse treatment and mental health services improves client retention and compliance.
- * Care for inmates with HIV improved during incarceration and postrelease, provided they remained in the CDP.
- * Helping clients secure some form of legal identification is essential to their ability to access services and benefits after release.

As expected, services were reduced once CDP funding ended in September 2004. Several CBOs, however, received funding to continue some of the education and case management activities. Funding sources included Ryan White Title II and State funds for discharge planning. All CBOs have been able to retain some level of services through community linkages, but all are now operating at a reduced level.

New York State Department of Health AIDS Institute

Partners and Collaborators

CDP funding was provided to the New York State Department of Health (NYSDOH) AIDS Institute. The AIDS Institute established partnerships with the New York City Department of Public Health, the New York State Department of Correctional Services (NYSDOCS), and CBOs to enhance and evaluate programs promoting continuity of care for HIV-positive and at-risk inmates and recent releases of correctional facilities.

The AIDS Institute had been providing HIV intervention and prevention services in correctional settings for more than 15 years through State aid to localities and funds from HRSA and CDC. Services were provided to State correctional facilities, local county jails, and juvenile justice centers throughout the State. The institute also funded community reentry programs to provide case management and supportive services in targeted metropolitan communities, to which a majority of parolees and releases return. The existing Criminal Justice Initiative (CJI) consisted of the corrections and community reentry programs. Prior to the CDP, the CJI was a \$3.3 million initiative that funded 13 agencies throughout New York State.

Prior to the CDP, the AIDS Institute had established limited collaborations with NYSDOCS and the NYS Office of Children and Family Services, the agency responsible for juvenile correctional facilities. Other relationships included the Division of Parole and the NYS Commission on Correction, the State oversight agency responsible for ensuring a safe, stable, and humane correctional environment and the delivery of essential services to inmates. Those existing relationships provided the administrative infrastructure for the CJI and the delivery of public health services.

Through its direct and contracted services, the AIDS Institute provided HIV counseling and testing in 62 State correctional facilities and test kits

and laboratory support for adolescents tested at juvenile detention centers. Characteristics of the service network were as follows:

- * Seven contracted CBOs provided HIV counseling and testing services at 30 State correctional facilities in central and north-eastern New York, the Hudson Valley, and New York City. The CBOs complemented services provided by the AIDS Institute's Bureau of Direct Program Operations.
- * Nine State correctional facilities and nine local county jail sites provided transitional planning for inmates living with HIV/AIDS and returning home. Planning started 3 months prior to an inmate's discharge date; about 500 transitional plans were completed annually.
- * Case management services were supported by the Medicaid fee-for-service reimbursement through the Consolidated Omnibus Budget Reconciliation Act (COBRA) Community Follow-Up Program and by State and Ryan White Title II funds. The AIDS Institute maintains an extensive case management network to provide inmates with readily accessible services upon release. The CJI also supports intensive, time-limited services for inmates who return to the New York City area (about 85 percent of all State inmates). This program allows HIV/AIDS inmates to be met upon their return to their home community and escorted to housing and initial medical or social service appointments.

Model

The model was rooted in the utilization, coordination, and implementation of a vast service delivery network that provided a wide array of services, including education, disease screening, discharge planning, community-based transitional services, training, and evaluation, as described below.

The AIDS Institute, through the Bureau of Direct Program Operations, offered educational services in three State correctional facilities: Auburn, Butler, and Marcy. Comprehensive educational sessions included topics such as HIV, STIs, hepatitis, and

discharge-planning and transitional services. Access to inmates was the most limiting factor, especially for inmates in drug treatment, who had little time to participate in other programs. The program overcame time constraints by offering additional education sessions and increasing counselor availability. Inmates were trained as representatives of the AIDS Institute and presented information on HIV counseling and testing, referral, and education services when counselors were not available. HIV counselor acceptability and inclusion as part of the corrections team increased significantly during the CDP.

The Altamont Program, which implemented the CDC curriculum “Be Proud! Be Responsible!”, was offered in three State juvenile detention facilities, four proprietary (privately funded) juvenile centers, two county jail adolescent units, and one community adolescent program. Inmate peer educator training was offered at two State correctional facilities with the largest number of adolescent inmates. All training sessions used the AIDS Institute’s Criminal Justice HIV Peer Educator curriculum. Altamont provided programs to juveniles at all of those sites except for the four proprietary centers. The CDP allowed services to expand to the proprietary juvenile centers, thereby complementing services provided at the State-operated sites. The major challenge facing the Altamont program was providing the HIV peer educator program to adolescents in State correctional facilities because of constant changes in the inmate census.

Rural Opportunities, Inc. (ROI) expanded its education and supportive services to women at the Albion Correctional Facility. Two new components were added to the facility’s education and peer education programs. A CBO was contracted to facilitate a curriculum-based group-level intervention, and support services were provided by Sisters Healing Old Wounds, a support group for inmate peer educators. Under the CDP, a newsletter written by inmates was published, and three ROI-sponsored AIDS awareness activities were open to all inmates. The greatest challenge ROI faced was training staff and maintaining staff stability.

The AIDS Council of Northeastern New York (ACNENY) developed and implemented a curriculum for incarcerated adolescents at highest risk of contracting HIV. The curriculum was provided to youth who tested positive for any STI upon intake. ACNENY overcame the problem of multiple-site placement of youth and staff limitations by training the Office of Children and Family Services nursing staff to deliver an individual-level intervention that was comparable to the group-level intervention for youth who were transferred.

The Center for Community Alternatives (CCA) provided education, supportive services, and discharge planning for women at the Onondaga County Correctional Facility. Additional funding allowed CCA to expand beyond client recruitment and HIV prevention to include in-facility community reentry assistance. The program addressed life skills, anger management, self-worth, and self-esteem. Funds also were provided for disease screening for chlamydia and gonorrhea for men entering the OCFS reception center in the Bronx. During the project, the STI urine-testing program expanded to three additional sites, and it further expanded to include women during Year 3. ACNENY provided enhanced education on HIV and STIs for adolescents who tested positive. All adolescents testing positive were encouraged to be tested for HIV.

The CDP supported discharge planning in two jail settings: Onondaga County Department of Correction (OCDC) and Riker’s Island Correctional Facility. The CCA provided discharge planning at the OCDC for high-risk female inmates recruited through an educational program. CCA helped link to community services through case management and a support group limited to women with chronic or mental health needs.

The Riker’s Island Transition Consortium also provided discharge-planning activities through a well-established community services provider at Riker’s Island. Through the CDP, services were enhanced in three areas: supporting a dedicated corrections officer to conduct outreach and facilitate inmate

movement within Riker's, an enrollment specialist to expand disease screening, and additional transitional planners to reach more inmates. Working with the contracted health provider, the Community Action Prenatal Care Program offered assistance to link pregnant women to care and to monitor their access to prenatal and perinatal services.

The Osborne Association in New York City was funded to provide an early recovery and relapse

prevention program for substance users upon their release to the community. The service model was based on harm reduction and was one of the few programs that allowed active substance users to participate. The Division of Parole was the largest source for referrals. The program provided HIV prevention education, skills building, counseling, and behavioral change interventions with a high level of client participation and supportive case management.

LESSONS LEARNED: NEW YORK STATE DEPARTMENT OF HEALTH AIDS SERVICES

Longstanding relationships between the NYSDOCS and the NYSDOH were reinforced through the CDP. Services for HIV education, counseling, and testing will be continued at facilities participating in the demonstration and will continue to be expanded to others. The AIDS Institute has implemented plans to retain the services of all providers under the CDP through a new application and award process for the CJI. A partnership with the State Bureau of STD Control will enable continued screening for STIs at select juvenile facilities. The following lessons were learned as a result of the project:

- * The presence of program staff within facilities improved participants' acceptance of HIV prevention programs, improved collaboration between agencies and CBOs, and increased opportunities to offer different services and programs.
- * Close proximity of HIV prevention staff allowed additional service time in facilities.
- * Coordination at all levels of executive, administrative, and other key facility staff, including program managers and security staff, was essential to access clients.
- * The services being delivered must be seen as furthering the goals of the facility.
- * Communication, flexibility, and constant collaboration are critical to sustain service delivery.
- * Incarcerated women's history of emotional, physical, and mental abuse must be addressed before they can hear the HIV prevention message.
- * Integrating skills-building activities enhances acceptance of HIV prevention messages.
- * Inmate participation in development and presentation of prevention materials through special projects increased the opportunity for delivery of education programs to other facilities and encouraged inmate acceptance.
- * Replication of service delivery models must address local needs, political considerations, and available services.
- * Locating HIV education programs in facilities that focus on drug treatment enhanced the relevance of educational programs.
- * Addressing the needs of juveniles under supervision in the community will require significant resources.



5

SUMMARY

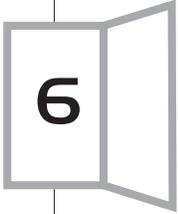
The CDP expanded capacity in three ways:

- * By enhancing existing programs in facilities
- * By developing new programs in facilities
- * By developing new community-based networks.

HIV, STI, and hepatitis prevention education, disease screening, and continuity-of-care (discharge and community case management planning) programs were established or enhanced in a number of juvenile detention centers, local jails, and State prisons. California, Chicago, Georgia, Massachusetts, New Jersey, and New York enhanced existing jail-based programs. In California, Florida, Massachusetts, New Jersey, and New York, prison programs were expanded or enhanced to include increased numbers of inmates returning to the community and to cover a broader range of activities. In addition, New York expanded the range of services available to prisoners within its previously existing HIV services programs. The San Francisco jail-based program likewise expanded the range of services available within the jail and in its continuity-of-care program for discharged inmates.

In some settings, the number of institutions where services existed was increased or new programs were developed, thereby increasing capacity. Georgia and Massachusetts developed new juvenile detention-based programs. Florida opted to develop a new jail-based program in one jurisdiction. California expanded services from one men's prison to include another prison for men and one for women.

Finally, capacity expanded through the development of wider networks of CBOs (including faith-based organizations) that could provide services for offenders returning to the community and linkages to other service providers. For example, the California prison-based program reported networking with nearly 100 CBOs in the San Francisco Bay Area and Central Valley with whom the grantee had previously not connected. Similarly, increases in networks of service providers and resources were reported across all State programs. In some cases, expansion was accomplished via new capacity in the CDP service provider organizations; in others, it involved the development of CBO networks. In summary, capacity expansion occurred for State and local agencies and CBOs involved in the CDP. Some States have institutionalized those developments.



6

SUSTAINABILITY

Developments at the State level following the conclusion of Federal funding for the CDP have been overwhelmingly positive with regard to integrating lessons learned from the project into existing activities.

In **California**, the State recognized the value of having an organization dedicated to continuity-of-care (CoC) planning and case management for releasees living with HIV. Centerforce, the prison-based provider for the CDP, has been awarded a contract to provide postrelease services for the parolees in the State system.

Florida has increased the number of postrelease planners in its State prison system to provide CoC services for releasees. Through general revenue funds, Florida also has expanded the number of county jails offering the CoC approach developed by the Jacksonville/Duval County Jail for PLWHA who pass through the system.

Georgia has developed a program for Department of Corrections (DOC) inmates that is modeled after the Florida program, even though Georgia's CDP did not involve the State DOC.

Illinois passed legislation that would develop a statewide CoC program modeled after the Chicago CDP program.

Massachusetts is working to integrate CDP approaches into its new statewide prisoner reentry program.

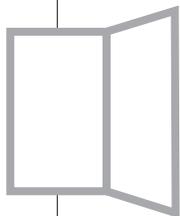
On the basis of their CDP activities, both **New Jersey** and **New York** continue to develop and strengthen the HIV-related services integrated into their State DOC programs.

Four of the CDP service providers have been selected by CDC's Division of HIV/AIDS Prevention to receive funding to provide services to inmate and reentering populations in their States. Rapid HIV testing approaches, pioneered by CDP jail-based programs, have been expanded to other jails and prisons throughout the Nation to determine whether they can be used in other jurisdictions.

The central role of jails in the recognition of infectious diseases in the community, in health education, and in linkages to treatment for vulnerable populations has begun to be integrated into the CDC's thinking about HIV, STIs, hepatitis, and other preventable and treatable diseases. This thought process is vital to determining the role of jails in the screening for and treatment of STIs and examining how the prevalence of those diseases in detainees may mirror the prevalence in the

communities where they lived prior to their incarceration.

Finally, the impact of the lessons learned from the CDP continues to unfold at local, State, and national levels. As data from this project are disseminated through CDC's final reports and State and local publications, the lessons may continue to affect not only the States involved but also the wider corrections and public health communities.



APPENDIX: OUTCOME STATISTICS

California Department of Health

- * A total of 65,436 inmates received prevention education from Centerforce under the CDP. Of those, 45,199 were offered HIV counseling and testing.
- * Discharge planning was provided to 245 high-risk HIV-negative inmates; all but 1 inmate enrolled in and accepted postrelease community case management services. The majority of those receiving discharge planning were African-American (53 percent). Another 22 percent were Hispanic, and 20 percent were White.
- * An outcomes-based behavioral study was conducted in a subset of 107 clients who participated in the community case management program.
- * The extent of services received influenced client retention rates: 46 percent of releasees participated for at least 8 weeks, and 23 percent finished the entire community case management program. Almost one-third were lost to follow-up within the first 48 hours, an indicator of the need for stronger inmate–community agency interactions prior to release.
- * Inmates who did not secure housing prior to release were significantly more likely to be lost to follow-up. Participants in the “Get Connected” program reported significantly less risk across several key indicators in the 30 days prior to the assessment:
 - Forty-three percent reported using drugs prior to incarceration; 0 percent reported injection drug use postrelease.
 - Twelve percent reported using condoms every time or most of the time prior to incarceration; 45 percent reported consistent condom use post-release.
 - Forty-six percent reported using drugs during sex occasionally or never prior to incarceration; postrelease, this proportion rose to 86 percent.
- * Approximately 130 inmates received prevention education services through Continuum’s community health resource fairs.

- * Between February 1, 2001, and September 30, 2004, a total of 256 HIV-positive inmates received discharge planning in the San Francisco County Jail; 214 went on to receive community case management services after their release into the community.
- * To evaluate the effectiveness of enhanced case management interventions for HIV-positive ex-offenders in the Homebase program, a randomized control trial (the San Francisco Department of Health HOPE Study) was carried out with 120 clients in the enhanced intervention and 120 in basic case management. Clients were followed for a total of 6 months. Preliminary analysis found the following results:
 - All but eight clients completed at least one postrelease follow-up interview.
 - Seventy-one percent of the clients in the enhanced intervention completed the 6-month follow-up, compared with 56 percent in the control group.
 - Fifty-two percent of the enhanced intervention group clients were reincarcerated by month 6, compared with 58 percent of the control group—a slight improvement.
 - Building relationships with participants during their incarceration in jail that continued in the community appeared to be the most important strategy to ensure postrelease follow-up.
- * As part of HRSA/CDC supplemental funding received in the last 2 years of the CDP, the HOPE Study/Homebase participated in a multisite cost analysis evaluation with the Economic Evaluation Center at Emory University. Because the program included optional housing, the costs were assessed for the full program as well as for the program without housing. Findings were as follows:
 - Societal cost per client was \$4,419 with housing and \$3,453 without housing.
 - The full Homebase program would provide cost savings if it could avert 0.73 new HIV infections; the program with housing would provide cost savings if it could avert 0.57 new HIV infections. Both thresholds appear realistic.

Florida Department of Health

- * The following services were provided in jail settings between February 2000 and September 2004:
 - 2,172 HIV educational sessions were provided.
 - 16,162 HIV tests; of those, 527 (3.3 percent) were positive. (A total of 176 prison inmates were tested; all tests were negative.)
 - 14,999 syphilis tests were conducted; 3.9 percent were positive.
- * Between February 2000 and September 2004, 11,383 inmates were tested for both gonorrhea and chlamydia. A total of 487 (4.2 percent) were positive for gonorrhea, and 981 (8.6 percent) tested positive for chlamydia. Between April 2004 and the end of the project in September 2004, 2,833 chlamydia and gonorrhea tests were administered; 95 (3.3 percent) were positive for gonorrhea, and 119 (4.1 percent) were positive for chlamydia.
- * A hepatitis screening and vaccination protocol was implemented in the Jacksonville/Duval Jail in January 2003. During the project, 2,900 inmates were screened; 410 (13.8 percent) tested positive for the hepatitis C antibody, and 587 (19.9 percent) were positive for the hepatitis A antibody. From January to November 2003, 988 doses of hepatitis B vaccine were given to 653 inmates.
- * The Jail LINC Project served 867 HIV-positive inmates prerelease; 802 of those inmates received prerelease discharge planning. A total of 264 inmates were served postrelease from February 2000 to September 2004. In the prison program, 196 releasees were provided intensive case management and follow-up.

Georgia Department of Human Resources

- * A total of 11,217 women were screened for chlamydia and gonorrhea; approximately 739 (7 percent) were found positive. Less than 50 percent (357) were treated and counseled prior

- to their release. Only 214 (2 percent) were positive for gonorrhea; 152 (more than 70 percent) were treated prior to release. Women ages 18 to 24 had the highest rates of chlamydia (48.8 percent) and gonorrhea (44.8 percent).
- * A total of 9,767 juveniles (80 percent) admitted to the Metro Regional Youth Detention Center were tested for chlamydia and gonorrhea. Of those tested, 10.6 percent were positive for chlamydia and 3.8 percent were positive for gonorrhea. Treatment rates prior to release were 64 percent for chlamydia and 71 percent for gonorrhea.
 - * A total of 2,396 detainees participated in prevention education services at the Fulton County Jail. Fifty-three percent were male, and 83 percent were African-American. Only 2 percent of the detainees were of Hispanic descent. Single education sessions were provided to 206 participants over a 12-month period, and 2,190 detainees received multiple education sessions.
 - * A total of 2,611 men and women received prevention education sessions at the Jimmy Helms and Metro Transitional facilities. An average of 15 participants received one prevention education session per month over a period of 2 years at the two transitional facilities. During the CDP, 319 participants received a total of 26 individual sessions.
 - * 4,150 male and female juveniles received prevention education services at the Metro and DeKalb Regional Youth Detention Centers. Seventy-six percent were male, 85 percent were African-American, and 5 percent were of Hispanic descent. Single sessions were provided to 2,600 participants.
 - * About 1,013 adult clients received discharge-planning services at the Fulton County Jail; 431 of those clients were formally discharged under the CDP, resulting in more than 1,700 post-release community case management encounters from 1999 to 2004. Medical care and housing were the largest referral and appointment categories, followed by drug treatment.
 - * Between January 2002 and July 2004, 97 inmates at the Fulton County Jail enrolled in intensive discharge-planning and postrelease case management services that included continuous follow-up for 6 months. Eighty-seven percent of the clients were HIV positive without AIDS. Most (88 percent) received a complete prerelease discharge plan. Of those, a total of 40 (47 percent) were accounted for 30 days after release. Their most mentioned needs were HIV care and medications, followed by cash, medical benefits, and housing. Sixty-five percent met their first scheduled appointment with their case manager. By the end of the CDP, 18 clients had successfully completed the full 6-month intensive postrelease program. Of those who did not, 14 percent were incarcerated; 9 percent had transferred to a permanent, long-term case management program; and 5 percent no longer wanted services. The remaining noncompleting clients (72.5 percent) were lost to follow-up. Eight of the 97 enrolled clients became aware of their HIV-positive status during their participation in the CDP.
 - * Georgia clients demonstrated moderate health care access, and 40 percent had access to HIV care. Access to medical care was cited by 50 percent as a problem. About 13 percent of clients had been diagnosed with major depression, and 3 percent had been diagnosed with bipolar disorder. Sixteen percent had taken or were taking medication for mental health conditions. More than 70 percent consumed alcoholic beverages prior to arrest. More than 80 percent reported having used illicit drugs prior to their arrest, and more than 30 percent had exchanged sex for money, drugs, or a place to stay.

Chicago Department of Public Health

- * The Illinois Public Health Corrections and Community Initiative provided services to 2,028 clients seen by Cermack Health Services and the CORE Center Clinic. Of those, 159 clients received both AIDS Foundation of Chicago (AFC) and Cermack Health Center/CORE medical services in the community; 20 clients were prescribed HIV

medications, 62 tested positive for hepatitis B, and 61 tested positive for hepatitis C.

Intensive case management services were provided at two sites (the Cook County Jail and AIDS Foundation Chicago):

- * A total of 797 clients within the Cook County Jail received services; 455 were tested for HIV, and 3.3 percent were HIV positive.
- * A total of 481 clients received intensive case management and transition services at the AFC. Most (79 percent) were male, and African-Americans comprised more than two-thirds (67 percent). Eleven percent were White, and nearly 11 percent of clients identified as Hispanic. Of the 481 clients, 295 (61 percent) were HIV positive; 17 percent (84) had confirmed AIDS. Transmission factors included heterosexual (49 percent), IDU (25 percent), men who have sex with men (12 percent), and unknown (17 percent). At the end of the project, 171 clients (36 percent) were still receiving AFC community case management, 112 clients (23 percent) had been reincarcerated, 92 cases (19 percent) were successfully closed and transitioned to Ryan White case management, and 66 clients (14 percent) could not be located. The rest (less than 7 percent) were hospitalized or had refused services.
- * A hepatitis program was added in June 2002 with supplemental funding from the CDP. This program provided education and hepatitis B immunizations to adolescents who had signed parental consent forms. The program educated 5,798 adolescents in 12-hour sessions; clients were primarily African-Americans (80 percent) and Hispanics (17 percent).
- * HIV prevention education services were provided to 1,051 adolescent females in the Cook County Juvenile Temporary Detention Center. The hepatitis program educated and vaccinated 358 adolescents in the 22-month program. HIV testing was provided to 483 females (46 percent); 0.4 percent tested positive.

Massachusetts Department of Public Health

- * The Transitional Intervention Project (TIP) served 884 clients, representing 1,265 cases.
 - A total of 22,863 service-related events were documented during the CDP. More than half of the events (12,431) were in the case management category; 3,375 were arraignment appointments, 2,670 were case reviews, and 1,729 were intake assessments. A total of 1,035 cases were closed.
 - The clients consisted of 674 men (76 percent) and 210 women (24 percent).
 - Twenty-three percent of clients were African-American, 29 percent were Hispanic, 38 percent were White, and 10 percent were “other.”
 - Ten percent of clients were ages 17 to 29, 46 percent were ages 30 to 39, 37 percent were ages 40 to 49, and the remainder were ages 50 to 79.
- * Clients ($N = 636$) identified the following areas as those for which they had the greatest need:
 - Medical/HIV care: 69 percent
 - Housing: 67 percent
 - Drug treatment: 58 percent
 - Basic needs: 46 percent
 - Transportation: 43 percent
 - Mental health treatment: 41 percent.
- * A total of 702 assessments were conducted, representing 476 clients.
 - Eighty percent of the HIV-positive clients were receiving treatment for HIV during their incarceration; a different 80 percent planned to seek HIV care upon their release.
 - Transportation was identified by 46 percent as barrier to keeping medical appointments; 22 percent indicated that someone would need to accompany them.
 - More than 22 percent of clients had no insurance of any kind.
 - Forty-eight percent had a history of mental illness; 66 percent had received mental health treatment.
 - Ninety-six percent were substance abusers; 74 percent had received substance abuse

treatment, and only 58 percent identified themselves as needing transitional substance abuse services.

- Seventy percent of cases had only one housing option; 19 percent had no options; and for 34 percent, the nature of their offense would be an obstacle in finding housing.
- * Closed cases included clients who had been released and were reincarcerated. A new case was opened if the client wanted services again upon release.
 - Seventy-five percent of case management events were completed.
 - Ninety-three percent of appointments were kept.

New York State Department of Health AIDS Institute

Education Programs

- * Prison-based: The AIDS Council of Northeastern New York (ACNENY) and the Altamont Program trained 400 adolescent inmates (ages 13 to 19) in State correctional facilities in upstate New York. AIDS Institute Bureau of Direct Operations staff and Rural Opportunities provided single and multiple HIV prevention education sessions to 16,468 inmates in both upstate and downstate New York.
- * Jail-based: The Center for Community Alternatives (CCA) provided prevention education programs for HIV-negative women prior to release from the Onondaga County Jail and in the community postrelease; a total of 196 clients received multiple intervention sessions. The Osborne Association provided services to recently released inmates; 1,482 clients received prevention education and support services, and about 25 percent successfully completed the program.
- * Juvenile: ACNENY and Altamont reached 1,132 juveniles in New York State Office of Children and Family Services group homes and residential settings. ACNENY trained 61 nurses

and physician assistants in HIV stage-based behavioral counseling.

Disease Screening

- * Prison: 3,267 inmates received HIV counseling and testing services; 40 (1.22 percent) were HIV positive, and 27 (67.5 percent) of those who tested positive were newly diagnosed cases of HIV. All were referred to medical assessment and treatment.
- * Juvenile: 4,896 male adolescents were screened for STIs; 27 cases of gonorrhea (0.55 percent) and 123 cases of chlamydia (2.51 percent) were identified. All cases received treatment.

Discharge Planning and Transitional Services

- * Jail: The Riker's Island officer provided new inmate orientations addressing HIV discharge-planning and other jail-based and community services to 4,106 inmates. Discharge-planning services were provided to 994 inmates (874 at Riker's and 120 at Onondaga County). Of those, 361 (261 from Riker's Island and 100 from Onondaga County) were enrolled in community-based case management programs.
- * Baseline interviews were completed for 222 participants:
 - A total of 62.2 percent were male, 59 percent were Black, and 68 percent were non-Hispanic.
 - Eighty-nine percent were HIV positive.
 - A total of 204 clients (91.9 percent) received case management services:
 - 88.7 percent received one meeting with a case manager.
 - 78.4 percent received some discharge-planning services.
 - 27.0 percent participated in individual or group HIV prevention education.
 - 54.9 percent were transferred and no longer received CDP services.
 - 81.8 percent (of 110 inmates remaining) received an appointment or referral for services in the community.

- Referrals were provided for mental health services (77.3 percent), substance abuse treatment (62.7 percent), HIV/AIDS treatment (57.3 percent), and housing (50.0 percent).

New Jersey Department of Health and Senior Services

Staff Training

- * New Jersey concentrated its training efforts on CBO staff training; 83 percent of staff trained were CBO staff. Juvenile staff received a 1.5-hour session on HIV, STIs, and modes of transmission.
 - Staff trained: 449 (373 CBO staff)
 - A total of 336 single and 276 multiple sessions
 - A total of 3,427 training hours.

Peer Education

- * Once inmates got over the fear of being labeled as HIV positive (overcome by including HIV-positive peers), they welcomed the program and promoted it to other inmates. Of those recruited to be peer educators ($N = 139$), 93 percent (129) completed training, 30 percent of whom were women. Seventy percent of the trainees were Black, 14 percent were Hispanic, and 16 percent were White. The Division of Young Adult Medicine of the University of Medicine and Dentistry of New Jersey provided peer education in the juvenile facility four to six times each year.

HIV Prevention Education

- * A total of 1,585 single prevention and education sessions, for a total of 32,975 inmates, took place in the 13 facilities. Nineteen percent of the sessions were peer led, and 5 percent were in Spanish. A total of 292 multisession prevention and education trainings took place, totaling 623 sessions; 9,537 of 11,724 (81 percent) completed the series. Peers led 48 percent of the sessions, and 14 percent of the sessions were in Spanish. The CBO held multisession health education/risk reduction classes in the juvenile unit that housed inmates; single-session classes were held in the other housing units. By the

end of 2002, all 13 correctional facilities had HIV prevention and education and risk-reduction classes.

Disease Screening and Treatment Programs

- * New Jersey screened and tested only for HIV under CDP's disease-screening and treatment component. By the end of 2002, HIV counseling and testing services were available at all facilities.
 - A total of 9,807 inmates were tested for HIV; of those, 134 (1 percent) were HIV positive and 69 (51 percent) of those testing positive were new positives.
 - Seventy-nine percent received partner notification and referral services.
 - Of the 134 HIV positives, 126 (94 percent) were referred for HIV care and treatment, and of those, 26 (21 percent) were treated for AIDS.

Discharge-Planning Programs

- * No services existed except at the Monmouth Jail prior to the CDP. Discharge needs were noted when clients enrolled in the CDP, and discharge planning was geared toward those needs. Services included links to HIV treatment and medications; mental health treatment and medications; substance abuse treatment; assistance with benefits applications (including ADAP and other health insurance); community case management for HIV-positive clients; basic needs such as food stamps, housing, and clothing; and identification.
 - A total of 1,920 inmates were served prior to release, of whom 9 percent were repeat clients.
 - A total of 1,497 inmates (78 percent) were released.

Community Transition

- * Before the CDP, few services were available in the communities for released inmates. The CBOs found that community agencies were initially hesitant about follow-up and case management, but over time, they became receptive.
 - A total of 1,492 releasees participated in discharge planning; 829 (56 percent) participated in CDP case management.

- Of those participating in CDP case management, 756 (91 percent) participated in post-release case management. A total of 737 (89 percent) cases were successfully closed.

New Jersey Cohort: Program Impact on Client Health Outcomes

The New Jersey Cohort database contained 314 clients who were a subset of the New Jersey CDP database of 487 clients. This database was created to follow the same clients as much as possible from entry through completion of the CDP. Following each client using the unique identifier on CDP enrollment forms was not possible in the time allowed. Findings from the cohort provided a more detailed portrait of client-level needs and service outcomes.

Demographics

- * The cohort of 314 clients was 76 percent male and 22 percent female.
- * English was the primary language for 84 percent of clients; Spanish was the primary language for the remainder.
- * Ninety-three percent were in prison, and the remainder (7 percent) was in jail.
- * Five percent were ages 20 to 29, 41 percent were ages 30 to 39, 44 percent were ages 40 to 49, 8 percent were ages 50 to 59, and 1 percent were age 60 and older.
- * Twenty percent were Hispanic, 17 percent were White, 66 percent were Black, 2 percent American Indian, and 13 percent were “other.”
- * Sixty-six percent had a grade-school education, and 68 percent had never been married. At the time of arrest, 28 percent were working full time and 11 percent had part-time or odd jobs.

HIV Status

- * At incarceration, 85 percent of the 314 cohort inmates were HIV positive, 58 percent of those who were HIV positive had an HIV care provider, and 42 percent were taking HIV medications. The level of educational sessions increased throughout the CDP. Eighty-one percent of the attendees in the multiple-session prevention and education series completed the full series.

- * The CDP provided encouragement and the opportunity to get tested for HIV. Inmate influence also was a major factor in other inmates’ attending educational sessions and being tested. At release:

- Eighty-five percent of the cohort were HIV positive, and 74 percent of those who were positive were on HIV medications (91 percent of those on medication were released with a supply, and 6 percent had a prescription).
- Fifty-four percent of those who were HIV positive had a specific HIV care provider appointment, and 24 percent had referrals for HIV care.
- At 1 month postrelease, more HIV-positive clients had an HIV health care provider and had gone to their first appointment than had an HIV care provider at arrest (79 percent vs. 58 percent). More clients were on medications at 1 month postrelease than at arrest (73 percent vs. 42 percent).
- At 6-month follow-up, more than 92 percent of HIV-positive clients had seen an HIV care provider. HIV-positive clients, for the most part, remained in care.

Mental Health

- * At incarceration, 35 percent of the cohort inmates had a significant mental illness (most commonly, depression [48 percent]). Of clients with mental illness, 57 percent had a mental health provider and 45 percent were on medication for their illness.
- * At release, 35 percent of cohort clients still reported a significant mental illness, but the proportion with depression had dropped to 42 percent. At the time of release, all inmates with a significant mental illness had received treatment and medications and were set to continue with care and treatment in the community.
- * At 1 month postrelease, the number of clients reporting depression had increased from 48 to 66 percent, and fewer clients (47 percent) reported having a mental health provider. CBO case managers indicated that adherence to mental health treatment was very important in HIV care compliance and retention in the program.

- * At 6 months, 40 percent reported some form of mental illness, but 60 percent had a mental health provider and more than 50 percent were on medication, an improvement from their status at arrest.

Substance Abuse

- * Substance abuse was a problem for clients in the CDP cohort:
 - At intake, 59 percent reported drinking alcohol and 79 percent reported street drug use in the days prior to arrest. The common reasons clients gave for not seeking drug treatment were alcohol and drug use, not wanting treatment, having dropped out of treatment, and other reasons. However, 40 percent had attended some type of treatment program in the 6 months prior to arrest (most often, detox and either drug or alcohol self-help or 12-step programs). Drug treatment was identified at intake as a discharge need for 69 (22 percent) of the 314 cohort inmates.
 - At release, 25 releasees had specific appointments for treatment, and the remainder had referrals. A higher percentage attended substance abuse treatment at 1 month post-release than prior to arrest (52 percent vs. 40 percent).
 - At 6 months postrelease, the number of clients attending treatment had increased to 59 percent of those still in case management. Adherence to substance abuse treatment regimens was the second most significant health condition affecting retention.

Other Health Concerns and Case Management

- * Of additional medical diagnoses noted for the 293 clients released, the most common were hepatitis C (41 percent), drug use and abuse (38 percent), and alcohol abuse (14 percent). Other diagnoses included asthma, diabetes, syphilis, TB, hepatitis B, and other STIs.
- * Of the 293 cohort clients, 47 percent were met at the gate by the CBO case manager, 28 percent by family or a friend, 20 percent by no one, and 6 percent by an unknown person.

More than 67 percent of the released clients had specific appointments with their case managers, and 22 percent had referrals. They also had referrals or appointments for other services, as follows:

- Housing or shelter: 37 percent appointments; 28 percent referrals for shelter
- Non-HIV health care: 8 percent appointments; 20 percent referrals
- Mental health: 38 percent appointments; 51 percent referrals
- Substance abuse treatment: 36 percent appointments; 74 percent referrals
- Transportation assistance: 23 percent appointments; 39 percent referrals
- Basic needs: 23 percent appointments; 39 percent referrals
- Educational assistance: 5 percent appointments; 27 percent referrals
- Employment assistance: 11 percent appointments; 33 percent referrals
- Medical benefits: 30 percent appointments; 35 percent referrals
- Financial assistance: 14 percent appointments; 39 percent referrals.

- * At 1 month postrelease, 73 percent of clients had attended their first case manager appointment. At 6 months postrelease, 93 percent of the 194 remaining clients indicated that they had a case manager in their correctional facility; the same proportion also had a case manager in the community. Ninety-eight percent of clients considered community case managers to be helpful, and 49 percent reported that the case manager was extremely helpful.