Residential Substance Abuse Treatment (RSAT)

Training and Technical Assistance

RSAT Training Tool: HIV Prevention and the Treatment Needs of Offenders at risk for or Living with HIV/AIDS

This curriculum is a cross-disciplinary training tool designed to increase knowledge and awareness in correctional settings of the relationship between HIV infection and substance use. It is directed at correctional program staff, behavioral health providers, case managers, healthcare workers and other professionals and volunteers working with criminal justice populations.

Niki Miller, M.S. CPS
Cherie Hunter

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RSAT Training Tool:
Understanding HIV Prevention in Correctional Settings and the Treatment Needs of Clients at risk for or living with HIV/AIDS

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By Niki Miller, M.S. CPS
Senior Program Consultant
Advocates for Human Potential, Inc.
and Cherie Hunter
Treatment Alternatives for Safe Communities

Others who assisted with developing this training manual include:
Dr. Andrew Klein
Dr. Lisa Braude
Christina Wigglesworth and
Cathy Cave

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About this Manual

Audience:

Residential Substance Abuse Treatment (RSAT) program staff, addiction professionals, case managers, healthcare professionals, mental health counselors, volunteers, peer recovery support specialists, community collaborators and chaplains.

Purpose:

This curriculum is a cross-disciplinary training tool designed to increase knowledge and awareness of the relationship between HIV infection and substance use in correctional settings. Professionals working with correctional populations, counselors and substance abuse treatment providers can enhance their ability to provide interdisciplinary care to people with alcohol and drug problems who are at risk for, or living with HIV /AIDS. RSAT programs that promote the knowledge and skills resulting in changes to high-risk drug use and sexual behaviors can help arrest the spread of HIV/AIDS in communities and among vulnerable populations. Men who have sex with men, African Americans, women, juveniles, people with methamphetamine, cocaine and IV drug problems, and their partners are all examples of high risk groups entering or leaving correctional facilities. Communities where disproportionate numbers of individuals are incarcerated, a large number of them for drug related crimes, are often the same communities where health disparities abound. RSAT programs are uniquely positioned to serve individuals and their communities. Addiction treatment contributes to public safety by ensuring offenders know how to prevent HIV infection, protect themselves, their partners and companions. RSAT clients living with HIV/AIDS need specialized care coordination while in treatment and upon re-entry. Staff can increase their knowledge of resources available, specifically for people living with AIDS, and connect re-entering offenders with recovery support and care coordination.

Objectives:

The expected outcomes of the curriculum are:

1. Increased knowledge about early detection, prevention, and treatment of HIV/AIDS in correctional settings.

2. Increased ability to educate and motivate RSAT clients to modify high-risk drug and alcohol use behaviors, participate in HIV testing, and practice safe sex.

3. Ability to present clients with options for testing, disclosure and treatment of HIV/AIDS and other sexually transmitted infections.

4. Ability to recognize cultural considerations, stigma, and health disparities that affect specific offender populations at-risk for or living with HIV/AIDS and their access to community services.

5. Familiarity with ethical and legal mandates regarding confidentiality, care coordination, reporting of sexual assault in prisons, healthcare, and protections from infectious disease.

Each of the modules in this series is centered on basic principles to foster professional development and promote safe, effective and efficient service provision. The modules contain participatory exercises, resources for additional learning, and a review of the topics covered. While it is impossible to address all aspects of programs and practices that have been effective with reducing the spread of HIV and the treatment of AIDS, the course offers concrete suggestions for counselors in correctional settings and resources that offer more complete information on a number of content areas.

Approach:

- **Strength-based** - emphasizes prevention, harm reduction, treatment options, and a holistic view. HIV is no longer a death sentence; addiction recovery and longevity for people with HIV/AIDS are both possible; reinforces healthy choices; supports new target behaviors regarding drug use and sex.
- **Recovery-oriented approaches**- Stresses the importance of health and recovery; recovery from substance use and co-occurring disorders means reducing high risk behaviors. A holistic approach to recovery and self-care; includes resources for at-risk and infected inmates and their families and communities.
- **Culturally aligned content**–highlights cultural stigma inside of correctional facilities and health disparities within diverse communities; its effect on disclosure, detection, prevention and treatment seeking behavior; maintaining medical confidentiality in correctional environments and knowledge of HIV among racial and ethnic minorities.
- **Integrated**- an integrated approach combines counseling, addiction recovery and health with security and the safety concerns of staff, inmates, family members and communities; a public health approach to reducing the spread of HIV targets high-risk populations, including inmates and people with substance use disorders.

- **Evidence-based strategies-**includes discussion of HIV/AIDS best practices in addiction treatment, safer sexual behaviors and motivating behavioral change, based on the latest research. Information on best practices for HIV prevention is included.

- **Accountability** – client confidentiality, ethics and counselor responsibilities, regarding HIV, which includes becoming familiar with state laws, facility policies and reporting requirements. New federal mandates aimed at reducing non-consensual sex in prisons and jails contribute to the complex ethical issues.

Why learn about HIV/AIDS?

There are at least 56,300 new infections every year in the U.S., and this number has not changed for the last 10 years. It is estimated that about a quarter of the one million people in the US that are infected with HIV are not aware of it (National HIV/AIDS Strategy, 2010). Many of these individuals do not get tested until they are at an advanced state of the disease. Unfortunately an estimated 50% of patients that develop AIDS do so within one year of first learning of their HIV status (CDC, 2011).

The treatment of HIV and substance use disorders (SUDs) is at a critical juncture. Changes to the healthcare system will pave the way for care improvements at the interface of general medicine, behavioral health, and substance treatment. Advances in the treatment of HIV/AIDS have made early detection critically important. New antiretroviral therapies can extend life considerably and delay the onset of AIDS related health problems, perhaps indefinitely for some. If individuals detect their infection earlier, adhere to a course of anti-retro viral medications and receive the specialized care they need, such as drug and alcohol treatment, they can remain healthy for decades. HIV testing in correctional settings has the potential to reach populations at risk for HIV/AIDS that might not otherwise learn of their HIV status, giving them an opportunity to access care.

Relevance to Corrections

Each year, an estimated one in five individuals with HIV passes through a correctional facility (Maruschak Beavers, 2009). Intervening with individuals with substance use disorders when they come in contact with the criminal justice system represents a tremendous opportunity for HIV prevention and screening. The potential to reduce the spread of HIV/AIDS, the healthcare cost savings and relief of human suffering is so great that that the National Institute on Drug Abuse (NIDA) has launched a wide scale research initiative to identify and treat inmates, parolees and probationers. *Seek, Test, and Treat: Addressing HIV in the Criminal Justice System* (NIDA, 2010b) is aimed at identifying HIV+ offenders and ensuring they have follow-up treatment when they are released into the community.

Substance abuse negatively impacts HIV/AIDS outcomes and multiplies a person's risk for HIV infection nearly 12 times (CSAT, 2000). The adverse impact of untreated substance use disorders on the criminal justice system and the prevalence of HIV among incarcerated populations make it critical to integrate knowledge about HIV detection and prevention into RSAT programs.

RSAT staff is the offender's primary source for addiction recovery treatment and support. Ideally, RSAT staff and substance treatment professionals are part of a team approach to care coordination and release planning; they cannot and should not function outside the scope of their knowledge, training and expertise. Medical care, case management, mental health treatment and other supports are needed. This manual provides the information RSAT staff need in order to participate in a team approach to HIV education and prevention aimed at reducing the risk of HIV transmission. RSAT staff can help familiarize inmates with testing procedures, explain the benefits of testing and support care coordination for HIV+ inmates.

Module I: Introduction HIV/AIDS in Correctional Treatment Settings

A. HIV/AIDS Basics: What is it, how is it transmitted and who is at risk?
B. Context and Background: HIV/AIDS Issues in Custody
C. Priorities for RSAT Staff
D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Define HIV and the symptoms that indicate progression into AIDS.
- Explain the ways HIV can and cannot be transmitted.
- Discuss the prevalence of HIV/AIDS among incarcerated populations and factors that place them at increased risk for HIV infection.
- List the advantages of HIV prevention, education and testing for RSATclients.

Knowledge Assessment Test

True False Questions

1. According to the CDC, the overall prevalence of HIV in US correctional facilities is at least roughly four times higher than in the general U.S. population.
   True

2. About one out of every five HIV-positive people in the United States has been in a correctional facility at some point in their life.
   True

3. There are clear guidelines and uniform standards for HIV testing in jails or prisons.
   False

4. HIV only causes one type of AIDS. The cause for other types of AIDS is unknown.
   False

5. If an HIV positive inmate spits on a staff member and saliva comes in contact with intact, unbroken skin, it is not considered exposure and there is no risk of HIV infection and no need to for staff to have a protective dose of medication to prevent HIV transmission. True

A. HIV/AIDS Basics: What is it, how is it transmitted and who is at risk?

Before we learn more about HIV prevention and testing in substance abuse treatment and in correctional settings, it is important to understand the basics of HIV/AIDS, the way it transmitted and the latest recommendations and guidelines.

Definitions

Human Immunodeficiency Virus Type 1 (HIV-1)
HIV is the retrovirus isolated and recognized as the cause of AIDS. HIV-1 is by far the most common cause of AIDS worldwide and the major virus type. Generally, when people refer to HIV without specifying the type of virus they are referring to HIV-1. HIV infection results in the virus inserting its own RNA into the host cell's DNA, preventing the host cell from carrying out its natural functions and turning it into an HIV factory.

Human Immunodeficiency Virus Type 2 (HIV-2) Note: The relatively uncommon HIV-2 type virus is concentrated in West Africa and is rarely found elsewhere. HIV type-2 is closely related to HIV type-1 and is transmitted the same way, resulting in similar opportunistic infections.

Acquired Immunodeficiency Syndrome (AIDS)
Usually, a person is diagnosed with AIDS once the virus has attached to the immune system and weakened it, resulting in severe health complications such as opportunistic infections or AIDS related cancers. The Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO) and others list numerous infections and health conditions that occur in the presence of HIV infection, constituting an AIDS diagnosis. Since AIDS is also defined by the degree of immunodeficiency in an HIV-infected individual, it is possible to have a diagnosis of AIDS without complicating health conditions. This occurs when the number of immune system cells (CD4 cells) in the blood of an HIV positive person drops below a certain level. Once the diagnosis of AIDS is pronounced, the central nervous system may be affected, resulting in neurological problems that can affect thinking and memory.

The above criteria are used to make a determination of AIDS and to indicate when treatment should begin for an individual with HIV infection.

Transmission of HIV- *How does one become infected with HIV?*

There are five common ways that people become infected with HIV:

1. Having sexual intercourse with an infected partner.
2. Injecting drugs with a needle or syringe that has been used by someone who is infected.

3. Mother to child transmission; infants can become infected during pregnancy, labor or delivery, or through breastfeeding.

4. Receiving a transfusion, blood product or organ transplant from an infected individual.

5. Healthcare professionals and staff can become infected through needle stick or other exposure to other contaminated products they handle under certain circumstances.

Exercise 1: Mode of Transmission
Please place the number of the mode of transmission listed above next to the correct corresponding prevention measure (1-5)

_____ *United States has seen a 95% decrease in this mode of transmission since 1992, when doctors began giving anti-retroviral drugs to pregnant women.*

_____ *Using a new syringe and never sharing equipment are the best precautionary measures, although information about procedures for disinfecting syringes may be outlined as a "last resort."*

_____ *Proper and consistent use of a latex condom is effective.*

_____ *In 1985 most sources were declaring the blood supply was safe due the new testing procedures that had been put into place.*

_____ *Once an exposure is evaluated for risk, post-exposure prophylaxis (PEP) is a 28 day course of anti-retroviral drugs- effective at reducing the likelihood of transmission.*

It is important to understand that for the HIV disease to develop, the virus must be passed from one infected person to another person. In general, the HIV infection formula requires that:

1. A specific body fluid serves as the vehicle transporting the virus;

2. The virus is in a sufficient quantity;

3. The virus has a means of entering the host's bloodstream and/or lymph system; and

4. The infective body fluid enters the host's bloodstream and/or lymph system within a very brief period of time after leaving the infected person's body.

Most people in the US that have been infected through the blood-to-blood transmission route have used a syringe or other drug delivery equipment that was used by someone with HIV. It is theoretically possible to be infected with HIV from equipment used to tattoo or pierce, if it had residual blood from an HIV infected individual and was used on

another person immediately. This is so uncommon in community settings that there are no documented cases of this type of transmission. In a prison setting, makeshift tattooing equipment is far more likely to contribute to the spread of Hepatitis than HIV, and presents a significant health risk for that reason. We will discuss Hepatitis and other infections that sometimes occur in combination with HIV later in this curriculum.

Exposure and Infection

Examining each of these factors in detail, let us first look at the specific body fluids that may be involved in the HIV infection formula. HIV has been isolated in virtually every body fluid that contains white blood cells including:

- blood
- semen
- vaginal/cervical secretions
- breast milk
- cerebrospinal fluid
- amniotic fluid
- bronchial secretions
- urine
- tears
- saliva

However, the quantity of virus in some of these fluids is not sufficient to pose a risk for transmission of HIV. Epidemiological studies have repeatedly demonstrated that person-to-person transmission occurs through blood, semen, vaginal/cervical secretions, and breast milk. The data has consistently failed to implicate other body fluids as a risk. The fluids that generally have sufficient levels of HIV virus to result in transmission are highlighted in red on the list above in the order of the amount of the virus they contain.

Although many viruses readily survive harsh environmental conditions, this is not the case with HIV. This particular virus is completely dependent on human tissue to survive. HIV can only be transmitted through specific types of person-to-person contact and cannot survive outside of the host. This information is important to keep in mind while working in an institutional setting. HIV exposure during casual contact is very unlikely. Exposure fears of both staff and inmates can’t be discounted completely, but they can be assuaged by providing accurate information on distinguishing high-risk from no-risk situations.

Sexual Transmission

Although the most efficient means of HIV transmission is through blood–to-blood contact, certain types of sexual intercourse (defined as the penetration of the penis of

one partner into the rectum, the vagina, or the mouth of the other partner) are also high-risk. They create the conditions necessary for transmission of HIV infection and are increasingly responsible for the spread of HIV, especially during male to male sexual contact and heterosexual anal and vaginal intercourse.

Since rectal intercourse involves excessive stress to the rectum and anus, there is sometimes bleeding of these tissues, regardless of whether the receiving partner is male or female. Penis-to-rectum intercourse is associated with a particularly high risk of HIV transmission; the highest risk sexual behavior is being on the receiving end of anal sex, whether the receiving partner is male or female. If it is a non-consensual situation, forced sex or a sexual assault, especially one involving more than one perpetrator, the risk of exposure is heightened, due the tearing and bleeding that can ensue. In the case of prison sexual assault, testing for HIV is part of the follow-up forensic medical examination for the victim (and assailant if they are identified**). HIV testing should be offered to all victims of sexual assault, no matter when the assault is reported or where it took place**. If the assault is recent, they should be evaluated for and offered post-exposure prophylaxis by medical staff responsible for their forensic examination, as appropriate (PREA, 2009). Post-exposure prophylaxis, or PEP, is a short course of anti-retroviral medication given right after a suspected exposure to the HIV virus that minimizes the chances of infection. Health workers and staff exposed to contaminated body fluids are usually evaluated for a course of PEP and given these medications when indicated. The current Bureau of Prisons (BOP) guidelines for staff exposures are included in the resources at the end of this module.

Heterosexual Transmission

Female partners of males with HIV/AIDS who engage in anal sex with them are at particular high risk for infection. This is because women rarely use condoms during receptive anal sex. One study showed that less than a quarter of women use condoms during anal sex as opposed to nearly two thirds of men who have sex with men (NYC Health, 2010). However, vaginal intercourse also carries a high risk of HIV transmission, especially for the female on the receiving end. A great deal of male and female sexual fluid is produced during vaginal intercourse. The large areas of mucous membrane that are exposed in the vaginal area place women at increased risk for exposure during sexual intercourse.

It is believed that oral intercourse (mouth-to-penis or mouth-to-vagina/vulva) also poses some risk of transmission, but epidemiological data proving this has been difficult to collect. Although there are documented cases of HIV transmission through oral sex, it is not considered a high-risk sexual behavior. However, the presence of sores or lesions in the mouth or on the gums can increase the risk. Barrier methods and other precautions are recommended.

Studies continue to illustrate the profound role alcohol and other drug use/abuse has in the spread of HIV. The use and sharing of non-sterile needles and unprotected sex are associated with drug and alcohol addiction. Non-sterile needles and unprotected sex are the most common modes of HIV transmission today.

Answers to Exercise 1: 3, 2,1,4,5

HIV Testing in Prisons

✓During 2008, a total of 24 states reported testing all inmates for HIV at admission or sometime during custody. Among these 24 states, 23 tested prisoners at admission, 5 tested while in custody, and 6 tested upon release.
✓All fifty states and the federal system tested inmates if they had clinical indication of HIV infection or if they requested an HIV test.
✓Forty-two states and the federal system tested inmates after they were involved in an incident in which an inmate was exposed to a possible HIV transmission.
✓18 states and the federal system tested inmates who belonged to specific "high-risk" groups.

Source: BJS (2009). HIV in Prisons, 2007-08. http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1747.

B. Context and Background: HIV Issues in Custody

Detection of HIV and treatment of AIDS in correctional settings is complex. Inmates in custody have a right to healthcare; however, there are no enforceable standards. There are wide variations in healthcare policies and capacities in state prisons and in jails. Confidentiality, costs, and continuity of care make HIV-related correctional health policy decisions challenging.

For example, some jails choose to offer HIV testing to all inmates as part of their routine medical intake procedure; however, many of these inmates are released prior to receiving test results.. Some prisons have had inmates with AIDS begin anti-retroviral medication treatment (ATR) regimens while incarcerated only to find that compliance was not possible upon release. Non-compliance with anti-retroviral drug therapy (halting use, intermittent use, or habitually missing doses) has caused some strains of HIV to mutate and create new iterations of the virus that are resistant to medications. The benefits of initiating treatment while incarcerated must be weighed along with the risks, since these compliance issues are associated with increased risk of serious HIV disease progression, severe complications, or death (Siegel & El- Sadr, 2006).

RSAT staff members need to be **armed with the facts**, prepared to **educate clients** about prevention and the risks of HIV transmission, extol the **benefits of testing**, increase **motivation to change** high-risk behaviors, and **provide support** to those in substance treatment who maybe living with HIV/AIDS.

The Prevalence of HIV among Offenders

In each year from 1999 to 2006, the data on known full-blown AIDS cases among the prison population has shown a rate between 2.7 and 4.8 times higher than the rate among the general U.S. population (Maruschak and Beavers, 2009). The overall rate of known HIV infection among people incarcerated in prisons and jails is estimated at more than five times the rate of the general population (Maruschak, 2006).

> ***Survey Data on Inmate Testing***
>
> *The Bureau of Justice Statistics conducts surveys of inmates in local Jails, State Prisons and Federal Prisons. The most recent survey data on HIV testing of inmates for HIV are list below:*
>
> - *18.5% of Jail inmates reported being tested for HIV since admission and reported a result.*
> - *69% of State inmates reported being tested for HIV since admission and reported a result.*
> - *77% of Federal inmates reported being tested for HIV since admission and reported a result*
>
> *Source: CDC, HIV Testing Implementation Guidelines for Corrections 2009*

However, rates of infection are known to be much higher for specific sub-groups of the prison population and in certain geographic regions. For example, Florida, New York, and Texas account for 46% of HIV/AIDS cases in state prisons (Maruschak and Beavers, 2009). HIV rates for incarcerated women are three times what they are for incarcerated men and five times what they are among women in the general population. In some northeastern states, studies have revealed a staggering 13% percent of women in state prisons are infected with HIV (De Groot and Uvin, 2005) and up to 38% have been diagnosed with Hepatitis C (Hayes and Jones, 2007).

HIV Screening and Detection

> ***HIV Rates in Jails are higher***
>
> *Infection rates of up to 25% have been found in samples of jail inmates tested for HIV (CDC, 2009).*

It is estimated that 1 to 1.2 million people are living with HIV/AIDS in the United States. As many as 25% of these people, or approximately 300,000, are unaware they have HIV infection. It is important to identify these individuals because they may be unknowingly transmitting HIV. Studies have shown that once individuals learn about their HIV infection, they substantially reduce their high-risk sexual behaviors. ***The transmission rate among those who do not know they are infected is 3.5 times higher than for people who know about their HIV infection.*** When re-entering offenders know their HIV status and what to do to prevent the spread of HIV the result is increased public safety and public health (Pacific AIDS Education Center, 2008).

The most recent survey data from the Bureau of Justice Statistic, 69% of State inmates, 77% of federal inmates and 18.5% of jail inmates report being tested for HIV since admission. The HIV status of many people entering and leaving correctional facilities is still unknown. Some jail studies have found rate of HIV infection as high as 25% in samples of jail inmates (CDC, 2009). Research has shown that men with a history of incarceration may avoid HIV testing while in the community (Kacanek, Eldridge, Nealey-Moore et al., 2007). Some men avoided HIV testing outside prison because they lacked time, lacked resources, feared knowing the results, or perceived themselves to not be at risk (MacGowan, et al., 2006). Inmates are more likely to receive voluntary HIV testing when prisons routinely provide testing to everyone during the intake medical evaluation (Kavasery, Maru and Sylla, 2009). This universal approach normalizes HIV testing, eliminates the onus on offenders to specifically request testing, and reduces the potential stigma within a custody environment that affords limited confidentiality (CDC, 2009).

New Testing Guidelines

The latest Centers for Disease Control guidelines for testing in correctional settings were released in 2009 (see resource pages). Testing guidelines are updated frequently based on new information, and have changed over the years.

In 2001, the Centers for Disease Control and Prevention made several modifications to screening guidelines for pregnant women aimed at making HIV testing part of routine prenatal care. By the mid-1990's, most doctors provided certain anti-retroviral drugs to pregnant women who were HIV+ to reduce the transmission of the virus from mother to child. Instead of pregnant women having to request an HIV test and sign a separate consent form, in 2001 HIV testing was incorporated into routine consent for medical treatment. Women were free to "opt out" of HIV testing, but they no longer had to "opt in." This motivated many more pregnant women to get tested, and as a result, the rate of HIV infection among infants dropped 74% (U.S. Department of Health and Human Services, 2005).

Hoping to replicate the positive impact of changes to testing protocols for pregnant women, the **2006 CDC recommended offering routine "opt-out" HIV screening for <u>all</u> individuals between the ages of 13-64 years**.

CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006

- HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.

The National Commission on Correctional Health Care also recommends routine universal HIV screening for people in correctional facilities (NCCHC, 2002a). Testing should be voluntary and undertaken only with the patient's knowledge *while also preserving the patient's option to decline HIV testing*. Recent studies demonstrate that voluntary HIV testing in high risk healthcare settings is an extremely cost-effective public health strategy (Lifson & Rybicki, 2007).

Federal Bureau of Prison guidelines differ: testing is mandatory for certain high risk or symptomatic inmates in federal facilities. Testing policies differ in various county and state facilities, and in some states, are dictated by law.

RSAT staff should familiarize themselves with the specific policies of each facility and the laws of each state. RSAT staff can provide information to inmates on what they can expect, what they need to know and what services are available to support them throughout the testing and notification process.

Stigma, Confidentiality and Discriminatory Practices

HIV and AIDS are associated with a high degree of stigma in the general population, and an even higher degree of stigma in within prisons and jails. Inmates fear stigmatization on a personal basis from other inmates and staff as well as institutional discriminatory practices.

Information is a valuable commodity in a prison. Offenders learn very quickly to guard personal information and to hide anything that could be perceived as vulnerability. Male inmates are motivated to hide HIV+ status because it may put them at increased risk for sexual or physical assault from other inmates. The assumption of homosexuality (founded or unfounded) can put a male inmate at risk for physical assault, gang rape, sexual slavery and HIV infection from forced or coerced unprotected sex (PREA, 2009).

Past (or current) institutional discrimination against inmates with HIV and AIDS has included segregated housing units, exclusion from work sites, vocational programs and prison jobs, and exclusion from rehabilitation programming and recreation. Numerous legal challenges to these types of discriminatory practices were unsuccessful until 2001 and 2004 when Mississippi and Alabama’s practices of discriminatory segregation of HIV positive inmates were disallowed (Sylla, 2008). These types of practices and attitudes in prison settings may motivate offenders to:

- Deny or hide their HIV status
- Fail to disclose their healthcare needs to medical staff upon intake
- Discontinue medications
- Avoid testing
- Avoid accessing services like mental health and substance abuse treatment
- Avoid accessing healthcare

It is important to note that segregation for purposes of exclusion is distinct from the practice of clustering offenders with AIDS for the purposes of providing medical services to high need offenders. There are housing units in states like California where people living with AIDS can take advantage of medical treatment resources, doctors who specialize in HIV/AIDS etc.

Confidentiality for HIV+ offenders and people living with AIDS is nearly impossible in some facilities. Although RSAT counselors, correctional case managers and others are usually well versed in confidentiality requirements and are careful about disclosure of client information, medical confidentiality is a different issue. Med call is a visible activity. Offenders know who is getting several pills at different points during the day, which inmates go down for sick call, when an inmate sees a specialist, and even when others have lab tests and obtain results. The security demands of the environment tend to compromise confidentiality and privacy. In small jails and high security prisons maintaining medical confidentiality can be a logistical impossibility.

Both males and females can be ostracized unnecessarily by staff and inmates because of misinformation about HIV transmission. Since the rate of HIV infection is much higher among people who are incarcerated, and among those with drug and alcohol problems, it is important that inmates, security staff and RSAT clients have the correct information and support.

C. Priorities for RSAT Staff

Amid all this complexity, what is the focus for RSAT staff? RSAT staff will benefit their clients greatly through **education** about HIV and AIDS **prevention** and **the risks of HIV transmission**. Staff can help **familiarize inmates with testing procedures**, **explain the benefits of testing** and **support them through notification and care coordination.** Staffs' motivational skills can help offenders choose safer sexual behavior, addiction recovery and health. Finally, staff can provide emotional support to RSAT clients living with HIV/AIDS and ensure available services are in place as they re-enter communities. This curriculum highlights the knowledge, skills, and attitudes that will help staff attend to the following priorities for RSAT clients:

- **Accurate information about the risk of transmission and prevention-** Educate RSAT clients to take precautions that prevent the spread of HIV during sex and during drug use. Modified behavior regarding drug use and sexual contact can reduce the chance of HIV infection for clients who are not infected and prevent HIV+ clients from transmitting the virus to others. Education can dispel irrational fears and contribute to personal and institutional safety.

- **The benefits of knowing their status-** Today, a HIV+ status is far from the death sentence it once was. Once a person knows their status, they can take steps that will improve the quality and length of their life and protect the health of

those they are close to. Inmates who learn they do not have HIV may also be more motivated to adopt preventative behaviors.

- **Emotional support-** If an individual in substance use disorder treatment must face a difficult health diagnosis, it is better that they deal with it while they are in treatment, where they have resources and support. The information can strengthen motivation to recover; conversely, finding out after leaving treatment can contribute to relapse unless an adequate support system is in place.

- **Motivating behavioral change and harm reduction-** In a perfect world every inmate would leave treatment and never use drugs again; inmates in RSAT programs would not have consensual sex while they are in correctional facilities and non-consensual sex acts would be eliminated. Unfortunately, this is not the case. Understanding harm reduction measures and motivating incremental behavioral change that reduces the risk of HIV infection makes a difference.

- **Ethical mandates –** Knowledge of client confidentiality rights, counselor responsibilities, public health reporting of HIV+ cases, resources for medical treatment, release planning and care coordination is critical. RSAT staff also need to know about new federal laws that mandate reporting of all sexual assaults in correctional facilities.

Exercise 2: Meet Joe. What do you know?

Joseph has just been transferred to your facility and is entering the RSAT program. He is an IV drug user from a Puerto Rican community in a large New England city. He is opting out of HIV testing, but has asked to talk with you because he has a lot of questions. Think about how you would answer each of his questions. Before you formulate an answer, consider the information provided.

Joe: *I am not gay or nothing and I don't like that they wanted to see if I had AIDS. That pissed me off. Why did they do that?*

Universal testing means you have an answer for Joseph. When HIV testing is routine upon intake, RSAT counselors can normalize the procedure. If your facility tests only high risk inmates, you can still explain that testing is now routine in substance abuse treatment facilities, pre-natal care and most health care settings for anyone 13-64. RSAT staff can emphasize that the decision to test is strictly the client's choice (unless facility guidelines mandate testing).

Your answer:

Joe: *If I take the test, how long do I have to wait to find out the answer?*

RSAT staff can find out what the facility HIV testing method and notification procedure is by consulting with health services or reviewing the written policy. If the facility offers rapid testing, Joseph can find out on the spot. Going over the pro's and con's of testing and leaving the decision to the client is likely to minimize resistance. Clients should be assured they will have your support and access to addiction treatment no matter what choice they make.

Your answer:

Joe: *I'm not taking the test because they send you to some crappy place up north with a bunch of skinners and tell everyone you got the worm. Are they going to tell my wife?*

Joseph can be told that court decisions against discrimination and segregation have been handed down in favor of inmates. Some facilities cluster inmates with AIDS needing intensive medical services. Become familiar with resources and practices so you can go over them with clients. Know the laws in your state that govern partner notification. If positive test results are reported to the health department and partner notification follows, RSAT staff should be able to explain this process fully to clients.

Your answer:

Joe: *Even if I had it, I wouldn't want to know. I can't stay clean anyway so why should I find out something that will make me want to get high more?*

Many people feel this way when they begin addiction treatment. RSAT clients generally have a persistent substance use disorder and have never had an opportunity to get the long term treatment they need. Increasing self-efficacy and motivation are fundamental treatment tasks. In Joseph's case, he may be motivated to stay clean once he knows he is not HIV+, which is the more likely result of testing. If he is HIV+ positive, he will have recovery support and limited access to drugs.

Your answer:

Joe: *What can you do for me in here if I was sick?*

Joseph should know he can get medical care, if he needs it, but one day at a time. RSAT staff can encourage clients to stay in today and deal with the issues at hand, rather than worrying about something that may never happen. The most important information is the advantages of testing. Advances in treatment mean that those who know they are HIV+ can get medical care live long and healthy lives. RSAT clients may also need to understand that there are specific programs that pay for the healthcare needs of people with HIV/AIDS.

Your answer:

For Discussion and Reflection:

How do you think Joseph suspects he may have been exposed?

How would you go about increasing Joseph's motivation, self-efficacy and hope?

How do you think Joseph's fears about HIV impact his drug use?

Did you have the information about facility policies and procedures, state laws, public health requirements and available resources to respond to Joseph's questions?

The resource pages included at the end of each module will help RSAT staff locate the information they need. Staff will need to also obtain information about their individual facilities, including:

- Facility HIV testing policies and procedures
- Information on the type of testing and treatment available
- State laws governing notification and public health reporting requirements

The resource pages can help staff locate:

- Listings of state laws, notification requirements and procedures
- Testing recommendations and clinical care guidelines for correctional settings
- Information and guidelines on HIV/AIDS and pregnancy
- Federal Bureau of Prisons guidelines on HIV/AIDS
- Materials and fact sheets for clients and families
- Training and consultation resources
- A hotline number for questions
- Addiction treatment best practices for clients with HIV/AIDS
- Evidence-based HIV treatment and prevention practices
- Resources for re-entering offenders with HIV/AIDS
- Advocacy and legal information
- Information on exposure protocols for staff

D. Resources and Review

RSAT Resource Sheet on HIV/AIDS- Guidelines and Clinical Care Recommendations:

1. The Centers for Disease Control and Prevention (2009) Guidelines for HIV testing in Correctional Settings: http://www.cdc.gov/hiv/topics/testing/resources/guidelines/correctional-settings/index.htm

2. HIV/AIDS Bureau of the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) updated clinical care guidelines for correctional settings (2011): http://www.aids-etc.org/aidsetc?page=cg-105_correctional_settings#.Tu5IAcCXMwo.email

3. Management of HIV-The Federal Bureau of Prisons Clinical Practice Guidelines (2011): http://www.bop.gov/news/PDFs/mgmt_hiv.pdf
4.
5. National Commission on Correctional Healthcare Position Statement: http://www.ncchc.org/resources/statements/admin_hiv2005.html

6. Medical Management of Exposures: HIV, HBV, HCV, Human Bites and Sexual Assaults-Federal Bureau of Prisons Clinical Practice Guidelines June 2009: http://www.bop.gov/news/PDFs/exposures.pdf

7. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States (2011): http://www.aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/224/whats-new-in-the-guidelines

8. DHHS Clinical Care Guidelines (2012): http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf

Test Laws, Training and Technical Assistance

A. The National HIV/AIDS Clinicians' Consultation Center
   - Warmline (800-933-3413) for individual clinician case consultations
   - PEPLine (888-448-4911) for consultations on post-exposure prophylaxis
   - Perinatal Hotline: 888-HIV-8765 (888-448-8765) for questions about HIV-infected pregnant women
   - *National State HIV Testing Laws Compendium*, describing testing laws and policies for each state, online at: http://www.ucsf.edu/hivcntr/StateLaws/Index.html

B. The AIDS Education and Training Centers (AETC) The Ryan White CARE Act funds 11 regional centers to provide training, professional tools, fact sheets and patient education material.
   - The AETC National Resource Center
   - The AETC National Multicultural Center
   - The AETC National Center for HIV Care in Minority Communities by HIV/AIDS
   - The AETC National Evaluation Center.

Research, Re-entry and Client Care Resources

The Health Status of Soon-to-Be-Released Inmates report from the National Center for Correctional Healthcare (NCCHC, 2002b) Volume I & II: http://www.ncchc.org/pubs/pubs_stbr.html

Series of 12 Fact Sheets for Clients and Family Members (may be given out sequentially over time) :http://www.aidsinfo.nih.gov/ContentFiles/HIVandItsTreatment_cbrochure_en.pdf

Center for HIV Law and Policy: http://www.hivlawandpolicy.org/public/resources/chlppublications

Review

- Offenders are at increased risk for HIV/AIDS. Offenders with substance use problems are especially high-risk. Screening people entering substance use treatment programs is considered a best practice.

- HIV is the virus that causes AIDS. It is mainly transmitted sexually and through blood products. It is not transmitted through casual contact.

- Testing guidelines have changed over the years. Current guidelines recommend HIV screening as a part of routine healthcare. Most guidelines recommend screening for inmates as part of routine medical care at intake.

- Opt out testing means that everyone is offered screening and consent for HIV screening is included with the consent form for general medical treatment. Inmates have the right to know they are being screened and a right to refuse screening (opt out).

- RSAT staff can benefit their clients greatly through education about HIV/AIDS prevention and the risks of HIV transmission. Staff can help familiarize inmates with testing procedures, explain the benefits of testing and support them through notification and care coordination.

Module II: HIV Issues in Addiction Treatment

A. HIV/AIDS and Substance Use
B. Best Practices
C. The Importance of HIV Testing
D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Discuss the reasons IV drug use, crack/cocaine, methamphetamine and other drugs heighten the risk of HIV infection.

- Describe the links between drug and alcohol use, unsafe sexual behaviors, and conditions and changes in target behaviors among RSAT clients.

- Identify best practices for addiction treatment and HIV risk reduction interventions.

- List the types of HIV tests and describe the elements of pre-test and posttest counseling.

Knowledge Assessment Test

True False Questions

1. Most people that have HIV in prisons and jails are infected while they are incarcerated. False

2. Only HIV rapid tests require a follow up confirmation test.
   False

3. Most RSAT clients that do not use IV drugs are at minimal risk for HIV infection.
   False

4. If RSAT clients test negative for HIV upon intake into a facility, but tell staff they have been recently exposed to HIV, then they should be retested.
   True

5. Even if some RSAT clients continue to use drugs, there are still ways they can reduce their risk of HIV infection.
   True

6. Condom use, needle exchanges and opiate replacement therapy are all examples of universal precautions. False

A. HIV/AIDS and Substance Use

Substance abuse prevention and treatment providers have a critical role in helping people reduce their risk of HIV infection. A 2009 survey of substance abuse treatment providers showed that about half of facilities offered counseling and education on HIV and AIDS, but only about a quarter offered testing (SAMHSA, 2010). The Center for Substance Abuse Treatment is now promoting rapid testing, counseling, and referral to care as an evidence-based practice for substance abuse treatment, with implementation grants to minority serving treatment providers (SAMHSA, 2007).

Drug and alcohol use places people at a higher risk for contracting HIV infection. Research shows that health risk behaviors tend to occur in combination with one another. This is true of substance use and unprotected sex, which can result in any number of sexually transmitted infections (STI's). Alcohol use has been linked with unprotected sexual activity, especially among youth and has also been associated with sexual violence, date rape and sexual assault. IV drug users are also at risk for blood to blood transmission and tend to place their partners at-risk (NIAAA, 2008; NIDA, 2010b).

People in the advanced stages of alcohol and drug addiction have a higher likelihood of experiencing a number health problems that can make them more vulnerable to HIV infection and to the progression of AIDS related diseases, including Hepatitis and other STI's. For those living with AIDS, use of street drugs may interact with medications, possibly causing ineffective levels of medication. The liver has to break down any drug ingested. It breaks down medications used to fight HIV, illicit drugs and alcohol. When drugs, alcohol and medications are all waiting in "in line" to use the liver, they can all be processed much more slowly. This can lead to high blood levels of prescribed medications, alcohol and/or illicit drugs, increasing the risk of overdose. An overdose of medication aimed at treating HIV can cause serious side effects. Illicit drug overdoses and alcohol overdoses can be deadly. About 4 of every 10 AIDS deaths are related to drug abuse (NIDA, 2010b).

Cocaine, opiates, and other substances may directly affect HIV disease progression, but most effects are still unknown (Cabral, 2007). What is known from research with offenders is that they are at very high risk of drug overdose upon release from correctional facilities.

Drug use and unsafe sex:

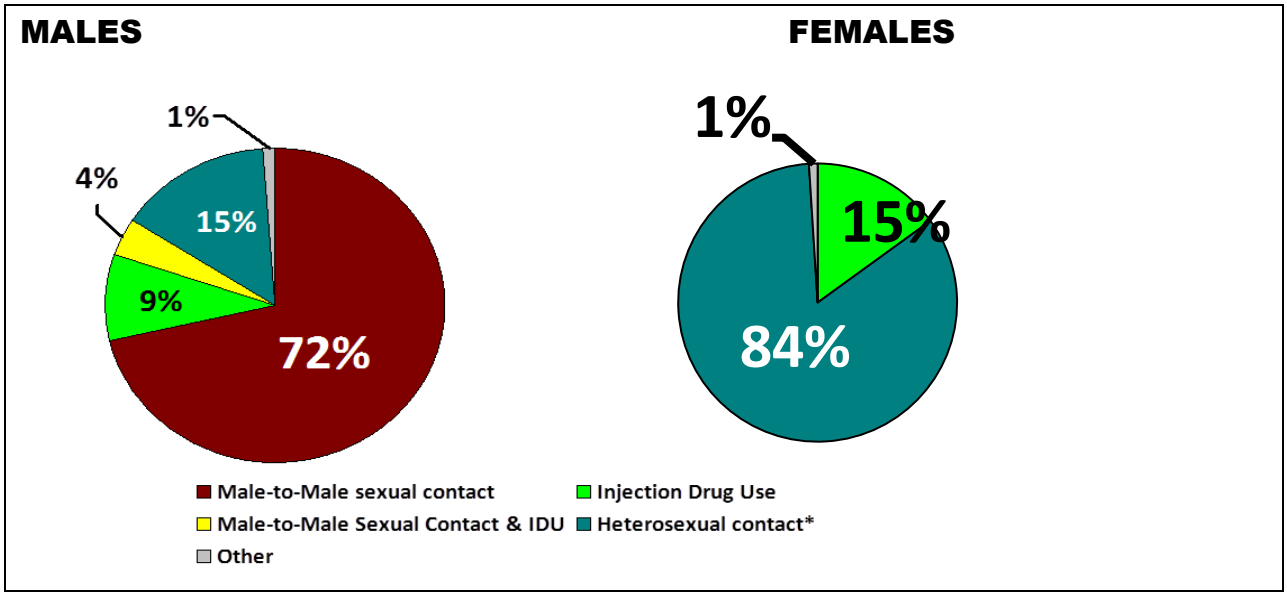
The relationship between substance use, unsafe sex and HIV+ transmission is complex. Adding incarceration and re-entry to the formula adds additional risk factors. For a lot of people, drugs and sex go together. When people are under the influence of alcohol or drugs their judgment is often impaired. Drug use, including alcohol use, increases the chance that people will not protect themselves during sexual activity. Substance users are more likely to have multiple sexual partners. People with drug addictions might be in the position to have to trade sex for drugs and may find it difficult to set limits on what

they are willing to do. It is likely that some clients in RSAT programs ***(male and female)*** may have been involved in sex work.

Impairment from substance use also makes people more vulnerable to sexual assault, less able to fight off or escape an assailant and less likely to report a rape. Substances are strategically used by sexual predators to assist them in carrying out an assault on a male, female or child victim. People who use substances are targeted by sexual predators (Dawgert, 2009).

Women in advanced stages of addictive illness may not have access to gynecological care and may have another untreated sexually transmitted infection, which ***greatly increases the chances of HIV infection***.

The charts below show transmission modes for men and women **newly** infected with HIV. This chart highlights the role of sexual transmission in new cases of HIV infection. It differs greatly from the distribution of modes of HIV transmission that were reported just a decade ago and will probably continue to change.



Source: CDC, HIV Surveillance - Epidemiology of HIV Infection (through 2008) Data from 37 states and 5 U.S. dependent areas with confidential name-based HIV reporting since at least January 2006.

Exercise 3: Pie Chart

For the following questions refer to the pie charts above that show mode of HIV transmission for newly infected cases among the US population:

a) Who is more likely to be infected via IV drug use?
b) Who is at greatest risk for infection from heterosexual contact?
c) Who is at greatest risk for infection from any sexual contact?
d) If these charts were only for people in prisons and jails, name one thing that might be different?

Answers: Women, Women, Men, Increase in percentage of IV drug use transmission

What Research Tells Us

"In fact, addicted people don't have as strong a pleasure response as people who are not addicted. Recent data are showing us that addiction entails a basic disruption of motivational circuits."

-Nora Volkow, MD, Director, National Institutes on Drug Abuse

It was once thought that people who become addicted to drugs and alcohol were deriving some kind of benefit related to the pleasure centers of the brain. Now it is believed that the reward and punishment or motivation centers are involved, along with areas of the brain that govern primitive survival responses and emotions. Drug abuse also affects the thinking centers of the brain and impacts cognitive activities such as decision making and inhibition, planning, and memory (NIDA, 2010a).

Research on the long term effects of drug abuse suggests the impact is likely to continue after drug use stops and there may be residual physical and psychological effects. Research also indicates that there is no one cause for alcohol, illicit drug, and prescription drug abuse and dependency. Genetic predisposition may be more of a factor in one individual than another. The role of brain chemistry, co-occurring mental health problems, trauma and other psychological influences can vary. Environmental and social factors differ. The bio-psycho-social model of addiction emphasizes the interaction of all three factors, accounting for differences in each individual. Hence, recovery is an individualized process. There is no one treatment that fits all. Gender, culture, recovery environments, marginalization, health disparities and community and family support are all factors that influence ongoing recovery for RSAT clients.

One thing that the research consistently tells us is that long term treatment in prisons and jails is effective, but only minimally effective if RSAT clients leave prison without connections to community recovery services. **Risk of recidivism is highest in the initial weeks and months following release from prison** (Council of State Governments, 2012). Studies have shown that offenders participating in long term prison based treatment and ongoing aftercare upon release were up to 36% less likely to return to prison than those in prison-based treatment alone (Burdon et al., 2007).

Abstinence Violation upon Release and Unwanted Sex

Research also tells us the majority of people in prisons and jails that are infected with HIV enter the correctional system with the virus; a much smaller number contract HIV in correctional facilities (CDC, 2006). Two factors that specifically affect the interaction between sex, drugs and HIV transmission among offenders are the role of unwanted sex and abstinence violation upon release. We will discuss sexual behavior inside correctional facilities in Module IV.

Studies on post release drug use and sexual behavior among men released from jails and prisons have shown that some offenders released from prison may adopt a "make up for lost time" attitude and engage in unprotected sex and drug use within hours of

release from prison. Studies on males who engage in unprotected sex upon release from prison indicate substance use is a predictor of high risk sexual behavior (Khan et al., 2011). This is especially true of offenders with substance abuse histories that have not participated in drug and alcohol treatment programs and have merely abstained from substances during incarceration and of offenders without primary intimate relationships. HIV prevention programs for offenders should target post-release behaviors (Okie, 2007).

In a study of post-release deaths of re-entering prisoners in Washington State, the first 2 weeks after release, the risk of death among former inmates was more than 12 times the risk for other state residents, with a markedly elevated relative risk of death from drug overdose. The leading causes of death among former inmates were drug overdose, cardiovascular disease, homicide, and suicide (Binswinger et al., 2007). These studies have been conducted in several countries with similar findings. Connections to immediate re-entry support for ongoing recovery from addiction is a crucial need for RSAT clients to prevent a return to often fatal drug use patterns and unsafe sex.

Specific Substances and HIV

Drug users represent a major vector of HIV transmission, yet relatively little is known about their continued drug- and sex-related HIV-risk behavior. Researchers are beginning to study various types of drug use. Some substances and certain methods of drug delivery place users at higher risk for HIV infection.

Exercise 4: Risk Factor

Using the substances numbered below; place the number next to the description that matches the HIV risk factors associated with it.

1. *Any injected drug use*
2. *Crack, cocaine use especially smoked and IV use*
3. *Opiate use, especially IV use*
4. *Methamphetamine use, IV smoked and nasal use*
5. *Alcohol*

A._____

Tolerance may develop quickly; users will frequently increase their doses to intensify and prolong the euphoric effects. Habitual use associated with exchanging sex for money or drugs, having multiple sex partners, inconsistent condom use and a continuation of high risk sexual contact even after learning of HIV+ status (Campsmith, Nakashima and Jones, 2000).

B._____

Associated with impaired judgment, intimate partner violence unprotected sex and unintended pregnancy, especially among youth; has also been shown to reduce condom use and safer sex practices, even among sex workers (Bryant, 2006). Adversely effects treatment adherence and disease progression among those living with HIV/AIDS.

C._____

Used to enhance sexual endurance which, can contribute to friction, dryness, irritation and tearing of the skin which increases the likelihood of transmission. (Drumright et al., 2006). Strongly associated with unprotected sex and HIV infection, especially among men who have sex with men; sometimes combined with erectile dysfunction drugs and club drugs.

D. _____

High risk of blood borne transmission of HIV. Users and their partners may also become infected through sexual transmission, even if they do not share equipment; increases risk of Hepatitis B and C infection. Consistently responsible for about a third of HIV infections over the years; some harm reduction measures can reduce the risk of HIV transmission.

E. _____

Risk of overdose for HIV+ clients on anti-retroviral drugs; high risk of blood borne infection depending on drug delivery method; increased risk of sexual transmission; extremely high risk of overdose fatalities for re-entering offenders, especially during the first 48 hours post release. Replacement therapy can be effective and is recommended for pregnant women.

Hepatitis, HIV and IV Drug Use

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) cause serious illness among millions of people. They also are closely connected with HIV, injection drug use, and high-risk sexual behaviors. They are more easily transmitted than HIV because the numbers of viruses in blood are much higher for both forms of Hepatitis (CDC, 2004). The rates of HCV among people entering correctional facilities is an epidemic at about 10 times the rate among the general public and 33% higher for women offenders. Inmates should be tested, assessed for liver damage and treated as appropriate. HIV testing should be offered and encouraged to any inmate diagnosed with any communicable disease or STI (Dwyer, Fish, Gallucci and Walker, 2011).

Co-infection refers to HIV+ individuals who also have another infectious disease. Hepatitis co-infection is fairly common among HIV+ injection drug users. Liver disease due to HCV infection is a leading cause of non-AIDS-related morbidity and mortality in HIV-infected patients (CDC, 2010a); therefore testing and treatment are important needs among RSAT clients.

Harm Reduction and Correctional Environments

One issue in addiction treatment that has been controversial is harm reduction. However, harm reduction is utilized in nearly every public health and primary care setting. Since there is no cure for HIV/AIDS, harm reduction strategies are well

integrated into many approaches. For example, needle exchange programs are a harm reduction approach to reducing HIV infection. Everyone agrees that it would be better not to use IV drugs, or better yet not to use drugs at all. However, if an IV drug user has a relapse or isn't able to stop using drugs altogether, using a clean syringe reduces the potential harm, by reducing the risk of HIV infection.

Providing information on disinfecting a used syringe with bleach before using it to inject drugs is also a harm reduction strategy. Bleach can kill the HIV virus. Some studies suggest the approach is minimally effective because once users are under the influence they abandon efforts to disinfect their equipment or do not do it properly (CDC, 2004). However, in a prison environment where makeshift equipment is at a premium and likely to be shared, disinfecting equipment with bleach could be a lifesaving measure. In the United Kingdom and other European countries, bleach pills have been distributed in some prisons with promising results (UNAIDS, 2004).

Other harm reduction methods include making condoms available to prisoners and the use of opiate substitution therapy (methadone, suboxone, vivitrol). Harm reduction techniques have been used in a few U.S. jails and prisons with some degree of success, but they are not widely used in U.S. correctional facilities (May and Williams, 2002). National Commission on Correctional Health Care recommends that correctional administrators implement harm reduction strategies. However, it is important to note that correctional facilities are often opposed to implementing strategies that may be perceived as condoning prohibited behaviors.

The National Institute on Drug Abuse (NIDA) has released the *NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users.* The manual has an Appendix with 24 cue cards with basic, understandable information that can be used to assist RSAT staff with pre and posttest counseling and client education (2001). Correct instructions on disinfecting drug delivery equipment are available in the cue card section at the end of the manual, which can be ordered at no charge or downloaded from:
http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf

Crack cocaine users have been one of the highest risk categories of drug users and have not responded well to past risk reduction efforts. Newer research on crack use and high-risk sexual behavior has included one-on-one interviews and focus groups with the target population. It has yielded the following key principles that can be applied to RSAT programs (NIDA, 2004)

- Offer counseling sessions on an individual basis- Subjects made it very clear that HIV risk behaviors involve many private, personal issues and things they'd never before discussed. They found it easier to discuss these experiences with one person, rather than a group.

- Adopt a holistic approach for re-entering clients. Interventions that help with safety, food, shelter, clothing and assistance in preparing for job interviews are more likely to be successful at reducing high-risk sexual contact.

- Address the person's multiple social roles in the intervention. Research subjects didn't want to be labeled simply as drug users. Instead, they wanted the social context of their daily lives to be addressed, including their family roles.

Co-occurring Disorders and Mental Health Support

The first National HIV/AIDS Strategy was released by the White House in 2010. It estimates that up to 50% of people living with HIV have a mental illness. Some data suggest these estimates may be low. As many as one in three persons with HIV suffer from depression. Mood disorders are 7-10 times more common and anxiety disorders are 5-10 times more common than among the general population (Bing, Burnman, Longshore, et al, 2001). If left untreated, depression in HIV+ inmates can increase the risk for suicide.

Correctional administrators need to ensure that sufficient mental health services are available to inmates with HIV, especially for those learning of their HIV+ status for the first time. RSAT staff can collaborate with mental health services regarding clients, keeping in mind that mental health assessment may be an ongoing need as health status changes or AIDS related conditions progress. The mental health assessment process for clients with HIV/AIDS can be complex. Psychiatric symptoms may be caused by HIV/AIDS, or by medications, or preexisting psychiatric disorders. Cognitive impairment can be present and may be attributable to a number of different causes. It is important for RSAT staff to make sure HIV+ clients displaying symptoms of cognitive impairment aren't perceived as deceitful, defiant or manipulative by security staff or others (CSAT, 2000).

Mental health services improve prevention efforts. RSAT clients with co-occurring disorders can benefit from education on HIV prevention, risk reduction and skill rehearsal. Many high-risk conditions and behaviors that contribute to the spread of HIV are associated with untreated mental health disorders, depression, sexual abuse and trauma histories and marginalization. Mental health staff should be involved in planning HIV prevention programs.

Mental health treatment improves health outcomes. If an RSAT client is HIV+, receiving mental health treatment generally improves his or her chances of treatment adherence. For this reason it is important to provide integrated mental health and substance abuse services to HIV+ clients before they begin ART treatment, whenever possible. Several studies show that receiving psychiatric treatment can lead to slower disease progression, better treatment adherence and lower mortality among HIV positive patients (Belanoff et al., 2005; Himelhoch, Moore, Treisman, & Gebo, 2004).

A. Crack, cocaine use especially smoked and IV use
B. Alcohol

C. *Methamphetamine use, IV smoked and nasal use*
D. *Any injected drug use*
E. *Opiate use, especially IV use*

B. Best Practices

According to the Center for Substance Abuse Treatment's publication*, Substance Abuse Treatment for Persons with HIV/AIDS, Treatment Improvement Protocol 37*

Treating substance abuse disorders without addressing risk behaviors leaves patients at a high risk for HIV infection (2000).

Best practices specific to HIV/AIDS in substance treatment include pre-test counseling and information on the advantages of testing, rapid testing and referral to treatment, HIV prevention education, risk assessment, risk reduction counseling, and information on preventing the spread of HIV if one is HIV positive. Motivating behavioral change, cultural responsiveness and skill rehearsal are key components of group or individual sessions. RSAT programs that incorporate HIV prevention groups should select an evidence-based curriculum suited to the population they serve. We will discuss resources and options later in this module. RSAT programs do not need to rely on existing staff to deliver these programs. Many correctional facilities make use of community providers, health departments, universities or cooperative extensions or local AIDS Service Organizations.

Individual risk reduction counseling is sometimes the most effective approach for high-risk clients. Many behaviors that place people at high risk for HIV are highly stigmatized and cannot be disclosed in a group setting, especially in a correctional environment.

Before discussing the substance treatment needs of people living with HIV+ it is helpful to review the clinical practices for RSAT programs that are based on the best available evidence. Treating HIV+ clients is a collaborative endeavor. RSAT programs will need to established collaborative linkages with a variety of services and systems both inside their facilities and outside. When collaborating with other systems, it is helpful to make use of evidence-based practices and ensure that all team members have access to the research and information that support decisions.

Basic Addiction Treatment Practices

- Cognitive Behavioral Approaches to Addiction Treatment
- Medication Assisted Addiction Treatment and Recovery
- Peer Recovery Support
- Motivational Therapies and Contingency Management (incentives)
- **Evidence-based HIV education and prevention programing**

Practices for People with COD's

- Psychiatric Medication Management
- Integrated Trauma Focused CBT
- Illness and Recovery Management

Practices for at Risk-Groups

- Gender Responsive Programs for Women
- Programs Designed for African Americans, Latinos and other Diverse at-risk Groups
- Intensive Case Management and Assertive Outreach and Follow up

Workforce Development

- Staff demonstrated competencies with African American, Latino, LGBTQ populations; women, youth, Indigenous Americans, immigrants and others
- Multi-disciplinary training; cross training linkages and collaboration

HIV/AIDS Prevention Best Practice Models- *Meet DEBI*

DEBI is the Centers for Disease Control and Prevention (CDC) equivalent of what substance treatment professionals know as an evidence-based practices. It stands for Diffusion of Effective Behavioral Interventions (DEBI). In the early days of HIV/AIDS, efforts to contain the spread of the virus were based on limited research. Since there was no cure in sight, many harm and risk reduction programs based their interventions on whatever they thought might work, moving quickly to respond to the fatal epidemic. Ten years into the epidemic, people began to consider the importance of evaluating these efforts. By 2003 the CDC began the *Diffusion of Effective Behavioral Interventions*. Evaluated approaches were catalogued and training and technical assistance to implement them became available. Some types of funding require the use of an effective behavioral intervention as part of service delivery.

Safe on the Outs

Target Population: Adolescents in juvenile detention facilities

Goals of Intervention

- Reduce risky sex behavior
- Reduce sex while drinking

Brief Description

Safe on the Outs is a group-level intervention delivered in a single session to typically 3-5 adolescents of the same sex. It combines a group psychosocial intervention (GPI) for sexual risk reduction with group motivational enhancement therapy (GMET). The GPI portion uses group activities, videos, condom demonstrations, a videogame, general HIV transmission information, and local information and health services resources to increase HIV knowledge, and develop self-efficacy, normative perceptions, and positive attitudes toward condoms. A movie depicting ethnically representative young people emphasizes and explicitly models being prepared for safer sex and the importance of good communication skills with current and potential sex partners. In a videogame participants make a series of choices related to sexual activity to consider how negative consequences of unprotected sex would impact life goals. Participants then pick a safer sex goal they want to accomplish in the next 3 months to increase positive intentions. The GMET portion focuses on alcohol use, including feedback on drinking behaviors, and uses the FRAMES (Feedback, Responsibility, Advice, Menu, Empathy, and Self-Efficacy) to organize its structure. It uses motivational interviewing (MI) and empathetic, open, and non-confrontational motivational-enhancement-therapy style group discussion….

Source: CDC Compendium of Evidence-based HIV Prevention Interventions

Today the CDC supports the replication of effective behavioral interventions. A *Compendium* of risk reduction programs for various populations is available at the CDC website (see example above). The interventions are now divided into risk reduction topics and treatment adherence topics, and listed as group interventions, individual or community level interventions. Interventions are also grouped according to target population characteristics. Some are geared to drug users, correctional populations, pregnant women, Native Americans, etc. Some of the interventions are a single session and others are more comprehensive. Three examples of effective behavioral interventions appear in the text boxes in this section.

The compendium of effective behavioral interventions is available at:
http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm

The CDC funds 11 regional training centers that offer a variety of courses, including on line courses, an HIV core curriculum and courses geared specifically toward substance use and HIV. Training in implementation of effective interventions is also available.
Regional training centers: http://depts.washington.edu/nnptc/regional_centers/index.html

Interventions for Women Offenders

Women in the criminal justice system are an extremely high risk population, at least three times more likely to be infected with HIV than male inmates (De Groot and Uvin. 2005). All pregnant women and women of childbearing age should receive counseling, testing and prevention education. This is a critical need, since certain anti-retroviral treatments during pregnancy can almost eliminate the possibility of transmitting the infection to the infant during labor and deliver"

Safer Sex Skills Building

Target Population

Heterosexually active women in drug treatment

Goals of Intervention

- Increase condom use
- Decrease unsafe sexual behaviors
- Increase safer sex negotiation skills
- Increase HIV/STD risk awareness

Brief Description

Safer Sex Skills Building (SSSB) is a group intervention consisting of 5 sessions, approximately 90 minutes each, designed to increase HIV/STD risk awareness, condom use, and partner negotiation skills of women attending community outpatient drug treatment programs. Two female counselors deliver the intervention to groups of 3-8 women over 3 weeks, using active problem solving, behavioral modeling, role-play rehearsal, interval practice, troubleshooting, and peer feedback and support. Topics include HIV transmission, testing and counseling, prevention and treatment; personal risk assessment and awareness, triggers, and support; skills for condom use, safer sex negotiation, and safety planning; partner abuse risk assessment; and "slip" behaviors. Special emphasis is placed on women's safer sex negotiation skills and safeguards against the risk of partner abuse that may result from safer sex assertiveness.

Source: CDC Compendium of Evidence-based HIV Prevention Interventions

Women are increasingly becoming a majority of individuals newly infected with HIV. **Young women** 13 to 29 represent 50% of new infections. Young women of color are particularly at high risk (CDC, 2010a).

African American women now make up 66% of new HIV infections in women; making AIDS the **leading cause of death among Black women 25-34** (Kaiser, 2011). That is 1 in 30 may be diagnosed at some point in her lifetime. Sexual transmission is the mode of infection for 83% of African American women; studies suggest they are most likely to be infected by a regular sex partner or spouse (CDC, 2011).

Women who use IV drugs are also at risk - 30% of white women and 17% Latina and African American women are infected as a result of IV drug use (Kaiser, 2011), but many more women are infected as a result of sexual transmission from an HIV+ partner that uses IV drugs.

Interventions for Women

Rates of past victimization among incarcerated females are estimated at 92%; co-occurring mental health and substance use problems are more the rule than the exception (Women's Prison Association, 2006). Women in prisons and jails are at

higher risk for HIV infection, current sexual and violent victimization and are likely to have a history of past abuse (Council of State Governments, 2005). Women who report early and chronic sexual abuse have a 7-fold increase in HIV-related risk behaviors and markers compared to women without abuse histories (Wyatt, et al., 2002). Risks of substance use disorders and criminal justice involvement are also higher in women with a history of traumatic experiences.

Project START
Target Population:
Young men soon to be released from prison
Goals of Intervention:

- Eliminate or reduce risk behaviors for HIV, STD and hepatitis after release.

Brief Description:
Project START is a 6-session individual-level HIV, STD, and hepatitis risk reduction intervention for men soon to be released from prison. It incorporates features of prevention case management, motivational interviewing, and incremental risk reduction. This intervention consists of 2 individual sessions conducted within 60 days before release and 4 individual sessions at 1, 3, 6, and 12 weeks after release. In the first in-prison session, the interventionist assesses the participant's knowledge of HIV/AIDS, STD, and hepatitis, conducts a brief HIV-risk assessment, and helps the participant develop a personal risk-reduction plan. The interventionist also provides information, skills training, and referrals and helps to identify incremental steps towards risk reduction. The second in-prison session focuses on community reentry needs and referrals for housing, employment, finances, substance abuse, mental treatment, legal issues, and avoiding reincarceration. The post-release sessions involve a review of the previous sessions and discussion of the facilitators and barriers to implementing the risk reduction plan. Additional sessions are available for participants in the enhanced session as needed during the intervention period.

Source: CDC Compendium of Evidence-Based HIV Prevention Interventions

Simply educating women about the risk of HIV infection can only be effective if they have the power to make a choice regarding safe sex. Many women live in high risk sexual conditions; "survival sex" is sometimes a more accurate description than "engaging in high risk sexual behavior." Studies suggest that a victim of a violent intimate partner seldom, if ever, is in a position to negotiate condom use and may perceive partner violence as a greater threat than HIV infection (El-Bassel, 2010; Raiford, DiClemente, & Wingood, 2009). High–risk "survival sex" is also common among both male and female homeless juveniles (Aetna, 2011). **Research with women and youth shows safety as a bigger predictor of changes in high risk behaviors than education** (NIDA, 2011; Raiford, DiClemente, & Wingood, 2009).

Interventions are now being developed to meet the changing demographic of HIV infection and people living with AIDS. The epidemic of new infections that first struck largely white, openly gay males, IV drug users, hemophiliacs and Haitians, is now hitting the African American community, young women and justice-involved populations. Men who have sex with men and IV drug users are still high risk for HIV infection, but access and adherence to treatment is beginning to determine who lives and who dies. Prevention and treatment must be culturally responsive to be effective for people with little access to healthcare, who experience disparities and discrimination, and who live with violence, addiction and periods of incarceration. We will learn more about cultural issues and treatment needs.

C. The Importance of HIV Testing

Recommendations and guidelines for correctional healthcare include routine HIV testing as part of routine medical care. HIV testing should be offered on a voluntary basis, as with any other screening or diagnostic test. Inmates have a right to refuse medical treatment, including HIV testing. HIV testing should not be performed without the patient's **informed** consent. Clients with a clinical indication of HIV disease and anyone who has engaged in high-risk behaviors should be encouraged to test for HIV RSAT counselors can help to motivate clients, discuss the benefits of learning their HIV status and help clients overcome their fears if they are reluctant to go through with testing (CDC, 2006).

Who Should Be Tested?

Outside of correctional facilities, it is recommended that testing for HIV infection be performed for as part of routine healthcare unless the population is documented as low risk. Testing should include:

- *All patients aged 13-64 years.*
- *All patients initiating treatment for tuberculosis (TB).*
- *All patients seeking treatment for any sexually transmitted infections (STI's*),
- *All pregnant women.*

In correctional settings and in substance use treatment settings, where the population is considered at a higher that average risk for HIV exposure, **testing should be included as part of routine intake health screenings for all individuals.**

Repeat Testing - Guidelines suggest correctional health care providers offer repeat testing to:

- High risk individuals –*annual* testing is recommended for injection drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, men having sex with men (MSM) or heterosexual persons with multiple partners or sexual contact with someone who has had multiple partners.
- Pregnant women who are at high-risk for infection may be retested in their third trimester.
- Any person receiving positive test results from an HIV rapid test.
- Any person whose blood or potentially infectious body fluid is the source of an occupational exposure to a health care provider.
- Any persons known or suspected to have engaged in drug use or sexual activity while incarcerated.
- Any victim or suspected victim of a sexual assault (and any identified assailants)

HIV testing detects the presence antibodies. Generally it takes about three months or more to produce a sufficient amount of HIV antibodies to be detected. This incubation period is known as the "window." This is one of the reasons tests should be repeated for high-risk individuals, or if a very recent exposure is suspected.

Correctional healthcare guidelines state that all pregnant women or women who might be pregnant should be tested for HIV. It is recommended correctional administrators and addiction treatment providers make HIV education for all women a priority and encourage them to be tested if they may be pregnant to decrease the incidence of mother to child transmission. (See CDC Fact Sheet on Preventing Mother to Child Transmission on resource page at the end of this module).

Consent and Pretest Information

The National Association of Correctional Healthcare now recommends consent for HIV screening be incorporated into the patient's general informed consent for medical care on the same basis as other routine screening or diagnostic tests. A separate consent form for HIV testing is no longer recommended. An opt out form should be available to document any refusals of HIV testing as part of routine health care.

What Patients Should Be Told: Qualified healthcare professionals are generally available in correctional healthcare settings to explain the points below to patients. In community substance use treatment settings, rapid tests are sometimes administered on-site and staff is trained to administer the test and go over pre-test information. It is unlikely that RSAT counselors will need to convey this information to inmates prior to testing, but it is very likely clients may feel comfortable with RSAT staff members and may bring questions to them about the process.

What RSAT Counselor's should know about all tests:

- Knowing you have HIV infection can improve your prognosis with treatment.
- Knowing you have HIV infection can help you take precautions to prevent passing HIV to others.
- Refusing an HIV test will not affect the care you receive
- Test results are kept confidential. However, in certain states (including California), if a confirmatory test is positive, the law requires that the results be reported to the health department.
- A negative test means you do not have HIV infection; however, the test may not show recent infection within the past 3 months.
- A negative test in patients recently exposed to HIV should prompt repeat screening in 3-6 months.
- If the test is positive, there are medications that help people live long, health lives.

About rapid tests:

- Results from rapid HIV tests are available at the same visit, usually in less than 1 hour.

- Results are very accurate- as accurate as conventional tests. But, a confirmatory test is always done when there is a positive test result. It is important for patients to return and get the results of the confirmatory test, as well. If the confirmatory test is negative, then the clients do not have HIV infection unless they were recently exposed (i.e. within the past 3 months).

Types of HIV Diagnostic Test

Two types of tests are required when diagnosing HIV: *a screening test* and *a confirmatory test*.

Screening Tests: Conventional and Rapid

1. *Conventional Tests Screening Tests*
   ELISA antibody test: looks for antibodies to HIV in the patient's blood. A patient's serum is placed in contact with particles of HIV in the presence of an indicating substance. If there are any HIV antibodies in the serum, they will bind to the HIV particles and cause the serum to change color. If the ELISA test is positive, **the laboratory automatically will perform a second confirmatory test.**

2. *Rapid Tests Screening Tests*
   Rapid tests are similar to the standard ELISA test in that they look for antibodies to HIV in the patient's blood. They are called "rapid" because the results are available within an hour or less. **If a rapid test is positive, it MUST be followed up with a confirmatory test.**

Confirmatory Tests

1. *Western blot (WB):* This is the most widely used confirmatory test. It uses an electrophoretic technique that separates out specific HIV particles, or antigens. On rare occasion, the WB will yield an indeterminate if the exposure was very recent (i.e. within the last 3 months).

2. *Immunofluorescence antibody (IFA*): Infected HIV cells are fixed to a microscope slide. Serum with HIV antibodies is added and allowed to react with the HIV. A fluorescent label will light up the slide if positive for HIV.

Conventional Versus Rapid Testing

Conventional HIV tests utilize the ELISA and then follow it with the WB or IFA to confirm the diagnosis of HIV infection. These tests can take up to a week to complete; results are not immediate. Studies of HIV infected individuals being treated in the community have shown that from 12%-31% of patients who have conventional HIV tests do not

return the following week to receive the results. Preliminary studies in settings that employ rapid testing have shown that clients who receive a positive rapid test result right away are liable to return for their confirmatory test results. Rapid testing is well suited to jail settings since patients can receive their results right away (CDC, 2010b).

How Should Rapid HIV Test Results Be Interpreted?

Any positive rapid test MUST be followed with a confirmatory test. A positive HIV rapid test ***usually*** means the patient most likely is HIV positive. Part of the likelihood that a patient testing positive on a rapid test is truly infected with HIV is calculated based on how common HIV is in the community. In a population with a high HIV prevalence, a positive rapid test result is likely to be a true positive, but in a population with a low HIV prevalence, a false positive is possible.

A *patient who receives a negative rapid HIV test result is almost assuredly not infected, barring recent exposures* (risky sexual contact or needle-sharing with an infected person within 3 months prior to the test date). A patient with a history of recent HIV risk behaviors or possible exposures should have a repeat test within three to six months.

Legal Issues

Laws regarding HIV testing vary from state to state. Some are specific to state prison and county inmates living in those states. Federal prisons are also governed by laws regarding high risk inmates and mandatory testing. State laws may differ in the type of consent they require (verbal versus written), their implementation of opt-out testing, pre-test and post-test counseling requirements and reporting requirements. Each RSAT program should become familiar with facility and state guidelines and align practices accordingly. The National HIV/AIDS Clinicians' Consultation Center, listed in the resource pages in Module One provides information on state laws and a hotline for clinicians with questions.

Post-test Counseling

Fortunately healthcare professionals are trained to provide information to individuals before and after HIV testing. In a correctional environment pre and posttest counseling may be limited and inmates may not get all the information they need. With the battery of tests involved in prison or even jail intake, questions may not come up until offenders settle in or find someone they feel they can trust. Individuals in substance treatment who find out they are HIV+ will need support from counselors and confidential information. A Series of 12 Fact Sheets for Clients and Family Members is available for downloading and printing. These are listed on the resources pages at the end of the module.

Risk reduction information specifically pertaining to drug use can be presented in a hierarchy that emphasizes changing the highest risk behaviors first and prioritizes safety measures that have the greatest effect. For example the number one risk reduction

measure for drug users is not using drugs; the lower points include not injecting drugs, and then not sharing needles (NIDA, 2001). The general components that pre and posttest education and risk reduction counseling include:

- Repeating drug and sex-related risk reduction messages at each contact
- Offering testing, information on reducing the risk of infection and preventing transmission to others.
- Enabling HIV+ persons to inform their drug and sex partners about the risk of infection and the importance of testing.

Post Test Counseling for an HIV+ Client

If an offender receives notification that they are HIV positive it is important to provide support, information and preserve medical confidentiality. Remember a confirmatory test is required before a preliminary HIV positive result is considered definitive; however, false positives are not common. An RSAT client finding out for the first time that they are HIV positive may need:

- Short term mental health support and mental health evaluation
- To be assessed and monitored for suicide risk
- Information on exactly how to interpret a positive test result
- Follow-up medical care
- Counseling on partner/contact notification

In these cases RSAT staff should be working with other staff including primary care and mental health, although RSAT clients may turn to their alcohol and drug counselors for motivation, support and information.

D. Resources and Review

Substance Abuse Treatment for Persons with HIV/AIDS, Treatment Improvement Protocol 37 http://www.ncbi.nlm.nih.gov/books/NBK64923/

Treatment Improvement Protocol (TIP), Addressing Viral Hepatitis in People with Substance Use Disorders. http://www.aids.gov/hepatitis/

SAMSHA Behavioral Health and HIV/AIDS Information http://www.samhsa.gov/hiv/

National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov/

NIDA Community-Based Outreach Model: A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users. (Appendix with 24 cue cards)
http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf

NIDA Principles of Effective HIV Prevention for People Who Use Drugs
http://archives.drugabuse.gov/POHP/principles.html

CDC Fact Sheet on Preventing Mother to Child Transmission;
http://www.cdc.gov/hiv/topics/perinatal/resources/factsheets/pdf/perinatal.pdf

The *Compendium* of effective behavioral interventions is available at:
http://www.cdc.gov/hiv/topics/research/prs/compendium-evidence-based-interventions.htm

Listing of CDC funded Regional training centers:
http://depts.washington.edu/nnptc/regional_centers/index.html

Central East Addiction Technology Transfer Center (CEATTC): Includes the Center for HIV, Hepatitis and Addiction Training and Technology (CHHATT)
http://www.attcnetwork.org/regcenters/c1.asp?rcid=2&content=CUSTOM1

Series of 12 Fact Sheets with Harm Reductions Information for Clients

Patient Information flyers developed by the Midwest AETC, available at:

- Harm reduction information for crack/cocaine users: http://aidsetc.org/pdf/p02-et/et-05-00/stimulant.pdf
- Harm reduction information for injection drug users: http://aidsetc.org/pdf/p02-et/et-05-00/injection.pdf
- Safe Injection information: http://aidsetc.org/pdf/p02-et/et-05-00/safer_inject.pdf
- Overdosing prevention information for opiate users: http://aidsetc.org/pdf/p02-et/et-05-00/overdose.pdf

Review

- Best practices in substance treatment include HIV testing, risk reduction and prevention education, referral and care coordination, for those infected with HIV or living with AIDS. RSAT staff may need to answer questions prior to testing or when clients receive results, and should be familiar with the processes and policies.

- The relationship between various substances, blood borne HIV infection, injection drug use and sexual transmission is complex. Risk reduction intervention and educational groups can be offered to RSAT clients through community providers or by staff members trained in an HIV/AIDS effective behavioral intervention. Use of certain substances carries additional risks.

- Most people with HIV have mental health needs; if an RSAT client first learns of these HIV+ status while in treatment, mental health support and ongoing assessment should be available. Risk of suicide may increase. All people with HIV infection need to be treated for mental health and substance use disorders prior to beginning anti-retroviral treatment.

- The demographics of newly infected people with HIV have changed considerably. African Americans and young women are increasingly affected. Prevention and treatment is effective when approaches are culturally responsive and consider safety, exposure to violence, discrimination, access to care and other issues unique to the background of each individual.

- Testing for pregnant women and women of childbearing age is critical; HIV risk reduction education, domestic violence services and mental health services should be available. Women who are pregnant will begin a course of anti-retroviral medication while they are pregnant to prevent mother-to-child transmission.

- Confidentiality is essential and individual counseling is often warranted for clients at high risk for HIV infection and for those who are HIV+. Harm reduction measures can be lifesaving. Information and fact sheets from reliable source are available. Long term evidence-based treatment for substance use and co-occurring mental health needs is beneficial for at-risk individuals and for people living with HIV/AIDS.

Module III: Meeting the Needs of HIV+ RSAT Clients and Clients Living with AIDS

A. HIV+ Individuals Entering Correctional Facilities
B. People Diagnosed with HIV/AIDS While in Custody
C. Re-entry and Continuity of Care
D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Explain the role of RSAT staff in supporting clients living with HIV/AIDS as they enter correctional facilities and substance use disorder treatment.
- List the types of supports RSAT staff can provide to clients learning of their HIV+ status while in custody and clients receiving medical treatment.
- Describe key elements and resources for re-entry planning and transitional care for RSAT clients living with HIV/AIDS.

Knowledge Assessment Test

True False Questions

1. HAART is the federally funded program that provides healthcare coverage to people living with HIV/AIDS. False

2. Re-entering offenders are not eligible for housing resources for people living with AIDS and Ryan White Care Act funded services.
False

3. HIV+ RSAT clients with mental health and substance use disorders should be treated for co-occurring behavioral health disorders prior to initiating anti-retroviral therapy. True

4. Prisons provide anti-retroviral medications to inmates living with AIDS.
True

5. The success rate of anti-retroviral therapy for people with HIV/AIDS receiving treatment while in prison is significantly lower than the rate of success for people receiving anti-retroviral therapy in the community.
False

6. Successful medication treatments can reduce the amount of HIV virus in the blood to point where it is undetectable. True

A. HIV+ Individuals Entering Correctional Facilities

Challenges of Diverse Care Needs

As we learned in Module II, most incarcerated people who have HIV are infected before they enter correctional institutions (CDC, 2006), but many of them may be unaware of it. Others may enter prisons or jail knowing their HIV status; some of them may be undergoing treatment for HIV/AIDS in the community prior to intake. Continuity of care for persons undergoing treatment for HIV/AIDS is of critical importance upon entry into facilities; transfers between facilities and upon re-entry into the community. Complex medical issues, behavioral health disorders and access to re-entry resources all present compounded challenges for an HIV+ inmate and for those responsible for their care.

The purpose of this module is to acquaint RSAT staff with the issues that offenders living with HIV/AIDS face. RSAT staff is the offender's primary source for addiction recovery treatment and support. Medical care, case management, mental health treatment and other supports are needed. Ideally, RSAT staff and substance treatment professionals are part of a team approach to care coordination and release planning; they cannot and should not function outside the scope of their knowledge, training and expertise.

However, RSAT staff will be better equipped to support HIV+ offenders in substance treatment when they understand the emotional and physical toll of coping with HIV/AIDS in early recovery. It is helpful for staff to understand client care needs at each stage of the progression of the disease, treatment options and the issues that emerge at various phases of the correctional system.

HIV+ inmates in RSAT programs have many of the same treatment needs as other RSAT clients. They need support to change their behavior. Behavioral change is possible, but there is nearly always ambivalence. Whether an offender is grappling with the decision to get tested, a commitment to safer sexual behavior, abstinence from substances or adherence to complex medication regimes, motivational counseling approaches that help clients resolve their ambivalence are useful. Empathy, authenticity and peer support has also been very useful with HIV+ inmates. Peer HIV educators have been evaluated systematically and demonstrated a high degree of influence of over behavior (Spector, 2007). Change is possible.

When HIV+ Inmates Enter Custody

If an offender enters a correctional facility and is aware they are HIV+ they may fall into one or more of several categories, each with different care needs.

a) Clients may not disclose their HIV status, even to medical staff.

Fear of ostracism, distrust of medical providers in general and correctional medical care, in particular, hopelessness, and concerns that they may be labeled or outed as gay can motivate an inmate to conceal their HIV status, to refuse to be tested and to avoid accessing the health services they need. Inmates who are gay, bisexual or transgendered may have experienced violence, harassment or sexual assault, perhaps even during a previous jail or prison stay.

RSAT Staff Approaches: Offenders reluctant to disclose their status may benefit from individual counseling sessions that review risk reduction principles; a clear discussion of confidentiality limits; participation in HIV education groups; assurances and measures to protect confidentiality and collaborative sessions with medical staff. In addition to trust and rapport building, RSAT staff can assure clients that testing and medical treatment is voluntary (unless facility policy mandates it); they can offer hope. In late stage addiction it is common for clients to feel hopeless. Research also indicates that many HIV+ inmates do not seek treatment because they think they are going to die anyway (Okie, 2007). It is important to educate clients about treatment advances and improved prognoses for people with HIV.

b) Clients may know their status but have had limited access to care.

Research indicates that many HIV+ offenders come from communities that are underserved, are often without health coverage and are members of minority groups that experience deep disparities in access to quality care (NCCHC, 2002a). When these offenders also have untreated substance use and mental health disorders, limited access, denial, avoidance and neglect of heath needs and economic barriers to care are compounded.

RSAT Staff Approaches: These clients benefit from periodic medical evaluations and routine care for HIV+ individuals. This includes: *Immunological Monitoring,* which provides information about T-cell counts and viral levels. Blood tests measure CD4+ cell counts (information about immune system function) and plasma HIV RNA levels (the amount of HIV virus present). This helps medical staff determine when to recommend starting anti-retroviral treatment. Other services include: diagnostic tests for TB and other conditions, pap smears for women, testing for hepatitis and other co-infections; vaccinations/ immunization for Hepatitis A and B, influenza and viral pneumonia; and treatment for common conditions. RSAT staff can outline the advantages of getting medical care and encourage clients to work with medical staff.

c) Clients may not have advanced to the point of needing treatment.

Staff will encounter RSAT clients that know their HIV status and are aware of their T-cell count and viral level. They may have been living with HIV for an extended period and

may be healthy and asymptomatic. Routine immunological monitoring, ongoing medical evaluation and care are necessary while they are in custody, but if they remain asymptomatic during their term of incarceration, medication therapy may not be needed.

RSAT Staff Approaches: These clients benefit from HIV education and risk reduction counseling as part of their substance treatment plan. Staff can help these clients focus on recovery from alcohol and drug addiction, knowledge of harm reduction strategies, safer sexual behaviors, self-care, health and wellness, and ensure they are screened for co-occurring mental health disorders as needed. Re-entry planning and access to community care for both HIV health needs and substance use treatment and recovery support are essential. Documentation of HIV status, medical records and lab results are critical for HIV+ inmates transferring between facilities, beginning work release programs or leaving facilities.

d) Clients may be at the point that treatment is medically indicated.

The box below summarizes the most up to date Department of Health and Human Services guidelines for beginning anti-retro-viral treatment (as of 2012). Even though RSAT staff is not responsible for clinical care of HIV+ clients, it is helpful for them to understand the medical decisions that clients face and the factors that influence the decision to begin medications to slow the progression of HIV/AIDS.

Summary of DHHS Recommendation for Initiating Anti-retroviral Treatment (2012)

→Treatment Initiation-of ART is recommended for most individuals with a CD4 cell count of less than 350 to 500. Most HIV+ clients who are asymptomatic do not initiate ART unless they have a CDC4 cell count of less than 350, but other medical factors may influence the recommendation to begin treatment.

Regardless of CD4 count, initiation of ART is strongly recommended for individuals with the following conditions:

→Pregnancy (see guidelines for more detailed discussion)

→History of an AIDS-defining illness

→HIV-associated nephropathy

→HIV/hepatitis B virus co-infection pretreatment

RSAT Staff Approaches: Offenders nearing release may be better served by beginning treatment once they establish connections with care in the community. Adherence considerations are critical. Mental health, addictive illness, cognitive impairment, poverty, side effects and stigma may influence a client's ability to stick to demanding medication regimes. RSAT staff can work with medical care providers as

they prepare clients for treatment and offer encouragement and support. The BOP recommends care teams consider the preparations below:

- Establish readiness to start therapy.
- Provide education on medication dosing.
- Review potential side effects.
- Anticipate and treat side effects.
- Utilize educational aids, including pictures and calendars.
- Engage family and friends.
- Simplify regimens, dosing, and food requirements.
- Utilize a team approach among nurses, pharmacists, and peer counselors.
- Provide an accessible, trusted health care team.

e) Clients may be undergoing treatment in the community.

The most challenging issues for offenders undergoing treatment for HIV/AIDS when they enter a facility include documentation and continuity of care. HIV advocacy groups advise offenders to prepare for incarceration by obtaining documentation of their HIV+ status, medical records and copies of lab tests and by having their doctor write a letter outlining their current treatment regimen and prescribed drugs (Lambda Legal, 2010). Even with these preparations, facilities may not have the required drugs on hand and are not required to continue the exact same course of treatment. It is more common for offenders to enter without documentation of their HIV+ status and medical records. Delays and gaps in medication dosages often result.

RSAT Staff Approaches: In these cases RSAT staff can help clients obtain medical records and treatment history, as appropriate, and work with medical staff to re-establish or continue care. RSAT clients who are undergoing anti-retroviral treatment may require flexibility and support in order to both adhere to their medical care plan and continue in substance treatment. Preserving confidentiality may be extremely challenging for these clients. Clients in RSAT programs in some women's facilities have been known to disclose their HIV status to the group; however, there should be no pressure to do so. If the client initiates a conversation about such a decision, RSAT staff can help them think through all the ramifications in individual session prior to acting.

f) Clients may have advanced to full blown AIDS and may have numerous health issues and complex treatment needs.

These clients may be very ill and symptomatic and may require medical care that interferes with program participation. They may also need behavioral health treatments, mental health and addiction recovery supports. Some of the symptoms and conditions they may be dealing with include:

Co-Infections- Clients may have co-morbid hepatitis C, tuberculosis, or other infectious diseases along with HIV/AIDS. Once their immune system is compromised and they have progressed into full blown AIDS, they become susceptible to many other opportunistic infections such as pneumonia, cryptococcal meningitis, herpes, toxoplasmosis, candidiasis (thrush) and other fungal infections.

Complicating Conditions -Complications that may occur include anemia, Kaposi's sarcoma and other cancers, skin conditions, seizures, diarrhea, blindness, wasting syndrome and HIV-associated dementia (Bureau of Prisons, 2006).

RSAT Staff Approaches: Clients should not be excluded from programming solely on the basis of their health status. Each individual's wishes should be respected along with the medical recommendations of the clinical care team. If participation in RSAT program activities interferes with meeting medical care needs, places a burden or presents a risk to the client, then alternate arrangements for recovery support are in order. End stage AIDS patients often require analgesic medications for pain management. Substance treatment professionals can support the care team by providing information on minimizing the potential for abuse, encouraging clients to adherence to doctors' orders, and helping them work through typical reactions, like guilt, craving and temptation to abuse medication. Physicians can access best practice information on pain management for former narcotics users (see resources at the end of this module).

For more information on meeting the needs of substance abuse clients with HIV or AIDS, see: Substance Abuse Treatment for Persons with HIV/AIDS. Treatment Improvement Protocol Series, No. 37, listed on the resource pages in Module I.

B. People Diagnosed with HIV/AIDS While in Custody

For many offenders with substance use disorders, entry into a correctional facility may be their first contact with treatment, their first chance at medical care in a long time and the first time they have been offered HIV testing. As testing in jails, prisons and substance treatment settings become more availible many inmates with HIV will learn about their status in these settings.

RSAT programs present an opportunity for offenders to access long term substance treatment and to ensure co-occurring disorders are identified and addressed. But, research also shows that incarceration can be a prime opportunity to treat HIV and related conditions, as well as an opportunity for detection, prevention education and risk reduction counseling (CSAT, 2000).

What is HAART?

HAART stands for Highly Active Anti-retroviral Therapy. HAART is an aggressive approach to medication treatment, consisting of a combination of at least three drugs, two of which are at least two different drug classes, which attack the HIV virus in a number of different ways. In 1992, AZT was first prescribed to help block the replication of the HIV virus; by 1997 AZT was conclusively shown to reduce mother to child transmission of HIV and a new class of drugs called protease inhibitors was being prescribed in combination therapies. By 2000, the medical community was aware that HAART had the potential to significantly extend the lives of people with HIV/AIDS. New combined anti-retroviral drugs that simplify medication regimes were approved as recently as last year (AIDS info, 2012).

The quality of correctional healthcare for a person living with HIV varies widely among facilities and states. While many correctional systems with large numbers of HIV+ inmates have improved responses, better care may be available in the community. However, research shows that when HIV/AIDS is treated during incarceration, results can be positive.

- One study showed that 75% of HIV positive inmates undergoing treatment began receiving anti-retroviral therapy after they were incarcerated.
- A study of over 1000 inmates who received 6 months of HAART while in custody found that 59% of them had undetectable viral loads by the time they left prison (Hubbard, Jones and O'Leary, 2010).

HAART can be as effective for offenders in correctional facilities as it is for people receiving treatment in the community; however, transitions in and out of prisons and jails often result in interrupted treatment (Clements-Nolle et al., 2008). Treatment adherence is a critical component of HAART. Medication regimes are complex; drugs must be replaced as patients experience side effects and develop drug resistance. Skipping doses, interrupting treatment and other adherence problems allow the virus to replicate, mutate and render medications ineffective. This can lead to drug resistant strains of HIV that can be transmitted to others and may limit the types of drugs left for patients utilize in the future (AIDSinfo, 2012).

Low adherence to HAART is associated with poor outcomes, including earlier death, for people living with HIV/AIDS. Adherence is a problem among women, African Americans, Native Americans and other diverse cultural sub-groups that experience economic and health disparities (Siegel & El- Sadr, 2006). Adherence levels of 95% are required for best results. Depression makes clients seven times more likely not to adhere to HAART regimes; the majority of HIV-infected intravenous drug users report less than optimal adherence (Battaglio-DeNero, 2007). Some studies show that

methadone and other opiate replacement therapies improve treatment adherence significantly, (plus or minus 20%) especially among re-entering offenders (Springer, Chen, Altice, 2010; Ullman et al., 2010). Although methadone dosages usually need to be adjusted or increased while undergoing HAART.

Not every RSAT client with will be involved with medication treatments. HIV Inmates who learn of their HIV status in correctional facilities also fall into several categories and have care requirements similar to those diagnosed as HIV+ prior to incarceration.

Asymptomatic - Some RSAT clients that learn of their HIV status will not require treatment. Even an HIV+ individual who does not receive any medical treatment may remain asymptomatic for 7-10 years. They will require routine medical care, vaccinations, treatment for other health conditions and immunological monitoring, as well as behavioral health treatment. These RSAT clients are considered “treatment naïve” HIV patients, meaning they have never had a course of anti-retroviral drugs.

Candidates for Treatment - Those with high viral loads and low T-cell counts may be considered for HAART. The decision to initiate treatment can be complex. Clients must remain in custody for a sufficient length of time, must be committed to treatment adherence, and should fully understand the ramifications of missing doses. They should be prepared to experience side effects. Since the best chance of successful HAART is usually the first attempt, it is important to consider all readiness factors with treatment naïve clients. They should be treated for substance use and mental health problems prior to receiving HAART (Bae, Guyer, Grimm and Altice, 2011).

Clients Receiving HAART - The correctional environment presents many challenges for an RSAT client on a medication regime. Flexible meal times and medication dispensing times are often out of the question; confidentiality is frequently compromised. Most facilities use one of two methods to dispense anti-retroviral meds.

> **DOT** is Directly Observed Therapy that involves nursing staff watching the patient take their medication. It has the advantage of better adherence and preventing misuse of medications. Disadvantages include risks to confidentiality and additional demands on the time of nursing staff. DOT also does not prepare the offender to manage their own care when they leave the correctional facility.
>
> **KOP-** is a more flexible option. It stands for Keep On Person, which means inmates can carry some of their medication with them, so they can take it when they need to. There are still some risks to confidentiality (a cell mate can find the meds), but it affords more privacy, may make program participation easier and promotes self-management skills.

Clients with AIDS- Early detection of HIV means people can live much longer. However, some offenders may progress into AIDS within a year or less if they were HIV positive for a long time prior to testing. Their needs may vary over time; effective drug therapies may bring down their viral level and they may improve significantly. Others may become very ill with opportunistic infections and complicating conditions listed in the previous sections. HIV related dementia, delirium and cognitive impairment are common.

Exercise 5: HIV Related Counseling Needs
Match counseling needs with HIV+ RSAT clients. Indicate the letter of the HIV related counseling topic or approach listed below that best match the client's need in the space provided.

a) Risk reduction counseling and HIV education
b) Motivational sessions, balancing pro's and con's
c) Mapping, schedules, calendars and visual aids
d) Permanency planning for children
e) Preparation and readiness for beginning AZT treatment
f) Expedited case management and advocacy
g) Counseling on partner notification

_____ **Tests positive for HIV upon entry**

_____ **Has progressed into full blown AIDS**

_____ **Tests negative for HIV upon entry**

_____ **Receiving HAART in facility**

_____ **Refuses testing**

_____ **Pregnant and tests positive for HIV**

_____ **Enters jail while currently receiving HAART in community**

C. Re-entry and Continuity of Care

Re-entry planning, connections to community care, resources and a support system are critical needs for every RSAT client. Research has shown that long term substance treatment initiated in correctional facilities is effective; however, it is significantly more

effective, when offenders receive follow up treatment in the community. For example, the Crest Program in Delaware found that after three years, re-arrest rates for offenders that completed substance treatment while in custody, followed up with aftercare in the community were 14% lower than for those completing treatment without community aftercare (Council of State Governments, 2012). Similar outcome studies have shown even more dramatic effects, such as the 2003 evaluation of Florida's program for high-risk drug using offenders. At 24 months post-release: clients who received treatment plus community-based aftercare showed a 42% lower rate of returns to custody for new crimes than treatment completers who did not participate in aftercare (Florida DOC, 2003).

The same is also true of HIV treatment. Linking HIV+ individuals to care prior to re-entry has recently become a priority area for federally funded initiatives that support people living with HIV/AIDS. Several pilot projects and workforce development efforts have been funded to enhance these connections. Laws and regulations have changed so that most HIV related services and benefits no longer deny formerly incarcerated individuals. Since at least a quarter of the HIV infected population and almost 40% of those infected with HCV (hepatitis) pass through correctional facilities each year, policy makers have realized that denying them prevention and treatment services will eventually increase infection rates among the general population (NYC Commission on AIDS, 2005).

The Ryan White CARE Act is a major funding stream for services to people living with AIDS; it was reauthorized in 2006 with increased resources directed toward outreach to incarcerated and re-entering HIV+ individuals.

HOPWA stands for Housing Opportunities for People living With AIDS; housing support is available to re-entering offenders as long as they meet the income eligibility guidelines. Ryan White pays for medical care for offenders on work release or re-entering from correctional facilities, provided those facilities are no longer responsible for their care.

ADAP is the AIDS Drug Assistance Program administered by the states. Low income offenders returning to the community can receive HIV medications through the program.

That's the good news. The bad news is that research suggests that most offenders who begin HAART in correctional facilities cannot or do not continue with HIV drug therapies once they are released to the community (Baillargeon, et al., 2009). One study found that less than 6% had their medication prescriptions filled within 10 days and only about 30% had them after 60 days post release. Those that had help filing an ADAP application were more likely to have their medications (Clements-Nolle, et al. 2008).

Data from drug court programs have shown that offering health and dental care alongside behavioral health treatment results in a 40% lower rate of entry into custody

as compared with programs that offer behavioral health services alone (NCP Research, 2010). The connection between behavioral health, physical health, wellness and recovery is becoming more central to planning the way services are delivered.

According to the Council of State Governments (2012), coordinated and integrated treatments for HIV/AIDS, substance abuse, and mental illness are critical to managing those ongoing health conditions, yet very few facilities are actively planning transitional services for offenders with that constellation of interrelated risk factors and needs.

This module assists RSAT staff with re-entry planning and with locating potential resources for HIV+ individuals. **Before examining the specific needs of HIV+ offenders, it is helpful to highlight some of the evidence-based principles of offender re-entry.**

- Risk of criminal behavior is highest in the initial weeks and months following release (Council of State Governments, 2012).
- Risk of fatality is high within the first 48 hours post release due to drug overdose, suicide or homicide (Bingswanger et al., 2007).
- Offenders benefit from ongoing substance abuse counseling, peer support recovery and mental health support and access to mental health care.
- High risk offenders need intense programming and structured time upon release.
- Major criminogenic risk factor should be addressed throughout re-entry planning.
- Criminal or anti-social associations are often the flip side of a lack of pro-social community affiliations, which must be developed.
- HIV+ offenders require trauma-informed care. Research shows that people with histories of trauma often avoid seeking medical care. Referrals that are a “warm hand off” -an introduction pre-arranged with agency contacts- increase the chance the client will show up.
- Family and partner support for treatment adherence during release planning and re-entry tends to improve outcomes, if family violence is not an issue.

Exercise 6: Steps to Ensure Clients Can Qualify for Care

Make notes in the space provided about how you or the client might go about locating the needed documentation, who to contact and how long will it take.

If they are to be successful, an HIV+ RSAT client preparing to leave the facility will need to make a seamless transition, especially if they are taking medications. The first thing they need in order to qualify for medical care, through Ryan White funded programs, is documentation.

1. *Verification of HIV status*- The original test that detected the HIV, or a copy of current lab work, or a letter from the treating physician documenting HIV status and outlining the current course of medical care.

_____
_____

2. *Verification of release* – A parole certificate or other verification of release date is helpful. Clients have up to 30 days to provide any missing documentation. If released from prison within the last 30 days they fall into an eligible category.

_____
_____

3. *Verification of residence in service area* – If the client will be released to the area, or to another catchment area, they'll need to verify residence.-

   _____
   _____

4. *Insurance cards, Medicaid, Medicare or VA enrollment cards*- Ryan White is "the payer of last resort" and needs to verify that no other coverage exists.

_____
_____

5. *Driver's license, photo ID & Social Security card*- proof of a social security number is acceptable. A state issued photo ID is important for re-entry.

_____
_____

6. *Income verification*- two paystubs, disability award letters, tax returns, unless they have no income- limits are 300% of poverty level or below.

_____
_____

7. *Medical records*-recent viral load and T-cell counts are especially helpful.

_____
_____

8. Name and contact for primary care provider- The facility doctor should be listed along with any primary care provider that may be lined up in the community.

_____
_____

9. *Denials of benefits* - HIV+ inmates should apply for all benefits they may qualify for; denial letters are important for Ryan White, as the “payer of last resort.”

_____

_____

How confident are you that clients can leave the facility with the needed documents? If there are administrative barriers to overcome, who might you go to? Are there AIDS Service Organizations in your area that can help?

Services, Resources and Needs

AIDS Action is a nonprofit AIDS advocacy organization that develops education materials, assist persons with AIDS and organizations that serve them, and advocates for funding, and social policy and legislative reforms (2007). A link to their workbook is listed at the end of this module: *Connection to Care: Addressing the Unmet Need - Rural & Formerly/Currently Incarcerated*. It contains examples of collaborative practices that correctional systems and community based agencies have evaluated. The authors have also identified some of the barriers they are working to help correctional agencies overcome.

- lack of HIV knowledge/expertise among staff in correctional settings;
- lack of privacy and confidentiality in the correctional setting;
- interruption in care upon release;
- lack of awareness of care resources when released;
- substance use; and
- mistrust of providers.

Care transitions for HIV+ inmates, especially those undergoing HAART, have mostly been inadequate, are in need of improvement and have resulted in treatment discontinuation and poor health outcomes for re-entering offenders (Hammett, Roberts and Kennedy, 2002). The Corrections system has made progress, but capacities vary and are limited, while treatment needs are complex. Re-entering offenders are best served by leaving facilities with a 30 day supply of their medications, although that is not always possible. RSAT program staff can help achieve better outcomes through collaboration with community-based HIV organizations. The resources and links on the last page of this module will take you to a listing of state fact sheets with rates of infection by state and county, gender and ethnicity, and the funding levels and the HIV/AIDS funding grant programs in your state. There is also a link to a listing of all local AIDS Service Organizations by state.

Ryan White Care Act Services (through US DHHS)

Ryan White was a 13 year old hemophiliac diagnosed with AIDS in 1984; he died six years later. His mother fought against discrimination to keep him in school, brought national attention to AIDS and to the biases born out of ignorance and fear. Since 2000, Ryan White funds have increasingly supported work with incarnated and re-entering people. All services are not funded in every state, but use link to state fact sheets at the end of the modules to view the programs available in your state.

- Part A – Funds services in cities that are disproportionately affected by HIV/AIDS
- Part B – Helps state health departments with services and funding for ADAP which helps with medications for low income families; Minority AIDS Initiatives for underserved and disproportionately affected groups; and the Supplemental Emerging Communities grants for towns with where increasing numbers of AIDS cases are reported.
- Part C – Early Intervention Services support competitive state level grants for HIV testing and medical care. Oral health services, risk reduction, outreach, medical case management, nutrition, medical transport and planning.
- Part D- Capacity Building and Women, Infants, Children, Youth and Their Families focuses on the growing vulnerabilities to HIV infection for women and women of color.
- Part E- Ryan White also funds ATEC -AIDS Regional Educational and Training Centers.
- Part F- Ryan White Care Act Dental Program pays for access to oral health services and education on HIV/AIDS for dentists.
- Part G- Ryan White SPNS (Special Projects of National Significance) projects pilot and evaluate new care models and innovations based on research. Recently, eleven jail SPNS aimed at improving linkages for HIV+ people in jails and returning to communities.

HOPWA (through HUD)

Housing Opportunities for People with AIDS is funded in states and cities with higher numbers of people living with HIV/AIDS. They are not available everywhere; but, recent projects in several urban areas have been specifically developed to serve re-entering people with HIV. Most require applicants to have income at or below a multiple of poverty level, usually between 300% and 500%. Generally, homelessness definitions are pretty lenient, as the purpose of the program is to ensure people with HIV/AIDS get into housing before they become homeless and their health is affected.

Other Community-based Services

Exercise 7: Collaboration with Other Agencies

List the agencies you work with. How well do they work with HIV+ offenders? Do you have a contact you can note that assists with re-entry planning?

- Substance abuse treatment _____
- Temporary Assistance for Needy Families (TANF) _____
- Job readiness and training_____
- Child Welfare_____
- Housing assistance_____
- Mental health services_____
- Recovery/ AA/ Peer Support_____
- Ministries, synagogues, mosques_____
- Domestic violence/ rape crisis _____
- Food pantry, clothing exchanges etc._____
- Gyms, YMCA, recreational programs_____
- Medication resources_____
- Minority community organizations_____

Several key governmental and non-governmental AIDS agencies have turned to justice issues and developed guidelines and webinars encouraging AIDS Service Organizations to work with correctional facilities. Some community-based organizations offer AIDS education workshops to inmates at orientation, work inside facilities on pre-release planning with HIV+ clients, assist offenders with Medicaid and Social Security applications and help people get stabilized in the community. RSAT program administrators are likely to be grateful for the help, and RSAT staff may have a re-entry resource for HIV+ inmates they haven't tapped, including Ryan White funded medical case managers for re-entering HIV+ RSAT clients.

Supporting HIV+ RSAT clients and people living with AIDS is challenging, but RSAT do not have to go it alone. Both internal and external care teams and partner can be utilized. Persons in recovery who are actively engaged in managing their needs are likely to achieve success. The same is true for HIV+ clients. In the healthcare field, patient centered self-management is the hallmark of success for individuals with chronic medical conditions as well. For people with substance use disorders who are at risk for or living with HIV, there is nothing more empowering than recovery and the ability to stay clean and sober.

D. Resources and Review

State Fact Sheets, Ryan White and Other Funding in States.
http://www.aidsunited.org/policy-advocacy/state-fact-sheet/

United State AIDS Service Organization by State:
http://www.thebody.com/index/hotlines/other.html

Housing Opportunities for People Living with HIV/AIDS (HOPWA) Portal
http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing/programs

AIDS Drug Assistance Program Site
http://pozitiveattitudes.com/adap-patient-assistance-programs/

National Re-entry Resource Center (HIV Articles and Reports)
http://nationalreentryresourcecenter.org/search?q=HIV

Connecting to Care: Addressing the Unmet Need in HIV, Rural & and Current/Formerly Incarcerated. Workbook II. AIDS Action Foundation:
http://www.connectingtocare.net/files/ctc_complete.pdf

Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative Transitional Care Coordination – From Incarceration to the Community
http://enhancelink.org/sites/hivjailstudy/Policy_brief_Transitional_Care_Coordination_Final_1.27.11.pdf

Opening Doors: The HRSA-CDC Corrections Demonstration Project for People Living with HIV/AIDS: http://hab.hrsa.gov/abouthab/files/openingdoors.pdf

Review

- HIV+ RSAT clients may fall into a number of categories which have varying care needs. This includes clients just learning of their HIV status, clients transitioning from community care to custody, asymptomatic HIV+ clients, those receiving treatment with anti-retroviral drugs and those with full blown AIDS.

- Care transitions and documentation are two important issues for HIV+ clients within correctional systems. Those taking medications for their condition must carefully adhere to treatment. This makes both confidentiality and program participation challenging. Transitional planning has generally been inadequate for most re-entering HIV+ offenders and results in risks to treatment continuation and health.

- RSAT HIV+ clients also have special counseling needs. Staff can support them through health decisions, offer encouragement and assist them with adhering to their treatment regimes. RSAT staff is not expected to practice beyond the scope of their training. A team approach that includes medical staff is effective.

- Re-entry planning for HIV+ includes all aspects of transition planning required by any RSAT client, including attention to risk factors that predict recidivism, the need for follow up community-based substance abuse treatment or after care and recovery community support. Counselor can also make sure clients are connected with Ryan White funded services and other programs for people living with HIV AIDS and medical services in the community.

- There are many resources that RSAT staff can tap to increase the correctional system’s capacity to serve inmates at-risk for or living with HIV/AIDS. AIDS Service Organizations can help with risk reduction education, and also with re-entry planning and connections to medical case management services, housing and healthcare coverage.

Module IV: Case Histories and HIV/AIDS Special Topics
A. Cultural Competency and Health Literacy
B. HIV issues for Underserved Groups: Youth, Women, African Americans and Others
C. Sex in Prison Settings and PREA Requirements
D. Resources and Review

Case Studies Appendix

Learning Objectives

After completing this module, participants will be able to:

- Discuss health literacy and cultural considerations in HIV prevention and treatment.
- Describe strategies to engage diverse clients and important issues affecting various sub groups of offenders.
- Define the Prison Rape Elimination Act and explain staff reporting responsibilities.
- Explore cultural dynamics, such as age, gender, sexuality, race, ethnicity, and socioeconomic status that impact HIV care and treatment through the use of case studies.

Knowledge Assessment Test

True False Questions

1. Women have fewer side effects from anti-retroviral and a better response to medication therapies for HIV/AIDS in comparison to men.
   False

2. Most African American women with HIV are infected through blood-born transmission due to IV drug use. False

3. Latino men and women have a higher rate of HIV infection as compared to Whites.
   True

4. PREA Law protects inmates from sexual assault, but it does not protect staff from sexual assault by inmates. True

5. Some Peer-led prison HIV education programs delivered by inmates have been shown to have a greater influence on reducing high risk behaviors than education programs delivered by professionals. True

6. If an inmate reports a sexual assault to an RSAT staff member, but doesn't want to tell anyone else, staff must report it to the authority responsible for investigating of PREA incidents. True

7. Inmates at high risk for sexual abuse include older inmates, those that have been in prison a number of times and unmarried inmates.
   False

A. Cultural Competency and Health Literacy

African Americans, Latinos and Indigenous Americans are grossly over represented in both adult and juvenile correctional settings. Survey data from the National Commission on Correctional Healthcare report, *Health Care for Soon-To-Be-Released Inmates: A Survey of State Prison Systems* shows increases in numbers of female, nonwhite, and foreign-born inmates and a profile of impoverished individuals from underserved communities with low levels of education, a high prevalence of untreated chronic disease and preventable illness and little access to healthcare services outside of hospital emergency rooms with (NCCHC, 2002b). Yet, research, training and information on culturally responsive practices in substance treatment and correctional settings remain woefully insufficient.

Changes in drug control policies and sentencing have altered the composition of the prison population. In 1985, only 8.6% of inmates were in state prisons due to drug offenses; by the year 1995 there was a 478% increase in drug offenders. In the decade between 1985 and 1995, the correctional population increased 78.5 % (NCCHC, 2002b).

The face of HIV has also changed; an epidemic that began in the US among predominately white, openly gay men has now become the leading cause of death among African American women between the ages of 25 and 35 (Kaiser, 2011).

• Complex burdens of poverty, racial and ethnic discrimination, inadequate medical care, little access to addiction prevention and treatment services, mental health problems and violence and trauma are operative among drug-involved HIV+ offenders.

• Such marginalization increases once people are diagnosed with HIV+ and once they have been incarcerated; justice involvement and low levels of social support contribute to the prevalence of depression, which acts as a significant barrier to initiating and adhering to retroviral treatment regimes. Health literacy also has emerged as a major barrier to treatment engagement and adherence.

Defining Health Literacy: The Partnership for Clear Health Communication (2003) defines health literacy simply as the ability to read, understand and act on health information. The U.S. Department of Health and Human Services definition further states: people need to be able obtain, process and understand information and services in order to make informed health decisions (2006). The exercise below highlights the skills and capacities required to be a patient in today's healthcare environment. Many of us working in human services take these capacities for granted.

Exercise 8: Health Literacy
Read the Instructions Below. Then check off the skills required to follow them.

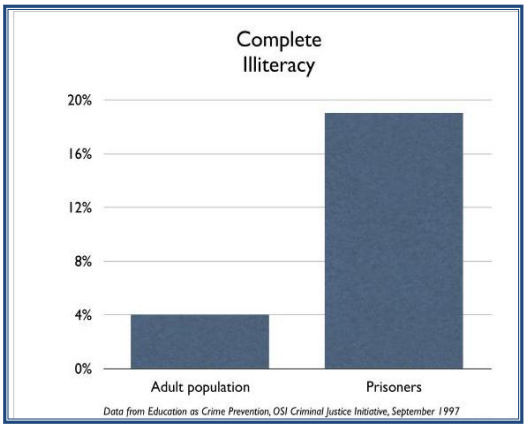
Take nothing by mouth from midnight the night before your procedure. Arrive at the office 15 minutes before your scheduled appointment. The nurse will instruct you on how to obtain a clean catch urine sample. Return your specimen to the front desk, with your name written on the label, prior to changing into the gown provided. Once your procedure is complete you must remain in the waiting room for 2 hours and 45 minutes unless you have pre-arranged transportation home. Do not drive a car until the next day. Be sure to wear the compression garment for 2 full weeks. Call the office immediately if bruising or swelling occurs. You may take up to 2 Tylenol at a time every 4 with meals for no more than 5 days.

☐ reading
☐ writing
☐ listening
☐ speaking
☐ math
☐ grasping abstract concepts
☐ conceptualizing knowledge
☐ following multi-step directions
☐ understanding consequences

Nearly half of all American adults (90 million people) have difficulty understanding and using health information as it is currently presented (Institute of Medicine, 2004). Hundreds of studies have confirmed that most patients cannot understand materials that are intended to inform about important health issues. Research has shown that this problem affects people from all ages, races, and income and education levels. Most of us, no matter how educated or well-read, will at some point be handed a medical form, an instruction sheet to prepare for a procedure or directions for taking a prescribed medication that we do not comprehend. The costs and consequences of health literacy problems amount to billions in avoidable healthcare expenses.

Limited health literacy may be more prevalent among medically underserved people. Minority and immigrant populations, older adults and low income families are among those at risk (U.S. Department of Health and Human Services, 2006). Low health literacy skills make it more difficult for clients to discuss diagnoses and health care issues with care providers; to read and understand client information sheets and consent forms; to share their medical history with providers; and to understand the connection between risk behaviors and health.

Researchers have found that the highest concentrations of adult illiteracy are among prisoners. *(Wagner, 2003).*



Most correctional systems scan materials developed for inmates for appropriate reading levels (usually between fourth and eighth grade), but health information on HIV may not be included. Two standardized assessment tools are used specifically to assess health literacy: 1) Test of Functional Health Literacy in Adults 2) Rapid Estimate of Adult Literacy in Medicine.

What Works: using simple language, short sentences, and defining technical terms; supplementing instruction with videos, models, and pictures; asking open-ended questions; organizing information so that the most important points stand out and are repeated; and crafting materials that are responsive to the age, literacy level, cultural, ethnic, and racial diversity of their clients. For clients with Limited English Proficiency (LEP), all information should be provided in their primary language (U.S. Department of Health and Human Services, 2006). The resource sections of this curriculum contain links to patient education materials that are clear and understandable.

Individuals are becoming increasingly more responsible for managing their own health care and for assuming responsibilities in personal health. Self-management is essential to the successful care of people with HIV infection and those recovering from addiction or co-occurring disorders. This is more difficult for those who have limited health literacy. RSAT staff can assist HIV+ clients with information, questions and explanations. Staff can check in on those receiving HAART to monitor adherence and make sure clients have a clear understanding of the dosage schedules and the consequences of skipping doses.

Answer to Exercise 8: All the skills listed are required.

There are four main elements of Health Literacy:

1. ***Empowerment/power dynamics*:** In most health care settings, providers have a high level of power and influence. Clients are frequently intimidated and reluctant to take responsibility for making decisions about their own health-related behaviors.

2. ***Assessment*:** A client's level of health literacy needs to be determined, along with other their health factors, including physical, mental, nutritional, social, and safety factors. Clients often give the false impression that they understand information given to them by providers. It is important to gauge the true level of a client's ability to take in and use information.

3. ***Responsibility*:** The provider has a responsibility to pass information to clients that can be understood if it is to be used to their benefit. Clients also have some responsibility, but may not know how to increase their health literacy capabilities.

4. ***Team effort:*** Appropriate communication can also take more time than one provider has available in one clinic visit. A team approach often includes nurses, social workers, health educators; case managers, peers and/or counselors. Increasing client understanding means better health outcomes.

Using the Case Study Exercises
Below are four learning objectives that can be applied to the case studies that accompany this section.

1. Discuss challenges to HIV care and treatment adherence for clients with limited literacy proficiency.
2. Describe ways to avoid and solve problems related to limited health literacy for individual clients.
3. Develop action plans that take health literacy levels into account.
4. Explore cultural dynamics, such as age, gender, sexuality, race, ethnicity, and socioeconomic status, that impact HIV care and treatment.

What is a Case Study?

Case studies can help staff apply leaning to everyday situations. Health literacy case studies are useful, since it has been challenging to train staff dealing with HIV+ clients on the impact it has on care and treatment adherence. The case studies are intended to help.

The following recommendations should be considered when using a case study from this group.

- A variety of cases are presented.
- The case studies are focused on health literacy.
- The case studies can be used in a large group discussion or in small groups.
- The four critical elements of health literacy can be applied to the case studies.

The Case Study section appears at the end of this module.

B. HIV Issues: Underserved Groups: Youth, Women, African Americans & Others

HIV and Women
Only 7% of AIDS cases reported in 1985 in the US were women and girls. That percentage grew to 27% in 2007. About 80% of women are infected through sex with an HIV-infected man (often an injection drug user). In the US, AIDS rates among women are highest in the Southeast and the Northeast. In 2005, about 64% of infected women in the US were Black, although they only represent 12% of the US population (De Groot and Uvin, 2005).

Women with HIV infection are at higher risk for mental disorders, violence, stigma and discrimination. At least half of HIV+ women have one or more psychiatric conditions--rates of post-traumatic stress disorder alone range from 20%-60% (El-Bassel et al., 2010). In recent studies between half and three quarters of HIV+ women reported

intimate partner violence (Tufts, Clements, & Wessel, 2010). Violent partners tend to have additional sexual partners outside the marriage or relationship, which contributes to risk of infection. Researchers conservatively estimate a 50% increase in risk of HIV infection among victims of intimate partner violence (Hale & Vasquez, 2011).

What Works: All women should be tested for HIV, especially women of childbearing age or those who may be pregnant. HIV risk reduction education and counseling developed specifically for women and groups of racial and ethnically diverse women are a priority for women in correctional facilities, juvenile detention facilities and RSAT programs. RSAT staff can also involve women with HIV and women who report past abuse from intimate partners in safety planning prior to leaving correctional facilities. RSAT programs that serve women should establish linkages with local domestic violence services prior to release. These agencies can assess the risk of intimate partner violence prior to release, prior to partner notification, and when women return to the community and attempt to negotiate safe sex with an intimate partner. Several HIV risk reduction interventions are available for women that address these issues. Examples are included in Module II along with links to the CDC Compendium of effective behavioral interventions.

Messages that bear repeating: RSAT staff can incorporate one or more of these messages into every encounter with women clients.

- *Repeatedly point out that women are at risk for HIV infection*. Many women with HIV do not know how they got infected; some at-risk women still think of AIDS as a disease of gay men.

- *HIV is passed on to women more easily.* A woman's risk of infection during intercourse is twice as high as a man's and highest with anal intercourse, or if she has a vaginal infection. High risk sex partners include injection drug users (even if it was in his past), someone with multiple partners or a partner who has had sex with men.

- *Women should protect themselves against HIV infection.* Condom use lowers the chance of HIV infection, if used correctly and consistently. Condoms also come in a female version.

- *Birth control pills, diaphragms, or gels do NOT provide protection against HIV.* There is not yet an available cream or gel that women can use to prevent HIV infection.

- *Women should get tested for HIV*. Many women don't find out they have HIV until they become ill or get tested during pregnancy. Women who get tested and treated can live as long as men.

- *Get to the gynecologist regularly.* Even untreated minor infections make it easier for women to get HIV during sex. Some problems like ulcers in the vagina and persistent yeast infections may be signs of HIV infection.

Treatment for Women*:* Women should be treated by health care providers experienced at treating HIV in females. Women get more and different side effects than men when they are treated for HIV/AIDS and have higher blood levels of medications for longer periods. Women are more likely than men to get skin rashes and liver problems, and to experience body shape changes. Bone loss is also a concern. In the US, women are more likely than men to die of AIDS; fewer women than men are getting HIV treatment. However, when they are supported and treated with HAART, they can respond and extend their lives at rates comparable to men's.

HIV and Youth

Young people in the United States are at high risk for HIV infection, especially minority youth; young girls of color are one of the highest risk populations. HIV prevention outreach and education efforts are required, especially among justice-involved youth. The following highlights are from the most recent CDC fact sheet on HIV and Youth, which can be downloaded and printed from: *http://www.cdc.gov/hiv/youth/pdf/youth.pdf*

- Young people aged 13–29 accounted for 39% of all new HIV infections in 2009.

- HIV infection progressed to AIDS more slowly among young people than among all persons with a diagnosis of HIV infection.

- In 2009, young blacks accounted for 65% (5,404) of diagnoses of HIV infection reported among persons aged 13–24 years.

- Young men who have sex with men (MSM), especially those of minority races or ethnicities, were at high risk for HIV infection.

Risk Factors and Barriers to Prevention for Youth

Sexual Risk Factors include: Early age at sexual initiation, including intercourse before age 13, is a risk factor for HIV. Education on risk reduction needs to take place early enough to reach young people before they engage in sexual behaviors that put them at risk. Heterosexual transmission, especially among girls of minority races or ethnicities, is increasingly the mode of transmission in new cases of HIV infection. Young MSM (men who have sex with men) are at very high risk for HIV infection and may not disclose their sexual orientation or seek testing, so if they become infected, they are less likely to know it. Young MSM who do not disclose their sexual orientation are likely to have female sex partners and may transmit HIV to them.

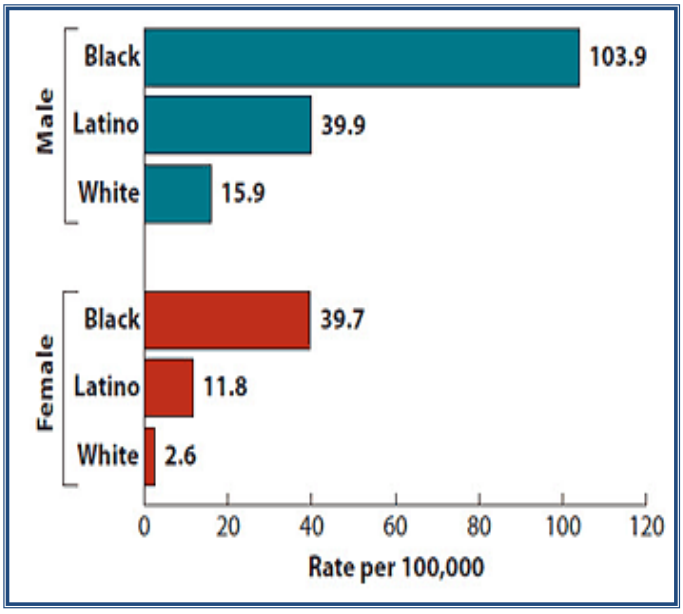
What Works: Adolescents need accurate, age-appropriate education that includes ways to talk with their parents or other trusted adults about HIV/AIDS, ways to reduce or eliminate risk factors, and how to talk with potential partners about risk factors. Information should cover topics such as dating violence, healthy relationships, condom

negotiation skills, local testing resources and correct condom use. Several HIV risk reduction interventions are available for diverse youth that address these issues. Examples are included in Module II.

African Americans, Latinos and other underserved groups

The chart below shows the ethnic/racial distribution of new HIV infections among males and females highlighting the impact on African American men and women and increased infection rates among Latinos as compared to Whites.

Source: CDC: Estimated rate of new HIV infections, 2009, by gender & race/ethnicity



According to a survey of Black Americans by the Kaiser Family Foundation (1998), about 70% of parents are very concerned about HIV prevention for their children and believe the government should step up HIV/AIDS efforts. More recent research shows health disparities that affect African Americans have a profound impact on outcomes for those infected with HIV. Whites fared better on several important measures of access and quality of HIV care; African Americans were more likely to report postponing medical care because they lacked transportation, were too sick to go to the doctor, or had other competing needs.

Not only do African Americans and other racial and ethnic minorities experience health disparities in services and health coverage, they are also under represented in research studies, including AIDS research. The same is true for women and especially true for women of color (Kaiser, 2011). There is distrust among significant sectors of the Black community regarding HIV, behavioral health services and research. Clinical trials of HIV drugs have been a resource for people living with HIV/AIDS. However, the history of unethical research performed on Black Americans has deterred many HIV+ African Americans from participation (El-Bassel et al., 2010). Recently, pharmaceutical companies have purposed that they be allowed to recruit research subjects for clinical trials of new HIV medications from prison populations (De Groot, Bick, Thomas and Stubblefield, 2001). Research on prisoners has been restricted and monitored more carefully, also due to past abuses and the vulnerability of the prison population. Whatever the outcome, it is important to connect all HIV+ offenders with AIDS Service Organizations and culturally specific community agencies that can provide them with information on clinical trials opportunities. RSAT staff should be able to make clients aware of the potential advantage of participating, while respecting the cultural perspective of diverse clients.

Latinos
The Latino population in the US is a relatively young population, often experiences language barriers that interfere with access to care, isolation from family living outside the US, employment discrimination and other stressors. Cultural and religious issues may present barriers to women's autonomy, reproductive health; and the stigma against MSM is severe. A fact sheet from the Latino AIDS Commission has additional information: http://www.latinoaids.org/docs/hiv_on_latinos_us.pdf

What Works: Approaches should account for stigma and for community norms in both African American and Hispanic communities, which tend to influence people to trust and rely on extended family networks rather than dominant culture institutions (this applies to other cultural groups at high risk for HIV infection, such as Native Americans, Alaska Natives, immigrants and others). Effective programs respond to the cultural issues that are part of the experience of various sub-groups, such as pronounced health disparities, disproportionate incarceration, poverty and discrimination. They also acknowledge limited access to high-quality care and distrust of medical and behavioral health providers and researchers.

The use of HIV peer educators in prisons and jails has been evaluated, is considered extremely effective and has been embraced in states like Texas and Oklahoma (Specter, 2007). Oklahoma's program provides college credit to inmates that volunteer to become peer educators and allows them to work in teams within each institution to develop an HIV prevention program. The inmates developed a manual for the Oklahoma program. Evaluation of the peer-led programs showed significantly higher scores on indicators of behavioral change among inmates that received risk reduction education from peers as compared to inmates receiving it from professionals.

More links to information relevant to treating various underserved groups with substance use disorders and people at risk for HIV are included in the resource section at the end of this module.

Good- Use of culturally specific risk reduction interventions available from the CDC, tailored to the needs of specific groups in RSAT programs.

Better- Contacting AIDS Service Organizations or culturally specific community groups to come in and deliver these interventions to RSAT clients.

Best- Have these groups train Latino, African American, female or other underserved RSAT clients to deliver peer-led HIV educational groups.

C. Sex in Prison Settings and PREA Requirements
In 2003, President Bush signed the Prison Rape Elimination Act (PREA) into law, which had unanimous bi-partisan support from Congress. The federal law is designed to protect incarcerated individuals from sexual assault or harassment. It applies to adult and juvenile facilities, state prisons, private facilities, jails, police lockups and immigration customs enforcement (ICE) detention facilities, and under some

circumstances, to certain community supervision settings. The provisions of the law classify prisoners as a protected vulnerable population that cannot consent to sex due to their diminished status, similar to the protections afforded to underage youth and children. It protects inmates from other inmates, staff, visitors, volunteers and contracted workers that come into facilities or have contact with inmates at work release sites.

RSAT staff who are corrections employees and contracted substance abuse treatment providers who have contact with inmates are required to receive PREA training. Each system should have a PREA policy. It is important to become familiar with the policy, staff and contractor responsibilities under the law, and the procedures for reporting PREA incidents at each facility.

PREA Law Requirements

The Act supports the elimination, reduction and prevention of sexual assault and rape within correctional systems; mandates national data collection efforts; provides funding for program development and research; and creates a national commission to develop standards and accountability measures. In February 2011, a draft of PREA standards became available for public comment and an implementation cost study was completed.

There is some controversy among correctional administrators regarding PREA. Everyone agrees that prison rape should be eliminated, but many correctional administrators are concerned about the cost of some of the requirements and standards, especially in smaller facilities with limited capacities.

The National Institute of Corrections (NIC) is a resource for information about PREA. Links to NIC PREA information and to a two-hour online PREA e-Learning course, which can be accessed at no charge, are listed on the resource page at the end of this module.

The Extent of Sex in Prison

There is no doubt that sexual behavior continues among some offenders when they enter correctional facilities, but research suggests there is wide variation in the nature and extent of consensual, coerced and forced sex in different facilities (BJS, 2010; BJS, 2009). The PREA law requires research and data collection activities including two yearly reports that are available through the Bureau of Justice Statistics: one compiles all reported incidents of sexual assault in US facilities; the other surveys a sample of inmates each year about sexual assault within facilities. The links to these reports are listed on the resource pages at the end of this module.

The inmate survey estimates show an average rate of sexual assault in US prisons and jails at a little less than 5% (PREA, 2009), with inmates at the most problematic facilities reporting rates as high as 20% and inmates surveyed at some facilities reporting no incidents at all.

A multi-year study in the Georgia State prison system showed that the majority of inmates reported some sexual activity while in custody. For those who reported consensual sexual activity, about one third reported using condoms or an improvised barrier method of protection. Protection was not used during non-consensual sex (CDC, 2006). While other studies have not reported as high a rate of sexual activity in custody, most research confirms that consensual sex is not uncommon.

Sexual acts in correctional facilities may be consensual or forced. There are also coerced sexual acts—where there is a threat of harm for not complying and strategic acts—where there is a promise of privileges or an exchange for something of value. These acts may be inmate on inmate or staff on inmate.

Consensual inmate on inmate contact is always a rule infraction and subject to disciplinary action, but it is not illegal in all states. Sexual acts with an inmate that involve staff, volunteers or visitors etc. are always illegal and covered by the PREA law even if the inmate appears to be a consenting or willing participant. State laws may also apply. The chart at the end of this section summarizes consensual, coercive and forced acts covered by PREA law. A link to a fifty state survey of state laws and legal sanctions against sexual assault in custody is also listed on the resource page at the end of this module. The examples below show how the PREA law can be applied.

Exercise 9: Scenarios
Read the scenarios below and select the correct answer to the questions that follow.

A female inmate is recorded by a surveillance camera during a visit with her boyfriend in the prison visitation area. On the recording, the visitor can be seen having sexual contact with the female inmate; her hand has contact with the male visitor's genital area; the visitor can also be observed stroking the female inmate's buttocks and breasts.

a) The inmate can be charged under the PREA law.

b) The visitor can be charged under the PREA law.

c) The contact was consensual; the visitor was a passive participant and shouldn't be charged.

d) The inmate was at fault for encouraging the contact and is the only one that can be disciplined, but the PREA law doesn't apply

A young homosexual male offender on parole comes to your office at the end of the day after attending the required substance abuse treatment program at a day reporting facility. He tells you that he was just sexually assaulted in the bathroom the by two other parolees.

a) It is a PREA incident because he was under the care of correctional authorities and his presence in a correctional setting was mandatory at the time.

b) The offender is considered at high-risk for sexual assault due to his age and sexual orientation. He will need access to HIV testing and post-exposure prophylaxis

c) After attending to his emotional state, you notify the officer in charge of a possible PREA incident and advise the offender not bathe, brush his teeth or change his clothes, since he will be taken to the hospital for a forensic exam and medical care.

d) All of the above

Legal Considerations and Inmate Rights and Protections

Basic rights are afforded to offenders through the eighth and fourteenth amendments to the Constitution and pertain to prohibitions against cruel and unusual punishment and guarantees of due process under the law. PREA law provides a basis for action if those rights are violated and assigns responsibility to correctional facilities for taking steps to prevent and respond to violations.

What RSAT Staff Needs to Know

All RSAT staff should become familiar with the PREA policy in their facility and reporting procedures. If an inmate makes staff aware of a sexual assault, staff must report it to the responsible authority. Both inmates and staff should know how to report an incident.

When a recent incident of sexual assault is reported (occurring within the last 72-96 hours), a forensic exam is usually performed at a local hospital by qualified staff trained in sexual assault evidence collection. Part of the protocol for any recent sexual assault is offering HIV testing, post–exposure prophylaxis (PEP) to reduce the likelihood of transmission; and in cases involving a female victim, emergency contraception.

It is also common for inmates not to report a sexual assault, to delay reporting or to report until they leave the facility where it has occurred or are released. Many inmate victims have been threatened, fear retribution or feel it is not safe to report an incident. They may, however, seek information about HIV testing and exposures or information about confidential services in the community.

RSAT staff can ensure information is available to all clients. The trauma of sexual assault can require mental health support. Any RSAT client disclosing a past assault should be offered mental health services. RSAT staff should be aware that such an experience can trigger the desire to use drugs and alcohol, and work with clients in need of support.

Answers to Exercise 2:

b) An inmate's status while incarcerated means he or she cannot legally consent to sex with visitors, staff members, volunteers or anyone having contact with inmates in custody. It doesn't matter if acts are perceived to be consensual. The inmate may be disciplined, but only the visitor has violated PREA law.

d) Offenders under community supervision who are sexually assaulted while attending mandatory activities at a parole office, day reporting center or other correctional setting are covered under the PREA law. Keeping evidence in tact is important if a sexual assault has just occurred. Forensic exams collect evidence from the body and clothes of the victim. The examiner should also offer HIV testing and other appropriate medical care.

Inmates at Risk for Sexual Assault

There are several risk factors for sexual abuse while in custody. Implementation of PREA law is intended to include screening inmates for vulnerability and risk of victimization and for predatory and violent tendencies, to prevent sexual abuse through housing assignments and inmate classification. One of the highest risk groups is sexual and gender non-conforming inmates. This includes gay, lesbian, bisexual, transgendered men, women and youth and individuals with intersex conditions (ACLU et al., 2010).

A National Institute of Justice funded study that interviewed more than 600 inmates found that inmates described the profile of someone vulnerable to sexual assault as young, small, white, with feminine physical features or gestures and no prison experience or companions or friends (NIJ, 2006). Lesbian women have also reported high rates of sexual abuse and harassment in custody settings. Other high risk groups include sex offenders, inmates with developmental disabilities, inmates with mental health disorders, and women with histories of prostitution. RSAT staff should be aware of the possibility of past or current victimization among clients that belong to at-risk groups and the effect it can have on a client's recovery. If a client is in current danger, RSAT staff can work with security to take steps to protect the inmate. Whenever possible the victim's program participation should not be restricted.

Sexual Risk Behaviors upon Release

All HIV education and risk reduction counseling should target changing risk behaviors upon release. A 1995 study in a California prison revealed that 50% of male inmates reported having sex within 12 hours of release. Many inmates in the study indicated they preferred not to use a condom. More than 1 out of 10 also used injection drugs the day after release (Morales et al., 1995). More recent research highlights the attitudes and thinking that accompany high risk behaviors upon release: the desire to make up for lost time; being a man, and a desire to escape. The strongest determinant of risk behavior was the co-occurrence of sex and drug use (Seal, Margolis, Sosman, Kacanek and Binson, 2003). Reduced risk behavior was more likely among re-entering offenders with stable housing and jobs, positive community support for safer behavior (e.g., drug treatment access, needle exchanges).

Substance treatment that targets risk behavior, educates clients about HIV and addresses criminal thinking, values and associates, combined with sound discharge planning and bridges to culturally responsive community support, drug and alcohol aftercare, HIV testing, prevention and medical care are all components of successful programming for RSAT clients at risk for and living with HIV.

Prison Sexual Victimization →	Includes all acts below willing and non-willing	Crime or Infraction	Nature of Contact
1. Inmate-on-inmate non-consensual sexual acts	Forced = Physical force→ Coerced =Threat of harm→	Always a crime Always an infraction Always a crime Always an infraction	Oral Genital Contact Anal Genital Contact Penetration: Anal, Vaginal Type: digital, penile or object
2. Inmate-on-inmate abusive sexual contact	Forced = Physical force→ Coerced =Threat of harm→	Always a crime Always an infraction Always a crime Always an infraction	Unwanted contact of genitals, breasts; Hand jobs; Touching thighs, groin, buttocks; Other areas or contacts; Exposures, voyeurism
3. Inmate-on-inmate consensual sexual acts	Strategic =Promise of reward→ Willing = Common in custody→	Crime in some states Always an infraction Crime in some states Always an infraction	Any sexual contact reported and perceived as willing by all the inmates involved
4. Staff-on-inmate sexual misconduct	Forced = Physical force→ Coerced =Threat of harm→ Strategic =Promise of reward→ Willing = Common in custody→	Always a crime for staff Always a crime for staff Always a crime for staff; Always an infraction and Sometimes a crime for inmate Always a crime for staff; Always an infraction and Sometimes a crime for inmate	Any and all acts mentioned above
5. Staff-on-inmate sexual harassment		Always a infraction Sometimes a crime	Verbal harassment, gestures, including exposures voyeurism etc. abuse of authority

D. Resources and Review

Office of Minority Health (OMB) Minority HIV/AIDS Initiative
(Note: Partners in the Initiative are: CDC, SAMHSA, NIH, HRSA, OMH, and HIS)
http://www.omhrc.gov/omh/aids/about/abt_toc.htm

National Standards for Culturally and Linguistically Appropriate Services in Health Care, Final Report. (2001). U.S. Department of Health and Human Services. Office of Minority Health. Retrieved from: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General: http://www.surgeongeneral.gov/library/mentalhealth/cre/

Making the Change Real: The State of AIDS in Black America: http://www.kaiwright.com/pdf/change.pdf

The Latina Commission on AIDS: http://www.latinoaidsagenda.org/

Henry J. Kaiser Family Foundation. (2011). Fact sheet: Black Americans and HIV/AIDS (No. 6089-09). Menlo Park, CA: Henry J. Kaiser Family Foundation. Retrieved from www.kff.org

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Bureau of Justice Statistics (BJS). (2010). Sexual Victimization in Prisons and Jails Reported by Inmates, 2008-09. Local Jails Federal and State Prisons, National Inmate Survey, 2008-09. Retrieved from: http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=2204

The Project on Addressing Prison Rape at American University. Fifty state surveys of state criminal laws and legal responses and sanctions available for sexual abuse in custodial settings. http://www.wcl.american.edu/endsilence/statesurveys.cfm

The National Institute of Corrections (NIC) PREA Page: http://nicic.gov/PREA.

NIC online PREA training e-Learning: *Your Role: Responding to Sexual Abuse*, is available at: http://nicic.gov/Training/PREA.

Review

- New cases of HIV infection are growing among African Americans, Latinos, women and youth. Prison and jail populations are disproportionately comprised of people of color, people with low literacy skills and those with little access to quality healthcare. Ethnic and racial minorities may also tend to distrust some providers and institutions, and rely on family and community networks that share their cultural roots.

- Health literacy problems among inmates require specialized strategies to ensure communications and materials pertaining to HIV prevention and treatment are clear and understandable. RSAT staff can help clients undergoing treatment by explaining materials and checking in with those on medication regimes.

- Women offenders have high rates of HIV infection, especially young women of color. All women of childbearing age should be encouraged to get tested for HIV. Domestic violence is associated with HIV risk; services such as safety planning and risk assessment for intimate partner violence are important for HIV+ women offenders and for those reporting past incidents of violent victimization.

- Youth offenders, immigrants, Latinos, Indigenous Americans, and MSM are at high risk for HIV infection. Linkages to culturally responsive community and faith organizations and groups that deliver HIV prevention services and assist re-entering offenders are helpful.

- The Prison Rape Elimination Act protects people in custody from inmate on inmate and staff on inmate sexual abuse. All RSAT staff should become familiar with PREA policy and sexual assault reporting procedures in their faculty and aware of which clients may be at high risk for sexual abuse.

- Re-entry planning, linkages to community support, programming that targets criminal values and thinking all result in behavioral change. RSAT programs can play a key role in helping clients with substance use disorders protect themselves and their loved ones from HIV infection and in helping HIV+ clients access the treatments they need to live long and healthy lives.

Case Studies
Case Study: Anna

Learner's Handout

Anna is an 18-year-old Hispanic woman who was infected with HIV four years ago during a sexual encounter with a 30-year-old man. She entered care in a pediatric HIV clinic two years ago when her diagnosis was confirmed after testing was recommended by a neighbor. Except for fatigue and frequent headaches, Anna has remained asymptomatic

When Anna graduated from high school, she moved to a city where she was attending junior college and found a part time job. She began using Adderall and other stimulants she obtained from friends. She began dating a student that sold drugs and got involved with distributing illegally obtained prescription medications and eventually, Methamphetamine. She was arrested for possession with intent to sell, refused to name her boyfriend or other contacts and was convicted and sentenced to 3-7 years in state prison. She was referred to the RSAT program at the women's prison for substance abuse treatment and described her encounters with medical staff to her counselor in an individual session.

Anna disclosed her HIV status upon intake. She was scheduled to see Dr. Kraig, the medical doctor that serves female inmates, but wasn't aware that she had to be transported to the clinic at the men's facility in order to have the required labs drawn. Anna had to be stripped searched and shackled, then transported by security staff. She was escorted to the clinic by a correctional officer, but had to walk by male inmates on work detail.

Dr. Kraig rushed into the exam room, introduced himself and looked at her chart. He said, "Well, we can't do anything for you except run some labs and look at your T-cell count and viral load." He filled out a lab form and left Anna with the female officer that had remained with Anna in the exam room. When the nurse came in to draw blood, Anna began crying. She asserted her right to refuse medical treatment, was again shackled and transported back to the women's prison, strip searched and returned to the general population.

Discussion Questions:

1. How do you think Anna felt after that encounter?
    - What steps can be taken with HIV+ RSAT clients to overcome barriers and to remain sensitive to health literacy and cultural considerations?
    - What are the reasons that health literacy and culture are often ignored in corrections healthcare settings.
2. What assumptions might Dr. Kraig have made to prompt his actions?

- What other assumptions could he have made?

3. What do we know about Anna's health literacy level and her understanding of HIV infection? What would you like to know?
4. How might the dynamics been changed to ensure Anna would be likely to consent to care? Why do you think Anna asserted her power in this setting?
5. Discuss the barriers to care that have to be overcome if Anna is to receive the right care and the role RSAT staff might play.

Response Points for Anna

1 Dynamics of health literacy and culture

- Anna Feelings: She may feel more hopeless, helpless, ashamed, re-traumatized and confused. Taking time with Anna and talking with her to put her at ease may help.

- Reasons Health Literacy and Culture is Ignored: Overworked staff; lack of procedures and policies, no training, stigma.

#2 Avoiding assumptions

- The doctor may have assumed that Anna was prepared for the transport to the men's facility and understood that her care would begin with immunological monitoring and baseline lab work.
- Although Anna is a new to his care, she is not new to HIV. He may have assumed that she knew all about lab tests.
- He could have checked things out with Anna prior to assuming she knew what she was being seen for and the procedures. He could have asked her how she was doing.

#3 Exchanging information

- Very little is known about Anna's health literacy, except that she is young and a high school graduate. She may have not had access to medical care for her HIV prior to incarceration.

- It would help to know her understanding of the following:

    - How she got infected.
    - How HIV can affect her body and symptoms she should report to her provider.
    - What various lab tests are for, normal values, and what lab results mean.
    - The availability of services while she is in custody and what to expect.
    - The need to stay in care even though she is not yet on HIV medications.

- The procedures for transport and reasons some services are only available at the men's facility.
- How to prevent acquiring additional STDs and blood-borne infections.
- How to prevent transmitting her HIV to others.

4 Building trust

- The medical staff at the women's facility or the doctor could have talked to Anna and assessed her understanding of HIV infection and her personal history with the disease and treatment. Staff could have made sure she understood that monitoring her labs has direct benefits.
- Anna may have asserted her right to refuse medical treatment because she felt it was the only power she had in the situation. She may have acquired HIV under traumatic circumstances and could have been triggered by the experience, or may have found it so unpleasant she doesn't want to continue since she sees no benefit.
- Anna's culture is oriented toward community and stresses the collective. She did not "betray" others and may avoid talking to outsiders about the circumstances under which she contracted HIV, especially if it was from an older man who is a member of her community. Her beliefs about gender roles may also influence her reluctance to confront a male authority figure such as a physician.
- If medical and behavioral health staff collaborated and worked together, then RSAT staff could have a role in teaching, informing and supporting Anna. She will have to trust staff and will need support to go through the process of getting her labs taken regularly. She will need to be fully informed of the benefits and will need assistance preparing herself for the ordeal.

Case Study: Arthur

Learner's Handout

Arthur is a 55-year-old African American male serving a lengthy sentence for armed robbery. He has a long history of arrests for drug and property crimes and heroin addiction. He is 2 years away from his minimum and has waited a long time to enter the RSAT program. He is HIV+ and has recently been advised by medical staff to consider beginning HAART. He has met with his RSAT counselor and disclosed his status in an individual session. Arthur has kept his status private during his incarceration, and is troubled by the possibility other inmates may learn that he is HIV+.

He is very suspicious of medical staff in the prison and doesn't feel HIV drugs are for him. He has a low level of confidence in their efficacy and isn't entirely convinced that the drugs have proven effective. He doesn't trust anyone involved in his medical care

and puts no stock in the lab tests. He also is very concerned about his spot in the substance treatment program and doesn't want to give it up. He views medical staff as a threat to his chance at treatment.

Arthur also has dedication to recovery and a strong belief in his church. He attends a prison ministry program that his church brings into the facility. He is committed to staying clean and wants to get out of prison and live with his daughter and her children; he plans to attend church and believes that is all the support he will need to stay clean. He says he deserves everything he got from his life as an addict and a hustler, including the time and the HIV. He cries in the individual session when he says that if he dies for his transgressions, then it is God's will.

Discussion Questions:

1. How do Arthur's cultural experiences affect his health literacy and his feelings about medical care?
2. What are the issues Arthur needs to address in substance treatment before he is prepared to deal with his healthcare decisions?
3. Based on the information we have, what is the best way to increase Arthur's information and motivation regarding HIV treatment?
4. How could RSAT staff accommodate Arthur if he does decide to undergo treatment?
5. Based on the case study discussion, what culturally responsive strategies to address health literacy and HIV might you include in his treatment plan?

Response Points for Arthur

#1 Dynamics of culture and health literacy

- At age 55, Arthur may have grown up prior to widespread enforcement of the Civil Rights Act of 1964, in a time of segregation and blatant oppression, especially against African American males.
- Health and economic disparities may have affected his parents, his family and his community--his access to medical care may have been limited; services that were available were likely to be of poorer quality.
- Until relatively recently very few physicians were people of color and there are still national shortages of providers of many cultural, racial and ethnic groups in comparison to the numbers of individuals who may prefer to receive care from them.
- Other indicators of health literacy that could have an impact are:
  - Language
  - Reading level
  - Oral and written comprehension of health information
- Religious sanctions against homosexuality in some communities may further stigmatize people with HIV, no matter what their sexual orientation.

#2 Understanding shame and stigma

- Arthur needs to address his assumptions that addiction is a moral weakness, is unforgivable and that HIV is his punishment. He will also need to understand that expanding his support system will benefit his recovery.
- He will need culturally responsive HIV/AIDS education, risk reduction counseling and should be fully informed on the benefits of treatment and adherence issues.
- Arthur should have received a mental health assessment when he entered prison. RSAT staff may want to review it or confer with mental health staff; if he shows signs of having mental health needs, he may need to be reassessed. However, unless mental health staff has concerns, Arthur may perceive the suggestion of mental health interventions stigmatizing or shameful. But, he is motivated to engage in substance abuse treatment.

3 Considering strengths

- In Arthur's case there are some apparent cultural strengths to build upon. The prison ministry from his church may offer support, pastoral counseling or even HIV education. African American community groups or AIDS Service Organizations may offer peer-led effective behavioral interventions.
- Arthur also may be more motivated to keep his treatment options open if he is reassured that he needs substance treatment if he is to begin HIV medication, and that he will not be kept out of the RSAT program because of the recommendation.
- Family is also very important to Arthur; if he believes that treatment can extend his time with his daughter and his grandchildren upon release, he may consider it.

#4 Offering safe choices

- If Arthur begins treatment while in RSAT he could be given keep on person medication or could be stepped down to a less intense level.
- Staff would have to involve Arthur in problem solving and planning measures that will ensure the greatest degree of anonymity. Arthur may have concerns about how his standing within the prison community could be affected if the information was leaked.

- He may also have real concerns about his safety. We can assume that Arthur has had exposure to danger and violence during his lifetime, and attending to his perception of personal safety will promote engagement.

#5 Resources

- Curricula tailored to African Americans, IV drug users and faith-based organizations are available from the Centers for Disease Control. Client education handouts from these interventions could be used to inform Arthur. Community HIV/AIDS prevention educators may offer responsive support for Arthur.

- Arthur could be offered an opportunity to train to become a peer educator. Films and videos are also available that respond to prison populations, drug users and diverse individuals. These can be shown in group to all RSAT clients.

- Arthur will also benefit from access to individual counseling regarding his health issues and opportunities to work with members of the medical staff.

- For more information see *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (2001): http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

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