

Module Nine

HIV, Mental Health, and Prisons

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1. Why a module for HIV, mental health, and prisons?

The U.S. is facing twin epidemics of incarceration and HIV-infection. Over the past decade in the U.S., the “war on drugs” and tougher sentencing policies have resulted in increasing rates of incarceration (Belenko, 1998), particularly among women and minorities. Inmates are serving longer sentences due to mandatory minimum sentences and “truth in sentencing” legislation. In addition, reincarceration for parole and probation violations is increasing. Because of the high costs of incarceration, less money is available for programs and services and correctional systems are moving in the direction of custody rather than rehabilitation. At the same time, prisons and jails are housing more people with HIV/AIDS and more people at risk for acquiring HIV-infection through substance use and high-risk sexual activities.

For most incarcerated people, the greatest risk for HIV/AIDS is not within the walls of prisons and jails, but in the “free world” before and after incarceration. However, there are increasing numbers of research reports on high-risk behaviors (sexual risk, drug injection, and tattooing) occurring within correctional systems and some evidence of HIV-transmission in correctional settings (e.g., Krebs and Simmons, 2002).

Although the confluence of HIV and other infectious diseases, substance abuse, and incarceration has strained correctional system resources, it has also provided a unique opportunity for collaboration between correctional systems, public health agencies, health care providers, research institutions, and community-based organizations. To seize these unique opportunities to enhance HIV-prevention and care within and outside the correctional system, community providers must become familiar with the unique constraints of correctional environments. In turn, correctional staff must become familiar with prevention and management of HIV/AIDS, hepatitis, sexually transmitted diseases, and other infectious diseases. Incarcerated individuals with HIV face multiple challenges. People with HIV are often dually diagnosed with chemical dependency and HIV, or triply diagnosed with HIV, chemical dependency, and a mental health disorder. Major depressive symptoms, physical pain, and coexisting schizophrenia-like disorders are common. Medical and psychosocial services are needed to help HIV positive individuals and those who are at risk for HIV adjust and cope in the correctional system.

2. Epidemiology.

A. Prisons and jails in the U.S.

Incarceration rates in the U.S. are higher than in all other nations of the world. In February 2002, the U.S. incarceration rate was 699 per 100,000 population (International Center for Prison Studies, 2002). The next highest incarceration rates were found in the

Russian Federation (676 per 100,000), the Cayman Islands (600 per 100,000), and Belarus (554 per 100,000). By comparison, the incarceration rate in Canada was 102 per 100,000 and in Mexico, 148 per 100,000.

At midyear 2001, prisons and jails in the U.S. housed 1,965,495 persons, including 1,334,255 in State, District of Columbia, and Federal facilities and 631,240 in local jails (U.S. Department of Justice, 2002a). From 2000 to 2001, the total incarcerated population increased 1.6% - a dramatic reduction from the 4% average increase reported each year from 1995 to 2001. At midyear 2001, 1 in every 145 U.S. residents was incarcerated.

Incarceration rates are highest among minority men aged 25 to 29: 13.4% of Black men, 4.1% of Hispanic men, and 1.8% of White men in that age range were incarcerated in 2001 (U.S. Department of Justice, 2002a).

The female inmate population more than doubled between 1990 and 2001; the number of female prisoners increased 114% while the number of male prisoners increased 80%. At midyear 2001, 94,336 women were under the jurisdiction of State or Federal correctional authorities, with 86,301 women serving sentences of more than one year. The annual rate of increase for female inmates averaged 7.5% between 1990 and 2001, higher than the 5.7% average annual rate of increase for male inmates. In June 2001, women accounted for 6.7% of all prisoners in the U.S. Incarceration rates for Black females were 380 per 100,000, compared to 119 per 100,000 for Hispanic females and 67 per 100,000 for White females. These differences were consistent across all age groups (U.S. Department of Justice, 2002a).

Jails are local facilities that house individuals before and after adjudication by the courts. Typically, jails house inmates serving short sentences (less than one year), but are also responsible for individuals awaiting trial or sentence; readmission for probation, parole, and bond violators; housing "overflow" for inmates from State and Federal facilities; and supervising community-based alternatives to incarceration. At midyear 2001, 702,044 persons were under jail supervision. The majority of people under jail supervision are minorities, with 43% White, 41% Black, and 15% Hispanic (U.S. Department of Justice, 2002a).

The correctional system is a revolving door with a continuous stream of inmates being admitted and released into the community (Rapposelli, et al. (2002). Half of all jail detainees are released back to the community within 24 to 48 hours. All jail inmates and almost all prison inmates are released eventually, bringing existing problems, medical conditions, and high-risk behaviors back with them into the community (Centers for Disease Control and Prevention, 2001). In 2000, 625,964 prisoners with a sentence of more than one year were admitted to State or Federal custody and 606,225 were released. Parole violation is an increasing problem, with the number of returned parole violators increasing 54% from 1990 to 1998, compared to a 7% increase in new commitments. Of 582,232 inmates with a sentence of more than one year entering State correctional systems in 2000, 350,431 (60%) were new court commitments and 203,569 (40%) were parole violators (U.S. Department of Justice, 2002a).

B. HIV/AIDS in U.S. prisons and jails.

The number of diagnosed AIDS cases in State and Federal prisons increased each year from 1995 to 1999 and declined in 2000 (U.S. Department of Justice, 2002b). In 1999, the rate of confirmed AIDS in State and Federal prisons was five times higher than in the total U.S. population - 0.60% for State and Federal prisoners vs. 0.12% for the U.S. population (U.S. Department of Justice, 2001) and in 2000, declined to approximately four times higher - 0.52% for State and Federal prisoners vs. 0.13% for the U.S. population (U.S. Department of Justice, 2002b). In 2000, confirmed AIDS cases ranged from 0.2% of all inmates in the Midwest to 1.1% in the Northeast, with the highest percentages in New York (1.6%), Connecticut (1.5%), Maryland (1.4%), and Massachusetts (1.3%; U.S. Department of Justice, 2002b). In 1999, 27.9% of all HIV+ inmates had received a diagnosis of AIDS (U.S. Department of Justice, 2001).

The number of AIDS-related deaths in prisons and jails has declined 80% since 1995. In 2000, AIDS-related causes accounted for 6% of all deaths among State prisoners, a decrease from 32% in 1995 (U.S. Department of Justice, 2002b). This dramatic decline in AIDS-related deaths in prisons corresponds with increasing access to screening and treatment programs in correctional settings during the 1990s. Federal and state prison systems now routinely provide access to highly active antiretroviral therapy (Rapposelli, et al., 2002). Interestingly, the rate (20 per 100,000) of AIDS-related deaths for State inmates in 1999 was lower than the rate (25 per 100,000) for a comparable group in the general population (U.S. Department of Justice, 2002b), suggesting that for some individuals, access to quality HIV care and treatment may be greater in the correctional system than in the “free world.” In 2000, AIDS-related deaths accounted for 8.4% of all deaths in State prisons and 7% in Federal prisons (U.S. Department of Justice, 2002b).

Rates of HIV-infection among State and Federal inmates also declined from 2.3% in 1995 to 2.0% in 2000. The percentage of inmates known to be HIV+ varied dramatically across geographic regions, from 0.9% in the West to 5.2% in the Northeast, with the highest percentages in New York (8.5%) and Maryland (4.3%; U.S. Department of Justice, 2002b). The burden of HIV and AIDS falls on local jails as well as on State and Federal prisons. In 1999, 1.7% of jail inmates tested positive for HIV, ranging from 0.8% in the Midwest to 3.8% in the Northeast. AIDS was the third leading cause of death in jails, accounting for 8.5% of all jail deaths in 1999 (U.S. Department of Justice, 2001).

Surprisingly, rates of HIV-infection are higher among female inmates in all regions: Northeast (10.3% females and 4.9% males), Midwest (1.2% females and 1.1% males), South (3.8% females and 2.2% males) and West (1.3% females and 1.0% males). In 2000, there were 2,243 female inmates with HIV, 3.6% of the female inmate population and 20,949 male inmates with HIV, 2.0% of the male inmate population. The highest percentages were in the District of Columbia, where 41.0% of female inmates were HIV+, followed by New York (18.2%) and Nevada (12.4%; U.S. Department of Justice, 2002b).

Legally, prison officials must provide health care for people living with HIV/AIDS in the correctional system. In 1976, the U.S. Supreme Court ruled that “deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment of the Constitution” (National Commission on AIDS, 1991). However, providing community standards of care for HIV/AIDS in correctional systems has, in many areas, strained correctional budgets and reduced funds available for other medical conditions and programs.

C. Sexually transmitted diseases and Hepatitis B and C in correctional populations.

Numerous studies have documented the high prevalence of STDs in prison and jail populations. Among states reporting to CDC as part of the Jail STD Prevalence Monitoring Project, the median percentage of reactive syphilis tests was 6.4% for women and 2.5% for men (Centers for Disease Control and Prevention, 2000). Although few prisons or jails conduct routine screening for asymptomatic STDs other than syphilis, rates of STDs among correctional populations are substantially higher than in the U.S. general population (Hammett, Harmon, and Maruschak, 1999).

Hepatitis C (HCV) is a blood-borne viral infection most commonly transmitted through injection drug use and sharing contaminated needles (Association of State and Territorial Health Officials, 2000). Approximately 15% of people infected with HCV will eventually clear the virus without treatment; however, 85% will develop chronic HCV infection and 70% will eventually develop chronic liver disease. HCV is the leading cause of liver transplants in the U.S., but because the disease progresses so slowly, most people with HCV are unaware that they are infected.

Rates of HCV infection are dramatically higher in incarcerated populations than in the general population. Each year, 1.4 million HCV-infected persons pass through correctional facilities, accounting for one-third of all HCV cases in the U.S. There is no vaccine to prevent HCV-infection and the standard treatment reduces HCV to undetectable levels in only 30% of patients, with no substantial benefit for the remaining 70%. Correctional systems are concerned about the potential financial strain that HCV will place on corrections budgets, given that treatment for one inmate with HCV can cost up to \$14,000 per year. However, not all individuals with HCV are candidates for treatment or will accept treatment.

Hepatitis B (HBV) is viral infection transmitted through percutaneous and mucosal exposure to blood, semen, and vaginal fluids (Blostein & Clark, 2001). Similar to HCV, it is a potentially life-threatening infection; however, unlike HCV, HBV is vaccine-preventable. Between 200,000 and 300,000 Americans become infected with HBV annually (McQuillan, Coleman, Kruszon-Moran, Moyer, Lambert, & Margolis, 1999) and 30% of these new infections have been detected in people with a history of incarceration (Goldstein, Alter, Williams, Moyer, Judson, Mottram, Fleener, Ryder, & Margolis, 2002). For over 20 years, a safe and effective vaccine has been available to prevent HBV, but few prisons or jail systems routinely vaccinate inmates.

D. Incarceration, HIV, and STDs in juvenile offenders.

Each year, approximately 1 million adolescents are placed in legal custody (Morris, 1995). Almost all the adolescents are male (90%). Approximately half are African-American (46%) with 36% Caucasian and 14% Hispanic-American. Most juveniles are incarcerated for property offenses (40%), violent offenses (26%), or drug offenses (14%). A small number of juveniles were incarcerated for status offenses (4%) or were held because they were abused, neglected or dependent youth (1%) (Office of Juvenile Justice and Delinquency Prevention, 1995).

According to the Centers for Disease Control, as reported up to June 2001, approximately 4,219 cases of AIDS among youth aged 13 to 19 years were identified. Of the adolescents identified, 54% were female and 46% were male. Of adolescents diagnosed with AIDS, half were African-American (50%), 28% were Caucasian, 20% Hispanic-American, and 2% were Asian/Pacific Islander (CDC, 2001). Among adults 20 to 29 years, 130,965 cases of AIDS have been reported, or approximately 40.6% of the total AIDS cases (CDC, 2001). Given that AIDS symptoms can take up to ten years to develop, many of these individuals were likely infected as adolescents.

While no studies have examined the actual rate of HIV infection among incarcerated juveniles, studies with comparable high-risk populations have shown a high rate of HIV infection. For example, a study of juveniles at a facility for runaway and homeless youth showed that 5.3% of the 2,667 adolescents tested positive for HIV (Stricof et al., 1991). Further estimates from runaway shelters indicate as many as 15-30% of homeless youth could test positive for HIV. When examining youth who engage in sex for money, that figure could rise to 50% (Hersh, 1988).

Rates of sexually transmitted diseases can give another indication of the actual rates of HIV infection among juveniles. Approximately 63% of all STD patients were under the age of 25 in 1990. Individuals 10-24 years of age accounted for 60% of gonorrhea cases, 74% of chlamydia cases, and 34% of all primary and secondary syphilis cases in 1990 (CDC, 1994).

Among detained youth, approximately 62% reported becoming sexually active by age 12, while 89% were sexually active by age 14 (Morris et al., 1995). Further, of the incarcerated youth who were sexually active, 52% reported eleven or more partners. Of sexually active youth, 67% reported that they did not use a condom during their last sexual intercourse (Morris et al., 1995).

According to the 1999 Youth Risk Behavior Surveillance 49.9% of all high school students reported having sexual intercourse in their life.

- Overall, African-American students (71.2%) were significantly more likely to have engaged in sexual intercourse than Hispanic-American (54.1%) or Caucasian (45.1%) students.

- Nationally, 8.3% of students reported sexual intercourse before age 13, with male students (12.2%) more likely to report sex by age 13 than female (4.4%) students.
- Of the students who reported sexual intercourse, approximately 16.2% reported having four or more sexual partners.
- Among sexually active students, 58.0% reported using a condom during their last sexual intercourse.
- Male students (65.5%) were more likely to report condom use than female students (50.7%).
- African-American students (70.0%) were more likely to use a condom than Hispanic or Caucasian students (55.2% and 55.0%, respectively).
- Alcohol or other drug use was reported by 24.8% of sexually active students during their last sexual intercourse.
- Nationwide, 6.3% of students reported that they had been pregnant or had gotten someone else pregnant.
- Overall, 90.6% of students had been taught in school about AIDS or HIV infection (MMWR, 2000).

E. Substance abuse

Prevalence. Substance abuse rates among prisoners are high and have increased in recent years (Mumola, 1999).

- Eighty-three percent of state inmates reported past drug use and 75% of all prisoners can be described as being involved with drugs or alcohol at the time leading to their arrest (Mumola, 1999), with 1 in 6 reported committing their crime to obtain money for drugs.

The rampant involvement with drugs is reflected in high rates of HIV infection, which are five times higher for prison populations and AIDS death rates are three to four times higher in this group than in the general population (Hammett et al., 1999).

Hepatitis C is a more recent concern, with estimates of 30-40% of the prisoners infected (Hammett et al., 1999).

Treatment.

Substance abuse services for inmates in prison have been declining while substance abuse rates have been increasing (Mumola, 1999).

- Among inmates who reported using drugs in the month prior to their arrest in 1997, only 15% of state and federal inmates reported receiving substance abuse treatment during their incarceration, a decline from approximately a third of inmates in 1991 (Mumola, 1999).
- Among individuals who were using drugs at the time of their offense, only 18% of both state and federal inmates in 1997 reported participating in drug treatment program, down from 40% in 1991 (Mumola, 1999).

F. Mental health problems

Prevalence. *1 in 4 persons have a mental health diagnosis (Dept of Justice).* In a report by Bureau of Justice statistics, it is estimated that 16% of inmates have a serious mental condition (Ditton, 1999). Other estimates place the percentage of mentally ill in prisons ranging from 7.6% to 36.5% (NIC, 2001), with 14.7% having such disorders within the past year.

The large number of mentally ill seen among prison populations is believed to be due, in part, to the de-institutionalization of mentally ill persons in the community (NIC, 2001).

Overall, almost a third of all inmates reported a current mental condition or had received mental health services at some time (Ditton, 1999). Compared to the general population, inmates are 5-30 times more likely to be given a diagnosis of a serious mental disorder (Chiles, Von Cleve, Jemelka, & Trupin, 1990).

A recent review of male and female prisoners world-wide in the literature concluded that 1 in 7 prisoners in western countries have a psychotic illness or major depression, while 50% of male prisoners and 20% of female prisoners have antisocial personality disorder.

Prisoners have twice to quadruple the risk for a psychosis or major depression compared to the general population (Fazel & Danesh, 2002). Specifically, 3.7% of men and 4.0% of women were diagnosed with a psychotic illness, 10% of men and 12% of women had major depression, and 65% of men and 42% of women were diagnosed with a personality disorder (of that, 47% of men and 21% of the women had antisocial personality disorder) (Fazel & Danesh, 2002).

It should be noted that the prevalence of psychiatric conditions among incarcerated women is estimated to be twice as high as men (NIC, 2001), with approximately 29% of Caucasian women and 20% of African-American women in prison identified as having a mental illness (Ditton, 1999).

Caucasian women who were 24 years or younger had the highest rates of mental illness (37%) compared to 17% of African-American women in this same age group (Ditton, 1999).

In addition to mental illness, women prisoners have high rates of physical and sexual abuse, with nearly 80% of incarcerated mentally ill females having been victims of abuse (Ditton, 1999).

Treatment

It is estimated that only 80% of mentally ill inmates receive mental health treatment while incarcerated in state or federal prisons. During incarceration, about 50% of mentally ill inmates received medication, and 44% received counseling or therapy.

Approximately a quarter (24%) had to be admitted overnight to a mental hospital or treatment program while incarcerated. For mentally ill individuals in jails, only 40.9% received some type of mental health treatment. Overall, approximately 17% of state inmates, 10% of federal prisoners, and 11% of jail inmates received mental health treatment during their incarceration (Ditton, 1999; NIC, 2001).

3. Ethical guidelines for conduct of research with incarcerated populations.

In May 2000, the Office for Human Research Protection (OHRP) instituted more stringent federal regulations to protect the rights of prisoners involved in research.

Prisoners are defined as “individual(s) involuntarily confined or detained in a penal institution” and the definition is intended to “encompass individuals sentenced to such an institution under a criminal or civil statute; individuals detained in other facilities by virtue of statutes or commitment procedures, which provide alternatives to criminal prosecution or incarceration in a penal institution; and individuals detained pending arraignment, trial, or sentencing” [45 CFR 46.303(c)].

Prisoners have long been considered a “vulnerable population” requiring stringent ethical safeguards for research. However, the new regulations limit the types of research that can be conducted with prisoners, pose extra responsibilities for investigators and Institutional Review Boards (IRBs); and require documentation of oversight by OHRP for all prison-related research. These regulations apply to researchers affiliated with institutions that are required by federal statute to have an Institutional Review Board; however, the spirit of the regulations - to protect the rights of prisoners - should be adopted by anyone conducting research with prisoners.

There are several main ethical concerns governing research with prisoners. These concerns have grown out of a history of abuse of prisoners in research in the U.S. and around the world. First, prisoners may not be exposed to harm or risks that are not commensurate with harm or risks that would be considered appropriate for research with other populations. Second, prisoners must receive benefit from their participation in research. Third, because of the inherently coercive nature of incarceration, the right of

prisoners to give or withhold truly informed consent for participation must be safeguarded.

The first two categories of safeguards are relatively straightforward. Some types of research that would expose prisoners to excessive risk are simply not allowable. In addition, prisoners may not be assigned to control conditions that confer no direct benefit.

The most complex requirements ensure truly informed consent. For research in any setting with any population, the fundamental protection for participants is their ability to be informed fully about the risks, benefits, and procedures of a study prior to giving consent to participate and the ability to give or withhold consent to participate. These requirements are more difficult and complex to ensure with an incarcerated population.

First, many incarcerated individuals have less education, fewer reading skills, and often, cognitive impairments due to mental illness, substance abuse, or injury. Therefore, the burden is on the researcher to present complete information about the study in ways that are understandable. The researcher must ensure that the prisoner is capable of providing informed consent and understands the information well enough to give informed consent. Examples of methods to ensure understanding are writing consent forms in simple language at a Grade 3 or 4 reading level; training staff to solicit and answer questions about the research; providing enough time for staff members to explain studies fully and obtain informed consent; and asking participants to explain important details of the study and their participation to ensure that they understand essential features before giving consent.

Second, participants must be free to give or withhold consent to participate. The researcher, who has a strong interest in recruiting participants, must nonetheless ensure that potential participants feel free to refuse participation. Correctional institutions are inherently coercive and there are few opportunities for inmates to refuse participation in programs or activities. Most often, refusing to participate results in disciplinary actions. Hence, incarcerated individuals are predisposed to agree to participate, whether they want to or not, simply because they have little experience of being allowed to refuse without negative consequences. Therefore, as much as it might pain an individual researcher, his or her primary responsibility is to ensure that the potential participant realizes that participation is voluntary, that he or she is free to refuse to participate, and that there are no negative consequences for refusing. This is contrary to most in-prison activities and requires much time, effort, and diligence by the researcher. Participants must also know that they are free to quit at any time, for any reason, without any negative consequences. Consent to participate and consent to continue to participate are voluntary – which is different from most programs in correctional facilities.

Closely related to the idea that potential participants cannot be forced or coerced to participate is the idea that potential participants cannot be offered overwhelming incentives to participate.

In most correctional facilities, a sizeable proportion of inmates have little access to spending money, snacks, treats, cigarettes, toiletries and stamps - everyday items that people in the free world take for granted. In some facilities, inmates earn money from prison industries or other in-prison employment, but in many facilities, inmates have little opportunity to earn money and rely on family members and friends to provide everyday necessities. Hence, incentives that would be modest in the free world might be so overwhelming that inmates could not turn them down.

One of the most powerful motivators in correctional systems is the opportunity for early release or parole - motivators that are so powerful that they would be coercive. Consequently, OHRP explicitly forbids parole, early release, or sentencing considerations being used as incentives for research participation. Researchers are responsible for ensuring that potential participants understand that there is no relationship between participating in research and any of the conditions of their incarceration. Many correctional systems go so far as to explicitly prohibit all incentives for research participation.

Numerous resources exist to help researchers design and carry out ethical studies within correctional systems.

- The website for OHRP (<http://ohrp.osophs.dhhs.gov/>) provides information on ethical safeguards for incarcerated populations and OHRP staff are available to answer questions and make suggestions to researchers.
- IRBs provide ethical oversight and additional safeguards for the rights of prisoners and OHRP provides final approval for all research protocols involving prisoners.

However, one of the greatest challenges that remains for researchers in correctional systems is the correctional system itself and corrections staff and administrators. Many correctional systems are happy to have research programs operating in their facilities and will go to great lengths to help researchers - sometimes to the detriment of ethical safeguards. One of the major tasks of researchers in correctional environments is educating administrators to understand ethical safeguards for prisoners and to help administrators set up internal review of prison-related research.

During the course of our prison research, we have had administrators attempt to “help us out” by ordering prisoners to attend information sessions and volunteer for our research programs. Parole boards have mandated participation in our research programs as a condition for release. In each of these instances, the intent was benign. The correctional system valued our programs and wanted to help; however, the unintended consequence was to place our research program in danger of ethical violations. Fortunately, with a little extra education on our part, corrections administrators realized that the greatest help they could provide was to allow inmates to choose freely to participate or to refuse. In research, as in any other endeavor in correctional systems, educating the system and the administration is fundamental to a successful collaboration.

4. Health Status of Incarcerated Populations

Medical costs for inmates currently account for 11% of the Department of Correction's budget and are expected to rise in the next ten years (Lamb-Mechanick & Nelson, 2000). For example, 1 in 6 inmates reported a medical problem, even though 88% of inmates are younger than 50. The most common medical problems reported were heart problems (1.1%), circulatory (2.4%), respiratory problems (1.4%), kidney and liver problems (0.9%), and diabetes (0.9%) (Maruschak & Beck, 2001).

Utilization of health care is particularly high among older inmates (50 or older), even though they only represent 4% of the overall prison population. It is estimated that 83% of inmates in Michigan over the age of 50 had at least one chronic illness (Thorburn, 1995). The most common complaint among older inmates is chest pain, which was reported by 61% (Colsher et al., 1992). Overall, while 65% of inmates over 50 rated their health as "good" or "excellent," about half reported that their health had declined since incarceration (Colsher et al., 1992). Further, among newly incarcerated individuals (of any age), approximately 40% had a significant medical condition (Albrecht, 1993).

Inmates utilize prison health care services at a higher rate than their non-incarcerated peers. The reasons for this higher utilization are complex and include prior poor access to health care prior to incarceration and unhealthy lifestyles. Because of these health problems, many inmates have aged more rapidly than their peers (Albrecht, 1993).

In addition, the stressful nature of incarceration may also have contributed to the declining health among inmates. Several studies have investigated the effects of negative life events on prison health utilization. In a prospective three month study of inmates in a federal correctional facility, Suls et al. (1991) found that negative life events increased the probability of clinic use and illness behavior. Contrary to the belief that inmate habituate to the stress of incarceration and are less affected by additional stressors, acute life changes also increased medical utilization. This finding was true for stressors inside prison as well as outside of prison.

Some of the stressors that inmates encounter inside the prison include overcrowding, violence, the effects of confinement, and a decline in prison programs and services (Kupers, 1996).

The threat of violence is particularly stressful and it is estimated that 20% of prisoners are raped during the course of their prison sentence (Polych, 1992). It is well documented that witnessing or being a victim of violence may lead to psychiatric conditions such as depression and post-traumatic stress disorder (PTSD). Isolation is one way that some prisoners may try to cope with the stressful nature of incarceration and it is estimated that 20% to 30% of prison inmates choose to spend the majority of their time alone in their cell and not interacting with other people. Further, it is estimated that approximately 10% of the prison population is confined in secured housing ("solitary confinement"). The effects of solitary confinement and isolation also increase the stressful nature of incarceration (Kupers, 1996).

Finally, African-American inmates used the health care clinic at a higher rate than Caucasian inmates, even when controlling for stress. This higher rate of utilization for African-American prisoners was believed to be due to more pre-existing health problems than other ethnic groups at the time of incarceration (Suls et al., 1991).

The National Commission on Correctional Health Care (NCCHC) provides excellent material on health issues and health care in correctional systems on their website at <http://www.ncchc.org>. This organization is a valuable resource for mental health and other professionals providing services in correctional settings.

Women's Health

Women who enter prison have numerous health problems that persist throughout their lifetime. Common health problems include substance abuse, psychiatric disorders, hypertension, respiratory problems, seizure disorders, gynecological problems, gastrointestinal problems, and obesity (Ingram-Fogel, 1991).

It is estimated that 10-50% of women entering prison have an STD (Ingram-Fogel, 1991). Among African-American women, the risk of cervical cancer is twice as high as Caucasian women entering prison, and African-American women have higher rates of diabetes mellitus, poor nutrition, lower self-esteem, and more adverse environmental conditions than Caucasian women (McGaha, 1987).

5. Special considerations for “free world” professionals providing services in correctional systems

This section is written to provide information for mental health and other professionals from the free world who are interested in providing services in correctional settings. The intent of the section is to provide background information to help outside professionals adapt to the unique constraints of practicing within correctional systems.

At first, most professionals are apprehensive and uncertain about working within correctional systems. However, with preparation, examination of personal attitudes and values, and willingness to work with correctional systems and administrators, providing services for offenders is satisfying professionally and personally. The most important caveat is that the free world is different from the correctional world.

Outside professionals need to understand the culture and constraints of the correctional system so they can provide effective services for needy and under-served individuals.

A. Knowing and feeling comfortable with inmates

The first step in providing effective services in correctional settings is becoming comfortable with inmates. Everyone carries stereotypes of prisoners into their work in the correctional system: - “most inmates are violent and dangerous;” “most inmates are in prison for a long time, if not forever;” “inmates are different from the rest of us.”

Prior to embarking on work in a correctional system, it helps to think about, and even write down, your expectations of inmates. One of the biggest challenges for professionals is to look beyond the prison uniform and the Department of Corrections number and see an inmate as a person not very different from people in the “free world.” In fact, given the high rates of incarceration and reincarceration in the U.S., most mental health and health professionals have – knowingly or unknowingly – provided services to individuals who were formerly incarcerated. In fact, approximately one in five individuals with AIDS has been incarcerated at one time or another (Maruschak, 1999).

All incarcerated individuals came from the free world and most return to the free world - sooner rather than later. Most inmates are incarcerated for relatively short periods of time for non-violent offenses and a common reason for incarceration is parole violation, suggesting that there are huge challenges to staying out of prison after release.

Note: *Recidivism* and *reincarceration* are often confused; recidivism generally refers to being incarcerated for a new offense and reincarceration generally refers to being incarcerated again for a previous offense. The most common reason for reincarceration is parole violation.

For women, the most common offenses are drug-related, usually simple possession, or non-violent offenses such as shoplifting or forgery.

Unlike the stereotype of incarcerated women as hardened, violent criminals, the majority of women in correctional settings are young, minorities, poor, uneducated, and mothers of young children. Most are desperately concerned about the welfare of their children, are grieved to be away from their children, and are primarily concerned with getting back to their children and providing a stable life for them. They are also concerned with how to keep outside relationships stable while they are incarcerated and how they will survive, find a place to live, get a job, earn enough money to support their families, and stay out of trouble when they are released.

Adolescent females in juvenile detention are often incarcerated for status offenses, generally sexual activity and incorrigibility.

Compared to women, men are more often incarcerated for violent offenses, but most are incarcerated for non-violent offenses and are serving relatively short sentences. They share many of the same concerns as incarcerated women: how to sustain outside relationships during incarceration, how to maintain contact with their children, how to stay out of trouble while in prison, how to find a job and a place to live on the outside, and how to avoid reincarceration.

Adolescent males in juvenile detention are often incarcerated for drug offenses and property offenses.

B. Understanding the corrections climate.

Correctional systems have a hierarchical and military structure. The immediate and primary goal of this structure is to maintain order and prevent injury to inmates, staff, and visitors. The best way to ensure a long and successful working relationship with the correctional system is to respect and work within this structure.

Correctional systems tend to be organized into several major components: administration, security, and programs.

- Administration includes superintendents and wardens and is responsible for adhering to Department of Corrections and State or Federal requirements and for the day-to-day management of the facility.
- Security is responsible for maintaining order and safety in the institution.
- Programs are responsible for educational and training programs, substance abuse and other treatment, and counseling and case management.

In most correctional systems, resources are allocated first to security and later to programs - which is often difficult for outside professionals, steeped in the importance of programs, to understand.

Uniformed security is military in structure and discipline. The lowest ranking officers are responsible for day-to-day management of inmates, adherence to schedules and rules, safety and order, and transportation of inmates within the institution. Generally, inmate movements are tightly controlled within correctional institutions and the activities of the institution are often interrupted for inmate counts.

A mental health professional from outside may schedule a group meeting or individual counseling session only to discover that the security staff was not informed or were not available to escort the inmates to the group or session.

Good advice for outside professionals is to take a book or other work with you to while away those inevitable times when you are waiting for inmates to be transported or waiting for an inmate count to “clear.”

Inmates have very little formal power in the institution. Therefore, their ability to get what they need is based primarily on their ability to influence other inmates, staff, or visitors - including outside professionals.

Outside professionals often find themselves distracted by inmates who view them as potential advocates in the legal system. Most new professionals find themselves overwhelmed by stories of judicial malfeasance, incompetent lawyers, and malice by security and administrators. Many of these stories are genuine and heart-wrenching and most professionals feel a sense of outrage and injustice. However, being able to provide the services you came to provide means figuring out how to avoid being distracted into another role, that of prisoner advocate.

Correctional systems are impersonal. Prisoners wear uniforms and are identified by number. Personal expression in jewelry, hair, and clothing is limited. However, people in prison work assiduously at maintaining individuality even while the system works to remove it. In many women's prisons, you will see beautiful and intricate patterns of creases ironed into prison shirts, giving individuality and beauty to uniforms.

C. Understanding the different cultures of public health, rehabilitation, and security

Outside professionals often view incarceration as a window of opportunity for rehabilitation, retraining, and education. However, the primary responsibility of correctional systems is for inmates to serve their time without incident. Many correctional administrators would prefer to focus on rehabilitation and education, but correctional systems are under extreme budget constraints and security is the main priority.

Many professionals in the area of HIV see incarceration as an opportunity for HIV education, prevention, counseling, testing, and treatment (Ehrmann, 2002). However, these activities are not top priorities in correctional systems with limited budgets. In addition, HIV-prevention, education, and management raise complicated issues in correctional systems.

Free world research has identified the essential features of effective HIV-prevention interventions: repeated sessions, behavioral skills training, and communication of specific prevention information. However, in correctional systems, sex and injecting drug use, the primary vectors of HIV-transmission, are proscribed activities.

Except for conjugal visitation, sex is forbidden and can result in disciplinary actions. In addition, the usual methods of harm reduction - sterile needles, bleach, or condoms - are contraband, with serious consequences for their possession.

Finally, correctional systems must approve the content and presentation of educational materials. Many correctional systems will not allow condoms or mock needles to be brought in for demonstration purposes and many will not allow educational materials that are deemed to be explicit or inconsistent with prison policies.

Therefore, HIV-educators in correctional systems must adapt their materials and presentations to institutional policies and regulations that vary from system to system and

across facilities within the same system. Outside professionals must be familiar with corrections regulations, adhere to those regulations, and be willing to work with corrections administrators.

HIV-educators view condoms, clean needles, and bleach as common sense harm reduction methods. However, in most correctional systems, counseling to reduce the risk of HIV-infection in prison is seen as providing inconsistent messages about sex and drugs to inmates and staff. Many HIV-educators work within those constraints by focusing on HIV-risk after release, rather than directly addressing HIV-risk in prison. Similarly, condoms, clean needles, and bleach are viewed as serious safety and security problems.

D. Understanding the lack of resources in correctional systems

Despite current publicity about the proportions of state and federal budgets that are devoted to corrections, most correctional systems are undergoing severe budget restrictions that affect their ability to offer anything beyond a secure environment for inmates and staff. Corrections budgets come from state and federal appropriations and are highly politicized.

Faced with state budget cuts for Medicaid, education, and other programs, few legislators are willing to argue for increased funding for educational or health initiatives within correctional systems, even when such programs could save money in community health care costs or recidivism. Prisoners have a constitutional right to health care because they are involuntarily detained.

Given the confluence of infectious disease (HIV, hepatitis, tuberculosis), mental illness, and substance abuse in correctional populations, prisons are finding their budgets increasingly consumed by basic health care costs, leaving fewer funds available for health prevention programs and education and rehabilitation programs. As health care costs consume increasingly large proportions of correctional budgets, money available for all other programs will decrease.

In this environment, prison administrators have little money to devote to programs and are often receptive to working with outside professionals and community agencies who can provide otherwise unavailable services for inmates. However, outside professionals have to be willing to work within the limitations of prison resources.

For example, in most correctional facilities, space is at a premium and programs are conducted in spaces that are noisy, crowded, or otherwise less than perfect from a pedagogical point of view. We've done assessments in libraries, lawyer's rooms, holding tanks, borrowed offices and conference rooms and conducted educational groups in libraries, conference rooms, visitor's centers, gyms, dining halls, chapels, rooms loaned from other programs, and occasionally, classrooms.

Before embarking on a program within a correctional system, an assessment of what is available to support the program is essential, including an assessment of space, security

staff time to escort prisoners to groups and assessments, VCRs, slide projectors, blackboards and easels, paper, overheads, pencils, books, slides, and demonstration materials. Often, outside professionals find themselves scraping up funds from outside sources to provide materials for in-prison programs.

E. Working within the rules and regulations of the institution

No matter how important the service you provide, as an outside professional, you are a guest in the correctional system, serving at the will and pleasure of the administration. You can be a welcome guest by knowing and adhering to the rules and regulations of the system.

Many correctional systems require outside professionals to complete volunteer orientation training before being permitted to offer programs or services. These orientation sessions generally cover prison rules and regulations, interacting with inmates and staff, and dealing with prison emergencies. This training gives information to work successfully within a correctional system. Untrained volunteers can readily and unknowingly create security and disciplinary problems, for example, by giving inmates innocent items that are contraband (pens, pencils, stamps, or money), or doing favors that are forbidden (making phone calls or mailing letters). A simple and unknowing act of kindness can result in an outside program being removed from the prison or in disciplinary consequences for an inmate.

F. Limitations on privacy and confidentiality within correctional systems

As mental health professionals steeped in the ethics of confidentiality, working in a correctional system where little is confidential is challenging. Most correctional systems respect the importance of confidentiality for outside providers operating in the system; however, each system has explicit requirements for reporting.

All professionals are accustomed to reporting requirements for credible threats of harm to the self or others or to children or vulnerable adults. However, in prisons, threats of harm can take the form of information concerning planned breakouts – a source of harm that outside professionals may not consider. It is important to clarify your ethical reporting responsibilities and procedures. Similarly, you must plan how you will inform inmates clearly about the limitations of confidentiality in your work.

One important consideration, which will be discussed in greater detail later, is the problem of reporting suicidal ideation. In correctional settings, professionals must carefully balance the potential threat of self-harm with the potential harm caused by reporting. In prisons, threats of self-harm are generally not met simply with understanding and reassurance. Inmates who report thoughts or attempts at self-harm may be strip-searched and placed in segregation. Hence, your responsibility as a professional is increased to ensure that all potential harms are considered in reporting.

In addition, as a researcher, it is your responsibility to put in place measures (e.g., federal Certificates of Confidentiality) to prevent disclosure of personal and potentially damaging information collected in the course of research. In HIV research, information on sexual behavior and substance use has potential legal and disciplinary consequences for inmates. Researchers must ensure that that information is protected and that information that is potentially damaging is not collected.

6. Special considerations for Department of Corrections professionals providing HIV/STD/hepatitis services to inmates

This section will discuss the specific problems and challenges that a professional from within the correctional system may encounter when trying to offer programs for HIV prevention. As was mentioned above, professionals within this system may feel pulled in several directions. It is important to remain clear in your boundaries and professional responsibility to both your patients (inmates) and your employer (prison).

A. Stigma

Being a mental health or medical professional within the correctional system can be very challenging and stressful. Often, you may be viewed suspiciously by inmates and correctional employees alike. Inmates may not trust you due to your affiliation with the correctional environment and may see you as an extension of the institution.

Correctional staff may not trust you because you are not part of security and may be viewed as someone who is sympathetic to the plight of inmates. In some correctional systems, medical personnel are required to be dually trained as correctional officers, including such things as learning to fire a gun, responding to crisis situations, etc.

Striking a balance in which you can develop a trusting and therapeutic relationship with inmates, while maintaining good relationships with other correctional employees is essential. It is important to keep in mind, first and foremost, issues of security come first in a prison, and deviations from that mentality can get damage your reputation and relationships with prison officials.

Administration and other correctional staff may stigmatize you for working in “undesirable” areas (sex, drugs, and HIV). Often these problems are viewed by some correctional officials as the fault of the inmate, and prison officials may not understand the rationale for providing services to prevent these things (e.g., the inmates should just not do it, and if they do, they deserve whatever they get).

As a mental health professional wanting to provide these services, you may be viewed as a 'bleeding heart liberal' or naïve about inmates. You may be viewed as gay/lesbian, HIV+, or a recovering substance abuser because of your work. Also, in these days of state budget crises and shortages, allotting money to these types of programs can be resented,

especially given that other important areas within the prison (e.g., security) are often understaffed and under-funded.

Trying to convince your administrator that these programs are desperately needed in your prison may be difficult to sell, when they are trying to balance ensuring the safety of the inmates, employees and visitors. Emphasize to officials that you are saving them money as preventing the spread of HIV/STDs and other communicable diseases is less expensive than providing inmates with medical attention. However, given the budget shortages, the best strategy to try and implement these types of programs is to either incorporate a section into an existing program (e.g., an HIV prevention module in an already existing substance abuse program, adding an HIV

prevention program to a mental health treatment group or program) or obtain outside funding.

Trying to obtain outside funding (e.g., NIH funding) may not be feasible given the tremendous workload most mental health professionals working in corrections find themselves under. That said, forming affiliations with research universities who may be interested in doing research within the prison system may be a way to bring additional programs. For instance, if researchers at a university want to obtain grant funding to test an HIV prevention program, both the researcher and the prison would benefit from this arrangement. The researcher would be able to conduct much needed and highly fundable research and the prison will get the latest and presumably, most effective HIV prevention programs tailored to their population for free. Other sources of outside funding may include community sources (e.g., church groups, HIV prevention organizations, etc.).

B. Confidentiality and disciplinary infractions

As was mentioned in the section above, be sure to be clear to both inmates and staff about your obligations and ethical responsibility for reporting. Inmates may divulge reportable offenses (substance use, sexual activity, possession of contraband) to you in the course of your counseling, education, or prevention interventions. While most prisons only require suicidal or homicidal intent or ideation, child/vulnerable adult abuse, and threats to security (e.g., elopement or escape plans), be sure to check your specific requirements.

Some states require the reporting of all sexual and physical abuse, no matter how long ago it occurred. If this is the case in your state, as a mental health professional, you may be required to report on abuse that occurred when your patient was a child (and the perpetrator may be dead). The important thing is to clarify these issues by calling your state licensing board and checking with the prison administration. Then, be sure to outline the limits of confidentiality to every patient that you work with at the prison. Understand that while confidentiality issues may be clear to you, some prison administrators may not abide by these limits and try to pressure you to violate confidentiality of your patient. Be polite but firm in stating your reporting obligations to administrators.

Finally, while generally inmate disciplinary infractions are rarely issued by mental health/medical staff, be aware that you may be called upon or may need to issue such infractions to inmates.

Refusing medical treatment or missing a therapy appointment is not generally an appropriate reason for a disciplinary infraction, as anyone, including inmates, has the right to refuse medical treatment. Refusing medical treatment or missing therapy sessions is generally best handled in the context of the therapeutic relationship and explaining to the inmate the consequences of the refusal (e.g., they may be discontinued from your caseload, their medical condition may not resolve, etc.) is a more appropriate way to handle this situation.

7. Special considerations in providing information to corrections administrators, uniformed staff, and other staff

A. Administrators

Administrators operate in a highly public, highly-politicized system and senior administrators serve at the “will and pleasure” of the governor and legislature.

Often, when a new governor is elected, a new commissioner or director of DOC is also appointed. Therefore, being aware of the consequences of what you or your staff may do, or not do, when providing care to your patients is very important and can make or break your career.

It is important to know the climate of your specific jail or prison. Wardens and Superintendents, while under the general auspices of the Department of Corrections, run each facility individually. What may be an acceptable program for one warden at one institution may get you into big trouble in another institution. Be sure to ALWAYS get the permission of the appropriate parties, generally the warden, before implementing any new programs, especially programs that can be viewed as controversial or containing sensitive material (e.g., HIV prevention). As one Superintendent stated, “I believe in what you are doing but don’t EVER do anything to get me, or the prison, in the newspapers.” Be willing to give prison officials and administrators credit for encouraging programming.

B. Uniformed staff (correctional officers)

Understand that correctional officers have a very difficult and dangerous job. Correctional officers are continuously being “tested” by inmates, and also are under pressure from their supervisors to ensure that everything is done correctly. They are often poorly paid and receive little respect from society, who often view them as corrupt, criminal, and incapable of getting a better job. Further, many officers have little education or formal training and often have significant reading deficits.

While the field has generally been a male dominated one, in several states, including Mississippi, female correctional officers now make up the majority of security staff. Correctional officers, especially in small, rural areas, may be put in the awkward position of having to be the security for their friends, neighbors, and even family members. Also, in depressed areas of the country, being a correctional officer may be the only job available.

Security staff appreciate being treated with respect and consideration. Understand that officers have limited power and may not be able to get the other officers to send your inmates, clear the count, or anything else that you feel may be holding up the provision of services. Developing a professional relationship with officers is very important. Correctional officers will be the staff most likely to respond if you find yourself in a dangerous situation (e.g., being threatened by an inmate) at a prison.

Correctional officers appreciate the opportunity to get additional on-the-job training, because this can be used for possible advancement in the system. Officers can be put in a negative situation by not having access to the same information about HIV/STDs/hepatitis as the inmates. Additionally, recent research has shown that officers have significant fears and misinformation about HIV.

Although there have been no documented cases of workplace transmission of HIV to corrections staff, uniformed staff are gravely concerned about the possibility of workplace transmission of HIV/hepatitis through casual contact, exposure to blood and body fluids during fights, contact with “sharps” during shakedowns or searches, and the possibility of deliberate exposure to body fluids leading to infection (McIntyre et al., 1999).

Because of fears of transmission of infection and stigma about people with HIV, many officers do not want to have contact with HIV+ inmates. There are numerous anecdotal reports of correctional officers isolating HIV positive offenders and kicking their food to them.

Education about HIV and an atmosphere in which to discuss and deal with fears and stigma are important for officers in charge of HIV+ inmates. At Bedford Hills Correctional Center, the counseling and testing program was discontinued when inmates and outside educators became too demanding.

A similar situation occurred at the Tulsa Jail when inmates tried to educate prison correctional officers. When the correctional officers realized how well informed the women were about HIV, they confiscated all HIV/STD inmate developed prevention manuals.

These unfortunate circumstances can be avoided by working with the correctional officers and other staff to provide them with information, education, and an opportunity to understand and contribute to your program.

8. Special considerations in working with inmates

Providing HIV education, counseling, and support for inmates requires understanding of the corrections environment.

A. Lack of privacy

Although living circumstances vary across prisons and jails, almost uniformly, housing arrangements in correctional settings are noisy, stressful, and lack privacy. Inmates often find it difficult to identify a relatively private and quiet spot to complete homework assignments or read materials about HIV away from the scrutiny of staff and other inmates.

B. Knowledge is power

Because inmates have few legitimate avenues to power or control over their circumstances in jail or prison, having knowledge of the thoughts, fears, or concerns of other inmates provides some "leverage" or control. Therefore, inmates are often hesitant to divulge personal information in groups with other inmates for fear that sensitive information may be used against them by staff or other inmates.

C. Low educational and reading levels

Although prisons and jails house inmates with advanced training and degrees, for the most part, inmates have low educational levels and poor reading skills. In conducting assessments and educational and counseling interventions, professionals must be cognizant of the reading level of materials used and sensitive to the shame and embarrassment experienced by many inmates who cannot read or read well.

D. Sexual relationships within prisons can be for a variety of motives

Sexual activities in prison are like the proverbial "elephant in the dining room." Most administrators consider illicit sexual activities a serious threat to order. In addition, prison staff and inmates are aware of sexual activities between inmates, between inmates and visitors, and between inmates and staff. However, sex in prison is a problem no one wants to discuss, let alone to acknowledge that it places inmates, staff, and visitors at risk for transmission of HIV, hepatitis, and other STDs. Several recent investigations of STD outbreaks in prisons and jails have documented wide networks of sexual contact among inmates, visitors, and staff.

Sexual activities in prisons and jails occur for a variety of reasons: sexual release, sharing affection and comfort, cementing a relationship, meeting needs for power and dominance, and for money and barter of otherwise unavailable commodities.

Sexual activities in prison present a conundrum for administrators and HIV-educators. Sexual relationships occur and, as such, present a risk for HIV, hepatitis, and STDs. The risk is compounded by the lack of information and protection methods (e.g., condoms and barriers) available to inmates.

Some prisons and jails make condoms available; however, these prisons are in the minority and administrators are concerned that making preventive methods available gives a mixed message about sexual activities in prisons. Some prisons offer the opportunity for conjugal visiting and family house visits; in those circumstances, condoms and other preventive methods may be available for inmates and their spouses.

E. Situations and priorities inside prison are vastly different from what inmates face in the free world after release.

Circumstances change dramatically for inmates after release. Inmates who attended HIV prevention, education, or counseling programs in prisons and who were greatly concerned about HIV and greatly motivated to prevent or manage HIV often find the challenges of survival after release overshadow their concern for HIV.

For inmates recently released, the difficulties in finding housing arrangements that will be approved by parole officers; getting a job despite the stigma of being “an ex-con” and often, little education or job training; getting children back from relatives or foster homes; reestablishing relationships with partners and family members; and avoiding old friends and staying out of trouble can be overwhelming. Not surprisingly, many inmates fear and dread release day, even as they are living for the moment they step off the prison grounds.

Recently released inmates often experience depression and anxiety, feel vulnerable and visible in front of people who know they are “ex-cons,” and are overwhelmed with the number of decisions to be made each day. Prisons insulate inmates from decision-making. During incarceration, the days are regimented and choices are few. Inmates are told when to get up, what to wear, when to eat, when to smoke, when to work, when to study, what to say, where to go, and where not to go.

On the outside, days are unstructured and decisions and choices are overwhelming. Preventing and managing HIV require problem-solving, planning, and assertiveness - skills that are actively discouraged in prisons. In prison, survival depends on “keeping your head down,” and “don’t buck the system.” To prevent and manage HIV in prison or after release, ex-offenders must muster the assertiveness to deal with service agencies, medical providers, and funding systems.

F. Special needs of incarcerated women.

Women represent the fastest growing population in prisons in the US, and women are disproportionately affected by the HIV epidemic.

In the eastern portion of the US nearly 26% of women who are incarcerated are HIV positive (De Groot, Hammett, & Scheib (1998). HIV positive inmates have health care needs, such as routine and more specialized dental procedures, gynecological check ups, HIV related case management, psychiatric care, and dietary assistance.

Female inmates often face the reality of losing their children, their looks and a sense of self. Of female detainees, 57% indicated that one or both parents were absent when they grew up (Haywood, et al 2000). In the Bureau of Justice Statistics Study (Snell, 1992), 40% of female detainees reported being abused either physically or sexually, often before the age of 18 (31%).

Once incarcerated women report anxiety over being separated from their loved ones and express concern about the custody of their children. The knowledge that their behavior caused the separation from their children causes guilt and shame, which further exacerbates depression and angst. Incarcerated women worry that their children will form closer bonds to their caretakers than to their own mother and that they may be too ill to take care of their children upon release. They acknowledge that their children are at risk.

Zierler and Krieger (1997) claimed that gender asymmetry, alcohol and other drugs (AOD), racism and violence are social injustices that produce increased risk-taking behaviors in women relative to men. Chemically dependent women have reported histories of childhood and adult mental abuse, incest and rape (Benward & Densen-Gerber, 1975; Schafer & Evans, 1987; Walker et al; 1982; Wilsnack, 1984).

These traumatic events likely impact a woman's ability to engage in self-preserving behaviors. High-risk activities that lead to HIV disease, including IDU, sex work, and AOD, which also lead to incarceration. The pandemic of HIV is analogous to the pandemic of incarceration.

9. Mental Health Issues For People in Prison

A. Substance Abuse Prevalence and Prisoners.

Eighty-three percent of state inmates reported past drug use and 75% of all prisoners can be described as being involved with drugs or alcohol at the time leading to their arrest (Mumola, 1999), with 1 in 6 reported committing their crime to obtain money for drugs.

PTSD (from childhood sexual abuse, rape, DV, incest, etc). Women who are incarcerated present with a unique profile. Many come from severe dysfunctional families, have experienced life-long adversity, suffer from a chronicity of abuse, engaged

in substance abuse to cope, and are victims of rape, incest, and sexual abuse (Waring & Smith 1991).

It is estimated that almost 80% of mentally ill female inmates have been victims of abuse (Ditton, 1999). Teplin et al. (1996) found that 34% of female offenders suffer from PTSD, possible from growing up in dysfunctional and chaotic family systems.

HIV bona fide mental health disorder-There is clear evidence to suggest depression is a common symptom among HIV positive people, especially those who are isolated from friends, family and support systems. Changes in mood and vegetative affect accompanied by inability to perform day to day tasks are common.

Antisocial personality disorder (ASPD) is found mostly in men.

Triple diagnosis (mental health, substance abuse, HIV).

Depression is common in both men and women.

ADD/ADHD.

Lack of self protective behaviors causing incarceration and HIV infection — In a study conducted by Baskin & Sommers, (1998) 40% of women interviewed who were involved in criminal behavior were severely and regularly beaten by a family member while growing up. The abuse was not limited to physical violence.

- 36% reported sexual abuse by a family member and 26% reported sexual abuse by someone in their extended family.
- 34% reported that during their childhood, at least one member in the immediate family was hospitalized for mental health problems. Typically, the respondents mother or sister.
- In addition, 69% of the women had a parent or sibling who had been arrested while they were growing up.
- Many of these women reported that their families were involved in drug dealing and 72% came from families that suffered from alcohol dependence. The presence of criminal behavior in these women's families provided these women with exposure to illegal behavior.

Lack of social and medical support in prison and upon release.

10. Substance Use/Abuse and the Relationship to HIV

Drug use is associated with poor decision-making and or lowered inhibitions. Many women who are incarcerated report participating in "freak shows." Freak shows are sex

shows where multiple people engage in multiple sex acts with several people and or objects to entertain those watching. In return for their sexualized participation, drugs are received. Methamphetamine use is common in the mid-west and southwest and is often called the poor man's cocaine. Methamphetamine use is believed to lower the brain chemical, serotonin, which in turn can produce hyper-sexuality in some users (Crenshaw, 1996). Anecdotal stories indicate that women trade sex for drugs, especially those women who inject methamphetamines. These women report little or inconsistent condom usage, especially if in need of a fix. Sharing works, cotton (filter), cooker, or water for cleaning injection drug use equipment can also facilitate HIV transmission.

Injecting cocaine abusers are more likely to engage in frequent needle-sharing (Chaisson et al; Schoenbaum et al, 1989). Chronic cocaine abuse can produce psychological manifestations such as irritability and violent behavior, depression, confusion, impaired thinking, anxiety, paranoia, memory loss, hallucinations, suicidal tendencies, and cocaine psychosis.

Because the desire to repeat the intense euphoria felt by cocaine users is so dramatic, users face loss of control when trying to detoxify. They are often willing to suffer the consequences for ones health, family, financial well-being, or even life itself to alleviate the craving and depression felt by the cocaine withdrawal symptoms. In other words, people describe "doing what it takes to get dope" when one is craving or "feeming" for a fix. Therefore, it is not uncommon for drug users, inclusive of cocaine users to have increased rates of

STD's. STD's often present with open sores and painful red irritations that further facilitate the transmission of HIV. In addition, if a woman is addicted to drugs and in a relationship where she maintains a submissive position she may not negotiate for health protective measures for fear of losing her fix, her income, or her life.

This submissive posture can take place inside or outside prison walls. If a woman is living with a man and she is in a dependent state she often does not have the power to negotiate for safe sex or clean needles. Within prison walls women often form a family unit similar to life on the outside.

If a woman finds herself in a relationship with another woman inside the prison and she is in an obsequious or submissive role, she is probably unable to seek protective measures or advocate for healthy behaviors. Younger incarcerated women may fall prey to older inmates who are familiar with prison procedure including how to score drugs. Sometimes younger women may need a "family" structure to feel safe from the general prison environment.

A 1998 CDC study reported that the prevalence of STDs among women in local jails was extraordinarily high: 35% had syphilis, 27% had chlamydia, and 8% had gonorrhea.

During a presentation at the 2002 National STD Conference in San Diego the following data was presented. Based on a hypothetical cohort of 10,000 detainees who were screened for chlamydia and gonorrhea, CDC estimated that universal screening was

considered cost effective at facilities when a prevalence of 8% was found for chlamydia and 6% or more cases of gonorrhea was detected. Universal screening was considered cost effective in the men's jail when chlamydia prevalence was 4% or higher, but universal testing was ineffective for gonorrhea in the men's facility.

Unfortunately, funding is always an issue at city/county jails. However, many folks leave city/county jails and re-enter society. If these individuals are not treated the general public runs the risk of even higher STD rates in their community. This point was recently exemplified in Miami Florida.

Health department staff in Miami began their syphilis elimination program in February 2002. They found that 20% of the city's cases came from individuals who had recently been to jail. Despite this elevated number of jail found syphilis cases, only 8% of the jail system's 100,000 annual detainees had been tested (STD Advisor, 2002). In addition to voluntary STD screening, health education, substance abuse prevention, counseling and specialized correction videos could enhance the process.

At the San Francisco jail, employees are available from 2:30 p.m. to 6:00 a.m. to accommodate male and female sex workers. Jail staff believe by offering STD screening during peak hours they are serving the highest risk population.

11. Special Assessment Needs of Inmates

A. Low reading level/education levels of inmates

Only 51% of prisoner have completed high school or obtained a GED compared to 76% of the general population (National Institute for Literacy, 2001). Even inmates who have obtained a high school diploma display lower basic literacy skills compared to individuals in the general population with a diploma. In fact, 70% of prisoners scored in the lowest two levels on the National Adult Literacy Survey (NALS) (NIFL, 2001).

This low literacy level demonstrated by prisoners indicates that many will have difficulty finding employment once they are released. In a report of the general population, individuals who scored in the lowest 2 levels on the NALS were less likely to be working, with only 34-53% out in the work force (Kirsch et al., 1994). It is estimated that only a small percentage of inmates with low literacy skills actually receive literacy education (7-10%) (NIFL, 2001).

Individuals with lower educational attainment are more likely to be re-incarcerated. A study in Virginia found a 49% recidivism rate of released inmates who had not participated in educational programs compared to 20% of those who did participate (NIFL, 2001). A study in New York demonstrated similar results and found that participants who earned a GED were less likely to be re-incarcerated than individuals who attended GED programs but did not receive their GED (NIFL, 2001).

B. Learning Disabilities

The prevalence of learning disabilities among adult prisoners is not known; however, approximately 11% of inmates report having a learning disability compared to 3% of the general population. It is estimated that approximately 40% of juveniles held in detention facilities may have some form of learning disability (NIFL, 2001). It is estimated that the rates of language and communication problems among female juveniles is approximately three times the rates for the general population (Sanger & Decker, 1999) and that over a half of juveniles have serious difficulties with writing skills (Svenson et al., 2001)

C. Resistance to psychological assessment

Access to Reports. Many inmates have concerns about completing psychological assessment because of how the assessment might be used. For example, writing a psychological assessment report to determine mental health needs with the individual may be reviewed years later during parole hearings and used for purposes of determination. Being sensitive to who might be able to access your reports and informing the patient of this information is fair and ethical practice. Similarly, never include raw data (i.e., WAIS-III scoring sheets, MMPI-2 answer sheets) in the medical packet. The psychological report may go in the medical packet, but the raw test data should be kept in a separate locked file in your office. This insures that individuals who do not understand the psychometric properties of the testing material or interpretation are not given the raw data to falsely interpret.

Secondary gain issues. Secondary gain is always a concern with this population and is especially relevant when conducting evaluations for the court. For example, one author used to conduct sex offender evaluations for parole determination. Inmates being evaluated are particularly motivated to try to present themselves in the most positive light as possible. However, even in the case of sex offender evaluations, it is still important to give informed consent to the patient. The patient should be informed that the evaluation would be written up into a report that will be sent to the parole board as one source of information that the parole board will review in making their determination. The author made sure to inform them that anything the prisoner said (or did say) would go in the report. She also made sure that she had the police reports and any other independent information about the crime at the time of the evaluation so that she could ask questions about inconsistencies between what the inmate was reporting and what the report stated. For example, an inmate who told the author he had consensual sex with a seventeen-year old female whom he believed to be eighteen may be quite a different story from the police report which states the girl in question was twelve and had not undergone puberty.

Secondary gain also plays a role when evaluating inmates for mental health needs. For example, being diagnosed with a mental illness, depending on your state prison system, may entitle the inmate to special housing or other benefits (i.e., receiving a snack bag to take certain psychotropic medications because they cannot be taken on an empty stomach). Additionally, some inmates may be motivated to get a mental health diagnosis

prior to leaving prison to build a case that they are mentally ill to apply for disability upon release.

The best way to try and determine fact from fiction when conducting an evaluation is to rely on independent corroboration whenever possible (i.e. mental health records from previous treatment prior to incarceration, etc). However, when independent information is not available, examining all the information for consistency and using good clinical judgement are important. Also, acknowledge in your report that you are relying exclusively (or to whatever extent) on the inmate's self-report and were unable to get information from outside sources.

Coercive environment and assessment. Whenever conducting assessment, it is important to be mindful of the coercive environment under which these individuals are maintained.

Explaining in clear terms what the assessment will be used for and who will have access to the report is very important as many inmates are used to doing what they are told and will likely not ask many questions. As with any patient, it is important to communicate to the inmate that they have the right to not answer any questions that they do not want to answer. The caveat to this is if this report is for a court-ordered evaluation, the inmate needs to understand the consequences of not answering questions (i.e., that you will document in the report that you asked a question and the inmate did not want to answer).

Security Issues. When conducting an evaluation, be sure to get as private a space (within the constraints of security) as possible. This communicates respect to your patient, in addition to just being good ethical practice.

Instead of having an officer in the room during the assessment, check to see if the officer could sit outside the room and look in through the window. This will be dictated entirely by security practices and if this is not possible, you will need to decide whether to conduct the assessment.

Whenever conducting assessments, check to see if there are any special restrictions with the inmate. For example, if you want the inmate to complete the MMPI-2 in his/her cell, make sure it is okay to give the patient a pen (in many facilities pencils are not allowed — again, check the rules in the individual facility).

Further, understanding what might be considered contraband within the prison is important (i.e., giving papers put together with staples or paperclips might be contraband because the metal can be used to make a weapon).

If an inmates arrives for assessment in leg and arm shackles and the assessment dictates the inmate be able to use his arms (i.e., many of the performance items on the WAIS-III), check to see if security will remove his shackles to allow the assessment. If it is simply not possible to have the shackles removed, document in your report that you were unable to conduct the assessment due to the inmate restraints.

12. HIV-related services for correctional populations

There is currently tremendous interest in the importance of addressing the full gamut of HIV-related services among correctional populations. An increasing number of AIDS Community Planning Groups have identified correctional populations as “priority populations” for prevention planning. CDC and HRSA (Health Resources and Services Administration) have numerous individual initiatives, as well as joint initiatives, to strengthen prevention, diagnosis, and management of HIV/AIDS within correctional systems. (See both the CDC and the HRSA websites for details of these and upcoming initiatives.) Needed services include screening, diagnosis, and treatment; counseling; prevention education; discharge planning; transitional case management; and support (Rapposelli et al., 2002).

In 2002, the journal “AIDS Education and Prevention” produced an entire supplement (Supplement B) devoted to HIV/AIDS in correctional settings. Several articles in that supplement provide excellent models for developing collaborations between correctional systems and other agencies and community-based organizations to provide the full range of HIV/AIDS services in correctional systems.

13. Areas for mental health professionals to provide HIV-related services in correctional settings

A. Counseling and testing for HIV/STDs/hepatitis

Although many health and mental health providers in the “free world” assume that prisoners are tested routinely for HIV and other infectious diseases on entry to and release from the correctional system, this is not the case. In 2000, of 52 jurisdictions (the 50 states, the Federal system, and the District of Columbia), 20 provided HIV-testing for all incoming inmates and four tested all inmates at release. Forty-six provided testing upon inmate request and 46 provided testing upon clinical indication of need. Forty-two jurisdictions tested inmates involved in incidents involving blood or body fluid exposure, 15 tested inmates belonging to “high-risk” groups, and 43 provided court-ordered testing. Four jurisdictions tested random samples and five tested the entire inmate population currently in custody (U.S. Department of Justice, 2002b).

In the free world, with few exceptions, testing for HIV is voluntary and requires informed consent by the individual tested. In correctional systems with mandatory testing, inmates are tested regardless of their consent or lack of consent. Even where testing is not mandatory, the coercive nature of correctional environments and the lack of resources for pre-test counseling makes it questionable whether HIV-testing in prison is truly voluntary or truly informed.

Increasingly, correctional facilities are providing HIV-testing for inmates, in part due to pressure from advocacy groups to provide testing and community standards of care for HIV-positive inmates. Most inmates have little or no access to health care in the free world, and the corrections system may provide their only opportunity for testing and

treatment for HIV and other infectious diseases. Associations of correctional officers, concerned about the occupational transmission of HIV, have advocated for expanded testing of all inmates and notification of correctional officers when they have HIV+ inmates under their supervision. In two states, HIV+ inmates are segregated from the general population to protect HIV+ inmates from health threats or reprisals from other inmates or staff, to reduce the potential spread of HIV to other inmates, and to provide treatment and counseling. One of these states, Mississippi, has recently come under criticism for denying HIV+ inmates the opportunity to participate with other inmates in educational and work programs during incarceration. Advocates argued that HIV+ inmates served “harder time” than other inmates because they were deprived of educational and work opportunities. Mississippi is actively working to integrate HIV+ inmates into prison programs while retaining segregated housing.

Rhode Island instituted routine testing for HIV for all entrants into correctional system in 1989. All individuals who are incarcerated for even a brief period receive HIV-testing unless they actively refuse testing. Between 1989 and 1999, 32.9% of all HIV+ tests reported in the state came from the state correctional institution (Desai, Latta, Spaulding, Rich, and Flanagan, 2002). Individuals who tested positive within the correctional system were more likely to be injection drug users, African-Americans, and younger than individuals who tested positive at other testing sites. The authors suggest that testing in the correctional system provides a valuable testing opportunity for individuals who might not have ready access to testing at other sites. However, testing and diagnosis is only a first step to providing comprehensive HIV care, including in-prison treatment, discharge planning, and linkage to community services after release (Rich, et al., 2001).

Despite the advantages to inmates in gaining access to medical care and counseling for HIV that they may not have had in the free world, HIV-testing in correctional settings is fraught with complications. Because of the burden on the medical budgets of correctional facilities, very little pre-test or post-test counseling is available. Inmates are often unaware that they have been tested for HIV, or mistakenly assume that they have been tested for HIV, hepatitis, and all other STDs. Inmates describe the “no news is good news” policy in many correctional systems - if you don’t hear about your test results, you can assume you are OK.

In most facilities, post-test counseling is provided only for individuals with positive test results and is often carried out by Disease Intervention Specialists with local health departments, who may be less familiar with the problems of HIV+ individuals in prisons. Post-test counseling for people with negative test results is uncommon. Public health advocates view this as a missed opportunity to provide education and counseling for large numbers of seronegative, but high-risk, individuals.

Correctional facilities view extensive pre- and post-test counseling as prohibitively expensive but post-test counseling for HIV- individuals in prison is an important area for community providers and community-based agencies to address. Although incarceration appears to provide an opportunity for HIV+ inmates to receive education, counseling, support groups, and even family counseling to prepare them for living with HIV, the

reality of limited budgets means that in most correctional facilities, little is available in the way of counseling or support for HIV+ inmates and even less for prevention with HIV- inmates.

An equally serious problem is the lack of confidentiality of test results in correctional facilities. In facilities with voluntary testing, inmates may be fearful to seek testing because of concerns that information about their test results would become known by prison staff and other inmates. News travels fast in correctional facilities and many HIV+ inmates fear reprisals from other inmates and staff members.

B. Peer education.

The authors recommend development of peer education teams and resource teams of volunteers who can provide prevention and treatment information to the rest of the offenders. Peer educators are often seen as credible, especially if they are members of the target population and in a position to speak frankly and openly about sensitive topics.

Department of Corrections and health department staff may be uncomfortable speaking to offenders about sensitive issues such as drug use and other risk behaviors. In addition, peer educators are more likely to change prison culture and group norms. For example, in a prison in Taft Oklahoma, peer educators provide weekly prevention messages and offender developed literature to new offenders entering the prison system.

Peer education efficacy is supported by the literature (Spector & Sleezer, 1998). In one case, peer led groups were compared to instructor led groups. The results indicated that individuals who participated in peer groups asked more questions, exhibited increased knowledge and, articulated the desire to use condoms more consistently (Lem, Sumarsga, & Packer, 1994).

At a maximum- security prison and medium security prison in Oklahoma select peer educators receive college credit for learning how to become peer educators. They in turn, develop curricula and teach other inmates about HIV prevention. The Oklahoma State Department of Health, and the Oklahoma Department of Corrections have developed partnerships with local community colleges to foster an adult peer education program. Encourage offenders to work with the university staff to develop credible, contextual curricula, prevention materials, and course syllabi that fits the context of prison life and that is understandable to inmates (Spector & Sleezer, 1998). For example, in a prison in Oklahoma City, peer educators developed an HIV prevention curriculum emphasizing domestic violence and the challenge of protection. Encourage the prison in your state to classify peer education as an approved course, that offers good time or time off the sentence for course completion.

Peer educators are in a position to talk about primary prevention or information for individuals not currently infected. They can provide information about HIV disease, transmission, the immune system, and the sociological outcomes of domestic violence, abuse, the dysfunctional family. Peer educators are in a position to challenge beliefs and attitudes concerning high- risk behaviors. Secondary prevention is for individuals with

HIV disease. At this stage peer educators can provide resources on how to access additional medical and social services and offer group and individual level support. Upon release, the HIV infected individual peer educators must address reintegration planning and encourage medical to provide one month of medications, condoms, and the names of community-based organizations that offer HIV related services.

Since 1986, Centerforce, a prison CBO in California, has been providing peer education for HIV prevention within San Quentin Prison. Their model programs have been well evaluated through collaboration with the Center for AIDS Prevention Studies at UCSF and are available through their website (<http://www.centerforce.org>).

C. Discharge planning and transitional case management.

It is not uncommon for HIV positive offenders to be released from prison with minimal funds, no means of transportation, and without life sustaining medications. In a landmark study by Warren et al (1994) in New York City, only 8 of the 32 newly released HIV positive offenders who received HIV medications in jail obtained medication post release (Warren, Bellin, & Zoloth, 1994).

The goal of discharge planning is to work with inmates prior to release to ensure a smooth link with services and resources after release. Although discharge planning is important for all individuals prior to release, it is particularly important for individuals with HIV or AIDS because of special needs for stable housing, medical services and medication continuity, drug treatment or other services, and financial and social support (Ehrmann, 2002).

An example of a coordinated discharge planning program is the ETHICS Program (Empowerment through HIV/AIDS Information, Community, and Services) program sponsored by the Fortune Society in New York City to link individuals being released from prisons and jails in New York State with community services (Ehrmann, 2002). Discharge planners in this program start working with inmates 6 months prior to their release and coordinate with prison staff and administrators and service providers and agencies in local communities through New York State.

In an ideal world, transitional case management (TCM) would pick up where discharge planning left off. TCM works solely with ex-offenders after they have been released from correctional facilities to locate permanent housing, financial support, medical care, counseling, and other services (Ehrmann, 2002). An example of an effective transitional case management program is the Transitional Services Unit (TSU) offered through the Women's Prison Association in New York City. This program effectively combines financial support from a variety of sources (e.g., Medicaid, Ryan White Title I funds, the New York City Medical Health and Research Association, and the New York State Department of Health's AIDS Institute) to assess needs of female ex-offenders and provide a wide gamut of services (Ehrmann, 2002).

D. Prevention for Positives (Prevention Case Management)

A Prevention Case Management (PCM) format could be used in correctional settings to focus on the client 's multiple needs. Schwartz and her colleagues (1994) reported on difficulties of HIV/AIDS patients who try to access case management services and who have multiple barriers to prevention. These barriers include lack of money, lack of child care, lack of transportation, lack of a telephone, lack of necessary documentation (social security card, citizenship papers, etc), active substance abuse, poor physical health, eviction, and long waiting lists for services. Prison life removes, to some extent, said barriers and provides an opportunity for those at risk for HIV/AIDS to access services. PCM has been described as a hybrid of HIV risk reduction counseling and case management (CDC, 1997).

PCM provides intensive, individualized support, and prevention counseling. PCM is intended for those individuals experiencing barriers to self-protective behaviors. PCM comprises essential components including the assessment of STD risk behaviors and medical and psychosocial needs, risk reduction counseling, and chemical dependency evaluation and treatment. PCM focuses on prioritizing HIV prevention for individuals who have difficulty prioritizing HIV prevention for themselves, and this may prove essential for the incarcerated individual (Falck, Carlson, Price, & Turner, 1994). A trusting, empathic, and ongoing relationship between the client and counselor/case manager is paramount for a successful PCM process.

PCM services can be used for HIV negative individuals who are partners of HIV positive people. The PCM concept can begin at the micro-level (prison setting), and develop to fit the post offender needs at the macro-level (community setting). PCM can entail prison outreach, individual level intervention (ILI) and group level intervention (GLI). ILI could consist of psychodynamic psychotherapy or cognitive behavioral approaches, which focus on the immediate prevention and or treatment needs of the client.

ILI PCM would help persons with particular difficulty modifying behavior and who may be likely to transmit HIV or acquire HIV. GLI could be used to support Freire's (1971) dialogical theory. Dialogue can be used to establish connections with other incarcerated people, disclose personal feelings, and adopt a caring perspective of others who live inside and outside of the prison.

The goal of GLI during the PCM process could be to: 1) develop an action plan about individual health and a caring perspective about the health of partners; 2) begin to act for individual changes, and articulate safe behaviors for family, friends and partners of HIV infected people; and 3) gain an understanding of social consequences and social responsibilities surrounding the HIV epidemic while imprisoned and upon release. PCM is highly intensive, of long duration, and it usually involves a professional counselor who works with a small to moderate number of clients. It is costly, and PCM uses primarily professional staff, which may be a challenge to the Department of Corrections.

E. Support groups for HIV-seropositive inmates.

Although support groups are a common and powerful intervention for managing HIV in the free world, they are less common in correctional settings and more difficult to develop and sustain. Concerns about lack of confidentiality, about being able to feel comfortable sharing personal stories and problems with other inmates and staff members, and the stigma of being associated with an “AIDS group” in a correctional facility make it more difficult for inmates to avail themselves of support groups in prisons and jails.

F. Juvenile HIV Prevention Services.

As reported previously, almost half of high school students are sexually active. Among juveniles incarcerated, approximately 89% were sexually active by age 14, with a high percentage reporting eleven or more sexual partners. Further, substance abuse rates among juveniles are alarming, with juveniles accounting for approximately 14% of all drug arrests in 1996, a 120% increase from 1992 (Office of Juvenile Justice and Delinquency Prevention, 1997). Approximately 39.4% of youth in long-term state run facilities were under the influence at the time of arrest for the current offense. Overall, approximately 13 of the youths in the survey had used heroin (Beck et al., 1987).

HIV prevention services with incarcerated juveniles are critical in helping to prevent the spread of HIV, since this is the population that is most at risk for acquiring HIV/AIDS. Peer education interventions appear to be well-suited for this population for the following reasons. Adolescents often turn to their peers for information and for social norms.

Numerous studies have shown that peer-education interventions increase HIV knowledge and decrease the frequency of risk taking behaviors (Sloan et al., 1993; DiClemente, 1993). Peer education can improve HIV prevention behaviors such as increasing condom use and decreasing sexual intercourse and number of sexual partners (Jermott et al., 1997).

A peer education program targeting African-American females found higher scores on general information about HIV from baseline to follow-up. Further, between baseline and follow-up, rates of high-risk sexual behavior decreased. At baseline, 44% of sexually active females reported no condom use compared to 33% at follow-up (Slap et al., 1991).

Several studies have found that adolescents are more likely to practice safe sex if they believe their peers are doing so as well. Specifically, adolescents are 2.3 times more likely to use condoms if they believe their peers support condom use compared to adolescents who do not believe their peers use condoms (DiClemente, 1991).

Finally, several studies indicate that peer education interventions are more effective in reducing risk-taking behaviors than adult led interventions. While these results do not suggest that adult led education interventions are ineffective, it suggests that having peers deliver the message may have more impact (Advocates for Youth Fact Sheet, 1997).