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The Corrections Initiative: A Collaborative Partnership

By the end of 2004, more than 2.2 million people were incarcerated in the United States, an increase of 1.9 percent from the previous year, but lower than the average growth of 3.2 percent during the last decade.¹ This is more than a six-fold increase compared with the 1970 incarcerated population of 325,400.² The steady increase in incarcerations can be attributed to the harsh sentencing guidelines passed in the 1990s, during a time when states could afford to build more prisons.³ Sentences by criminal classification among federal and state prisons have varied considerably since the enactment of sentencing reforms. By 2003, more than half (55 percent) of sentences in federal prisons were attributed to drug offenses, more than one-quarter (27 percent) to public-order offenses, and the rest to violent and property offenses. Among state prisons, violent crimes (51 percent), property (20 percent) and drug offenses (21 percent) constituted the majority of sentences in 2002.⁴ Sentencing reforms have resulted in the highest incarceration rate ever experienced in the United States, straining resources of correctional systems, particularly in the area of health care.⁵

Inmates suffer disproportionately from infectious and chronic diseases, substance abuse, mental illnesses and a constellation of socioeconomic problems. The majority of the incarcerated come from impoverished, medically underserved areas and have engaged in a variety of high-risk and often violent behaviors. These behaviors and high-risk lifestyles make them vulnerable to serious health problems and increase the prevalence of infectious

diseases such as HIV/AIDS, tuberculosis, sexually transmitted diseases and hepatitis. In addition to infectious disease, drug addiction, lack of access to health care, poverty, substandard nutrition, poor housing conditions and homelessness contribute to increased risk for chronic conditions such as hypertension, cardiovascular disease, skin conditions, gastrointestinal disease, diabetes and asthma. And incarceration may be high-risk individuals' first contact with health care. It is estimated that up to 80 percent of chronically ill inmates received no medical care prior to incarceration and may have been using the local hospital emergency room as their primary care provider.⁶

The Corrections Initiative

From 1999 to 2004, the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services jointly funded a national corrections

demonstration project in seven states (California, Florida, Georgia, Illinois, Massachusetts, New York and New Jersey) involving jail, prison and juvenile settings. The program targeted inmates with HIV/AIDS, hepatitis B and C, tuberculosis, substance abuse, and sexually transmitted diseases. In two states (California and New Jersey), it supported an array of services that included treatment for HIV and other diseases on the inside, discharge planning prior to release, case management linking incarcerated patients to services after release, and prevention case management for inmates at high risk, but testing negative, for disease.

This project was an effort to develop effective collaborations among corrections, the community and public health. It promoted partnerships between state and local health departments, contracting community-based organizations (CBOs) and AIDS Service Organizations (ASOs.) The project provided services to thousands of inmates and has collected a tremendous amount of data and information that is being used to develop similar collaborative efforts in others parts of the country.

Recognizing this need and opportunity, the CDC and HRSA developed a partnership in 1999 to provide funding “to support demonstration projects within correctional facilities and communities that develop models of comprehensive surveillance, prevention, and health care activities for HIV, STDs, TB, Substance Abuse, and Hepatitis.”⁷

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

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

The initiative was targeted for persons living in correctional settings, including prisons, jails, detention centers and transitional halfway houses, and would extend to the community upon their release. The target population included African-Americans and other racial minorities who are disproportionately affected by the HIV/AIDS epidemic and are detained or incarcerated in the criminal justice system, especially jails and juvenile detention facilities. Projects were designed to develop collaborations between correctional settings and community-based health care and support service providers that would support continuity of health care and provision of ancillary and supportive services to effect positive behavioral change, increase health care access and improve health status.

Models of linked networks of health services, including HIV/AIDS, STD, TB, hepatitis, and substance abuse prevention and treatment during and after incarceration, were to be developed and evaluated for replication by other primary care, prevention, criminal justice and community service organizations. The initiative sought to create a combination of services, including surveillance, medical and behavioral screening and assessment, prevention education and counseling, primary health care, and referral linkages. It

supported a multitiered focus on jails, prisons, juvenile detention centers and transitional halfway houses for the provision of services, the ability to work within correctional and community-based systems of care, and the ability to implement long-term systemic change. Special emphasis was placed on working with jails and juvenile detention facilities because of their direct links to the community.

This CDC-HRSA initiative was limited to the District of Columbia and 11 states, which had high rates of HIV and a large proportion of HIV and AIDS in their correctional systems. The states included California, Connecticut, Florida, Georgia, Illinois, Maryland, Massachusetts, New Jersey, New York, Pennsylvania and Texas. These locations were identified as priority areas because they represented:⁸

- 56.2 percent (635,483) of total prison population in 1997;
- 74.7 percent (76,679) of all African-American AIDS cases in 1997;
- 82.7 percent (19,361) of all HIV-positive inmates in state prisons; and
- 26 of the 30 highly impacted Metropolitan Statistical Areas (MSAs) for African-Americans.

Priority for funding was given to applicants with the greatest potential to increase access to prevention and primary health care and improve the health status of both incarcerated and at-risk African-Americans and other racial/ethnic minorities.

Funds supporting this initiative were part of a larger pool of resources targeting the AIDS epidemic and were made available as a result of activities initiated by the Congressional Black Caucus in response to a state of emergency issued in 1998 by the caucus and CDC. Approximately \$7 million was available to fund five to eight demonstration projects, each with unique objectives, for three years (later expanded to five years).⁹ The application stipulated that at least 40 percent of the provided funds be directed to community-based prevention, primary care and other ancillary service providers to support and develop models of linked networks of health services. These services would include HIV/AIDS, STDs, TB, hepatitis, and substance abuse prevention and treatment during and after incarceration.

CDC/HRSA also provided technical assistance, staff development and evaluation providers/consultants to ensure that the projects would have the technical support and assistance needed to undertake the outlined activities. To assure the definition and measurement of appropriate project outcome measures, CDC/HRSA issued a separate request for proposals to identify and select an evaluative entity that would be called the Evaluation Support Center (ESC). The role of ESC was to work with the projects to develop a collaborative data collection plan, including data collections instruments and procedures. The ESC was to produce a series of formative cross-program evaluations to identify and describe program components critical to health-seeking behaviors among those previously incarcerated, the costs associated with program interventions inside and outside of correctional settings, and the lessons learned. Each project would develop analyses of their own outcome indicators to monitor and support program management and evaluation.

Health departments from California, Florida, Georgia, Massachusetts, New Jersey, New York and from the city of Chicago, were awarded funding from CDC to implement their projects in prisons, jails, juvenile facilities and other related correctional settings. The programs and services provided under these projects — collectively called HIV/AIDS Intervention, Prevention, and Continuity of Care Demonstration Project for Incarcerated Individuals within Correctional Settings and the Community — have become known nationally as the “Corrections Demonstration Project” or CDP. HRSA’s Special Projects of National Significance (SPNS) backed the Emory University Rollins School of Public Health in Atlanta and its collaborator, Abt Associates from Cambridge, Mass., to coordinate the evaluation of the initiative. Three additional organizations were provided assistance by CDC and HRSA as technical assistance providers for the grantees and their subgrantees or contractors. They included the National Minority AIDS Council (NMAC) in Washington, D.C.; the Southeastern AIDS Training and Educational Center (SEATEC) in Atlanta; and the Hampden County Correctional Facility (Public Health Model of Correctional Care) in Ludlow, Mass. Funds were awarded in September 1999, and the project began the following month.

Each of the seven CDPs received approximately \$1 million per year to conduct continuity of care service activities for HIV/AIDS. Existing activities at a few sites were enhanced by CDP funding, while others were enabled to implement the HIV/AIDS services in correctional settings. By early 2001, an assessment compiled for the annual grantee meeting revealed that services were being provided in 24 jails, 48 prisons, more than 100 juvenile justice facilities and 26 community corrections settings. After initial startup problems during 2000, CDP cross-site activities fell into eight identified categories: 1) HIV/AIDS clinical evaluation/treatment, 2) HIV/AIDS prevention education, 3) peer education, 4) disease screening/counseling/testing, 5) staff development and training, 6) discharge planning, 7) continuity of care case management and 8) prevention case management. There was considerable variability within each category and within each correctional setting.

While the CDP provided ample resources and technical support, all projects were plagued to some extent during the first year by local political environments, the lack of trust between corrections and public health, and cumbersome fiscal and management policies. As a result, it was not until mid-2000 that basic services were sufficiently in place to begin quantitative data collection on critical process indicators.

The following section provides aggregates of data collected from all projects participating in the CDP, arranged by service category and facility type. It reflects the services supported by the CDP and tracked by the ESC. It does not reflect the comprehensive array of services that each project provided inside participating correctional facilities. Many projects saw this initiative as an enhancement of existing services, while others used CDP resources to plan and implement previously unavailable services. As a result, cross-site evaluation data do not reflect the true extent of efforts that were provided during the entire project.

Aggregate Findings

During the five-year delivery of prevention and care service, the CDC/HRSA Corrections Demonstration Project provided HIV, STD and hepatitis prevention education to more than 123,000 people, disease screening services to more than 41,000, and discharge planning and community case management services to nearly 7,000 living with HIV (Table 1).

HIV, STD and hepatitis prevention education was offered in juvenile detention, local jail and state prison settings. In some areas, the prevention education services were also offered to the staff working in those institutions. The vast majority of those receiving prevention education were located in state prison settings (93,160), followed by those in local jails and juvenile detention centers.

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

Adults screened in county jail settings revealed a similar pattern of disease prevalence. Chlamydia was the most frequently recorded test ($n = 27,760$) and displayed the highest positive rate (7.36 percent), followed by gonorrhea ($n = 22,166$; 3.36 percent positive). Although there were fewer HIV tests conducted ($n = 14,450$), the percent positive (3.45) was slightly higher than for gonorrhea. Syphilis tests were the least frequently reported among the jails and had a positive rate of 3.86 percent.

State prisons tested only for HIV, perhaps due to the probability that other STDs would have been detected and treated in county jails, through which most of the state prisoners would have passed. Over the course of the project, participating prisons conducted 12,861 HIV tests. Only 1.39 percent of the prison tests were positive.

The CDP focused primarily on linkage of prisoners living with HIV to services inside the correctional setting, discharge planning for release and community case management services after release. Table 3 shows that 6,298 individuals had discharge service plans prepared by project staff (mostly community-based organizations). Most of those for whom plans were developed (60 percent) were in jail settings. More than 80 percent (5,186) of those for whom plans were developed were released back into the community during the course of the CDP. Of those released, 69 percent (3,568) received at least one service from CDP providers once back in the community.

Summary

The CDP expanded capacity by: 1) enhancing existing programs in facilities, 2) developing new programs in facilities and 3) developing new community-based networks. During the course of the CDP, HIV/STD/hepatitis prevention education, disease screening and continuity-of-care (discharge/community case management planning),

Table 1. CDC/HRSA Corrections Demonstration Project, 1999-2004: Number of Individuals Served by Type of Education Session

Education Setting	Juvenile Detention Facilities	Jails	Prisons	Staff (variety of correctional settings)	Total
Single Session	5,082	16,910	76,764	2,585	101,341
Multiple Sessions	3,443	1,159	16,396	1,118	22,116
Total	8,525	18,069	93,160	3,703	123,457

programs were established or enhanced in a number of juvenile detention centers, local jails and state prisons.

California, Chicago, Georgia, Massachusetts, New Jersey and New York enhanced existing jail-based programs. In California, Florida, Massachusetts, New Jersey and New York, prison programs were expanded or enhanced to include more inmates returning to the community and to cover a broader range of activities. In addition, New York expanded the range of services available to prisoners within its previously existing HIV services programs. The San Francisco jail-based program also expanded the range of services available both in the jail and in their continuity-of-care program for discharged inmates.

In some settings, the number of institutions where these services existed was increased or new programs were developed. Georgia and Massachusetts both developed new juvenile detention-based programs, increasing capacity. Florida opted to develop a new jail-based program in one jurisdiction, increasing capacity. California expanded services from one prison for males to include another prison for males and one for females. The third way in which states expanded capacity involved the development of wider networks of community-based organizations (CBOs), including faith-based organizations, that could provide services for individuals returning to the community and linkages to other service providers. For example, the California prison-based program reported networking with nearly 100 CBOs in the San Francisco Bay Area and Central Valley with whom they had previously not connected. Similar, although perhaps not as dramatic, increases in networks of service providers and resources were reported across all state programs. In some instances, this was accomplished by developing new capacity in the CDP service-provider organizations, in others, it involved development of CBO networks. In summary, capacity expansion occurred for state and local agencies and CBOs involved in the CDP. Some states have institutionalized those developments.

Sustainability

The developments at the state level following the conclusion of federal funding for the CDP have been overwhelmingly positive with regard to integration of lessons learned from the project into existing activities. California recognized the value of having an organization dedicated to continuity-of-care (CoC) planning and case management for releasees living with HIV. Centerforce, the prison-based provider for

the CDP, has been awarded a contract to provide post-release services for the parolees in the state system. Florida has increased the number of post-release planners in its state prison system to provide CoC services for those being released from its prisons. Through general revenue funds, Florida also has expanded the number of county jails offering the CoC approach, developed by the Jacksonville/Duval County Jail, for individuals infected with HIV who pass through the system. Georgia also has developed a program for department of corrections (DOC) inmates that is modeled after the Florida program, even though Georgia's CDP did not involve the state DOC. Illinois has recently passed legislation that would develop a state-wide CoC program modeled after the Chicago CDP program. Massachusetts is working to integrate CDP approaches into its new state-wide inmate reentry program. On the basis of their CDP activities, New

Jersey and New York both continue to develop and strengthen the HIV-related services integrated into their state DOC programs.

Four of the CDP service providers have been selected by CDC's Division of HIV/AIDS Prevention (DHAP) as directly funded CBOs to provide services to inmate and reentering populations in their states. Rapid HIV-testing approaches, pioneered by CDP jail-based programs, have also been expanded to possibly be used in other jurisdictions. CDC has begun to integrate the central role of jails, in the recognition of infectious diseases in the community, in health education and in linkages to treatment for these vulnerable populations, into its thinking about HIV, STDs, hepatitis and other preventable and treatable diseases. This approach is vital to the role of jails in the screening and treatment of sexually transmitted diseases and reveals how the prevalence of these diseases in jail detainees may mirror the prevalence in the communities where they lived prior to incarceration.

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

Table 2. CDC/HRSA Corrections Demonstration Project, 1999-2000: Number of Tests Performed and Percent Positive for Persons Screened

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

Table 3. CDC/HRSA Corrections Demonstration Project, 1999-2004: Number and Proportion of Persons Receiving Discharge Planning Services

Discharge Services	Juvenile Detention Facilities	Jails	Prisons	Total
Plan Developed	167 (3%)	3,789 (60%)	2,342 (37%)	6,298
Discharged	122 (2%)	3,254 (63%)	1,810 (35%)	5,186
Received Services in Community	54 (2%)	2,298 (64%)	1,216 (34%)	3,568

ENDNOTES

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⁴ Beck, A.J. 2005.

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