Evidence-Based HIV Prevention Programs for Correctional Settings:

How Do You Know What Works?

By Roberto Hugh Potter

Just about every warden or chief jailer has been approached by a health department or community-based organization (CBO) asking to provide HIV (and other sexually-transmitted diseases, including hepatitis) programs to increase inmate counseling, testing and prevention activities. The variation in approaches can be astounding. So, how is someone who is not immersed in the HIV/STD world supposed to know what types of programs work — especially what types of programs work in jails, prisons and community corrections settings? This column will outline the basic process by which HIV/STD-related programs move from ideas to evidence-based practices, and it will provide a few examples of programs that have shown promise in correctional settings.

How Does CDC Decide What to Promote?

More than a quarter century into the HIV epidemic, many street-level providers and academics have ideas about how to encourage people to: get tested for HIV (and other infections); learn the ways HIV is transmitted and how transmission can be avoided; and ideally, practice those prevention behaviors. Not everything works, of course. In 1996, Centers for Disease Control and Prevention (CDC) staff in the Division of HIV/AIDS Prevention (DHAP) set out "to systematically review and summarize HIV behavioral prevention research literature." The goal was to translate scientific evidence from the research literature into practical information to be used by providers, state and local health departments, and HIV prevention researchers.[1]

As a result, DHAP developed a pyramid-shaped model to convey how programs move from untested to evidence-based. At the bottom are all of the well-intentioned programs that have not yet been subjected to rigorous empirical research. Working upward on the pyramid, tiers IV and III are "theory-based," or programs "based on sound behavioral science theory but do not have sufficient empirical evidence to satisfy CDC criteria for evidence-based interventions."[2]

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These interventions have some empirical evidence in the form of process data or outcome monitoring data, and at a minimum, these interventions have a logic model. A logic model is a diagram or chart-style presentation that presents the sequence of actions and their intended impact or outcomes in a program or intervention; it is the logical flow of the how, why and what to expect.[3]

Tiers II and I are evidence-based interventions based on "direct, high-quality, empirical evidence that demonstrates a reduction in HIV/STD incidence or reduced HIV-related risk behaviors." These are often referred to as DEBIs, or "diffusion of evidence-based intervention" programs.[4] Tier I and II interventions can be separated further into "best-evidence" and "promising-evidence" types of programs, depending on their levels of demonstrated effectiveness. Best-evidence interventions are HIV behavioral interventions that have been "rigorously evaluated" and show "significant and positive evidence of efficacy." They are considered "scientifically rigorous" and demonstrate the "strongest" evidence of being effective. Following behind, promising-evidence interventions are "sufficiently evaluated" and also show "significant and positive evidence of efficacy." They are considered "scientifically sound" and demonstrate the "sufficient" evidence of being effective.[5]

Where Is CDC Now With DEBIs?

There are few HIV/STD interventions that have been designed specifically to fit correctional settings and few that have been subject to efficacy studies, much less replicated and rigorously evaluated in these settings. Here we want to review a range of interventions that have been conducted in correctional settings but are at different stages of the evidence-based process. All of these programs have been featured in educational sessions at ACA conferences during the past several years.

Jails — VOICES/VOCES. Video Opportunities for Innovative Condom Education & Safer Sex seeks to increase condom use among heterosexual African-American and Latino men and women who visit STD clinics. It is a single-session, group program that is video-based. The Georgia Department of Human Resources, Division of Public Health is currently operating the VOICES/VOCES program in medium and small jails in portions of the state. The program has a strong evidence-base in community STD clinics but requires replication and evaluation with jail populations, especially after reentry into the community.

Prisons — Project START. Project START is a multisite research study that compared two HIV, STD and hepatitis prevention interventions for young men recently released from prison.[6] The project was conducted in eight state prisons across four states. Participants were recruited and enrolled during their incarceration and systematically assigned to one of two intervention conditions: a prerelease, one-shot education program only or the program combined with community follow-up and counseling (enhanced intervention). Participants were then contacted in the community for six months after their release to obtain measures of sexual risk-taking behaviors. Initial results indicate that a "multisession, community reentry intervention" can reduce sexual risk behavior among young men released from prison. Significantly lower rates of unprotected intercourse were observed at 24 weeks after release from custody for men assigned to the enhanced intervention compared to those assigned to the single session intervention. The program is currently being replicated in more correctional settings as part of the DEBI process.

Post-release/Community — MISTRS Project. The Men in Service to Reduce STDs Project (MISTRS) was originally aimed at men exiting a county jail system but was expanded to include any man who had been released from a correctional facility in the prior six months. The program is a two-week, multisession brief intervention, with follow-up contacts by the research staff for six months to gather behavioral information. The unique aspect of MISTRS is that it focuses not only on sexual risk behaviors but also criminogenic behaviors, such as substance abuse and anger management issues, that place men and their partners at risk of both disease acquisition and arrest. The efficacy evaluation has not yet been completed, and no further replications of the program are currently in operation.[7] At this point, it would fit into the "unevaluated" base of the DHAP pyramid.

What to Take Home

There is a difference between basic HIV/STD/Hepatitis/TB education and prevention interventions. Whether basic education intervention by itself produces significant changes in behavior inside facilities and in the free world remains an open question. However, intervention programs focused on reducing disease transmission inside a facility or back in the community may be a different matter, especially if they involve investments of facility resources such as personnel, space and time.

As a practical matter, if a health department or CBO approaches a system or facility and asks to implement an HIV/STD prevention intervention, system directors and facility administrators should not hesitate to ask where the intervention stands in terms of the "tiers of evidence." If the department or organization does not know, the director or administrator should suggest it go back and determine its tier position so that the system or facility can make a more informed decision about whether the program is going to be valuable. By the same token, if a facility or system has a great idea to provide HIV/STD interventions in its setting, it should contact the local health department and public health and/or criminal justice departments at a local university to get the evidence-based process started from the beginning.

What happens in the community affects what happens inside; what happens inside affects the community when individuals reenter from corrections. Knowing how to effectively and efficiently provide HIV/STD services that have a real impact on the community is simply a part of good management, informed by good science.

ENDNOTES

[1] Centers for Disease Control and Prevention. 2007a. *Updated compendium of evidence-based interventions*. Washington, D.C.: CDC. Available at www.cdc.gov/hiv/topics/research/prs/evidence-based-interventions.htm.

[2] Ibid.

[3] Stinchcomb, J. 2001. Using logic models to focus evaluation efforts: Translating operational theories into practical measures. *Journal of Offender Rehabilitation*, 33(2):47-65.

[4] DEBI information and the description of the VOICES/VOCES program are based on the Diffusion of Effective Behavioral Interventions project (DEBI) Web site at www.effectiveinterventions.org.

[5] CDC. 2007a.

[6] CDC. 2007b. Project Start. Washington, D.C.: CDC. Available at www.cdc.gov/hiv/topics/research/projectSTART/index.htm.

[7] Williams, Samantha. 2007. Addressing sexually transmitted diseases (STDs) in the correctional setting. Presentation at the ACA 2007 Winter Conference, 20-24 January in Tampa, Fla.

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