



Serving Women  
in the  
Corrections System  
Through

**Ryan White CARE Act Programs**



Through education, training and advocacy, **AIDS Alliance for Children, Youth & Families** addresses the needs of children, youth and families living with, affected by, or at risk for HIV and AIDS.

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# Chapter One

## Introduction and Overview

Over two million people are in U.S. jails and prisons today, and the United States is battling Russia for the title “The World’s Largest Jailer.” With just five percent of the world’s population, we have a quarter of its prisoners. Although men far outnumber women in the U.S. corrections system, the number of women in jail or prison in the U.S. has skyrocketed in the past two decades – doubling between 1990 and 1998 and increasing 500 percent between 1980 and 1998 (Government Accounting Office (GAO), 1999).

Women of color are dramatically overrepresented among women inmates. In 2000, African American women were three times more likely than Latinas and six times more likely than white women to be incarcerated (Bureau of Justice Statistics (BJS), 2001b). Women inmates are much more likely than the general population of women to have HIV disease, as well as Hepatitis C and STDs. They are much more likely also to suffer from other serious health problems, including substance abuse and depression, and to be victims of past physical and sexual abuse (De Groot, Anastos, Leibel, & Stubblefield, 1999; GAO, 1999). Overall, women in jails and prisons have an HIV infection rate that is 35 times that of American women in general (De Groot, et al., 1999).

Serving Women in the Corrections System Through Ryan White CARE Act Programs is a resource for CARE Act grantees who serve or plan to serve women living with HIV/AIDS who are incarcerated and transitioning back to the community or newly released. We identify the scope of the problem, highlight the connection between jails and prisons and the community, convey tips to help grantees get started, offer examples of innovative programs across the country, and direct interested grantees to resources for more information. The Appendices include the HIV/AIDS Bureau’s (HAB) policy statement on the use of Ryan White CARE Act funds for this purpose, samples of a variety of forms developed by community programs serving incarcerated and newly released women, and a list of AIDS Education and Training Centers (AETCs).

### The Scope of the Problem

Nothing engages CARE Act programs faster than recognizing the scope of the problem. The number of women affected and their unique needs as women make a compelling argument to get involved.

### The Numbers

Little more than 20 years ago, fewer than 13,500 women were in prison or jail in the United States (CDC, 2001c). Today, over 92,000 women are in state and federal prisons alone – not counting women incarcerated in local jails – and just the state of Texas has almost as many women in its prisons as the entire

country had in both jails and prisons in 1980. At the end of 2000, the most recent year for which comprehensive data is available, 3.6 percent of women in prison or jail were HIV positive, compared to 2.0 percent of men (BJS, 2002). These combined national figures, however, do not convey the true imbalance. In several states, women inmates have HIV infection rates fully three times as high as their male counterparts. Hepatitis C infection prevalence ranges between 22 percent and 55 percent among women inmates (CDC, 2001c).

**Geography.** As with the epidemic in general, the HIV/AIDS numbers for jails and prisons vary considerably by geographic region, from state to state, and from locality to locality. HIV in jails and prisons, among both men and women, is most prevalent in the Northeast – where 10.3 percent of women inmates are known to be HIV positive – with the South coming in second. New York has the most incarcerated women known to be HIV-positive (600), followed by Florida (371), Texas (272), and California (134) (BJS, 2002). These four states also account for over half of confirmed AIDS cases among women in state prisons. As is true for the general population, many women in jails and prisons are infected with HIV but do not know their status.

Three states have shocking rates of known HIV infection among incarcerated women – the District of Columbia at 41.0 percent, New York at 18.2 percent, and Nevada at 12.4 percent. Other states with over five percent of women inmates known to be HIV positive include: Maryland (9.8), Florida (9.0), Connecticut (8.1), New Jersey (6.8), and Vermont (5.0). (Delaware did not report for 2000, but for year end 1999 reported that 5.6 percent of its female inmates were HIV-infected.) Only four states have no women inmates identified as HIV positive: Hawaii, Maine, North Dakota, and Wyoming. (BJS, 2002)

### Women's Unique Needs

*Women inmates need special attention and programs designed just for them.*

– Centers for Disease Control and Prevention, 2001b

Although women in jails and prisons who are living with HIV have many needs and concerns in common with incarcerated

Table 1

### Facts About Incarceration in the U.S.

- Over three percent of adults living in the U.S. are under the control of the criminal justice system. About 1.4 million are in federal or state correctional institutions, and half as many as that – over 650,000 – are in county or city jails. Over 4 million others are on parole or probation, or otherwise supervised by the court.
- Over 92,000 women are under the control of federal or state prison authorities (BJS, 2001).
- Over 125,000 juveniles are in correctional facilities (CDC, 2001a).
- Between 1980 and 1996, the prison population tripled, largely because of drug-related convictions. Over one-fourth of all people in prison or jail are there for drug-related offenses, including using, possessing, or trafficking drugs. (CDC 2001a)
- The great majority of men and women in prison have serious drug problems (CDC 2001a).
- The rate of AIDS in prison is four times higher than in the general U.S. population (BJS, 2002).
- The rate of HIV infection among women in jails and prisons is 35 times higher than among women in the general population (De Groot, et al., 1999).
- At the end of 2000, almost 25,088 state and federal inmates were known to be HIV infected (BJS, 2002); in the middle of 1999, over 8,600 local jail inmates were known to be HIV positive (BJS, 2001).
- Seventeen percent of HIV cases in the United States each year are reported from jails and prisons.
- One in three Hepatitis C cases in the U.S. occurs in people who have been imprisoned. Hepatitis C infection rates are 9-10 times higher than in the general population. (CDC 2001a; The Body, 2001)

men, they also have unique needs as women. Despite the phenomenal growth in the number of incarcerated women, men still outnumber women in the corrections system by 14 to one, and this imbalance often causes the special needs of women inmates to be overlooked. For example, few correctional facilities provide gender-specific HIV services, such as AZT for pregnant HIV-positive inmates to reduce mother-to-child HIV transmission. This remains true, despite the fact that in 1998, more than 1,400 American women delivered a baby in prison. (CDC, 2001c) Women inmates also need and use health care services much more than men do, for reasons that include their “more complicated reproductive system,” apart from pregnancy (National Commission for Correctional Health Care (NCCHC), 1994, p.1).

Women inmates differ considerably from their male counterparts in other ways beyond the physical. They have consistently higher rates of substance abuse than do male inmates, as well as extraordinarily high rates of past physical or sexual abuse – a factor often linked to drug use and to a broad array of other mental health problems such as depression, stress, and anxiety disorders. According to the National Commission for Correctional Health Care (1994), care providers both inside and outside jails and prisons generally have not been well-trained to look for and address the results of victimization, and this acts to limit the quality of care women receive.

More so than male inmates, women are much more likely to be caring for minor children before entering a correctional facility. Three-quarters of women in jails and prisons are mothers who are separated from their children. Well over half of these mothers are single parents, and two-thirds of them have children under age 18. (CDC, 2001c)

Although between six and 10 percent of women inmates are pregnant when they are arrested, most corrections systems take babies away from their mothers shortly after birth. Only 11 states and the Federal Bureau of Prisons have residential programs for inmate mothers and their infants (GAO, 1999). There is a desperate need for services related to parenting and custody for female inmates.

Dr. Anne De Groot, a pioneer in caring for incarcerated women, reflects on the complexities facing women inmates living with HIV disease and how that affects care provision:

If my work is to “take care” of HIV infected women, then understanding why these women use drugs, do sex work, don’t go to their HIV clinic appointments that I set up for them on the outside, and end up coming back to see me at the HIV clinic at the prison, is part of the work that I have to do. Understanding why my patients have eating disorders will enable me to intervene effectively, so that the medications they are taking for their HIV disease are absorbed. Learning more about my patients helps me set priorities: is it more important to find safe housing, away from an abusive spouse, or start a new antiviral drug? It is more important to reunite them with their families, than to urge them to move to a city where they might have access to HIV care? Which intervention will save the life of my patient? (De Groot, 1997)

## Overview of the Guide

**Chapter Two**, “Why Women in the Corrections System Are the Business of CARE Act Programs,” explores two primary reasons why Ryan White CARE Act grantees should get involved and stay involved with their local jails and with state and federal prisons in their communities: correctional facilities are revolving doors, and most incarcerated women with HIV disease will be CARE Act clients after their release. Starting early makes good sense, both medically and economically. Also reviewed are links between the CARE Act and corrections system that are required by the 2000 reauthorization.

**Chapter Three**, “Getting Started,” sketches an overview of the corrections system in the U.S., lists some of the most common barriers to high-quality care for women living with HIV/AIDS in prison, and suggests ways to overcome them, including partnerships between the community and corrections and listening to women on the inside. Also included are the things we heard most often in response to the question, “Do you have any advice to offer CARE Act programs interested in serving these women?”

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**Chapter Four**, “What Agencies and Programs Are Doing,” offers examples of how CARE Act grantees and other organizations across the country are serving incarcerated and newly released women. The examples are drawn from our conversations with dozens of administrators and care providers over the past 18 months.

**Chapter Five**, “For More Information,” lists publications and organizations that CARE Act grantees may find useful to learn more about how they can serve incarcerated women and provides cites for the references used throughout the guide.

The **Appendices** reprint the HIV/AIDS Bureau’s policy for CARE Act grantees working with people who are incarcerated. Readers who have questions or who would like help interpreting the policy statement can contact HAB directly for more information. The Appendices also provide samples of a variety of forms that may be of use, including a sample memorandum of agreement, intake forms, and discharge or transition plans, as well as a list of national and regional AETC’s, many of which provide information or training on this issue.

## Chapter Two

# Why Women in the Corrections System Are the Business of CARE Act Programs

The revolution in HIV/AIDS care since the introduction of combination therapies in the mid-90s resulted in hundreds of thousands of Americans living longer, healthier lives with HIV disease. This remarkable achievement means that more people are needing HIV/AIDS care for longer periods of time. As a result, CARE Act grantees in communities all across the country CARE Act grantees are struggling to keep up with this need for more services and for more complex services, such as adherence support. Grantees already facing these challenges sometimes hesitate to take on new programs or populations, but women in the corrections system who are living with HIV are very much the business of community-based CARE Act programs. This chapter explores the reasons why and reviews some things grantees need to know about the links between the CARE Act and the corrections system.

### Reasons to Engage

Many CARE Act grantees want to engage with the corrections system to serve women living with HIV simply because it is the right thing to do. It is also, however, the practical and cost-effective thing to do for two reasons:

- virtually all women living with HIV in jails and prisons will become the responsibility of the CARE Act once they are released, so it makes good sense to seize the opportunity that incarceration represents to protect and improve their health status; and
- jails and prisons are a revolving door, and the health of inmates has the potential to affect everyone in their communities.

### An Opportunity

For many women living with HIV, being incarcerated represents their first real encounter with access to health care. A series of federal court decisions over the years — especially the 1976 Supreme Court decision in *Estelle v. Gamble* — established that inmates have a Constitutional right to health care, the only Americans determined to have such a right. In practice, however, the extent to which inmates, especially those living with complex and expensive to treat diseases such as HIV/AIDS, have access to quality health care varies considerably depending on the kind and location of the institution in which they are incarcerated. Even so, for many women being imprisoned creates a first chance for them to have basic health care, substance abuse treatment, and HIV/AIDS prevention education, counseling, testing, and care (CDC, 2001a).

## The Revolving Door

*Slowly, there is a growing realization that the health status of prisoners affects us all, and that better linkages must be in place to provide health care to this populations as it moves back and forth between jail/prison and the free world.*

– Joseph Black, M.D.

*In short, good correctional health is good public health.*

– Gary Michael McClelland

The nature of incarceration – removing inmates from society – has led to the common view that jails and prisons are separate and apart from the rest of us. To the contrary, a staggering number of people come into and out of jails and prisons every year. NCCHC found that in 1995, 10 million people were processed into and released from American jails, while another 850,000 were released from state and federal prisons (NCCHC, 1995). Some estimates today are that as many as 22 million people cycle into and out of jails each year.

The steady flow of people into jails and prisons and back out to their communities means that their health is inextricably linked to the health of society at large. This relationship is especially apparent with infectious diseases such as HIV/AIDS, STDs, and Hepatitis C.

By helping to ensure that women in jails and prisons and women returning to the community get the health care and support they need, CARE Act grantees can help break the “cycles of addiction, incarceration, and disease transmission and...benefit inmates’ families and the larger community through reduced disease transmission, reduced medical and social welfare costs, and reduced drug-associated crime” (CDC, 2001a, p.2).

### On the “Outside”

Not all CARE Act programs will choose to develop or participate in programs that serve women in the corrections system. What all grantees who serve women can do, however, is make sure that they know the issues and provide or have links to programs that provide services designed specifically to support newly released and formerly incarcerated women. Despite remarkable progress in recent

years, there is still a gap in community-based services that encompass the range of physical and mental health care and psychosocial support needs of this group of women, as well as their housing, daily survival, and legal needs.

For example, most states have chosen not to opt out of provisions of the 1996 welfare legislation that deny foodstamps and Temporary Aid to Needy Families (TANF) for life to people who have a felony drug conviction, a category that includes many HIV-positive formerly incarcerated women. Twenty states have adopted the ban in full; another 22 enforce a modified version of the ban. A similar public housing ban on residents with drug convictions further complicates the search for housing for many soon-to-be and newly released women, who must struggle with stigma, discrimination, and no options for second chances. These and other gaps in community-based support allow the “cycle of incarceration and ill health” to begin again (Greenspan, Jones, Rivera, et al., 1997, p.1). CARE Act grantees can help break that cycle by reaching out to these women with tailored programs and services.

By creating this necessary continuum of services, community-based programs also support HRSA’s CARE Act goal of getting underserved populations into care and keeping them in care.

### New Requirements in the 2000 Reauthorization

Recognizing the growing problem of HIV/AIDS in correctional facilities and acknowledging this challenge to quality care both inside and outside these institutions, the 2000 reauthorization of The Ryan White CARE Act includes new requirements for collaboration and coordination. Title I (EMA) planning councils must now include representatives of people who have been released from jail or prison within the past three years and who were HIV positive at the time of their release. Another provision requires that the Secretary of Health and Human Services, in collaboration with corrections, states, CARE Act providers, and others “construct a plan for medical case management and provision of support services to individuals who were HIV positive when released from incarceration” (HRSA, 2000, p.8).

# Chapter 3

## Getting Started: Tips for CARE Act Grantees

In interviews with dozens of CARE Act grantees and other community-based organizations (CBOs) serving incarcerated women living with HIV/AIDS, one thing was clear: there is no one way that works best to get started. There are as many ways to succeed — and to stumble — as there are jails, prisons, and communities. This chapter offers information to help programs consider the first steps. It provides a sketch of the corrections system in the United States, lists some of the most common barriers to high-quality care for HIV-positive incarcerated women, and suggests partnerships between the community and corrections and listening to women on the inside as ways to help overcome these barriers.

### The Corrections System – The Basics

For most CARE Act grantees, working with incarcerated or newly released women requires learning the ins and outs of a new system — one with vastly different priorities and a complex structure. Understanding the differences between jails and prisons will help CARE Act programs find a good fit between what they have to offer and what the needs are in their community.

There are many ways in which women in the U.S. can be under the control of the corrections system. They may be incarcerated in local jails, or in state or federal prisons. Or, they may be in various alternative settings in the community, such as halfway houses, workrelease centers, or electronic home monitoring. After release from any of these settings, they may remain on parole or otherwise under the control of the court. Most incarcerated women are in state prisons, as are most HIV-positive incarcerated women.

#### Jails

Jails are locally operated short-term facilities, holding both pretrial and presentenced detainees and inmates with short sentences, generally a year or less. Sixty percent of people who enter a jail leave within 24-48 hours, and many others are there for less than a week (MMS, 2000).

Table 2  
Jails

- receive individuals pending arraignment and hold them awaiting trial, conviction, or sentencing
- readmit probation, parole, and bailbond violators and absconders
- temporarily detain juveniles pending their movement to appropriate health facilities
- hold individuals for the military, for protective custody, for contempt, and for the courts as witnesses
- release convicted inmates to the community upon completion of sentences
- transfer inmates to Federal, State, or other authorities
- house inmates for Federal, State, or other authorities because of crowding of their facilities
- relinquish custody of temporary detainees to juvenile and medical authorities
- sometimes operate community-based programs and alternatives to incarceration
- hold inmates sentenced to short terms (generally under one year).

Source: Bureau of Justice Statistics, 2001b

These short stays considerably complicate adherence to antiretroviral regimens, as people cycling through jail this way often have no access to their medications, which can lead very quickly to viral resistance.

There are about 3,300 jails in the U.S., and they are notoriously autonomous, with the vast majority of policy and decisions in most localities made by the sheriff. This autonomy is a help when a sheriff is open to improving care for HIV-positive women and a hindrance when he or she is not. In either case, the enormous variability within and between jails challenges CARE Act grantees exploring how to work with the many different kinds of jail detainees (see Table 2).

### Prisons

Unlike jails, prisons are not locally controlled. Prisons in the U.S. are run both by the states and by the federal government, and they typically house inmates who have been tried and sentenced for periods of longer than a year. The Federal Bureau of Prisons and most states have separate facilities for women, although some women are housed in prisons that also hold men.

Because prisons, unlike jails, are not local operations, a woman sentenced to prison may serve her time a long way from home. With just 15 women-only federal prisons in eight states, many women in the Federal Bureau of Prisons system will end up imprisoned far from their communities and from their children and families. About 30 percent of women who are federal prisoners are incarcerated more than 500 miles from home (GAO, 1999), and, in larger states, women in state prisons may also be incarcerated a long way from their children. This distance not only isolates women from their families — the majority of imprisoned mothers are never visited by their minor children (GAO, 1999) — but also complicates transition to community HIV/AIDS services.

HIV/AIDS is more prevalent in the state prison system than in the Federal Bureau of Prisons. Unfortunately, state prisons are also much more likely than the federal system to be strapped for cash and therefore less likely to provide high-quality HIV/AIDS care for inmates. There are a number of

states, however, that do provide the standard of HIV/AIDS care to inmates who are living with HIV disease, often in partnership with outside medical centers and community-based AIDS organizations.

CARE Act grantees in Alaska, Connecticut, Delaware, the District of Columbia, Hawaii, and Rhode Island should be aware that in those states jails and prisons form one integrated system, which eliminates issues of local versus state control.

### Barriers to Care

The purpose, nature, and structure of the corrections system in the United States all combine to create significant barriers to high-quality HIV/AIDS care for incarcerated women. Among the most common barriers are:

- Many women in jails and prisons have little or no access to HIV specialists.
- Many jails and prisons do not have doctors trained in obstetrics/gynecology, putting women at risk for breast and ovarian cancer going undetected.
- Many facilities use the same screening instrument with male and female inmates when they enter the system, resulting in a failure to capture essential information about the women's health status.
- Few jails and state prisons provide sufficient substance abuse treatment, and fewer still tailor such treatment to women's circumstances, such as their higher rates of victimization and mental illness (CDC 2001c).
- Jail and prison policies governing how and when medications are administered can be serious threats to the ability of incarcerated women to follow their treatment regimens. Some facilities dispense drugs only on certain days or at certain times of the day, with little or no regard for prescribed timing or directions for use. Some prisons have public roll calls for medications and medication lines, which may prevent women concerned about the stigma of disclosure — which can be considerable in prisons, both with staff and other inmates — from seeking treatment.

- Nonadherence to treatment regimens is often considered a discipline problem, rather than a medical concern, further discouraging women from seeking care.
- Security needs often trump medical ones. Lockdowns where inmates are confined to their cells, for example, can interfere significantly with antiretroviral treatment regimens.
- Although a right to treatment exists for all inmates, there is enormous variability in how states and localities interpret this right. Federal courts have issued wildly different rulings on what is acceptable care. Some courts have found that grossly poor care such as a regimen limited to two antiretroviral drugs is acceptable, while other courts have ruled that causing a prisoner to miss two days of medications is “deliberate indifference to serious medical need,” the term that defines a violation of the Eighth Amendment right to treatment according to a 1976 Supreme Court decision.

Perhaps the single greatest strategy available to CARE Act grantees to help overcome these barriers to HIV/AIDS care and prevention is to form partnerships with the corrections system.

### Partnering with the Corrections System

There are as many ways for community-based CARE Act grantees to partner with the corrections system as there are jails, prisons, and communities. Among the most critical areas in which such partnerships occur are:

- HIV screening, counseling, and testing to identify positive inmates and get them into care;
- prevention case management to help incarcerated and newly released women remain HIV negative;
- training and support for peer education programs;
- transition case management to ensure continuity of care between institutions in the time before and after release;
- shared training and staff development, often with a focus on HIV/AIDS medicine and standards of care;

### Table 3 Potential Partners for CARE Act Programs Serving Incarcerated and Newly Released Women

- Corrections, including prisons, jails, prosecutors, public defenders, drug courts, juvenile systems, probation and parole boards, and community-based sanctions
- Federal, state, and local public health agencies
- Substance abuse treatment agencies
- HIV prevention programs and community planning groups
- Other CARE Act programs, including AIDS service organizations, planning councils, etc.
- Community-based organizations and social service agencies providing housing, employment and training, welfare, legal aid, child protection, etc.
- Primary health care and mental health care providers
- Faith communities
- Academic medical centers

Source: Adapted from:  
Centers for Disease Control and Prevention, 2001.

- information and resource sharing to develop a continuum of care at the local level; and
- policy development and joint advocacy efforts to improve care.

The specific programs and services that define any local partnership should arise from needs identified in the community through community planning processes as well as through needs assessments by grantees and by other — non HIV/AIDS — programs serving this population of women. In fact, these non-HIV/AIDS community-based agencies and

organizations are excellent resources and partners for the CARE Act/ corrections partnerships.

### Barriers to Partnerships

Although the opportunities for creative and fruitful partnerships between CARE Act grantees and the corrections system are many, there are significant barriers to such partnerships as well. Knowing some possible barriers in advance will prepare grantees for success and help them stick with the partnerships when they inevitably encounter difficulties. Of course, no two communities are alike, and it is likely that surprises will be in store even for the most well-prepared community-based organization.

Among the most common barriers to corrections/ community partnerships for serving incarcerated women living with HIV/AIDS are:

- The primary responsibility of the corrections system is maintaining security, and the primary responsibility of the community-based organization is promoting the health and well-being of clients — a mission clash that takes mutual patience and commitment to overcome.
- Getting required clearances for community-based staff to work with or within jails and prisons typically takes a great deal of time.
- CBO staff who are themselves former inmates are more likely to be trusted as peers by women in jails and prisons, yet many correctional facilities require a clean record for community-based staff who will be working inside the institution.
- Staff turnover — both within the correctional facility and the community-based organization — can mean starting over from square one.
- All written materials used with inmates typically must be cleared in advance, and there are often restrictions on what can be taught or brought into the correctional facility. Condoms, for example, are considered contraband in most jails and prisons, and demonstrations on the proper use of condoms are frequently banned. Getting approval for materials and curriculum is often an lengthy process.
- Jails and prison systems may be reluctant to test inmates for HIV — or to encourage them to be tested — because of the high cost of treatment. Yet, testing is key to identifying HIV-positive women and getting them linked to community services before release.
- Restrictions on the use of CARE Act funds to serve women in the corrections system can inhibit grantees' efforts to promote high-quality care for these women.

### Overcoming Barriers

CARE Act grantees and other community-based programs serving incarcerated and newly released women have a wealth of experience and advice to offer when it comes to overcoming — or working around — barriers. Asked what they think CARE Act programs interested in serving women in jails and prisons should know, programs from across the country responded with remarkably similar advice. Table 4 presents that advice, in their own words. And, as with all women living with HIV and AIDS, CARE Act grantees know that a prime strategy for any program must be listening to the women involved.

### Listening to Women

*Women living with HIV/AIDS in prison need special services while they are incarcerated and during their reentry to the community. The participation of formerly incarcerated women and the voices of women inside are critical to developing these services.*

— Judy Greenspan, 2002

A key lesson of the AIDS epidemic has been that consumers of services must be involved in the design and evaluation of the programs set up to serve them, and this truism is especially relevant for incarcerated and newly released women whose experiences inside may be alien to many community-based program staff. The best way to know what services this group of women need in any individual community is to ask them; the following women's voices are offered as an illustration.

- There is a trust factor when it is peer education, and we can communicate on that level. It is not someone with a doctorate degree telling me all this stuff. It is someone who has been there and through all this stuff.

— *Veronica Flornoy, a prisoner in Bedford Hills Correctional Facility, writing about her participation in the ACE program (Gruzuk, 1999).*

- I also have a problem with confidentiality at med line. No, I do not take meds and I made the conscious choice based on the knowledge that I have. For the women who have to take meds, these lines last a long time. They have to stand in extreme heat, they stand in severe cold weather just to get their regimen.... If you are the only woman standing in line picking up a 3-med package every single day, someone is going to ask what are you taking.

— *Beverly Henry, HIV-positive inmate testifying at a state legislative hearing (Greenspan, 2001).*

**Table 4**  
**Straight from the Source:**  
**Advice from Programs Serving Women in**  
**Jails and Prisons**

- Work within the system as it exists — that's essential! Getting angry doesn't work. Neither does being an advocate first.
- Be prepared to take baby steps forward. Getting in is the biggest hurdle. It will take months — maybe even years — to be accepted by the corrections system. Don't give up. The investment of time and effort will be worth it.
- Approach the system in terms of what your program can offer. Say what you can do and ask, "What do you need?"
- Be fully funded. Don't expect the jail or prison to be able to pay.
- Familiarize yourself with all of the rules and regulations of each facility before sending staff there. Remember, when you go into the prison, you are in their territory. The prison owns you while you are there.
- Go in respecting the custody staff and their constraints, which we may know nothing about.
- Approach the medical staff, guards, and other corrections staff in a spirit of good faith. Assume good motives on their part, and recognize the day-to-day difficulty of their jobs.
- Approach the women with the same spirit of respect and recognition of their dignity as human beings and as women.
- Be a beacon of light — and honesty — with the women.
- Bring women through the time warp. Help them get ready for the ways in which the world has changed since they've been inside. Think of all the aspects of daily life that are different than they were when an individual woman was imprisoned.

**Table 4**  
**Straight from the Source:**  
**Advice from Programs Serving Women in Jails and Prisons**  
 (continued)

- Know what you can and cannot provide. In other words, recognize the limitations of your program.
- Local sheriffs are key allies for jail programs. Wardens are key in prisons. Win them over — convince them of the value of what you have to offer — and your program will be well on the way to success in improving care for incarcerated and soon-to-be-released women.
- Get line staff on your side, as well. Remember that you are working within a closed system, and everyone counts.
- Follow up with people. Many jails and prisons have very few resources for training medical staff in HIV/AIDS standards of care, and the medical staff often welcome this kind of technical assistance from the community. If some individuals just aren't interested, try to get permission to move on to other staff.
- Include prison physicians, nurses, chaplains, and other staff in AETC (AIDS Education and Training Center) trainings.
- Support what is already there. Peer education programs, for example, can typically use outside support.
- Peer education is the most important thing you can do. To avoid AIDS stigma, peer education can happen under almost any guise — women's health information, chronic illness awareness, etc.
- If there is a good program in your community already working within the corrections system, try partnering with them for an HIV/AIDS component. Such partnerships enable your agency to "borrow" the credibility that the other CBO has already built with the jail and prison systems.
- Not only does this policy affect those of us who do take medication (you know — every 8 hours, with different needs around food intake in correlation to med taking) but now we're being denied one of our doses on Sundays and holidays because there is no midday med line on those days... Even with my limited knowledge of meds, I knew when I committed to take them that it was a commitment for the rest of my life.  
*— Judy Ricci, an HIV-positive prisoner and prison activist, writing about prison medication line policies (Women Alive, 1999).*
- It was like a revolving door — once you get into it, it is hard to get out of it and then you become a part of the system... If it hadn't been for the Jail Release Linkage Project, I would have gone back to the street and would be either in jail or dead by now.  
*— Susan Larkins, an HIV-positive formerly incarcerated woman, writing about the critical importance of programs linking jail and community (MMS, 2000).*
- I hate going to HIV clinic, because it takes so much work: If you don't know what questions to ask, and you don't keep piping up and asking them, your visit with the doctor won't give you the information you need. There are a dozen women right here in the waiting room with me, dealing with this same thing, yet I feel alone. The confidentiality codes of the Federal Bureau of Prisons (BOP) regarding HIV are extensive. The prison administration says that having us all gather in one place — for, say, a support group — would put a strain on the policy regarding HIV confidentiality. So we sit here in one room, silent in our confidentiality. Everyone knows why we are here: It is HIV clinic day. We take turns going through the same door. Dealing with the same doctor, dealing with the same fears. There are some women waiting for other doctors, but even they know what this door is for.  
*—Jennifer Poteet, an HIV-positive federal prisoner, writing about her experience trying to*

**Table 4**  
**Straight from the Source: Advice from**  
**Programs Serving Women in Jails**  
**and Prisons (continued)**

***start a support group for women living with HIV***  
***(MMS, 2000).***

- While some of us were friends when we first came together, most of us knew each other only in passing. What united us was that we were all affected by AIDS. We shared a need to survive the epidemic. If you had used the word “community” about life in prison, we would have laughed. But in the end, we came together with a common goal and created a community which gives us strength.

***— The women of the ACE Program, Bedford Hills Correctional Facility, a groundbreaking peer education program (see Chapter Four).***

## **One Woman's Story**

Paulette Nicholas' story is both typical of HIV-positive incarcerated women and remarkable — typical because, like most other women in prison, drugs got here there, and remarkable because she came out stronger and ready to advocate for other women struggling with HIV infection, incarceration, and addiction.

***I learned that I was HIV positive in 1994 when I was in a drug rehab. It was mandatory to be tested for HIV, and that was my first HIV test, even though I knew I was at risk — very high risk at that. I ended up in prison as a result of my crack habit. I would do anything to get the drug.***

***My addiction took me to the point where I lost the custody of my children. I could not handle this at all, so drugs were my source of comfort; my addiction took control, and I lost all my hope. That's when I started stealing. I hooked up with some other addicts who were thieves, and we supported our habit by going into stores stealing computers, tvs, camcorders, expensive clothing — anything the drug dealer wanted.***

***I was arrested with three felony arrests in one month and was certified as a habitual offender. I was sentenced to serve 10 years in prison. I was denied parole and served three years on 10, from December 1997 to April 2001. Those three long hard years blessed me and changed my life.***

***While I was in prison, I participated in an intensive therapeutic drug treatment program called SAP. The program provided me with an opportunity to really look at myself and see my sick soul from my dysfunctional past stemming from childhood. I had an opportunity to see Paulette, and for once I learned about me — who I was, what I felt, and more importantly to***

*feel emotions and not medicate them away as I'd done all my life.*

*Through harsh prison conditions, I learned to live life on life's terms — after all, the only freedom I had was the freedom to choose how I responded to the events of the day, whether right or wrong and the hope to live through the situation and to live life outside the prison.*

*When I was in prison, the ignorance and fear about HIV caused the prison officers and officials to ostracize HIV-positive inmates. I had been an HIV activist before prison, which allowed me to educate inmates and staff. I was very committed to working with women on meds and on getting them their meds on time. I also established the first HIV library in the prison. I went on national television and radio about the conditions in my prison, and I even filed a lawsuit against the prison. All of this contributed to my rehabilitation, to a change in what I call the "core person" of me.*

*My life going into prison was so spiritually and physically bankrupt that I was desperate and willing to do anything to change, and I believe that that is why the miracle of change took place. It was the gift of life I received, and I live with that gift today. I grew up and became a woman, and I am an even better woman today from that experience and from life today without drugs.*

*There was no release program to help me when I was released. I had a sponsor from a 12-step program who helped me with release planning. I had nowhere to go. I had established supportive friends who were staff at the prison, and they supported me in prison and out of it. The job I have now has also been a strong support system.*

*I help positive women because I want to give back what was so freely given to me by those who believed in me and asked me to give to another what they were giving me. That is my pleasure — to gladly give back and to be there for another woman until she can be there for herself. I don't look for these opportunities, but God puts them in my path, and it becomes my pleasure to do all I can.*

*I strongly feel that we need to do more to address the needs of women who are transitioning from prison back into society. Prerelease should consist of intensive planning and preparation, and available community resources should be in place before a woman is released. That means help with things like obtaining I.D., housing, substance abuse aftercare, medication assistance, and other social/financial needs such as food stamps, and employment, job training, or school.*

*Also, women should be connected with a woman who has had a successful release and is doing well in the community. She can be a peer leader or buddy to the newly released woman and perhaps can be part of the planning process before release. She can help that woman with her transition to society, until that person can make it independently and maybe even do the same for the next woman coming along. I believe this can be a foundation of support that prevents women from being released to nothing, where the only place for them is the same old people, places, and things that caused them to be in prison in the first place. A woman released to nothing and no one may have the only place to go be the crack house, and then the endless cycle begins all over again.*

# Chapter Four

## What Agencies and Programs Are Doing

Just as there is no one best way to get started, there is no one program model or approach that is best for all communities. This chapter offers examples of the diverse approaches that are working in communities across the country to provide care and support to incarcerated and newly released women living with or at risk for HIV and AIDS. Although most of these programs provide an array of crosscategory services and supports, for the purposes of this guide we are describing programs within the following categories:

- providing peer education;
- identifying positive women and getting them into care;
- planning transitions and continuity of care; and
- working with correctional care providers.

Finally, one program is described from its inception to the present day as an illustration of how comprehensive programs can grow from new partnerships and small first steps. For readers who want to find out more, contact information is included for each program example.

### Providing Peer Support and Education

Peer support and education is widely considered to be the single most important strategy for reaching incarcerated and newly released women living with HIV and AIDS. Although peer support has long been acknowledged as a powerful resource for women living with HIV/AIDS, it may be even more so for incarcerated women, who often distrust information coming from the outside.

#### AIDS Counseling and Education Program

ACE — the AIDS Counseling and Education program — was the first, and is still the largest, peer support and education program for incarcerated women living with HIV.

The program began in 1985 at the Bedford Hills Correctional Institute in upstate New York, when a dozen women inmates wrote the prison warden asking for permission to visit women sick with AIDS in the infirmary. Because inmates are confined to their units, asking to be allowed to cross the corridors and go into inpatient care and

**Table 5**  
Features of Promising Programs

A study funded by the National Institute of Justice identified features common to innovative and promising programs for women offenders. They include:

- Well trained and dedicated staff who care about the welfare of the women and their families and who serve as positive role models for program participants.
- Women-only programming.
- Program materials focused on skills development and meeting women's particular needs.
- Willingness to tailor approaches to meet individual needs.
- Treatment with appropriate controls.
- Use of peer support and development of peer networks.
- Formal recognition of participant achievement.
- Options for women who fail.

Source: National Institute of Justice (1999).

residential medical units was a bold request. But these were, and are, remarkable women, and the warden, Superintendent Elaine Ward, is no less remarkable. She agreed, and ACE was born, breaking the mold in terms of inmate responsibility.

Today, ACE operates with a paid inmate staff of 12 peer educators who provide HIV prevention education, pre- and post-HIV test counseling, crisis intervention, mentoring through a buddy program, support groups, adherence counseling and support, advocacy, and discharge planning to prepare women leaving the prison and reentering the

community. ACE also does presentations to combat AIDS stigma throughout the prison, holds memorial services, and raises funds for AIDS programs on the inside and outside. All ACE programs are built on the principle of women talking with other women living the experience.

ACE inmate staff, who include both HIV-positive and negative women, train other women inmates to be ACE volunteer peer educators. Volunteers attend an eight week train-the-trainers workshop to learn everything from the basics of HIV 101 to the complexities of peer crisis intervention.

Superintendent Lord speaks to the value of ACE and other peer education programs for incarcerated women living with HIV:

*It's about the women owning the program and saying that this is a problem they want to wrestle with... I think it takes longer and has a different staff commitment, and I think that's why other [prison] programs kind of shy away from it. If it's top down or if you have a kind of setup program, with a brochure and this is how it's done, then that gets implemented faster. You don't go through the stresses of trying to work things through with people. But by doing that, it lends it the power that we know and see. It took a while to get here. It isn't without frustration. But I think it is well worth it.*

(Gruzak, 1999)

The ACE program receives outside support through coordination by a community-based organization — the Women's Prison Association (WPA) — that responded to a request for proposals from the New York State AIDS Institute in 1992. The Women's Prison Association, which has over 150 years of service working with women pre and post incarceration, describes its mission as creating opportunities for change in the lives of women prisoners, ex-prisoners, and their families.

WPA acts as a liaison between the ACE program and the outside and provides a number of services to inmates, including HIV testing at Bedford Hills and at another women's facility, Taconic Medium Security Prison, where WPA also coordinates a sister program to ACE, Counseling AIDS Resources Education (CARE). WPA coordinates these

peer education programs as part of its comprehensive Transitional Services Unit (TSU). TSU is described later in this chapter under “Planning for Transitions, Discharge, and Continuity of Care.”

*For more information about ACE, contact: Nilda Ricard, AIDS Counseling and Education Program, 247 Harris Road, Box 33, Bedford Hills, NY 10507, (914) 241-3100 or Kim Collica, Taconic Correctional Facility, Women's Prison Association, 250 Harris Road, Bedford Hills, NY 10507 (914) 241-3010 ex. 6125. To learn more about ACE from the women themselves, read *Breaking the Walls of Silence*, a book written by the women of ACE in 1998 (see Chapter Five).*

### AIDS Resource Center of Wisconsin

AIDS Resource Center of Wisconsin (ARCW) exemplifies a community-based agency that saw a need, got started with a small program to meet the need, and expanded services and supports as the need grew. AIDS Resource Center operates a peer education program at the Ellsworth Women's Correctional Facility in Racine, Wisconsin, where inmate volunteers are trained to be AIDS Information Mentors. ARCW and these peer trainers offer a series of six training sessions over three weeks, then start the sessions over. Sixteen women attend each series and discuss issues such as HIV and STD 101, communication, values, and goal setting.

Although the focus of the program is primarily HIV prevention, invariably a woman will approach AIDS Resource Center staff after a session and confide that she is HIV positive. Positive women are linked to case management and other services and provided with transition plans before discharge.

After struggling — as every CBO does — to get into the correctional system, AIDS Resource Center now provides a wide array of outreach, HIV prevention, and transition services to men, women, and youth in the correctional system. Their original street outreach was expanded to include city and county jails, state correctional facilities, and

halfway houses, and they now provide HIV counseling and testing in women's facilities across the state, including the Taycheedah Correctional Institution in Fond du Lac, as well as a peer education program at the Southern Oaks Girls School, a juvenile detention facility that shares grounds with the Ellsworth Women's Correctional Facility.

*For more information about AIDS Resource Center's correctional programs and partnerships, contact Scott Stokes, AIDS Resource Center of Wisconsin, 820 North Plankinton Avenue, P.O. Box 510498, Milwaukee, WI 53230, (414) 225-1511, [Scott.Stokes@arcw.org](mailto:Scott.Stokes@arcw.org).*

### Great Brook Valley Health Center

The Great Brook Valley Health Center in Worcester, Massachusetts, uses a participatory education approach and a harm reduction case management model to reach incarcerated and newly released women living with or at risk for HIV/AIDS. Great Brook Valley's peer education program operates at the Massachusetts Correctional Institute - Framingham, a state facility that includes women awaiting sentencing, as well as women who have been sentenced, because some counties do not have jail facilities for women. Some women in Framingham are there for a 65-day drug treatment program; some are there for life.

Great Brook Valley trains women for four weeks as peer educators for other women, with a dual focus on information and skill enhancement. About 12-15 peer educators — some HIV-positive, some not — participate in the program at any given time, and the women volunteering include those from every stage of the correctional process.

Once the peers are trained, they hold a series of weekly training sessions for other women, including both an English and a Spanish series, which run concurrently. About 15-20 women participate in each Spanish series, about 20-25 women in each English series. The training, which is 10 weeks long, encompasses basic HIV education, with a very strong women's health component. Decreasing AIDS stigma and developing a more positive atmosphere in the prison around the disease is a major purpose and benefit of the training series. This is especially important, because many

women are afraid to share a cell with a positive woman. Great Brook Valley staff provide the peer trainers with ongoing support throughout the training series, meeting with them for two hours in the afternoon before the evening training sessions, which are typically held from 6:30-8:30. Evening classes are an accommodation to the prison schedule. Going to school in the day gives women “good time,” which can reduce their sentences, so any program held in conflict with school is not likely to succeed.

A total of 600 women have taken the training series, and the notion of becoming peer educators themselves is introduced in the sessions. The training series, which is promoted to inmates as “come learn about women’s health,” is advertised throughout the facility.

Among Great Brook Valley Health Center’s many other programs for incarcerated women are HIV counseling and testing, referrals for positive women, treatment education, and one-on-one and group support, which may make use of drama, story writing, and other methods to deal with issues such as how to negotiate safer sex and how to feel good about one’s self. Through a collaborative discharge planning program called the Transitional Integration Project (TIP), Great Brook Valley works with HIV-positive women who are going to be released, starting at least six months out. They work with the infectious diseases nurse and assign a short-term case manager who may focus on housing, employment, health insurance, etc. The case manager picks women up when they are released and then works with them up to a year after release to get the woman connected to and using community services. TIP is one component of the Massachusetts Department of Public Health’s CDC/HRSA Corrections Demonstration Project (see Chapter Five for information about this joint CDC/HRSA initiative).

*For more information, contact: Leo Negron Cruz, Massachusetts Prison HIV Awareness Project, External Programs/Health, Great Brook Valley Health Center, 30 Great Brook Valley Avenue, Worcester, MA 01605 (508) 854-3260.*

## Identifying Positive Women and Getting Them Into Care

The (PDAP), a Title IV program at Morehouse School of Medicine in Atlanta, Georgia, recently started a project to work with the Metro Atlanta Regional Youth Detention Center to help adolescents stay out of the corrections system, reduce high-risk behavior, and identify HIV-positive youth and get them into care. The project — which is coeducational, serving about one-third girls and young women — operates under a letter of agreement between the Pediatric AIDS Demonstration Project and the medical director of the detention center.

The youth detention center is in some ways very much like a jail, with a high volume of turnover. Most kids get in and out quickly; some are sent from the center to jail. The average turnover is about 15 days. Therefore, young people going back into the community are the project’s main focus, and staff have to act fast to reach kids during the window of opportunity while they are there.

The project model uses group sessions and one-on-one case management to identify needs and begin discussions with the youth about their health and risk behaviors. The group sessions generally last an hour and are offered every day. Group size may be as large as 8-10 or as small as three. Many kids are from the same neighborhoods and know one another or know friends of friends, which means word of mouth about the program can be a help in engaging youth in services.

HIV counseling and testing is available in the detention center, and the project encourages youth to be tested so that they can be linked to care. All kids — positive and negative — are connected to community services to meet their needs as identified during their stay in the center. PDAP negotiates with service organizations in the community so that these discharge planning referrals are meaningful. As part of that effort, the project has a memorandum of agreement with three CBOs.

After youth are released, the project follows up with both the young person and the agencies serving him or her.

Among other things, the project wants to know if youth are using services and if services are youth-friendly and culturally competent. While youth are in the detention center, an assent to services exists; once outside, permission to provide follow-up services must be obtained from parents or guardians.

Finding staff able to go into the detention center and other juvenile facilities can be tough, because the same life experiences that make them credible to the young people may make them ineligible to work within the corrections system.

*For more information, contact: Natasha William Morehouse School of Medicine, Atlanta, GA, (404) 756-1334.*

## New Transitions: Blacks Assisting Blacks Against AIDS

The New Transitions Program for Formerly Incarcerated Women Living with HIV/AIDS is a program of Blacks Assisting Blacks Against AIDS (BABAA). Serving metro St. Louis, BABAA is Missouri's first and only African American AIDS organization and a Title IV Network Affiliate. New Transitions works with women of color coming through the court system who are HIV positive or at high risk, seeking to get them into care through a comprehensive system of enhanced HIV/AIDS health care and support services. The project offers prevention case management, transitional case management, and a mental health component that helps women examine and change behavior that puts them at risk.

Collaborating with BABAA on New Transitions are the St. Louis City and County Divisions of Corrections, the St. Louis City and County Departments of Health, and community-based organizations working with incarcerated women. New Transitions is a pilot project sponsored by the Office of Women's Health, HRSA, U.S. Department of Health and Human Services.

Through a creative and exciting partnership with the Administrative Judge in the City Court of St. Louis, women

are referred to New Transitions as a condition of release from sentencing. Women appearing before the City Court are charged with violations of city ordinances — most often prostitution — and face sentences that range from one day to two years in prison and fines from one dollar to \$500. Judge James Sullivan, a mover and shaker in this community/corrections partnership, mandates that every woman coming through the door of his court attend New Transitions or drug rehabilitation as part of her sentence. Refusing to participate means that there is no reduction in sentence length. A BABAA transitional case manager meets briefly with each woman, usually at her court appearance, to set up a later appointment for a needs assessment that will lead to a comprehensive discharge plan.

Transitional case management helps women identify their needs, and BABAA then provides both direct services and referrals to other community organizations to meet those needs. Prevention case management — which takes place both within the jail and in the community — supports HIV-positive women with secondary prevention, such as treatment education and adherence. Negative women are offered primary prevention support, such as skills for negotiating safer sex and self-esteem building. Prevention case management while the women are still incarcerated includes a series of five educational sessions that encompass a range of HIV/AIDS and mental health concerns.

The mental health component of the program primarily uses an eight-week series of support groups to help women gain insight into themselves and the behavioral patterns that led to their incarceration. The New Transitions support group curriculum directs discussion to issues of family, culture, life skills, survival, and self-esteem, offering the women both emotional support and empowerment strategies for decision making. Three series of support groups are available: one for HIV-positive women, one for women at high-risk, and one for partners and families. Completion of the support group curriculum is recognized with a graduation ceremony and certificate of completion, presented in Judge Sullivan's court.

For more information about *New Transitions* or *Blacks Assisting Blacks Against AIDS*, contact: Dana Williams, BABAA, 625 N. Euclid Avenue #320, St. Louis, MO 63108, (314) 865-1600, [babaaadmin@primary.net](mailto:babaaadmin@primary.net).

## Planning for Transitions, Discharge, and Continuity of Care

Planning for discharge and other transitions to ensure continuity of care and to bridge service gaps in the community is an important CARE Act focus. Although planning for discharge — in a very real sense — should begin as soon as a woman is incarcerated, restrictions on the use of CARE Act funds for services while people are incarcerated means that most CARE Act programs begin formal discharge planning no earlier than six months before release.

### Metropolitan Title IV: Prison Initiative

In several North Carolina counties, women living with HIV/AIDS were being released from prison with no connections in the community, no medications, and no place to live. They were on no one's radar screen until they ended up sick in the emergency room. Metropolitan Community Health Services in created a Title IV Network project to change this situation, in partnership with local CBOs and the corrections system.

Initially, the project was designed to work directly inside state prisons, with the goal of getting women ready for their release and creating a support system for them within their communities through collaborative agreements with local CBOs. However, getting the necessary clearances for staff proved to be an arduous process, taking 18 months for staff to get certified. It was not possible to get similar clearances to work with youth facilities. In a creative response to these difficulties, the project shifted its primary strategy from working directly inside the prisons to recruiting clergy who were already accepted inside and training and supporting them as the inside workers. The project continues to seek more and stronger linkages between the prisons and local CBOs as part of its effort to build a system that connects women to care and housing.

Discharge planning begins at 120 days before release. Many of the women want to relocate when they get out — to get a fresh start and get away from their social network of drug users. They want to know what resources are available in various communities they may be considering. They also want to know how to disclose their positive status to their families before they come out of prison and how to get their loved ones tested for HIV. This takes preparation and support directly with the families, so that the women are not rejected when they get out.

A significant achievement of the project in its first year was changing discharge practices related to continuity of care. Women were being released with no or very little supply of their antiretroviral medications. Today, as part of their discharge plans, women are routinely given a 30 day or six week supply, enough to last until they get enrolled into ADAP.

For more information, contact: Rev. Lynn E. Bolden, Metropolitan Low Income Housing CDC, 102 West Fourth Street, P.O. Box 1886, Washington, NC 27889, (252) 948-0710, [health@beaufortco.com](mailto:health@beaufortco.com).

### Get Connected, Centerforce

Centerforce is a well-known and long-time leader in community/ corrections partnerships throughout the state of California. In recent years, Centerforce has expanded its programs to include services for incarcerated women living with HIV/AIDS. Through Get Connected, a component of a statewide collaborative CDC/HRSA Corrections Demonstration Program SPNS project, Centerforce serves women living with or at high risk for acquiring HIV/AIDS at the Central California Women's Facility at Chowchilla.

Get Connected has four components: peer education, reentry education, prevention case management, and a health programs initiative. Centerforce staff train and supervise five paid peer educators and 25 volunteers. The peer educators are paid by the prison; it is their prison job. A group of peer educators meet women when they first arrive at Chowchilla.

They offer a voluntary sign up for HIV counseling and testing and also encourage women to be tested for Hepatitis C and vaccinated for Hepatitis A and B, all in the context of daily health education workshops. The peer educators are allowed to go into the housing units on an ad hoc basis. The prison is organized into four yards, with four housing units within each yard, and 250 women in each housing unit. There is at least one peer educator per yard, and typically several volunteers.

Centerforce Get Connected staff join with the prison staff to offer reentry education. The prison teaches a six-week class for women before their release. Two days in a row, Get Connected comes in to teach four-hour sessions as part of the prison's reentry program. Centerforce staff, the peer educators, and speakers from the community team up to teach the sessions, which cover a variety of health topics important to women who will soon be released, such as harm reduction, HIV/AIDS 101, and STDs/Hepatitis.

During these reentry education classes, Get Connected staff identify and recruit women for prevention case management — five months of intensive transitional support. Eligible women are those who will be paroled to the five counties in the Get Connected Fresno service area: Fresno, Madera, Merced, Kings, and Tulare. Get Connected meets with the women about 16 times in the 60 days before their release and then follows up with them eight to 12 times in the first 90 days after they are out. Follow up is sometimes in person and sometimes by phone, depending on the client.

Get Connected prevention case management begins with an assessment of client need, with the woman leading the way. Based on this needs assessment and an individual risk assessment, the client and staff develop a client-centered service plan that includes risk reduction and facilitated referrals to community-based organizations. Get Connected provides bus tokens and clothing vouchers for women after release, as well as food vouchers for fast food, groceries, and calling cards. Each woman also receives a health and wellness basket, with toiletries, condoms, etc.

Get Connected's Health Promotion Initiative features community specialists who come into the prison to offer

special projects with a health focus for women as they prepare for release. For example, a health fair brings CBOs into the prison once a year to talk about their services. An AIDS Memorial Quilt display is also offered once a year.

*For more information about Get Connected, contact: Stacey Shank, Centerforce, 3122 N. Millbrook Avenue, Suite F, Fresno, CA 93703, (559) 241-6160, ex 107, sshank@centerforce.org.*

### Transitional Services Unit Women's Prison Association

The Transitional Services Unit (TSU), which receives Title I EMA CARE Act funds, is the outreach program of the Women's Prison Association. TSU works with New York City's Rikers Island jail and with five state prisons for women, providing a broad array of outreach services that includes HIV education, individual and group counseling, facilitation of inmate support groups, HIV counseling and testing, peer training (for ACE and CARE, as previously described), training of jail and prison staff, discharge planning, and transitional case management.

TSU services bridge the correctional facility and the community. Inside, women are offered education, training, support, and advocacy on the issues of most concern to them, such as harm reduction, substance abuse treatment, domestic violence and abuse, parenting — all with a focus on coping with these issues after release. As part of the CARE program at Taconic Medium Security Prison, for example, every July an AIDS Awareness/Resource Day brings 20-25 outside agencies to the prison to set up information tables and speak to the women about getting connected to resources such as housing, medical care, GED, and college. Discharge planning begins when women are six months out from release, and transitional case management spans the first three months after release, allowing women plenty of time to qualify and enroll in Medicaid and other entitlement programs.

Housing is such a major discharge planning issue for incarcerated women — who almost always have great difficulty finding safe, affordable housing where they can stay clean and sober — that the Transitional Services Unit has

three staff members who work on nothing but housing. For more information about TSU or the Women's Prison Association, contact: Kim Collica, Women's Prison Association, Taconic Correctional Facility, Women's Prison Association, 250 Harris Road, Bedford Hills, NY 10507 (914) 241-3010 ex. 6125.

### Tarzana Treatment Centers

Under a Title IV subcontract Tarzana Treatment Centers, Inc. provides transitional case management and discharge planning for incarcerated HIV-positive women who will be returning to Los Angeles County after their release. Staff and clients jointly develop a discharge plan that encompasses transportation, housing, substance abuse treatment, medical and mental health care, long-term case management, help in obtaining food vouchers, referrals to support groups, financial assistance, and other areas of identified need.

For more information, contact Jenell Laggard, HIV Incarcerated Services, Tarzana Treatment Centers, Inc., Tarzana, CA (818) 342-5897 ex. 152, or [jlaggard@tarzanatc.org](mailto:jlaggard@tarzanatc.org).

### COCOA

Although COCOA — Corrections Outreach to Communities for Offenders with HIV/AIDS — recently lost its funding, we are including the program here because it exemplifies a creative partnership between a state CARE Act program and the state departments of health and corrections.

COCOA was a joint venture of the Washington State Department of Health and Department of Corrections (DOC). In a three-way brainstorming session with the local jail, the project took shape as an opportunity to create a seamless linkage between jails and prisons and the community for people living with HIV and AIDS. COCOA was funded through a Ryan White CARE Act Title II contract from the Department of Health to the Department of Corrections.

COCOA's purpose was to develop standardized protocol identifying a continuum of services for HIV-positive offenders — starting with the safe disclosure of an HIV diagnosis and including appropriate medical intervention,

continuity of care, and discharge planning for release back to the community. COCOA formed partnerships with all 10 Washington prisons that house HIV-positive inmates, including the Washington Corrections Center for Women in Purdy, where the Department of Corrections is in the process of setting up a center of excellence for women-specific HIV/AIDS care. To improve the quality of HIV/AIDS care available to them, women will go to the center of excellence for diagnostic work, to get the right treatment regimen, etc., then go back to their own facilities with monitoring and liaison, with the goal of medical staff in those facilities looking to the center of excellence as a resource for HIV/AIDS standards of care.

Video telephones at Purdy are linked to CBOs, enabling a woman to connect with the person who will be her case manager after release, no matter the distance from the prison. Any form of connection between prisons and CBOs is a help; not all CBOs have welcomed former prisoners into their programs.

COCOA began with just one staff member, with intense support and commitment from the DOC's health care coordinator. A second COCOA staff member was added to provide direct case management and discharge planning, 90 days pre-release. An important focus of this case management was linking people again, or for the first time, to eligibility for ADAP and Medicaid, programs people are not eligible for while they are in prison, but will likely need immediately upon release. Washington state continues to provide a full treatment program for Hepatitis C in prisons, and ensuring continuity of care is critical in this area, as well.

### Working with Correctional Care Providers

Because so many state prisons and local jails are overcrowded and underfunded, many health care providers in the corrections system say that they do not have access to the education and training they need to provide the HIV/AIDS standards of care. CARE Act grantees and other community-based organizations have a wealth of this information to share. Connecting the community to the corrections providers, though, can be difficult. Many

programs report that the hardest part is just to get into the corrections system. Once that happens, the changes in the quality of care available in jails and prisons can be enormous.

### Pacific AETC

The Pacific AIDS Education and Training Center (AETC) at the University of California, San Francisco is a partner in California's CDC/HRSA Corrections Demonstration project. Pacific AETC is making connections with jails and prisons in California to get in and work with the health care providers, offering them the latest information and training on HIV/AIDS standards of care in a supportive and non-judgmental environment. Outside the demonstration project, the AETC also is working on this issue with programs in Nevada, Arizona, Hawaii, and the U.S. Pacific jurisdictions.

Recognizing that the quality of care varies dramatically from institution to institution, the AETC focuses on helping correctional care providers identify their individual needs and assess their environment in terms of whether it supports HIV/AIDS standards of care. For example, the way medications are distributed often works against adherence, but medical staff may not be aware of this unless they fully understand combination regimens and adherence. Pacific AETC approaches each provider with respect for the job that people are trying to do. They validate what people are doing that is working at the same time that they provide education and training designed to improve care. Instead of approaching prison health care providers with, "I can't believe you started someone on a two-drug regimen!" AETC staff ask them, "How can we help? How can we support what you are doing? Here are some things that are working..."

*For more information, contact: Carol Dawson Rose, Pacific AETC, Center for AIDS Prevention Studies, University of California San Francisco, 74 New Montgomery Street, Suite 600, San Francisco, CA 94105, (415) 597-9338, CDawson@psg.ucsf.edu. For a complete list of AETCs, see Appendix C.*

## Profiling a Comprehensive Program — The CORE Center

The CORE Center's programs for incarcerated and newly released women living with HIV/AIDS illustrate how great things can grow when people are willing to take a chance on new ideas. The CORE Center is part of Chicago's Bureau of Health Services (BHS), a public health entity that includes Cook County Hospital, where in the late 1980s, Dr. Marge Cohen created health educator position to be based in the local jail. The health educator would offer women HIV counseling and testing, and refer positive women to care upon release and offer risk reduction education for women who tested negative. That idea was such a success that the Cook County Jail eventually hired their own team of health educators.

Building on that first success, in 1997, the Women & Children's Program of the HIV Primary Care Center, a BHS program that is now part of the new CORE Center, created a liaison position funded by Title IV to identify HIV-positive women in the Cook County Jail and help them get into care when they get out. The liaison has a Cook County Jail ID, which enables her to work freely with jail staff. She attends periodic staffings at the jail where she learns about women who are HIV positive, including former CORE clients; women ready to be released to community or to the county day reporting program; women who have been newly identified with HIV; and women who are new to the jail. From this list, the liaison makes contacts with the women, telling them about CORE's programs for women and offering them services, which might include talking to probation or parole on their behalf.

Expanding the scope of the liaison to include state prisons seemed like a logical next step, and once that happened, the partnership grew to include the top administrator from the Illinois Department of Corrections, as well as prison doctors, nurses, medical discharge planners, and social workers. Once this group began talking with staff from the Women and Children's Program, the natural progression was to begin to discuss and problemsolve around other common concerns, especially barriers to care for incarcerated and newly released women. For example, access to most publicly funded care in Illinois requires a

state ID card, something many women prisoners do not have. Continuity of care is virtually impossible without that card, so the group got the Secretary of State involved in making it possible for women to get a state ID while they are still in prison.

In 1999, this corrections partnership on behalf of incarcerated women living with HIV/AIDS took another step forward with the creation of the Continuity of Care Task Force. The Task Force includes representatives from the CORE Center, Cermak Health Services of Cook County — the BHS division that provides health care to Cook County's daily population of 10,000 inmates — and three state prisons with female inmates, as well as a work release center. The Task Force meets regularly to identify needs, barriers, and solutions to ensure against gaps in care.

The CORE Center also offers a Continuity of Care Clinic for HIV-positive men and women who are newly released from jails and prisons. The center funds a physician in the jail to see inmates before their release; one day a week he is at the CORE Center where he can then see newly released clients for their first visit. Continuity of Care Clinic community case managers see these clients for their first three visits, after which they move on to their preincarceration case manager if they have one.

Of special importance to women living with HIV/AIDS who are involved in the corrections system is the CORE Center's partnership with the Illinois Department of Children and Family Services AIDS unit, which funds the center's intensive case management to keep families intact. The CORE Center gets involved quickly when it appears that a woman is likely to be incarcerated to prevent her children from entering the foster care system, helping to place children in safe homes with loving relatives or neighbors. For more long-term arrangements, the center helps with guardianship and permanency planning.

*For more information, contact: Deane Taylor, The CORE Center, Chicago, IL (312) 639-4315, dtaylor@corecenter.org.*

# Chapter Five

## Where to Find Out More

Ryan White CARE Act programs interested in learning more about serving incarcerated and newly released women living with HIV/AIDS have available to them a number of easily obtained resources, most of them free and many of them available on the Web. The Health Resources Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) are excellent sources of information, as are a variety of HIV/AIDS and corrections organizations. This chapter provides a sampling of helpful publications and organizations.

### Publications

- **HEPP News** is a newsletter on HIV/AIDS in jails and prison, with an emphasis on the state-of-the-art treatment. Each monthly issue includes goals for the reader, such as “after reviewing this month’s issue, readers should be able to identify appropriate ART regimens for treatment-naïve patients.” *HEPP News* often includes charts that present complex information — for example, “Antiretroviral Agents Dosing and Administration Recommendations” — in a straightforward manner that allows comparison. Produced by the HIV Education Prison Project (HEPP) of Brown University School of Medicine, *HEPP News* also provides self-tests for Continuing Medical Education credits.

This free newsletter would be an excellent resource for CARE Act grantees to share with corrections health care providers, many of whom may not have easy access to the latest information in HIV/AIDS treatment. It is available online at [www.hivcorrections.org](http://www.hivcorrections.org) and by mail by contacting:

**HIV Education Prison Project,  
Brown University AIDS Program**  
Box G-(Kilguss)  
Brown University  
Providence, RI 02912  
(401) 277-3651 or (401) 277-3655  
[www.hivcorrections.org](http://www.hivcorrections.org)

- **Criminal Justice Fact Sheet Series** is an informative collection of fact sheets from the Centers for Disease Control and Prevention. Included in the series — which is available on the Web — are: “Drug Use, HIV, and the Criminal Justice System,” “Drug Users and the Structure of the Criminal Justice System,” “Substance Abuse Treatment in the Criminal Justice System,” “Women, Drug Use, and the Criminal Justice System,” “HIV/AIDS Counseling and Testing in the Criminal Justice System,” “Providing Services to Inmates Living with HIV,” “Helping Inmates Return to the Community,” and “Working with the Criminal Justice System.” The fact sheet series is available at: [www.cdc.gov](http://www.cdc.gov).
- **CorrectCare** is the quarterly newspaper of the National Commission on Correctional Health Care. It features articles on a variety of correctional health care topics, including HIV/AIDS and is a good source of information about health care in jails and prisons. Free subscriptions are available by contacting:

**National Commission on Correctional Health Care**

1300 W. Belmont Avenue  
Chicago, IL 60657  
(773) 880-1460  
[www.ncchc.org](http://www.ncchc.org)

- **Breaking the Walls of Silence: AIDS and Women** in a New York State Maximum-Security Prison is a powerful book written by HIV-positive women who are imprisoned at Bedford Hills Correctional Facility. The women share their stories and the story of ACE — AIDS Counseling and Education — the country’s first peer-education AIDS program started by women inmates. In the words of the authors, “We are women struggling with the AIDS epidemic....We knew that we would have to help ourselves and each other. We started ACE because we felt that as prisoners, we would be the most effective in education, counseling, and building a community of support.” The book is published by The Overlook Press and is commercially available in bookstores across the country as well as online from Amazon and other online booksellers.

- **A Guide on the Inside: Women Talking to Women about HIV.** Women incarcerated in the Massachusetts Correctional Institute at Framingham, with support from the Great Brook Valley Health Center and AIDS Action Committee of Massachusetts, wrote this excellent, informal guide to HIV/AIDS for women living with and at risk for HIV/AIDS in prison. Among the issues discussed are the basics of HIV/AIDS, treatments and side effects, and disclosure. This informative guide is available free of charge from The HIV Health Library, (617) 450-1432.

## Organizations and Agencies

- **The CDC/HRSA Corrections Demonstration Project** is a joint initiative of the HIV/AIDS Bureau and the Centers for Disease Control and Prevention. This program seeks to improve access to HIV/AIDS care and prevention both inside and outside corrections institutions and to develop model programs for ensuring continuity of care for inmates as they leave jails and prisons. Seven state health departments or their agents are currently funded, including: Chicago Department of Public Health, Florida Department of Public Health, Georgia Division of Public Health, Massachusetts Department of Public Health, New Jersey Department of Health & Senior Services, New York State/City Department of Health, and the State of California Office of AIDS. The Rollins School of Public Health of Emory University and Abt Associates are funded under the initiative as the program’s Evaluation and Program Support Center (EPSC). For information about the crosssite evaluation including the outcomes being examined, see the corrections initiative summary at: <http://hab.hrsa.gov/reports/15.htm>. The seven grantees also have access to technical assistance through the Southeast AIDS Training and Education Center, the National Minority AIDS Council, and the Hampden County Correctional Center in Massachusetts.

Grantees work with community-based organizations to develop continuity of care models to provide an array of services including primary care, HIV prevention, and

referral systems that link the correctional facilities with the community. For more information, contact: Melinda Tinsley, HRSA project officer, (301) 443-3496, or see the ESPC website at: [www.sph.emory.edu/HIVCDP](http://www.sph.emory.edu/HIVCDP).

- **National Commission on Correctional Health Care** (NCCHC) is an organization dedicated to improving the quality of health care provided in jails, prisons, and juvenile confinement facilities. NCCHC develops and maintains the nationally recognized standards for correctional health care that are used to accredit jails, prisons, and juvenile confinement facilities, and to help monitor the quality of medical services provided in these settings.

NCCHC, through a cooperative agreement with the CDC, also developed an intensive two-day workshop called “Comprehensive HIV Education and Prevention for Incarcerated Youth.” NCCHC offers this workshop free of charge to service providers working with juveniles housed in various correctional settings. NCCHC describes the workshop as “practical and important training in comprehensive HIV education and prevention techniques that can be implemented in group homes, training schools, boot camps, and other state or county juvenile facilities.” The training is designed to enable participants to implement an HIV education program in youth correctional settings.

The workshop curriculum focuses on issues that put youth, particularly incarcerated youth, at high risk for HIV infection. Among the topics included are: adolescent alcohol and drug use; adolescent concerns regarding sexuality and risk-taking behaviors; methods for conducting effective adolescent risk awareness and risk reduction assessments; issues that place incarcerated youth at high risk for HIV infection; new HIV treatment and testing issues and HIV counseling techniques; and how to develop and start a peer-to-peer education program in a correctional setting. For information about workshops in your area, contact:

**National Commission on Correctional Health Care**

1300 W. Belmont Avenue  
Chicago, IL 60657  
(773) 880-1460  
[www.ncchc.org](http://www.ncchc.org)

- **The Prison Initiative** is a program of the National Minority AIDS Council (NMAC). The Prison Initiative provides technical assistance to CBOs in seven states as part of the CDC/HRSA Corrections Demonstration Project. As part of this project, NMAC's website offers a resource list on HIV/AIDS and corrections, at [www.nmac.org](http://www.nmac.org).
- **The Mother-Child Community Corrections Project** is joint project of the Center for Effective Public Policy, the International Community Corrections Association, and the National Institute of Corrections. The project, which is funded by the U.S. Department of Justice, supports the development of criminal justice responses to women offenders that take into account their roles as mothers and primary caretakers of children and that support them in these roles. A goal of the project is to further the health development of the children and to prevent further criminal justice involvement of the mothers. The Mother-Child Project provides direct assistance to a small number of developing mother-child community corrections programs; produces written materials to support mother-child community corrections programs; and increases public awareness about the needs of women offenders and their children and of the programs that serve them. For more information, see [www.nicic.org/services/special/women/mcccp/default.htm](http://www.nicic.org/services/special/women/mcccp/default.htm), or contact:

Judy Berman  
**Center for Effective Public Policy**  
8403 Colesville Road, Suite 720  
Silver Springs, MD 20910  
(301) 589-9383  
[jberman@cepp.com](mailto:jberman@cepp.com)

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# Appendix A

## HAB Policy Notice 01-01

**Document Title:** Use of Ryan White CARE Act Funds for Transitional Social Support and Primary Care Services for Incarcerated Persons

**DATE:** July 23, 2001

Enclosed is the HIV/AIDS Bureau policy describing the use of the Ryan White CARE Act funds for transitional social support and primary care services for incarcerated persons. The enclosed policy supports the use of CARE Act funds for incarcerated persons as they prepare to exit the correctional system as part of effective discharge planning or when they are in the correctional system for a brief period, which would not include any discharge planning.

If you have any questions regarding the content of the HAB Policy Notice, please contact your project officer. Thank you for your attention to this important matter.

Joseph F. O'Neill, M.D., M.P.H.

Associate Administrator

### Overview

The following policy establishes guidelines for allowable expenditures under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act for incarcerated persons (a) as they prepare to exit the correctional system as part of effective discharge planning, or (b) they are in the correctional system for a brief period, which would not include any type of discharge planning. "Incarcerated person" refers to an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential

half-way house) if the individual is still involuntarily confined to those settings.

The intent of all Ryan White CARE Act funds is to ensure that eligible HIV-infected persons gain or maintain access to HIV-related care and treatment. This policy recognizes that many incarcerated persons will ultimately be the responsibility of CARE Act programs, so early detection, entry into care, and access to and continuity of care are important reasons to use CARE Act funds for incarcerated persons. The purpose of the policy is to provide grantees flexibility in providing necessary, and otherwise unavailable, transitional primary care and social support services to incarcerated persons in the custody of a local, State, or Federal correctional system who are either nearing release

or whose incarceration is of short duration. Grantees who want to develop these linkages should become familiar with local prisons or jails and the State and Federal correctional facilities and the procedures established to prepare inmates for release into the community. These systems could vary greatly across localities and regions. Grantees should work with the appropriate corrections administrators to determine what health services are legally expected to be provided within the correctional system and how, and whether, the correctional system addresses the discharge planning needs, continuity of treatment, and community linkages for inmates.

We envision grantees who establish transitional social services will link the inmate to HIV care and treatment and transitional primary care services. These services could be provided in the correctional facility prior to release as part of discharge planning (or if it is a short term facility, like a local jail, which does not provide discharge planning, it would be outside of the jail or prison). In either situation, these services are not covered by the correctional system. Transitional primary care services can also be provided on a short term basis in an outpatient setting. Grantees must determine, working with the correctional system, the release status of the inmate, that is, when they will be released, sort out what health care services are covered and provided by the correctional system, and what services the Ryan White CARE Act can provide.

There are several important provisions within the CARE Act and statutory points of reference that define the ability of CARE Act to provide services for incarcerated persons. Specifically, it is important to recognize that the purpose of the policy is not to supplant resources that are otherwise available, or can reasonably be expected to be available, for social service or health-related benefits for incarcerated persons under any State program, an insurance policy or under any Federal or State health benefits program, or an entity that provides services on a prepaid basis as stated in the statute and usually referred to as payer of last resort language found in Sections 2605(a)(4)(A) and (B),

2617(b)(4)(F)(i) and (ii) and 2664(f)(1)(A) and (B) of the Public Health Service Act. For instance, in 1996, the Office of the Inspector General's (OIG) audit of a State's CARE Act Title II program found CARE Act funds were used to provide transitional services to inmates within 90 days of release, even though under that State's law inmates have a right to medical care and prison officials have a corresponding duty to provide such care. The OIG did not disagree with the use of CARE Act funds to support transitional services for inmates, but rather in this audit, said that the State used CARE Act funds to support such services when the State was already paying for transitional services for other inmates. Additionally, within the newly reauthorized CARE Act, Congress highlighted the critical nature of coordinating and increasing access to social services and health-related services for incarcerated persons and directed that the Secretary develop and submit to the Congress, within 2 years, a comprehensive plan to address the provision of such services (Section 2675(e)).

Under the context as described above, the policy provides for the use of funds for transitional social services (e.g., medical case management and social support services) to help achieve immediate linkages to community based care and treatment services upon release from custody, where no other services exist, or where these services are NOT the responsibility of the correctional system. Second, the policy also provides for the use of funds for transitional primary care services prior to release or during a period of short-term incarceration where no other services exist, or where these services are NOT the responsibility of the correctional system.

### **Policy for Use of Ryan White CARE Act Funds for Incarcerated Persons**

Federal funds received under the Ryan White CARE Act, as established in Title XXVI of the Public Health Service Act, may be used for short-term, transitional social support, and primary care services for an incarcerated person as they prepare to exit the correctional system as part of effective

discharge planning (or who are incarcerated for a brief period with no formal discharge planning) and are otherwise eligible for CARE Act services under the following conditions:

#### IV. Incarcerated Person

“Incarcerated person” refers to an individual involuntarily confined in association with an allegation or finding of behavior that is subject to criminal prosecution. Thus, the policy applies to individuals who are involuntarily living in the secure custody of law enforcement, judicial, or penal authorities. Furthermore, this includes individuals who reside in a community setting (which is not part of the institutional setting of the prison system such as a pre-release residential half-way house) if the individual is still involuntarily confined to those settings.

#### II. Transitional Social Services

A. Funded transitional social support services must be related to establishing or re-establishing linkages to HIV care and treatment services in community-based systems of care for incarcerated persons prior to release from custody during the time period as indicated in this policy. A service, such as medical case management, that links the individual with established primary care is an example of a transitional service that would be appropriate.

B. Recognizing that the determination of non-covered services is unique to each local, State, and Federal facility, and the grantee is responsible for assessing the extent to which such services are or should be covered by the correctional institution, the grantee must delineate precisely what services will be provided by the grantee and by the correctional system that are otherwise not available.

C. The grantee must ensure that these services supplement, but do not supplant, existing programs or responsibilities administered by the correctional system, or other local, State, or Federal agencies.

#### II. Transitional Primary Care Services:

A. Transitional primary care services are services delivered in an outpatient basis or an outpatient setting for a brief period of time until a more permanent health care provider can be arranged, which includes a comprehensive continuum of care, such as, primary medical care and prescription drugs. These services may also include HIV counseling and testing and referral services to obtain health care. CARE Act funds may only be used for these services when other sources of funds are not available.

B. This policy does NOT generally permit the use of Ryan White CARE Act funds in State and Federal prison facilities, since the State and Federal prison systems are responsible for providing health care services to all individuals remanded to their facility. Such care is the responsibility of law enforcement, judicial, and penal authorities in whose secure custody the individual is held. This limitation, however, does not apply to State or Federal inmates about to be released to the community and who are receiving health-related services using community resources, when not actually living in the correctional facility, such as home detention and half-way house programs, based on III. E.

C. Grantees wishing to institute a program of transitional primary care services in a local, State, or Federal correctional setting must either deliver these services directly or through sub-contracts with qualified HIV community-based providers to deliver HIV primary care services directly to eligible incarcerated persons to ensure that CARE Act funds are properly expended and only for services not otherwise available to any incarcerated persons.

D. Grantees can use CARE Act funds to support local (e.g., county, city) jails if these institutions are not legally responsible for meeting the HIV health care and treatment needs of persons in their custody.

E. Grantees can use CARE Act funds to support primary care services for incarcerated persons who reside in the community (e.g., an individual who is not part of the prison

or jail system but resides in a pre-release facility) ONLY to the extent to which services are not available or should not be reasonably expected to be available to the incarcerated person involuntarily confined. Furthermore, funding is available only to support incarcerated persons who are expected to be eligible for and the responsibility of CARE Act programs.

#### **IV. Timeframe**

Flexibility in the timeframe available is essential to the effectiveness of our programs. The determination of the exact amount of time that is required should be determined by a collaborative effort between the Ryan White CARE Act project staff who will be involved in care during and after release, the correctional institution's medical staff who are providing the care while the inmate is in custody and based on inmate needs. While recognizing that the timeframe must be flexible and determined collaboratively, it is recommended not to exceed 180 days. The time delineation must be done in collaboration with Ryan White CARE Act HAB project officers.

Recognizing that the determination of non-covered support or primary care services is unique to each locality, the grantee is responsible for assessing the extent to which such services are or should be covered. The grantee must delineate precisely what services will be provided by the grantee and by the correctional system that are otherwise not available.

VI. The grantee must assess the availability of other public resources for social support and health-related services and benefits programs in order to ensure the CARE Act funds remain the payer of last resort.

VII. The HAB expects that grantees will coordinate the use of funds for prison health services among publicly funded HIV-related community-based organizations across the other local, State, Federal, and public programs, in order to assure an efficient, seamless, and comprehensive continuum of HIV care for the transition of incarcerated persons into the community.

VIII. Grantees must develop methods to ensure that communication between the correctional system and the grantee and/or qualified provider preserve and protect patient privacy and confidentiality, including the patient's right not to disclose or to have disclosed her or his HIV status. Grantees and/or qualified providers must ensure that only those incarcerated persons who wish to receive primary care and/or transitional services are referred for participation.

IX. The grantee must have a mechanism to report to the HAB on the use of funds to provide transitional services and social services in correctional systems, and to include the individuals served in the same reporting process as other CARE Act service recipients for primary care services.

# Appendix B

## Sample Forms

CARE Act grantees and other organizations and agencies serving HIV-positive women in the correctional system have put considerable effort into developing needs assessments, transition plans, and other forms that will be useful to community-based programs wishing to start or improve services to incarcerated and newly released women living with HIV/AIDS. Included in this Appendix are samples of a variety of such forms.

INSERT A

# Appendix C

## AIDS Education and Training Centers

### Regional Centers

#### Delta Region AETC

Serving Arkansas, Louisiana, Mississippi  
**Louisiana State University Health Sciences Center**  
*Department of Public Health & Preventive Medicine*  
136 South Roman Street, Third Floor  
New Orleans, LA 70112  
(504) 903-0788  
[www.deltaaetc.org](http://www.deltaaetc.org)

#### Florida/Caribbean AETC

**USF Center for HIV Education & Research**  
*University of South Florida*  
13301 Bruce B. Downs Boulevard  
MHC-1338  
Tampa, FL 33612  
(813) 974-4430  
[www.FAETC.org](http://www.FAETC.org)

#### Great Lake to Tennessee Valley AETC

Serving Michigan, Ohio, Kentucky, Tennessee  
**Wayne State University AIDS Research & Education Program**  
2727 Second Avenue, Suite 138  
Detroit, MI 48201  
(313) 962-2000  
<http://sun.science.wayne.edu/~gltaetc/>

#### Midwest AETC

Serving Illinois, Indiana, Iowa, Minnesota, Missouri, Wisconsin  
**The University of Illinois at Chicago**  
*Jane Addams College of Social Work*  
808 South Wood Street, Room 173  
Chicago, IL 606127303  
(312) 996-1373  
[www.matec.info](http://www.matec.info)

#### Mountain-Plains AETC

Serving North Dakota, South Dakota, Utah, Colorado, New Mexico, Nebraska, Kansas, Wyoming  
*Department of Medicine, Division of Infectious Diseases*  
**University of Colorado Health Science Center**  
4200 East 9th Avenue  
Campus Box A089  
Denver, CO 80262  
(303) 315-2516  
[www.uchsc.edu/sm/aids](http://www.uchsc.edu/sm/aids)

#### New England AETC

Serving Connecticut, Maine, Massachusetts, New Hampshire, Vermont, Rhode Island  
*Office of Community Programs*  
**University of Massachusetts Medical School**  
23 Miner Street  
Boston, MA 02215  
(617) 262-5657

#### New York/New Jersey AETC

*Mailman School of Public Health*  
**Columbia University**  
600 West 168th Street, Seventh Floor  
New York, NY 10032  
(212) 305-8291  
[www.nynjaetc.org](http://www.nynjaetc.org)

#### University of Medicine & Dentistry of New Jersey

*University Hospital, HB-240*  
150 Bergen Street  
P.O. Box 1709  
Newark, NJ 07101  
(973) 972-7115  
[www.nynjaetc.org](http://www.nynjaetc.org)

**Northwest AETC**

Serving Washington, Alaska, Montana, Idaho, Oregon

*Center for Health Education & Research*

**University of Washington**

901 Boren Avenue, Suite 1100

Seattle, WA 98104

(206) 685-6844

[www.northwestaetc.org](http://www.northwestaetc.org)

**Pacific AETC**

Serving Nevada, Arizona, Hawaii, California

*Department of Family & Community Medicine*

**University of California, San Francisco**

74 New Montgomery Street, Suite 600

San Francisco, CA 94105

(415) 597-8198

[www.ucsf.edu/paetc](http://www.ucsf.edu/paetc)

**Pennsylvania/Mid-Atlantic AETC**

Serving Pennsylvania, Delaware, Maryland,

Virginia, West Virginia, Washington, D.C.

**University of Pittsburgh**

*Graduate School of Public Health*

*Department of Infectious Diseases & Microbiology*

130 DeSoto Street, A453 Crabtree Hall

Pittsburgh, PA 15261

(412) 624-1895

[www.pamaaetc.org](http://www.pamaaetc.org)

**Southeast AETC**

Serving Alabama, Georgia, North Carolina, South Carolina

*Department of Family & Preventive Medicine*

**Emory University School of Medicine**

735 Gatewood Road NE

Atlanta, GA 30322

(404) 727-2929

[www.seatec.emory.edu](http://www.seatec.emory.edu)

**Texas/Oklahoma AETC**

**Parkland Health & Hospital System**

1936 Amelia Court

Dallas, TX 75235

(214) 590-2181

[www.aidseducation.org/](http://www.aidseducation.org/)

**National & International AETCs****National AETC Resource Center**

**University of Medicine & Dentistry of New Jersey**

*François-Xavier Bagnoud Center*

30 Bergen Street, AMDC #4

Newark, NJ 07103

[www.aids-etc.org](http://www.aids-etc.org)

**National Minority AETC**

**Howard University**

2112 Georgia Avenue NW, First Floor

Washington, DC 20059

(202) 865-3300

[www.nmaetc.org](http://www.nmaetc.org)

**National Evaluation AETC**

*Joseph L. Mailman School of Public Health*

**Columbia University**

600 West 168th Street

New York, NY 10032

(212) 305-1549

**National HIV/AIDS Clinicians' Consultation Service**

*Department of Family & Community Medicine*

**San Francisco General Hospital**

**University of California, San Francisco**

UCSF Box 1365

San Francisco, CA 94143

(415) 476-7070,

Warmline (800) 933-3413,

PepLine (888) HIV-4911

[www.ucsf.edu/hivcntr](http://www.ucsf.edu/hivcntr)

**International Training & Education Center on HIV (I-TECH)**

**University of Washington**

*Center for AIDS & Sexually Transmitted Diseases*

901 Boren Avenue, Suite 1100

Seattle, WA 98104

[www.go2itech.org](http://www.go2itech.org)



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