▶ ***An HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration***

Starter Kit

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Acknowledgements

We acknowledge the support provided by the Centers for Disease Control and Prevention (CDC) through cooperative agreement #1-U65-PS-000231-01 for the development of this product. Most especially we acknowledge Charles Collins, Ted Duncan, Laurie Reid, Agatha Eke, Aisha L. Wilkes, and Susan Shewmaker for their continuous support and thoughtful input into the project.

In addition, we acknowledge the support provided by the Academy for Educational Development and specifically Nicole Engle, Kristin Wunder and Sharon Novey for their support in the further development and testing of the materials presented in the Project START package.

Community Advisory Board

We acknowledge the following individuals who participated in our Community Advisory Board for their wide array of perspectives and input into this project:

Adam Anderson, *Healthy Relationships Coordinator,* Centerforce

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Pilot Sites

We also acknowledge the support and valuable input from the following agencies, staff, and clients who agreed to be a part of our pilot case studies. The following agencies participated in both pilot trainings and in a 6 month pilot of the intervention:

SPAN Inc., Boston, MA (with support from the **Massachusetts Department of Public Health, HIV/AIDS Bureau**)

Valley AIDS Council, Brownsville, Texas

The following agencies participated in pilot trainings:

ABCD Health Services, Boston, MA
Action AIDS, Philadelphia, PA
AIDS Council Of Northeastern New York, Albany, NY
Association for the Advancement of Mexican Americans (AAMA), Houston, Texas
Atkins House, York, PA
California Prevention Education Program, Oakland, CA
Center for Health Justice, West Hollywood, CA
Centerforce, San Rafael, CA
Coastal Bend AIDS Foundation, Corpus Christi, TX
Community Health Action of Staten Island, Staten Island, NY
Exponents, Inc., New York, NY
Forensic AIDS Project – San Francisco Department of Public Health
HIV Education and Prevention Project, Oakland, CA
Kansas City Free Health Clinic, Kansas City, MO
La Clinica Del Pueblo, Washington, DC
People of Color Against AIDS Network, Seattle, WA
Sierra Foothills AIDS Foundation, Auburn, CA
Tarzana Treatment Center, Reseda, CA
The Program for Women and Families, Inc, Allentown, PA
United African American Ministerial Action Council, San Diego, CA
Volunteers of America Bay Area, Inc, Alameda, CA
WestCare, Fresno, CA
Women Accepting Responsibility, Inc, Baltimore, MD

Original Research Principal Investigators

We also acknowledge the entire Project START study group for the original research on which this product is based. The following is a list of study partners and principal investigators involved in the research:

California

Olga Grinstead, PhD, MPH (University of California, San Francisco, Center for AIDS Prevention Studies)
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Mississippi

John Askew, PhD (Jackson State University)
Gloria D. Eldridge, PhD (University of Alaska Anchorage)

Rhode Island

Kathleen M. Morrow, PhD (The Miriam Hospital/The Warren Alpert Medical School of Brown University)
Timothy Flanigan, MD (The Miriam Hospital/ The Warren Alpert Medical School of Brown University)

Wisconsin

David Wyatt Seal, PhD (Medical College of Wisconsin)
James Sosman, MD (University of Wisconsin School of Medicine and Public Health)

Centers for Disease Control and Prevention

Juarlyn Gaiter, PhD (1997–98)
Robin MacGowan, MPH
Richard Wolitski, PhD

Finally, we acknowledge all of the incarcerated men and women who took part in the original research and the follow-up pilot studies for their willingness to participate in Project START.

NOTE ABOUT MANUAL ▶ The information found in this manual is based on the policies and practices used in the original study sites and input from the pilot agencies that tested this package. Some of the information presented may vary by state or local jurisdiction. This is especially true as it relates to the policies and practices of many correctional facilities. Sites adopting Project START should make modifications to fit local policies and practices without compromising the program's core elements. Additionally, the terms used in this manual are typical of the terms used at the original study sites. Examples of such terms include warden vs. superintendent, correctional staff vs. security staff. Other regions may use different terms and those should be replaced to reflect local terminology.

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CDC Statement on Nonoxynol-9 Spermicide, May 10, 2002

CDC Statement on Study Results of Products Containing Nonoxynol-9

SECTION ▶ 1

How to Use the Starter Kit

The Project START Starter Kit was developed as a resource for agency administrators. The information in this kit provides an overview of Project START and can help agency administrators determine if the program would be appropriate for their agency and the clients they serve. The kit includes the following:

Section 1	Introduces the content and intended audience for the starter kit.
Section 2	An overview of the program including a brief background, description of its conceptual framework and program strategies, and a presentation of the Core Elements and Key Characteristics that make it successful.
Section 3	A comprehensive implementation plan that includes all of the tools necessary to effectively plan for developing and operating the program. Tools include: organizational review and readiness assessment, stakeholders checklist, resource list, staffing plan, client eligibility and recruitment, timeline/work plan, budget overview and sample cost sheet.
Section 4	An overview of the main challenges an agency may face when working within a correctional setting including a discussion of issues and presentation of different solutions.
Appendix I	Copies of articles and a fact sheet describing the original research and outcomes of Project START.
Appendix II	Disclaimer Statements from the Centers for Disease Control and Prevention.

Definition of Terms

The following are a list of key terms used throughout the starter kit that may not be known by the general public but are important to understanding Project START.

Correctional Setting ▶ Refers to any locked facility that is being administered by a correctional agency. Examples of a correctional setting include: prisons, jails, Native American Justice System facilities, community correctional programs including work-release programs and half-way houses run by a correctional agency, alternative sentencing programs such as "boot camps," or detention centers. The following are not examples of correctional settings: residential substance abuse treatment centers or half-way houses run by a non-correctional agency.

Transitional Planning or Transitional Needs ▶ Refers to the process of identifying and planning for the specific needs incarcerated people may have as they prepare for their release back into the community. Examples of transitional needs include housing, employment, substance abuse and mental health treatment, medical care, restoring official identification cards (e.g., driver's license, social security card), or reporting to parole officers.

Facilitated Referral ▶ Differs from a traditional community referral because it involves greater involvement from the staff providing the referral. This involvement includes identifying a specific contact at the referring agency who can be a direct link for clients. In addition, facilitated referrals may involve staff actively setting up appointments with clients and/or attending appointments at the referral agencies with their clients. Facilitated referrals may include connections to a variety of different community services including linkages to care, access to substance abuse and mental health treatment, enrollment in employment programs and support with entrance into housing assistance programs.

SECTION ▶ 2

Getting Started

Program Overview

What is Project START?

Project START is an HIV/STI/hepatitis risk reduction program for people returning to the community after incarceration. The program includes an enrollment session plus six program sessions with each client and works with them one-on-one to serve as a "bridge" to their return to the community. The program begins up to 60 days before clients are released and continues with clients for 3 months in the community after they are released from the correctional facility.

The main goal of Project START is to reduce HIV, sexually transmitted infection and hepatitis risk behaviors in the client's life after incarceration. To do this, the program uses a client-centered step-by-step approach. Project START also provides a range of counseling and prevention strategies to tailor the program to the unique strengths and resources of each individual. These strategies include goal setting, problem solving, strengthening motivation, decision making, and facilitated referrals. Project START also covers many other issues and challenges people face when they are released from a correctional setting into the community (e.g., finding affordable housing, securing viable employment, or dealing with substance abuse and mental health issues).

Enrollment plus two of the Project START program sessions are to be completed before release, and four program sessions are to be completed after release from the correctional setting. During the enrollment session, participants learn about the program, sign an agreement for services and complete other enrollment paperwork. In the first program session, program staff and the client review the client's risk to acquire or transmit HIV, sexually transmitted infections and hepatitis. Then program staff works with the client to develop a post-release risk reduction plan. In the second program session the staff and client review the client's transitional needs. Transitional needs are other life resources and services that a client may need for a smooth and easy re-entry into the community. A client's transitional needs may include housing, employment or treatment for substance abuse. The program staff works with the client to rank these needs in order of importance and develop a plan for meeting these transitional needs. In the last four program sessions, conducted with

the client after release, program staff and the client review the client's needs and goals, work toward meeting these goals, and update the client's risk reduction and transitional plans. In these post-release sessions, condoms are provided to the client by program staff. Also, facilitated referrals are provided to connect the client to services in the community.

Why is Project START Necessary?

There were over 2.3 million adults incarcerated in the United States in 2008. Add the number of people on parole or probation and this number increases to over seven million individuals. The AIDS rate among people in prison is 2 ½ times the national rate.[2] Sexually transmitted infection and hepatitis rates among U.S. prisoners are also higher than in the general population.[3, 4, 5] Finally, individuals in correctional settings often report behaviors before their incarceration that place them and their partners at risk for HIV, sexually transmitted infections and hepatitis. These behaviors include unprotected sex with multiple and high-risk sexual partners, injection drug use and sharing drug injecting paraphernalia (e.g. syringes or needles).[6]

Most people who are incarcerated are eventually released back into the community. Results of the formative research on Project START showed that, during the first week after release, much more sexual behavior happened within the first 24 hours than on any other day.[7] Results also showed that people with less stability, for example, people who do not have adequate housing or employment, and those whose friends and/or family members are engaging in risk behaviors, reported more sexual partners and a higher rate of reincarceration.[8] Therefore, there is a need for HIV, sexually transmitted infection and hepatitis prevention programs for incarcerated individuals getting ready for release. Such programs will help to prevent and reduce the spread of these infectious diseases after individuals return to their communities.[9]

Challenges and Possible Risk Behaviors

Individuals being released from correctional facilities may experience stress because of

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[1] Prison Inmates at Midyear 2008: *Bureau of Justice Statistics Bulletin*, Washington, DC: Office of Justice Programs, US Department of Justice; 2009; NCJ 225619.

[2] Maruschak, L. HIV in Prisons, 2005: *Bureau of Justice Statistics Bulletin*, Washington D.C. Office of Justice Programs, US Department of Justice 2007; NCJ 218915.

[3] MacGowan, R.J., Sosman, J., Eldridge, G., et. al. Sexually transmitted infections in men with a history of incarceration. Poster presentation at : XV International Conference on AIDS; July 11–16, 2004; Bangkok, Thailand.

[4] Sosman, J.M., MacGowan, R.J., Margolis, A.D., et. al. Screening for sexually transmitted diseases and hepatitis in 18–29 year old men recently released from prison: feasibility and acceptability. *International Journal of STD & AIDS*. 2005; 16:117–122.

[5] Mertz K, Voigt R, Hutchins K, Levine W, Jail STD Prevalence Monitoring Group. 2002. Findings from STD screening of adolescents and adults entering corrections facilities: Implications for STD control strategies. *Sexually Transmitted Diseases*. 2002; 29:834–9.

[6] Margolis, A.D., MacGowan, R.J., Grinstead, O., Sosman, J., Iqbal, K., Flanigan, T.P., the Project START Study Group. Unprotected sex with multiple partners: implications for HIV prevention among young men with a history of incarceration. *Sexually Transmitted Diseases*. 2006; 33:175–180.

[7] Morrow, KM, Eldridge, G, Nealey-Moore, J, Grinstead, O, Belcher, L, Askew, J, & the Project START Study Group. HIV, STD, and hepatitis risk in the week following release from prison: An event level analysis. *Journal of Correctional Health Care*. 2007; 13, 27–38.

[8] Seal, D.W., Eldridge, G.D., Kacanek, D., Binson, D., MacGowan, R.J., & the Project START Study Group. A longitudinal, qualitative analysis of the context of substance use and sexual behavior among 18- to 29-year-old men following their release from prison. *Social Science and Medicine*. 2007: 65, 2394–2406.

competing demands in their lives. They may face many challenges as they try to restart their lives in the community. Some of these challenges may include:

- Finding housing
- Getting a job
- Reestablishing relationships with family and friends
- Substance abuse issues, including drug and alcohol addictions
- Depression and other mental health issues
- Continuity of medical care
- Working with probation and parole and avoiding reincarceration

These challenges may make it harder for people to avoid high risk behaviors. For example, people who are unable to find stable housing could resume drug use, and get involved in other criminal activities. These situations may, in turn, reduce people's ability to practice safer behaviors that prevent transmission of HIV, sexually transmitted infections and hepatitis. Therefore, they may be more likely to do riskier things such as having unsafe sex, using drugs and/or sharing syringes.

How Transitional Services Reduce HIV/STI/Hepatitis Risk

While the goal of Project START is to reduce the risk for HIV, STIs and hepatitis, clients may be more interested in the transitional planning than in the risk reduction planning. By helping clients address their most immediate needs such as housing and employment, they are much more likely to value the program and continue to attend. In turn, if clients continue to attend sessions, they will have received repeated risk reduction counseling, information, and resources and be more likely to reduce their risk behaviors.

In order to maintain the client's focus on the HIV/STI/hepatitis risk reduction goal of Project START, the program does the following:

- Introduces the goal of HIV/STI/hepatitis risk reduction and prevention at the very beginning of the program
- Dedicates all of session one to HIV/STI/hepatitis risk reduction
- Requires that every participant develop a personalized risk reduction plan
- Incorporates HIV/STI/hepatitis risk reduction planning and goal setting review in *every* program session
- Offers condoms consistently at every post-release session and at pre-release sessions if allowable by the correctional facility

[9] Zack, B. and Kramer, K. *What is the role of prisons and jails in HIV prevention?* Fact Sheet 13R. University of California San Francisco, Center for AIDS Prevention Studies, March 2009.

The Research Behind Project START

The Project START program was tested in a research study of young men ages 18 to 29 who were being released from eight prisons in four states (California, Mississippi, Rhode Island and Wisconsin). Both HIV-positive and HIV-negative participants were enrolled into the study though most of the participants were HIV-negative. The study compared participants receiving the multi-session Project START intervention (the 'study group') to a group receiving a single pre-release session intervention (the 'comparison group'). The goal of the study was to compare how these two approaches might help young men reduce their risks for acquiring or transmitting HIV/STI/hepatitis.

Participants assigned to the single-session program received a 60- to 90-minute individually tailored HIV, sexually transmitted infection and hepatitis risk reduction counseling session. This session was held in prison about 2 to 4 weeks before release. The session included:

- Review of HIV, sexually transmitted infection and hepatitis knowledge
- Assessment of sexual and other safety or risk behavior
- Information about basic disease prevention knowledge
- Development of an individualized plan of small steps to reduce risk for HIV, sexually transmitted infection and hepatitis after incarceration
- Provision of a local community services resource guide
- Skills training and problem solving work to support participants' risk reduction efforts

Participants assigned to the full six-session program (Project START) received two [60- to 90-minute] individual sessions before release and four [50- to 75-minute] sessions after release. The following is an overview of each of these sessions:

Session 1 Conducted in prison about 2 to 4 weeks before release. This session was the same as the one that the single-session comparison group received.

Session 2 Conducted in prison about 1 to 2 weeks before release. It covered a review of community re-entry needs such as housing, employment, financial problems, social relationships, substance abuse and mental health treatment, legal problems, and avoiding reincarceration. This session also included development of a plan to address these needs, discussion of problem solving strategies, and referrals to support services.

Sessions 3–6 Conducted in the community at about 1, 3, 6, and 12 weeks after release from prison. These sessions covered a review and update of the participant's transitional and risk reduction plans from the previous session. These sessions also included a discussion of what helped or prevented participants from acting on their plan, plus ideas for what could help further support the participants' success. Referrals to existing support services in the community were actively provided as needed. Condoms were provided to clients at each session.

Results and Lessons Learned

Overall results of the study showed that participants in the multi-session intervention group (Project START) were *less likely* to have unprotected vaginal or anal intercourse at six months after they were released from prison compared to those in the single session group. Copies of articles describing the original research can be found in Appendix I of this kit.

Lessons learned from the Project START study suggest that HIV, sexually transmitted infection and hepatitis risk reduction programs for people being released from correctional settings are more effective if they:

1. Start where the client is and stay client-centered.
2. Use small incremental steps to help clients work on their goals.
3. Include HIV/STI/hepatitis risk reduction with an individual's more pressing post-release needs (e.g., housing, employment, etc.).
4. Focus on bridging the gap from prison back to the community.

Helping people solve their more immediate, basic life needs (such as food, housing and employment), makes HIV, sexually transmitted infection and hepatitis prevention more meaningful and important for people leaving correctional facilities. HIV/STI/hepatitis prevention programs that are combined with transitional services are feasible and effective for this high risk population.

Modifications to the Intervention ▶ Project START

During its preparation for use in the field, Project START was modified in the following ways to make implementation more feasible and to expand the capacity of the intervention.

Project START originally targeted young men (18 to 29 years old) leaving prison. The program has been expanded to target anyone (regardless of gender or age) returning to the community from a correctional setting (e.g., prison, jail, or community correctional programs). These recommendations for expansions are based on experiences and feedback from the pilot agencies during the replication process. In addition, one of the pilot site agencies successfully implemented Project START with HIV-positive clients. Expansion of Project START to these different populations proved to be successful though results were not tested for effectiveness.

Another modification to the original protocol was to change the recommended window of time to meet with clients for their first post-release session from 1 week to 48 hours. This change was made due to input from both the Community Advisory Board that consulted with the Project START replication team and from input of the pilot site agencies. Given the large amount of risk behaviors that occur within the first 24 to 48 hours after release, this suggestion has been systematically incorporated into the program.

NOTE ▶ During each of these modifications, all of the core elements shown to be responsible for Project START's effectiveness were maintained.

Core Elements and Key Characteristics

Core Elements

Core Elements are required elements that represent the theory and internal logic of the program and most likely produce the program's main effects. To implement Project START, you must incorporate all of the Core Elements without changing or adapting them in your program. Project START has nine Core Elements:

1. Hold program sessions with clients transitioning back to the community from a correctional setting prior to release and continue holding sessions with clients after they are released into the community.
2. Use a client-focused, personalized, incremental risk reduction approach that helps clients to develop step-by-step solutions to minimize risk behaviors within their individual life circumstances.
3. Use assessment and documentation tools to provide a structured program which includes risk assessment, problem solving and goal setting, strengthening motivation and decision making, and facilitated referrals.
4. Staff your program with people who are familiar with HIV, sexually transmitted infection and hepatitis prevention activities *and* with the specific needs of people being released from correctional settings (for example, parole/probation, substance abuse prevention and treatment, homelessness and mental health issues).

5. Staff-client relationships and rapport developed during pre-release sessions must be maintained during post-release sessions to promote client trust and willingness to continue with the program. Thus, the same staff member should conduct both pre-release and post-release sessions with his or her clients. In the case of staff turnover or extended illness, every effort should be made to ensure a smooth staffing transition.
6. Conduct enrollment and schedule two pre-release program sessions within 60 days of a client's release, focusing on:
   a. giving HIV, sexually transmitted infection and hepatitis information
   b. reviewing a client's HIV, sexually transmitted infection and/or hepatitis risk
   c. identifying other transitional needs that may affect your client's HIV, sexually transmitted infection or hepatitis risk (for example housing, employment, or substance abuse issues)
   d. working with each client to develop a personalized risk reduction and transitional plan
   e. making facilitated referrals as needed to community-based support services
7. Schedule four post-release sessions. Hold the first as soon as possible, ideally within 48 hours of release. The next three sessions should be spaced out over three months after release. The post-release sessions should focus on:
   a. reviewing and updating the risk reduction/transitional plan(s) developed during pre-release sessions
   b. discussing what prevents and supports clients in moving forward with their risk reduction/transitional plan(s)
   c. giving them facilitated referrals to needed services using a detailed resource guide
8. Provide condoms at each post-release session.
9. Actively maintain contact with clients, using individual-based outreach and program flexibility to determine the best time and place to meet with them.

Key Characteristics

Key Characteristics are crucial activities and delivery methods for conducting a program, which may be tailored for different agencies and at-risk populations. Key Characteristics may be altered to match your agency's circumstances and particular client populations. Key Characteristics for Project START include:

1. When conducting sessions inside a correctional facility do it in the most confidential space available. When conducting sessions in the community, conduct them in a location that is as safe, convenient, accessible and as confidential for the client as possible.
2. All sessions are intended to be held face-to-face. However, you can conduct sessions over the phone if there are special circumstances, for example, if a client has moved out of your service area.
3. If clients are re-incarcerated for a short period of time during the post-release period, continue their sessions within the correctional setting whenever possible.
4. Schedule additional sessions within the 4 to 5 month time period of the program when your client and staff agree this is useful and possible.
5. Give additional resource materials to your clients as needed, such as educational materials (brochures on HIV, sexually transmitted infection and hepatitis) and other useful resources such as hygiene or toiletry kits or phone cards.

Conceptual Framework

Incremental Risk Reduction

Project START is based on formative research with young men about to be released from prisons and incorporates features of prevention case management, motivational enhancement, decision making, and harm reduction.[10, 11] Its goal is to use all of these features to help participants develop an individualized risk reduction plan and lower their risk behaviors following their release from a correctional setting. For the purposes of this document, we will be using the term "Incremental Risk Reduction" to represent the harm reduction approach used in the formative research.

Incremental Risk Reduction is a client-centered approach that encourages people to become more aware of their risk behaviors and provides them with tools and resources to reduce their risks. It is personalized and non-judgmental. It promotes motivation, prioritizing needs, problem solving, goal setting, and other skills the client may need to successfully carry out a plan. The key principles of an Incremental Risk Reduction framework are:

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[10] Grinstead, O., Eldridge, G., MacGowan, R., Morrow, K., Seal, D., Sosman, J., Zack, B., and the Project START Study Group. An HIV, STD and Hepatitis Prevention Program for Young Men Leaving Prison: Project START. *Journal of Correctional Health Care*, 14:3 183–196 July 2008.

[11] Wolitski, R. J., et. al. 2006, p. 1855.

- Risk covers a wide range of risky to less risky behaviors, with abstinence as one possible option.
- Builds step-by-step on small successes.
- Deals with the whole person rather than focusing solely on their risk behaviors.
- Follows a flexible approach, with creativity and new ideas that match a person's overall life situation.
- Understands that working on individual risks starts best by working on the least difficult problems and increasing to more difficult risk situations.
- Supports access to local and community-based services (for example mobile clinics) instead of institutional, formal services (for example hospitals).
- Works with people based on where they are in their lives rather than forcing them to fit into pre-set goals.
- Recognizes that people need to be able to fully understand the behaviors that put them at risk *and* receive the tools necessary for change.
- Accepts that people change *what* they want to change, *when* they are ready to change and when their *environment* allows for that change.
- Understands that the end result may not eliminate all risk but will help to reduce risk.

Incremental Risk Reduction includes strategies that help people:

1. Identify their current and/or past risk behaviors;
2. Develop individualized step-by-step solutions that will help them reduce their risk behaviors as much as possible.

As a client-centered approach, Incremental Risk Reduction allows you to work together with your clients to identify their individual needs, possible barriers to meeting their needs, how to remove these barriers, and ways to use personal resources to meet their goals.

Some people may be concerned about the possible conflict between using an Incremental Risk Reduction approach with Project START when referring clients to another service agency that may use an abstinence-based approach (e.g., some substance abuse treatment programs). This difference does not need to be a conflict. Abstinence-based goals can be part of a larger Incremental Risk Reduction Plan (e.g., clients want to get clean and sober so that they are more likely to engage in healthier behaviors). Make sure that clients choose programs that are closest to what they want or if not, that they are ready and willing to take the step of abstinence involved in the program. It is important that the plan does not set the client up to fail.

Parole and probation departments also work with an abstinence model. It is necessary to have honest conversations with clients about this while acknowledging their personal goals and limitations (e.g., client has a goal to stay out of prison but acknowledges his or her likelihood of continuing to engage in illegal behaviors. Staff may want to work with the client to reduce the level or amount of illegal behavior).

Cultural Awareness

Cultural awareness is about being sensitive to, and understanding the characteristics, history, values and belief systems of members of a cultural group.[12] Clients in Project START are part of many cultural groups. Some of the cultures they may identify with include:

1. Culture of the correctional facility
2. Culture of the correctional population
3. Culture of the community where the client returns
4. Culture of the community where the client lived prior to incarceration
5. Other cultures that people identify with (e.g., regional, ethnic/racial, and behavioral such as drug users or men who have sex with men-MSM)

It is important for Project START staff to know about these cultures and how they can affect the client's success. Agencies can learn best about the specifics of the cultures their clients belong to from local resources such as the correctional facilities, community providers and leadership groups, community cultural centers, outreach workers, faith-based community groups, and from the clients themselves. Therefore, program staff should make contacts with such local groups to have discussions or get training about the cultures of their clients before they plan the program.

[12] Dogra & Karim, Association of American Medical Colleges Task Force on Spirituality, Cultural Issues, and End of Life Care, 1999, p. 25; 2005)

Some of the characteristics of the cultural subgroup that the clients may be a part of while incarcerated include:

- Ethnic and racial groups
- Group affiliations (e.g., gangs, families) and other group identities
- Home communities
- Seriousness of crime, length of incarceration and/or where they have done time
- Security levels or housing units in the correctional facility
- Correctional facility approach: rehabilitation culture vs. punitive culture
- Sexual orientation including situational sexual identity ("gay for the stay")
- Gender identity (especially in transgender communities and whether they are sent to male or female facilities/housing units)
- Health status
- HIV sero-status (especially as it relates to housing segregation, medicine distributions, medication packaging, differences in meal packages)
- Education levels
- Income levels
- Language and/or nation of origin
- Religion
- Customs and practices (especially those that are allowed to be practiced on the inside and those that are not)
- Age
- Family history of incarceration
- Music and dance
- Food

It is also important to note that belonging to a cultural subgroup in a correctional facility may be determined by:

- Identity of incarcerated individuals themselves;
- Pressures or standards set by the larger prisoner population (e.g., gang affiliations, racial identities);
- Rules or standards set by the correctional system (e.g., protocols to house or separate individuals by race, health status, gang affiliations).

The culture of the communities that clients are returning to may be similar to the culture they were part of on the inside or they may be very different. Some of the characteristics of the cultural environment that the clients may be a part of when they get released are:

- Ethnic and racial groups
- Income levels
- Age
- Sexual Orientation
- Language
- Music and dance
- Family
- Religious Affiliations
- Restricted vs. unrestricted environments
- Education levels
- Customs and practices
- Gender
- Gangs and other group identities
- Parole Culture
- Food
- Rural vs. urban environments
- Regional Affiliations

There is also the culture of "getting released." Some of the issues that clients may face when they are released include:

Community Norms ▶ In some communities, incarceration is more of a community norm than in others. People coming out of a correctional setting may have a "rites of passage badge" as they return to their home communities. Whereas, in other communities, there is a stigma associated with incarceration.

Change in Pace and Structure ▶ The pace inside correctional facilities is usually slow and structured. Thus, people may be leaving slow structured settings and returning to a fast-paced community setting.

Emotional Connection ▶ People are not supposed to show their feelings on the inside and then are expected to "act normal" as soon as they get out.

Release is a Crisis ▶ For some people, leaving a correctional setting is very challenging and seen as a crisis, especially if these individuals have no place to go or very few support systems on the outside.

Returning to the Problem ▶ Many people return to the same lifestyles, relationships, or communities that got them into trouble in the first place (e.g., drug use, criminal behavior, violence).

Working with Parole and Probation ▶ Some people think they are "free" when they leave the correctional facility, when in fact they are still under supervision and must report to their parole or probation departments. They may have "conditions of parole" that require them to engage in certain activities (like keeping mental health appointments, or getting substance abuse treatment) that if they do not attend, they may be 'returned to custody' as a parole violator.

It is important for your agency to take the time to understand the role these cultures play in your programs and your clients' lives. Parts of these cultures may provide strength and support for your clients. Other parts of the cultures may act as barriers to your clients' success.

Some Examples

Example #1 ▶ Clients are involved with a gang while incarcerated. The gang provided them with valuable protection on the "inside." But this gang involvement may influence where and how they live their lives once they are released. Clients may "owe" the gang and therefore are obligated to be a part of the gang's illegal business on the "outside."

Example #2 ▶ Clients become involved with a faith-based support system for the first time while they were incarcerated. Clients may want to become involved with a religious community after they are released. This community may provide them a more positive and supportive environment in the community than they were in before they were incarcerated.

Finally, it is important for your agency to look at its internal policies and practices as they relate to planning a program that is culturally sensitive for this population. Some useful things you can do include:

- Hire staff that reflects the cultural diversity of the client population (such as diverse age, gender, race and ethnicity, sexual orientation, language).
- Hire staff with experience serving incarcerated people and/or their families.
- Provide cultural awareness training for staff, delivered by people from diverse cultures.
- Recognize and appreciate diversity within your agency and your clients.
- Develop outreach strategies that include and reach a full range of possible eligible clients.

NOTE ▶ People who have been incarcerated or have a family member who has been incarcerated are often interested in working with the program. While they can provide valuable insight and true empathy with the clients and can help increase the cultural sensitivity of your program, you may have difficulty getting security clearance for them to enter your correctional facility. Be sure to find out the facility's policy on criminal backgrounds, incarceration and clearance before you post positions.

It is important for your staff to understand and be aware of the influences the cultures inside correctional facilities and in the community have on your clients. However, your staff are not expected to act as experts on every culture of every Project START client.

Understanding and being more aware of the cultures of your clients will help your agency to:

- Be more client-focused in your program delivery.
- Develop a better relationship with clients, correctional facilities, and partnering community providers inside the correctional facility and in the community.

Program Strategies

Project START helps clients by using a number of strategies including:

- Problem solving and goal setting
- Strengthening motivation and effective decision making
- Facilitated referrals to support services
- Providing condoms, lubrication and other prevention materials

The following is a brief description of each of these strategies:

Problem Solving and Goal Setting

Problem solving and goal setting involve a dialogue between clients and staff that helps clients to identify their problems and to set realistic goals related to the problems. Staff help clients work towards their goal by discussing a range of possible solutions to the problems. They also help the clients create a plan of action based on at least one of these solutions and support the clients in their efforts to work on these plans. Problem solving and goal setting techniques used in Project START should help clients:

- Identify a problem
- Set a realistic goal (desired outcome)
- Think of several possible solutions
- Identify the consequences and benefits for each solution
- Choose the best solution based on these consequences and benefits
- Create a realistic plan of action with specific tasks and a timeline
- Identify existing resources (such as materials and people)
- Generate “to do” activity lists
- Take action
- Reassess progress

Strengthening Motivation and Decision Making

Project START uses the strategies of strengthening motivation and decision making to help clients change their behaviors. Clients often have the skills necessary to change a certain behavior but may lose the motivation to maintain long-lasting change. They may become discouraged when they are not able to follow through with their intent.

Helping clients understand their own motivations can help them identify, evaluate, and compare the major factors that contribute to the "push and pull" between two choices. For example, your client may be feeling conflict about whether to:

- ▶ Pay off back child support **OR** Buy a car instead
- ▶ Get a legal but low-paying job **OR** Make more money selling drugs
- ▶ Go back to school **OR** Get a full time job and make money
- ▶ Live with their family and save money **OR** Rent their own apartment
- ▶ Use condoms with multiple partners **OR** Have unprotected sex with one partner

Helping clients understand their conflicting motivations and develop good decision making skills allows them to make better choices. With good decision making skills, clients are able to identify the reasons to choose or not to choose a certain option and then weigh the costs of that choice. With this information, clients can strengthen the motivators that support their goals and weaken the motivators that conflict with their goal. By doing so, clients can more clearly see the value of a certain choice and stay motivated to follow through with this choice.

Strengthening motivation and decision making techniques used in Project START should help your clients:

- ▶ Come to their own informed decisions about which behavioral choices better serve their goals.
- ▶ Recognize the motivations behind their choices and strengthen the motivators for those choices while weakening the motivators that conflict with these choices.
- ▶ Understand the link between strengthening the motivators for their choice and their ability to maintain their desired behavior change.

Facilitated Referrals

Project START uses a type of community referral called a facilitated referral. Facilitated referrals help to link clients to community resources like other types of referrals, but they are different from standard community referrals because:

1. Referral sources have been screened to match the special needs of Project START clients.
2. Contact people at the referral agencies have been identified.
3. Program staff actively work with clients to make contact, set up appointments, and help prepare for appointments at referral agencies.
4. Program staff may attend referral appointments with clients.

By using facilitated referrals, clients are more likely to follow through with connections to community agencies. As well, community agencies are more likely to receive clients and work with them. Thus, facilitated referrals are well worth the extra effort and work to make them happen.

Given the many different needs of clients coming out of correctional settings, it is important for your agency to identify as many referral agencies as possible. This process will help you clearly define what you are able to provide for your clients, what referrals you will need to provide and what gaps there may be in services.

When collecting referrals for Project START, compile a list of as many appropriate resources as possible (e.g., social service agencies, health centers, community centers, hospitals and individuals). Include phone numbers and other contact information. Sort these resources by whether they offer local, statewide, or national level assistance. This will help you identify the type of service to expect from each resource.

National-level Resources ▶ tend to act as distributors of information and as larger scale referral services (e.g., National Clearinghouse for Alcohol and Drug Information).

State-level Resources ▶ tend to offer referrals to local agencies and information on city or county government resources (e.g., State Health Departments).

Local Resources ▶ are more likely to provide actual direct services for your clients (community health clinics and social service organizations).

Screen each resource, confirm the services they say are available and identify a specific contact person's name and number. Make direct contact with every local service organization and thoroughly explain this program. The following are some possible screening questions to ask each agency:

- Is the contact information complete and current, including street address, phone number, e-mail?
- Whom may we list as a contact person? What is his/her phone number?
- What services does the agency currently provide?
- Where is the agency located? Is it in a neutral or safe location for our clients?
- Can clients get to the agency on public transportation?
- What languages are spoken at the agency?
- How does the agency provide for special needs clients such as those with different physical or mental abilities or clients who must bring along their small children?
- What are the days and hours of service?
- Does the agency have "drop-in" hours? If so, when?
- How does someone become a client or patient of the agency?
- Are there specific eligibility requirements for services? Are there exclusions?
- What is the intake (interview) process to become a client? Is there a waiting list for any or all services?
- Is there any particular paperwork that clients will need to bring with them to the appointment?
- Is there a fee for services? If so, how much? Do they have a flexible payment scale and/or scholarships?
- Does the client need insurance to access services?
- What are the agency's policies regarding 1) client confidentiality; 2) release of information to law enforcement; 3) subpoenas for client information?
- Is the agency familiar with other agencies in this area that might be good resource agencies to include in this Project START referral system? (If so, call that agency and repeat the process.)
- Does the agency share client information with other agencies through a common database? If so, with whom and how does this impact client confidentiality?

The following questions should also be raised, as they are specific to people who have been incarcerated:

- Has the agency worked with parolees or probationers in the past?
- Have they served people who were previously incarcerated?
- Does the agency have a relationship with the Department of Corrections or Parole Department?
- Does the agency understand the requirements of someone on parole and how these requirements may affect the client's ability to access services (e.g., limited time available on particular days to access services, restrictions on where a person can live, or who they can associate with)?
- Is the agency in a location that is off-limits to special condition parolees (for example, is it located near a school, which would be off limits to a sex offender)?
- Does the agency provide service hours for someone sentenced to community service?

The best way to find out this information is for a member of the Project START team to physically visit the agencies you are screening for referrals. You can gain more information from a physical visit than from a phone call, such as:

- How does the agency look and feel?
- How helpful is the front office staff?
- What is the reception area experience like?
- How busy is the agency?
- From your observation, what has been the experience of other clients in the reception area?
- What kinds of reading materials are available in the waiting room (such as brochures, magazines, posters)?
- How easy was it to find the agency? Is there really public transportation?
- What is parking like?
- What is the surrounding area like? Is it safe for your clients?

A referral should also include the specific name of a contact person at the referral agency—someone who knows about your program and is willing to work with your clients and have an ongoing relationship with Project START.

Your program staff may also actively set up appointments for or with clients and, in some cases (as appropriate), go to the appointments with their clients. Examples of such situations include:

- Clients who have a negative history with an agency.
- Clients who have low reading and writing skills and wish to have someone join them to help with applications or other written materials.
- Clients who are very hesitant to use services without program staff present (e.g., are not comfortable at social service agencies or have a fear of discrimination).

Providing Condoms

Providing condoms is an important part of Project START. It is a required task of post-release sessions (Core Element #8). While every client may not be ready or willing to use condoms, it is important that program staff provide prevention materials, including condoms, for all clients in every post-release session. Some clients may decline to accept prevention materials after one session, but may accept them at a later session. For clients who are not ready to use condoms, program staff may suggest that clients offer them to their friends.

It is also recommended to include condom use discussions and distribution in the pre-release sessions if possible. Most correctional facilities will not allow condom distribution (none of the sites in the original study were allowed to distribute condoms inside the correctional facility). But some correctional facilities do allow condom distribution. It is important for you to check with your local correctional facilities before you start this program to see if condom distribution inside the facility is an option. If correctional facilities will not allow condom distribution, see if the facility provides resource packets for individuals at release. If so, you may wish to ask the facility if you can include condoms and lubricant in these release packets. Given the high rate of sexual activity that happens within the first few hours and days of release, having condoms available in these release packets can be an important risk reduction strategy for Project START clients.

SECTION ▶ 3

Implementation Plan

A key part of getting started is for an agency to put together an implementation plan. This section provides all of the information and tools that are part of effective implementation plan, including:

- Identification of Host Organization and Effective Partnerships
- Organizational Review and Readiness Assessment
- Stakeholders' Checklist
- Staffing Plan
- Client Eligibility and Recruitment
- Sample Timeline/Work plan
- Budget Overview and Sample Cost Sheet

Host Organization and Effective Partnerships

There are many different types of organizations that can effectively offer the Project START program, including:

1. community and non-governmental service organizations
2. health and/or human service departments, and
3. faith-based organizations.

Correctional facilities may also be interested in offering Project START. It is important for correctional facilities to partner with local community agencies to provide the program together. Clients will then view the program as an "outside" program and not as part of the correctional system itself. This is important for establishing connection and trust with the clients. Read more about this in the "Working With and Within a Correctional Setting" chapter in this manual.

No matter who the host organization is, it is important for your agency to get buy-in from all of the key partners, including the correctional facility, parole/probation departments, partnering service providers, community leaders and the clients themselves. It is important to note that there may be groups that believe they are your key partners and your agency does not. Thus, it is important to be aware of the implications of those whom you choose not to develop partnerships.

Organizational Review

If your agency is considering using Project START, conduct an organizational review to find out if your agency is ready and able to include and manage all the required parts of this program. Some agencies may have a strong history of providing HIV, sexually transmitted infection and hepatitis prevention programs but may have little experience providing programs in a correctional setting. Other agencies may have provided services in a correctional setting but do not have experience with health education and prevention programming. Other agencies may have provided services in "reception centers" for people as they entered correctional facilities but not have experience in the "pre-release" units working with people as they prepare to leave the facility. Proper training and partnerships can ensure that any of these agencies can provide this program. However, an agency that has a history of working within correctional settings, specifically in the pre-release units and providing HIV, sexually transmitted infection and hepatitis prevention programs will face the least number of barriers and will probably be the most likely to succeed.

Organizational Review Chart

Does our agency have the experience and ability to deliver programs within correctional settings?		
Does our agency have the experience and ability to deliver HIV, STI and Hepatitis prevention activities?	**NO**	**YES**
NO	Our agency does *not* have the experience or ability to provide either correctional programs *or* HIV-prevention activities. ▶ **Least chance of success**	Our agency *has* the experience and ability to provide correctional programs—*but not* HIV-prevention activities. ▶ **Better chance of success**
YES	Our agency *has* the experience and ability to provide HIV-prevention activities *but does not* have the experience or ability to do this within a correctional setting. ▶ **Better chance of success**	Our agency *has* the experience and ability to provide correctional programs *and* also has experience and ability to provide HIV-prevention activities. ▶ **Best chance of success**

Organizational Readiness Assessment

Once you have placed your agency in the appropriate place on the Project START Organizational Review Chart, you can complete the Project START Organizational Readiness Assessment. The results of this assessment will help you develop an action plan and identify the best use of resources to ensure a successful program. The Project START Organizational Readiness Assessment includes four key areas:

- **Correctional Setting Readiness**
  Your agency's ability to identify, approach, and work effectively with a correctional facility.
- **HIV, Sexually Transmitted Infection and Hepatitis Prevention Education Readiness**
  Your agency's ability to provide HIV, sexually transmitted infection and hepatitis prevention programs, and to identify additional resources as needed.
- **Agency Readiness**
  Your agency's ability to find the necessary funding and support to sustain the program within your existing organizational structure.
- **Community Readiness**
  Your agency's ability to identify, approach, and work effectively with community partners to provide a network of support and services for clients after release.

You and your agency should fully complete and discuss the Organizational Readiness Assessment prior to beginning any program activities. Then develop a complete and thorough work plan based on the information you gain from this review. If results of the assessment show that your agency is not ready to implement Project START, you may opt to seek capacity building training, technical assistance, or program development consultation before beginning the project. The following is the Project START Organizational Readiness Assessment.

Organizational Readiness Assessment

Correctional Setting Readiness	Yes | No	Comments | Next Steps
1. Have you identified an appropriate correctional facility?		
a. Does the facility have potential clients that are close to release?		
b. Does the facility have the ability and willingness to identify potential clients for you?		
c. Will potential clients be released from this facility to a geographic area that your agency can serve?		
2. Have you worked with this correctional facility in the past?		
3. Do you have a specific contact person within the correctional facility?		
4. Do you have a back-up contact/s if your main contact is transferred, on vacation or out sick?		
5. Does this facility have a history and/ or system in place to work with outside service providers? If not, is the facility open to starting such a relationship with you?		
6. Is the correctional facility comfortable offering transitional services with an HIV/ STI/hepatitis prevention focus?		
7. What type of HIV/STI/hepatitis screening does the facility currently provide (for example, upon arrival and/ or pre-release)?		

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Correctional Setting Readiness, *cont'd*	**Yes | No**	**Comments | Next Steps**
8. Are you prepared to describe how Project START supports the mission of the correctional facility?		
9. Is there any part of the program that the facility has concern about? (for example, holding private one-on-one meetings with clients, or content materials which will teach about safer sex and safer drug injecting paraphernalia use)?		
10. Will the facility make Project START a required program?		
11. Which facility policies and procedures should you consider when approaching the facility and/or launching and conducting the program?		
12. Are there any facility politics you should consider when approaching the facility?		
13. Are there work shifts within the facility that you should consider when creating schedules for the program?		
14. Dave you contacted other service providers already offering services in this facility so you can ensure complementary service delivery and to gain helpful insight from them regarding how best to work with this facility?		
15. Does your agency have an existing relationship with the Parole and Probation Department? If not, do you have a contact (and back-up) at the Parole and Probation Department?		
16. Do you have a plan of how you intend to work with the Parole and Probation Department?		
17. Does all of your staff understand the "conditions of parole" and their implications for your work with clients in Project START?		

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HIV/STI/Hepatitis Readiness	Yes | No	Comments | Next Steps
1. Is your agency willing and able to provide HIV/STI/hepatitis prevention services?		
2. Do you have staff that has experience providing HIV/STI/hepatitis prevention programs? If not, do you have a training plan in place?		
3. Do you have the resources to hire staff with experience providing HIV/STI/hepatitis prevention programs?		
4. Have you identified HIV/STI/hepatitis training educational resources and funding for your staff?		
Agency Readiness		
1. Does your Board of Directors support this program?		
2. Have you found all the necessary funding for your program?		
3. Do you have support from all of the agency staff who will be involved in this project including direct-line staff, supervisors, and administrative support staff?		
4. Have you hired staff who has obtained security clearance from the correctional facility?		
5. What is your agency's current knowledge and experience with client-focused, personalized incremental risk reduction, problem solving, and goal setting strategies? Have you included these skills into your staff training plan?		
6. Do you have staff that has worked in a correctional setting in the past? If not, do you have a training plan in place?		
7. Have you identified or set up additional training for your staff (for example, risk reduction counseling, prevention case management, or community outreach)?		

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Agency Readiness, *cont'd*	**Yes | No**	**Comments | Next Steps**
8. Do you have the capacity to develop a work plan that will be modified to meet local client needs?		
9. Do you have the capacity to develop an evaluation plan? Have you included time in your work plan/ timeline to account for the development of your evaluation plan?		
10. Do you have a storage system in place for client files and that will protect client confidentiality?		
11. Will you be required to collect and report evaluation data to funders and other key stakeholders (e.g. PEMS)? If so, do you have a plan in place and information management system to support these activities?		
12. Will you be required to clear an Institutional Review Board (IRB) for your evaluation plan? If so, have you identified an IRB? Do you have the capacity or history of working with an IRB? Have you included time in your work plan/timeline to account for getting approval from an IRB?		
Community Readiness		
1. Do you have community buy-in that includes support from other community service providers, community leaders, and local parole and probation departments?		
2. Have you reviewed and measured your agency's ability to provide follow-up services for your clients in the community?		
3. Have you identified your gaps in services and developed a list of additional service needs for your clients beyond the scope of your own agency?		
4. Do you have contacts with community service providers that can serve as a network for the referrals you will be making?		

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Community Readiness, *cont'd*	**Yes | No**	**Comments | Next Steps**
5. Have you identified community meeting places that are accessible to your clients for their post-release sessions?		
6. Do you have contacts in the community to secure client resources or incentives as needed, for example, public transit tokens, toiletries, phone cards or food vouchers?		
7. Are there any community politics you should consider when offering post-release services?		
8. Have you considered the larger public opinion and support of this project including the local media?		
9. Do you have a plan to deal with any general public conflict with this project? (e.g., editorial against program in local paper).		
10. Do you have a dissemination plan to publicize the outcomes of the project?		

Stakeholders

A stakeholder is any individual person, organization, funder, or public agency who has an interest in the success of a program. Your stakeholders will have valuable information and perhaps even resources necessary for the success of your program. They may serve in an advisory role, provide access to the client population or other resources, or simply have a strong interest in the success of your program. Keep them informed throughout the program so they continue to support it. The following is a list of suggested stakeholders and the roles they can play in your Project START program.

- **Agency Board of Directors**
  provide overall support and approval of the program.
- **Agency Staff** *(including management, administration and direct services staff)*
  provide day-to-day management of the program including, program, procedures and guidelines management, administrative support, and delivery of all program activities.
- **Correctional System Representatives**
  (including Administration, Custody, Medical, and Education/Programs)
  provide approval for your program to be delivered on site, access to your client population, space for your program activities, and security for your staff and clients.
- **Parole or Probation Representatives**
  provide support for program including designated "program friendly" officers to work with your clients.
- **Other Community Agencies currently providing service within the Correctional Facility**
  provide contact people within the facility, information on how to work within the facility, client referrals, and shared resources.
- **Other Community Agencies currently providing services in your clients' home communities**
  provide space for meetings with clients in the community, access to services through referrals, and suggestions for other services and resources.
- **Currently or formerly incarcerated individuals and their family members**
  provide input into program development, review materials for language and appropriateness, outreach to and referrals for clients, training and insight on prison culture.
- **Community Advisory Board**
  provides ongoing input into your program guidelines and procedures, activities and materials.
- **Public Agencies** *(such as state or local health and human service departments)*
  provide financial and other resources, staff training, outreach and overall support.

- **Policy Makers** *(especially those interested in changes in the correctional system)* provide guidelines, procedures and legislative policies that inform and effect program delivery.
- **Researchers/Evaluators** *(especially those interested in correctional health, reentry or correctional social services)* provide information and research to help inform your program and support the evaluation of the program.
- **Funders**
  provide financial resources, other resources, and input and guidance into the set up and delivery of your program.

Stakeholders' Checklist

You can use the following checklist to work with your stakeholders. This checklist contains items you can use to identify stakeholders, inform them of your program and gain their support and involvement in your efforts.

- ☐ Assess the community to determine whether they will support the Core Elements of Project START.
- ☐ Identify your stakeholders based on the description provided in the previous section.
- ☐ Inform stakeholders of the program.
  - ☐ Call stakeholders to inform them of your project and ask for suggestions of other potentially important stakeholders.
  - ☐ Send program overviews and letters.
  - ☐ Conduct follow-up phone calls.
  - ☐ Hold at least one stakeholders meeting at the correctional facility (if possible).
- ☐ Gain their support.
  - ☐ Ask what they see themselves bringing to the program.
  - ☐ Describe several (other) specific roles they could play.
  - ☐ Emphasize the benefits of their involvement
  - ☐ Invite them to commit to supporting the program by taking on one or more roles.
  - ☐ Keep track of commitments.

- ☐ Get them involved.
  - ☐ Call to thank them for making a commitment to the program.
  - ☐ Send thank you letters that specifies the role(s) they agreed to take on.
  - ☐ If they did not commit, send letter thanking them for their interest and ask them to keep the letter on file in case they reconsider later.
  - ☐ If they committed to a role that is important to pre-implementation, put them to work as soon as possible
  - ☐ If they committed to involvement later in the process, send them brief progress updates and an idea of when you will be calling on their support.
- ☐ Show appreciation and keep them involved.
  - ☐ Hold periodic celebratory meetings for supporters to acknowledge your appreciation for their contributions.
  - ☐ Update stakeholders on the program's progress through emails, newsletters, news clippings, etc.
  - ☐ Keep them engaged through invitations to program events, meetings, and/or volunteer commitments.

Staffing Plan

Finding quality staff for your program is an important part of the program's success. Project START requires that you "staff the program with individuals who are familiar with HIV/ STI/ hepatitis prevention activities *and* with the specific needs of individuals being released from correctional settings" (Core Element #4).

Having staff with these skills is very important given how complex it can be to provide HIV/ STI/hepatitis services within a correctional setting. Not everyone who can provide health education and prevention programs can work successfully in a correctional setting. Likewise, everyone who can work in a correctional setting is not able to provide quality health education and prevention programs.

Finding staff with this background or who can be trained to develop these skills will increase the chances that your staff will be:

- ▶ Committed to the special focus of the program
- ▶ Able to handle the complexities of working in a correctional setting
- ▶ Able to effectively interact ("connect") with incarcerated clients

In addition to the above background and knowledge, effective program staff should have specific characteristics and skills that will help them to be successful with Project START.

Examples of important characteristics for Project START staff include:

- Nonjudgmental
- Outgoing
- Empathetic
- Patient
- Honest
- Flexible
- Confident
- Sincere

Examples of important skills for Project START staff include:

- Effective listener
- Organized
- Good mediator
- Streetwise
- Able to maintain good boundaries
- Good communicator
- Strong counseling skills
- Speak a second language
- Use good judgment
- Able to talk about sensitive topics (e.g. sexual behaviors or mental illness)

Staff members with the right combination of knowledge, characteristics, and skills will be more successful and less likely to leave the program. Reducing staff turnover and developing trustworthy and effective relationships with both incarcerated clients and correctional staff are crucial to your agency's ability to effectively work with the correctional facility.

A NOTE ABOUT STAFFING ▶ People who have been incarcerated or have a family member who has been incarcerated are often interested in working with the program. While they can provide valuable insight and true empathy with the clients, you may have difficulty getting security clearance for them to enter the correctional facility. Be sure to find out the facility's policy on criminal backgrounds, incarceration histories for both individuals and their family members, and clearance screenings before you post positions. Conduct clearance checks early in the hiring process of potential candidates. If possible, it is best to receive formal security clearance for individuals before finalizing the hiring process.

Staffing Plan and Client Load

The following staffing plan is based on serving 50 clients per year for each full time program staff. A full client case load will require your staff to schedule 25 client sessions per month or roughly one session per day.

Staff will often schedule two to three sessions per day when they are in the correctional facility or in the community. This schedule allows them to work in the field three to four days per week and in the office one or two days per week. While this case load may seem full, it has been shown to be successful.

In order to implement Project START at this client level, you will need a program manager, the equivalent of at least one full-time program staff, and a program assistant. Your agency may want to consider hiring two or more part-time program staff instead of one full time position. Having a few part-time program staff may help to bring diversity to the staff team, allow for more flexibility with staff schedules, and provide more opportunity for staff coverage in case of illness, vacation or staff turnover. It is also highly recommended that you hire a peer outreach worker although this is not a requirement for the program.

The following gives a brief description of each position's role in the program.

Program Manager (0.40 Full Time Equivalent [FTE])

Responsibilities include, but are not limited to:

- Conduct overall program administration, coordinate and supervise program staff
- Provide general oversight of day-to-day program administration, guidelines and procedures
- Hire, train, and supervise all program staff
- Represent the program at your agency's meetings
- Coordinate staff scheduling and supervision
- Be the primary contact with the correctional facility administration and staff
- Oversee quality assurance activities
- Oversee evaluation data collection, and client paperwork
- Review evaluation and quality assurance results and make program adjustments
- Review client retention
- Prepare program reports as needed
- Coordinate and facilitate weekly team and supervision meetings
- Coordinate and facilitate Community Advisory Board meetings
- Coordinate meetings and communication with stakeholders
- Work with other community agencies
- Additional responsibilities as needed

Program Staff (1.0 FTE or 2 part-time 0.5 FTE)

Responsibilities include, but are not limited to:

- Coordinate program outreach and client recruitment
- Schedule and conduct all program sessions with clients
- Complete all client paperwork
- Actively stay in contact with clients to help them stay in the program
- Stay in contact with other community agencies to ensure quality facilitated referrals and expanded community resources
- Attend weekly team and supervision meetings
- Attend Community Advisory Board meetings as requested
- Willing to work flexible hours (such as weekends and evenings)
- Stay up to date on latest information on HIV/STI/hepatitis prevention and other training needs
- Additional responsibilities as needed

Program Assistant (0.20 FTE)

Responsibilities include, but are not limited to:

- Provide day-to-day administrative support for all staff
- Maintain up-to-date facilitated referral database and community resource guides based on information from Program staff
- Prepare program session packets and coordinate program supplies
- Enter data for program evaluation
- Additional responsibilities as needed

Peer Outreach Worker *(optional)* (0.25 FTE)

Responsibilities include, but are not limited to:

- Provide feedback for policies and practices of the program based on personal experience with incarceration
- Research possible agencies to be used for facilitated referrals and community resource guides
- Provide support for ongoing contact with clients including street outreach and following re-incarcerations and new admissions to local jails and prisons
- Additional responsibilities as needed

Staff Training

It is important that all program staff hired for Project START have been trained thoroughly on all parts of program. Given the realities of staff illness, vacation, and turnover, all program staff should be prepared to work with any client involved in the program. Thus, before starting the program, it is important to have a comprehensive training plan in place for each staff member. This training plan should focus on six areas:

1. Specific information and details about Project START
2. Requirements for working in the correctional facility
3. HIV/STI/hepatitis information
4. Safety and street outreach
5. Skills building (e.g. risk reduction counseling or Comprehensive Risk Counseling and Service [CRCS])
6. Specific information relating to particular client populations
7. Agency-specific information, policies, and practices

Program Training ▶ This training is provided by a Project START trainer(s). It includes an overview of the program and key program activities, skills building and role plays. It also includes training on client paperwork, evaluation and quality assurance.

Correctional Facility Training ▶ This training usually includes guidelines for entering and exiting a correctional facility. It also covers safety issues, disaster readiness, dos and don'ts of the facility and any other facility rules for providing services. This training may be provided by the local correctional facility or correctional department.

HIV/STI/Hepatitis Training ▶ This training includes an overview or update of basic information on transmission, prevention, treatment and vaccines (if appropriate) for HIV, STIs and hepatitis. This training is usually provided by a local health department, Prevention Training Center or AIDS service organization.

Safety Training ▶ Beyond the safety training given by the correctional facility, your staff should be trained in safety issues related to this program. This can include street outreach, gang awareness, working with clients who are using drugs, and working with clients with mental health issues. This training may be provided by local law enforcement, community agencies, or local health departments.

Skills Building ▶ Additional skills training may be needed depending on your staff's experience and knowledge. Your staff should have solid skills in the following before implementing Project START: HIV/STI/hepatitis education, effective communication skills, risk reduction counseling, and CRCS.

Client-Specific Training

More training may be necessary to address the specific needs of different clients. Examples include:

If serving women ▶ training on domestic violence or child welfare and custody issues

If serving HIV-positive clients ▶ training on disclosure of HIV status, medication adherence or partner services

Agency-Specific Training

Additional training may be required and provided by each agency providing Project START for its own staff. This may include training on site-specific guidelines and practices.

Client Eligibility

The following client eligibility guidelines are strongly encouraged for your program:

Scheduled for release within 60 days ▶ Client should be scheduled for release within 60 days. This time is recommended to give clients enough time remaining in their incarceration to reasonably complete recruitment and enrollment, risk assessment, and transitional planning prior to release. The minimum required days before release may differ across sites because of differences in correctional facility procedures. Release dates are also sometimes delayed for different reasons within the correctional system. If this happens, you can approach those potential clients again later to include them in your program.

Able to provide agreement for services ▶ Clients should be able to understand the program and give their agreement to participate.

Released to service area ▶ Because face-to-face contact is required after release, your clients must be released into your agency's service area. Service areas will differ across different sites. It will depend on your agency's ability to provide follow-up services and travel to meet your clients. It will also depend on your ability to make contacts with other community providers to develop a solid network of facilitated referrals in your designated service area.

Willing to provide contact information ▶ Potential clients must be willing to provide at least one piece of 'locator' (contact) information so that your staff can reach them after release. The Project START Locator Information Form lists personal contact information for the client, other personal contacts, "hangouts," work or school information, and contact information for the parole or probation officer. Program staff may need to help clients collect names and telephone numbers, and to check this locator information for accuracy before release. To make sure your staff is not viewed as "checking up on clients," ask for the client's permission before checking their information. Program staff can check phone numbers or addresses through phone books, directory assistance, or the internet.

Released to environment that is not restricted ▶ Potential clients must be released into an environment where your program staff will not have restricted contact and can therefore have face-to-face meetings. Examples of restricted environments are work camps and locked treatment units that have "no access" policies. In these cases, residents are not allowed to talk or meet with anyone outside their program.

You may decide to add other eligibility guidelines depending on the needs of your particular client population, correctional facility, or agency. Once you have determined the specific eligibility criteria for your program, your agency should develop an eligibility checklist. The information included in this checklist should be given out during recruitment and verified with individual clients during their enrollment session.

Client Recruitment

Recruiting clients in a correctional setting can be challenging. It is important to get feedback from the correctional facility on best practices and procedures for their facility. People who are incarcerated at your targeted correctional facility can also provide useful information. They can give feedback on where best to recruit, good language for recruitment materials, and ways in which they can help you recruit. They may also help you develop ways to identify the clients with greater needs who could most benefit from your program.

It is important to get the "buzz" out in the facility as early and as much as possible. In order to do this, it is important to develop interesting materials that will catch the eye of as many potential clients as possible. Do not rely on one method, but instead create many different ways of recruiting inside the facility, including:

- One-on-one outreach by program staff in recreational yards and in housing units
- One-on-one outreach by incarcerated individuals who have been educated about the program, including peer health educators and inmate advisory committee members
- Targeted referrals from correctional staff , including social workers, correctional counselors, substance abuse counselors, reentry coordinators, discharge planners, nurses, doctors, and teachers
- Referrals from past or current clients who are either inside the facility or who have been released and still have contact with potential clients within the facility
- Flyers posted in various parts of the facility, including housing units, program areas, classrooms, recreational sites, hospitals and libraries
- Information sessions presented by program staff at other facility events, classes, and treatment groups
- Program staff getting a list of people who are to be released within the next 60 days from the correctional facility

Timeline/Work Plan

It will take your agency anywhere from 6 to 12 months to fully launch Project START within the correctional facility. This timeline depends on your agency's existing relationship with the correctional facility and the facility's ability to begin new programs. After the program has been launched, it will take about 10 to 12 more months to complete the program with a case load of 50 clients per each full time program staff. Thus, realistically, it takes 2 full years to completely implement and run a full cycle of Project START.

Timeline/Work Plan

	(Yr 1)												(Yr 2)											
Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Organizational Readiness																								
Conduct Organizational Assessment.																								
Gain support from Board of Directors, agency staff and administration.																								
Find funding.																								
Identify and set up Community Advisory Board.																								
Correctional Setting Readiness																								
Select correctional facility.																								
Make contact and explain your program.																								
Gain facility approval and/or department approval.																								
Develop guidelines and procedures in consultation with facility																								
Maintain contacts with facility staff.																								
Develop relationship with parole and probation departments (if applicable).																								

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▶ Timeline/Work Plan, *continued*

	(Yr 1)												(Yr 2)											
Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Staffing																								
Identify potential staff candidates (both internal and external).																								
Interview and screen potential staff for security clearance.																								
Hire staff.																								
Complete correctional facility required training.																								
Conduct initial Project START training.																								
Provide more training and ongoing supervision as needed.																								
Program Development																								
Identify currently incarcerated individuals to act as advisors.																								
Review program and materials with your Community Advisory Board and Peer Advisory Board.																								
Update and adjust materials to reflect advisory input.																								
Gain facility clearance for all program materials.																								
Identify outside community agency referrals and develop contacts within those agencies.																								
Develop local community resource guides for clients.																								

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▶ Timeline/Work Plan, *continued*

	(Yr 1)												(Yr 2)											
Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Program Development, *continued*																								
Organize program supplies (such as client folders, educational brochures and condoms).																								
Develop client outreach materials.																								
Organize program paperwork (such as client forms, staff forms and evaluation forms).																								
Program Implementation																								
Conduct outreach for clients.																								
Recruit new clients.																								
Begin enrollment with clients.																								
Complete pre-release session #1 including risk review and risk reduction planning.																								
Complete pre-release session #2 including transitional needs review, transitional planning, and facilitated referrals.																								
Complete post-release sessions #3 through #6 including transitional planning, facilitated referrals and condom availability upon release.																								
Provide appropriate closing activities with clients during session #6.																								
Complete all necessary client-level paperwork.																								

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Project START

▶ Timeline/Work Plan, *continued*

	(Yr 1)												(Yr 2)											
Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Program Implementation, *continued*																								
Maintain contacts with community agencies.																								
Maintain contacts with Parole and Probation Departments.																								
Program Support and Review																								
Hold weekly one-on-one supervision meetings with staff, review program and client progress/barriers.																								
Hold program team meetings.																								
Hold program team retreats and planning days.																								
Hold ongoing file reviews, observe program activities, and/or review staff procedures and materials to ensure quality and fidelity.																								
Provide ongoing staff recognition.																								
Program Evaluation																								
Develop an evaluation plan.																								
Identify consultants and/or evaluation partners (if needed) to assist with program adaptation and evaluation.																								
Complete Institutional Review Board (IRB) and Informed Consent approvals (if required).																								

continued on back

Timeline/Work Plan, *continued*

	(Yr 1)												(Yr 2)											
Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Program Evaluation, *continued*																								
Develop an evaluation and reporting system.																								
Develop database for evaluation information.																								
Train staff on evaluation reporting system.																								
Launch and conduct evaluation reporting system.																								
Review the evaluation information.																								
Use the evaluation information to adjust your program as necessary.																								
Provide reports to funders.																								

Notes

Budget Overview

The main costs of the Project START program are staffing, rental of office and meeting spaces, communication expenses, travel and mileage reimbursement, and program materials. Incentives may be an additional cost if agencies elect to provide them for clients. There are very few other costs for this program.

To serve 50 clients per year using Project START, your agency will need at a minimum, the equivalent of:

- 0.40 Full Time Equivalent (FTE) Program Manager to oversee all aspects of the program including staff supervision, evaluation and quality assurance—and to act as an ongoing contact person/agency liaison (or representative) for the correctional facility
- 1.0 FTE or 2 part-time 0.5 FTE Program Staff to conduct all of the program activities
- 0.20 FTE Program Assistant to provide administrative and program support including maintaining the community resource referral guide and/or evaluation data entry

Your agency may also choose to hire a part-time peer outreach worker. This person should ideally have personal experience with incarceration and can therefore act as a representative peer for the program.

- 0.25 FTE Peer Outreach Worker to research community agencies and referrals and provide support for maintaining contact with clients

This staffing plan does not include any resources for evaluation besides a program assistant for entering information into an evaluation database. However, if your funding agency requires more resources be spent for evaluation than what is listed in the staffing plan and job descriptions; please allot additional staff and resources such as an Evaluation Manager or Data Manager.

Before starting the program, each staff member will need to attend a 32-hour training on Project START in addition to the training time required by the correctional facility for security clearance. Some of your staff may also need more time for training on additional issues such as risk reduction counseling, HIV/STI/hepatitis prevention and education, and outreach and safety practices.

Add in the number of hours you will need to receive approval and develop all of the guidelines and procedures required by the correctional facility for providing this program. This may take up to 12 months if your agency identifies an interested facility but you have no previous history working with them. The actual number of hours and costs of start up in a correctional facility depend on many things, including:

1. The facility's history of working with outside providers.
2. The facility's willingness and readiness to provide HIV/STI/hepatitis prevention programs.
3. Your agency's history of working inside a correctional facility.
4. The security level of the facility (minimum, medium, maximum).
5. The ability of your contact person within the correctional facility to get things approved and started.
6. The political climate of the department of corrections, local sheriff's department and the larger community for this type of program.

The following is a sample cost sheet of possible costs associated with providing Project START. Depending on the number of clients you intend to serve and/or agency-specific costs (such as travel costs and mileage reimbursement costs), these figures will be different for each organization.

Cost Sheet to Conduct Project START

Categories	Before the Program Begins		Delivering the Program	
Staffing (% FTE time spent on program)	# staff	% time or # hrs/wk (% FTE time spent on program)	# staff	% time or # hrs/wk
Salaried Staff				
Program Manager	1	40%	1	40%
Program. Assistant	1	25%	1	20%
Program Staff	1	100%	1	100%
Peer Outreach Worker (optional)	1	25%	1	25%
Fringe benefits (e.g. staff health insurance or payroll taxes)	to be determined by your agency		to be determined by your agency	
Agency Facility(s)	(% time used for program)		(% time used for program)	
Rent[13]				
Office	$___x	% =	$___x	% =
Client meeting space	0		$___x	# sessions =
Utilities	$___x	% =	$___x	% =
Communications[14]	$___x	% =	$___x	% =
Maintenance	$___x	% =	$___x	% =
Insurance[15]	$___x	% =	$___x	% =
Equipment	(% time used for program)		(% time used for program)	
Computer	$___x	% =	$___x	% =
Copier	$___x	% =	$___x	% =
Equipment maintenance	$___x	% =	$___x	% =
Supplies				
Educational materials	0	0	5 x # of clients	$ /each =
Condoms (male and female)	0	0	25 x # of clients	$ /each =
Lubricant	0	0	15 x # clients	$ /each =
Client incentives	0	0	$ x	#clients =
Postage and mailing	$	$		
Copying and printing			$	

[13] Your agency may offer to provide rent money to the correctional facility for confidential meeting space on the inside and/or rent money to outside Community Agencies for confidential meeting space.

[14] Telephone, fax, internet/e-mail, (Include the cost of both land lines for all staff and cellular phones for field staff.)

[15] Consider the insurance expenses associated with staff travel to meet clients and/or transporting clients in agency vehicles or personal vehicles.

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Cost Sheet to Conduct Project START, *continued*

Categories	Before the Program Begins		Delivering the Program	
Office Supplies				
Paper	1 ream x	$/ream =	3 reams x	$/ream =
Pens 1 dozen x	$/doz. =	1 dozen x	$/doz. =	
Client folders	0	# x #clients	$ /each =	
Printed Materials				
Community Referral Guides	0	0	# x # clients	$/each =
Information sheets/flyers	100 x	$/each =		
Recruitment (of staff/volunteers)				
Advertising/in newspapers or online	10 column inches x	$/inch =	10 column inches x	$/inch =
Travel[17]				
Miles to/from client sessions, community meetings, and trainings (if other than regular work place)	# miles x	¢/mile =	# miles x	¢/mile =

[17]Consider other travel costs such as parking and/or tolls.

SECTION ▶ 4

Working With and Within a Correctional Setting

The information in this section discusses the special issues and situations your agency may encounter working with and within a correctional setting. This section also offers recommendations for many guidelines and practices that need to be in place to run Project START inside correctional facilities.

This section includes information on:

- ▶ Key Terms
- ▶ Approaching a Correctional Facility
- ▶ Critical Issues
- ▶ Addressing Challenges
- ▶ Building a Relationship with Incarcerated Clients
- ▶ Working Effectively with Parole and Probation Departments

Key Terms

The following are brief definitions of some key terms used in correctional systems and facilities. These are 'general' terms and many localities have a more detailed definition that meets the local jurisdiction.

Jail ▶ Most jails are run by a city or county and operated through a local sheriffs' department. Some states also operate jails. Jails house people who are waiting to be charged with a crime, currently on trial, or who have been sentenced to shorter terms of incarceration. People in jail may have been charged with a wide level of crimes, including misdemeanors and felonies. There is a high level of turnover because length of stay in jails is generally shorter than in prison.

Prison ▶ Most prisons are run by a State Department of Corrections or the Federal Bureau of Prisons. Everyone incarcerated in prison has been tried and convicted and is serving a term of incarceration determined in their sentencing. Prisons generally house only people with felony convictions. Most prisons have a security level rating of low, medium or maximum, and people are (usually) housed in facilities that match their security level.

Probation ▶ Probation is a sentence ordered by the courts, usually instead of serving time in jail. Sometimes courts order both a jail sentence and probation. Thus, some Project START clients who are coming out of jail will be on probation. In addition, individuals coming out of a correctional facility including both jail and prison may be on probation for a previous conviction. Typically people on probation are required to live a lawful and productive life, to work, and to support their dependants. They are to maintain contact with their probation officer and remain within the region of the court. Since probation is a release that depends on the person's actions (a 'conditional' release), it does not guarantee absolute freedom. Arrests for new crimes or violating the conditions of probation can result with incarceration or a return to prison.

Parole ▶ Parole is a conditional release from a correctional facility *after* a person has served his/her sentence in prison. People on parole are released under a series of conditions. Violations of these conditions can result in being returned to prison to complete one's sentence. Parole conditions are fairly similar from state to state and can be grouped into two general areas: (1) reform conditions that require the person to follow laws, stay employed, support dependants, and avoid the use of drugs; and (2) control conditions that require the person to report to a parole officer upon release and periodically afterward. They also require cooperating with the parole officer, and getting permission from the officer or letting him/her know of any changes to employment or housing.

Recidivism ▶ The term "recidivism" is used in a wide range of situations. It is most often used when someone is returned to custody (for either a violation of their conditions of parole or for a new crime) after being released from custody. However, the term may also be used to mean:

- ▶ Someone is arrested (with or without a formal charge);
- ▶ Someone has any interaction with police;
- ▶ Someone is charged with a new crime and is awaiting trial.

Approaching a Correctional Facility

The first task in providing services within a particular correctional facility is figuring out the appropriate correctional facility to approach. Things to consider when deciding which correctional facility might be best suited for Project START include:

- Does the facility have potential clients that are close to release?
- Does the facility have the ability and willingness to identify potential clients for you?
- Will potential clients be released from this facility to a geographic area that your agency can serve?
- Have you worked with this correctional facility in the past?
- Does this facility have a history and/or system in place to work with outside service providers? If not, is the facility open to starting such a relationship with you?

Once you have identified an appropriate correctional facility for implementation of Project START, your next task is to determine how best to approach that facility. The following is a brief overview of some key steps to consider:

Step 1 ▶ Contact Other Agencies Currently or Previously Working inside the Facility

First do some research to find out if there are any other agencies within the area that are currently providing services or have provided services within the facility.

It is a good idea to meet with any agencies you identify that are already working with that facility. This information can help you gain a better understanding of the facility. Building a relationship with these agencies can also help limit turf battles or a sense of competition. This way you can prevent "getting off on the wrong foot" with the correctional facility or other agencies.

You may wish to ask the following questions in these meetings:

- What types of services are you currently providing in the facility?
- Are there other agencies providing services?
- If so, who are they and what type of services are they providing?
- Who are the key supervising staff (for example: Warden, Deputy Warden, Public Relations Officer, Community Relations Officer) in this facility?
- Who are other key staff?
- Who is coordinating your efforts on the inside?
- Who do you recommend as a contact for us in this facility?
- What is the attitude of the facility toward working with community agencies?
- What is the attitude of the people who are incarcerated toward these community agencies?
- What is the best time to provide services?
- What do you enjoy most about working in this facility?
- What are some of your challenges? How have you dealt with these challenges?

Step 2 ▶ Identify All the Key Players inside the Facility

There are five important groups of staff within a correctional facility that may affect the success of Project START. Do your best to find out who are the key players in each of these groups. Some staff may have more than one role in a correctional setting. For example, Custody or Security staff may also serve as Medical Technicians or Correctional Counselors.

1. **Administration** ▶ Warden or Superintendent, Chief Deputy Warden, Assistant Wardens, Captains, Public Relations Officers, Assistants to the Warden, Community Relations Officers.
2. **Custody or Security Staff** ▶ Lieutenants, Sergeants, Correctional Officers, Watch Commanders, Yard Officers, Gate Officers.
3. **Medical Staff** ▶ Chief Medical Officer, Physicians, Psychiatrists, Dentists, Nurses, Physician Assistants, Medical Technicians.
4. **Program Staff** ▶ Social Workers, Educators, Vocational Staff, Coaches, Substance Abuse Counselors, Correctional Counselors.
5. **Religious Services** ▶ Chaplains, Ministers, Rabbis, Imams, Prison Ministries

Step 3 ▶ Identify your Best Contact Person

Decide who in the facility is your best contact. This decision can be based on:

- ▶ Advice from other agencies
- ▶ Who in the facility or department has the decision making power to approve programs
- ▶ Who has the role and responsibility to work with community groups
- ▶ Who has shown interest in your program
- ▶ Who is most regularly available to meet with you

Step 4 ▶ First Meeting with Facility Contact Person

After you have determined your best contact, set up a meeting with him or her. Ask who else should be a part of this meeting. Based on the content of Project START, it may be wise to have representatives from medical staff, education staff, and/or substance abuse treatment programs. Come to this meeting prepared with brief but thorough materials.

Make sure the materials:

- give an overview of the program,
- show how the program will support (and not endanger) the safety and security mission of the facility, and
- explain clearly what is needed from the facility for program implementation (such as space, staff, and materials).

Talk about the funding source for the program. If funding is not coming from the Department of Corrections, stress this point with your contact person.

Plan to present your information in less than one hour. Be prepared to leave written materials behind for review. Try to get from your contact person a sense of next steps, a timeline for decision making follow-up as well as a back-up contact.

Step 5 ▶ Visit Key Staff within the Facility

Once you have had your first meeting with the facility and have a sense for how your program might run there, ask for a tour. This will give you a chance to meet some of the key facility staff that you and your staff may work with from day to day. This tour can also help you explore possible confidential meeting space(s) for your program and visit other programs in the facility.

Key facility staff people to meet include:

- Gate officers
- Custody or security staff in the location of your program
- The watch commander for the shift and location of your program
- Coordinators of other programs

Give each of these people:

- A brief overview of your program
- A sense of how many of your staff members will be in the facility
- When you will be there
- A sense of how you will interact with the facility staff

Ask your contact or tour guide the names and titles (ranks) of each of the people you meet. Make sure this information is part of your staff training so they know how to address the facility staff they will be working with.

Step 6 ▶ Gather Input from Potential Clients

Ask the facility to help you meet with some incarcerated individuals who are close to release to talk about your program.

In this meeting, ask for their advice on:

- how to recruit program clients
- ideas for program space
- who might be interested in enrolling in the program
- what possible problems with enrollment may exist
- any concerns they may have about the program

For more information about how to include incarcerated individuals in your program development, see the section on "Roles Incarcerated Individuals Can Play in the Start-Up Phase" presented later in this chapter.

Step 7 ▶ Finalize Proposal with Contact Person

Once you have met key facility staff, toured the facility, and talked with potential clients, set up another meeting with your contact person. In this meeting, present the specific details of your proposal for his/her feedback. With this information you can develop a formal proposal to present to the facility administration.

Step 8 ▶ Meeting with Facility Administration

With the help of your contact person, set up a meeting with the facility administrators. This meeting may include the Warden (Superintendent) and/or other Executive Staff that have the decision making authority to approve your program. Come prepared with a formal proposal that includes implementation details specific to this facility.

Again, make sure the proposal includes:

- An overview of the program
- An explanation of how the program will support (and not endanger) the safety and security mission of the facility
- Clear requests for what the facility should provide to implement the program (such as space, staff, and materials)

Also plan to explain funding for the program and costs to the facility, including the burden of work for correctional staff.

Plan to present your proposal in less than an hour. Be prepared to leave written materials behind for review and final approval.

Step 9 ▶ Get an Approval Letter for Correctional Facility Administration

Once you have received approval from the facility, make sure that you receive in writing exactly what you have approval to do, including the name(s) of the official who has granted the approval; this written approval will be important for program staff to have whenever they are in the facility.

Critical Issues in Working With A Correctional Facility

There are a few critical issues to consider before implementing your program in the facility. The following section will explore the issues of building relationships, safety and security, staff safety, trust, consistency and follow-through, flexibility, facility chain of command, and the role of Project START staff within a correctional facility.

Building Relationships

Working effectively inside a correctional facility is all about who you know. Building relationships is vital to success on the inside. The time you spend building and nurturing these relationships will greatly affect your success with all other critical issues. Keep in mind that correctional personnel have a high rate of turnover. Keeping a broad range of contacts within a facility lessens the likelihood your program will experience disruptions when key contacts leave.

Give careful consideration and time to build and sustain relationships with key correctional staff including:

- Wardens and Deputy Wardens
- Captains and Lieutenants
- Watch or Shift Commanders
- Correctional Officers
- Administrative Support Staff
- Designated Project Liaison within the Correctional Facility
- Social Workers and Counselors
- Chaplains and other Religious Leaders

Safety and Security

The top priority for any correctional facility is the safety and security of the staff and the individuals incarcerated in the facility. This priority should be held in the highest regard by any community agency hoping to work successfully in a correctional facility. All discussions with the facility, program procedures, and daily practices should be conducted with safety and security in mind.

If your agency embraces these priorities and includes them in your policies and practices, you will gain the trust of the facility much more quickly. You will also have a better chance of maintaining your presence within the facility. Any agency action or guideline that comes into conflict with this policy will not be tolerated and may endanger the entire program.

This issue should not be taken lightly, nor should it be "tested." Instead, all agency staff should follow correctional system practices of safety and security. Demonstrate how your agency's efforts help support the safety of the facility. Keep in mind that people who are actively working to better themselves in preparation for release are also less likely to get into trouble on the inside.

Staff Safety

Be sure to pay attention to the safety of your staff while they are working inside. The following are some suggestions to help you do this:

- Require that correctional staff train all of your program staff in facility safety *before* they begin their work.
- Make sure your staff keeps safety equipment that is required or permitted by the facility with them at all times. These may include identification cards, personal alarms, and whistles.
- Make sure your staff are aware of the "no hostage policy" in the facility if there is one. Explain clearly what that means to your staff. It usually means that the facility will not bargain for your release during a hostage situation.
- If program staff are unsure of safety in a particular area of the facility, ask a correctional officer to escort clients to the meeting space.
- Make sure all program staff know where the closest correctional officer is located in relation to your program space.
- Have program staff introduce themselves to the correctional officers in the location and on the work shift of their programs.
- Encourage program staff to be aware of personal safety in open and public areas of the facility such as recreational yards, housing units, and education classrooms.

In rare cases, a client may experience feelings of suicidal thoughts or extreme anger. It is important to know the crisis plan for the correctional facility in order to protect the safety of your staff and the client. Staff members should know what to do in a crisis situation. The rule may be to sound an alarm, blow a whistle, or contact the closest correctional officer. They should also know what *not* to do, such as deal with the situation themselves. Finally, staff members should be aware of the procedures to follow with the facility after the crisis situation has been resolved (such as filling out an incident report).

Issues of Trust with Correctional Staff

The best way to gain trust is to continue to follow through on promises in a timely and professional manner. It is also important for new agencies to fully embrace all correctional system rules and guidelines. Add these rules and guidelines clearly into your program's own guidelines and procedures.

The following suggestions will also help you to establish trust with the correctional staff:

- Require that all program staff attend facility orientations and pass security clearance screenings as early in the hiring process as possible. Document their completion of initial and ongoing training as required.
- Readily agree to and consistently uphold any security procedures the facility requires of all staff. This includes dress codes and wearing whistles or personal alarms.
- Stress to your staff the importance of following security procedures including:
  - not bringing contraband [or banned items] into the facility,
  - not taking anything out of the facility that was given to them by clients.
- Be flexible in finding a time slot for services based on the facility's existing schedule. Suggest program time slots that will support the schedule of the facility.
- Check in regularly with key correctional staff to ensure that your staff is following the rules and the program is going well.
- Have your staff carry a letter from the warden approving the program.

Once you create a sense of trust with the prison administrators, realize that you will also need to create a similar process of trust-building with direct-line correctional staff.

These staff may include

- Gate officers
- Correctional officers
- Sergeants
- Yard sergeants
- Watch/Shift commanders
- Other correctional staff working in and around your program space

These are the people your staff will be working with on a daily basis. They will be providing the daily support and resources needed to implement the program.

Make sure your staff carries with them written materials about the program and written approval from the prison administration. These materials will help to explain who they are, what the program is, and what they have approval to do within the facility.

It is also helpful to have your contact at the facility keep a project file on site. This file can include copies of a program overview and all of its materials, approval letters and agreements with the correctional facility, and any other key documents. Encourage the contact to forward this file to whomever takes his/her place if this person should leave or change positions.

Consistency and Follow-Through with Correctional Staff

Programs need to be consistent with their rules, guidelines and practices. It is important to follow through on what you say you are going to do—and not promise things you cannot deliver on, even if you are pressured to do so.

Programs need to have consistent messages, staff, practices, and policies. If a program has certain eligibility requirements, they should be clearly written, honest and consistent. If a program or individual staff person says they are going to do something on a particular day and time, they need to deliver on this promise.

Word travels quickly in a facility and programs are only as good as their reputations. Programs in correctional settings are possible only if the staff is considered to be reliable and trustworthy to everyone involved.

Flexibility

Another very important lesson to learn about providing services within a correctional facility is flexibility. It is important to set clear rules, guidelines and practices. However, it is also important to realize that on any given day, circumstances out of the control of your agency and staff can and will override these practices.

Some examples of such circumstances include:

- Lockdowns
- Correctional and administrative staff changes
- Safety training drills
- Paperwork to release incarcerated clients for your program not being processed
- Clients transferred to another facility or housing unit without your knowledge

Any of these situations may limit or disable your program for a day or a more extended time period. It is important for staff not to get into a power struggle with the facility staff if a disruption occurs. Instead, your staff should remain courteous and bring the problem back to your agency's administrators.

It is up to your agency to rely on its flexibility and creativity to deal with these circumstances. An agency that is seen as inflexible will be thought of as unable to work within the correctional system and will lose its access.

Chain of Command

It is important for community agencies to understand that a correctional facility—much like the military—has a chain of command. All communication and decision making within the facility runs through this chain of command.

Your agency should learn the chain of command at the facility you are working in and make sure that all staff know and use this chain of command. Learn who in the facility needs to be kept updated on decisions and activities. Learn also their preferred method of receiving this information, such as word of mouth or in written form.

Know Your Role in the Facility

It is very important for all staff members involved in your program to know what their role *is* and what it is *not* in the correctional facility.

While your staff may not always agree with what they see in a facility, it is important for them to realize that they have been granted permission only to run their program. They are not security staff and should not become involved in any security situation unless it involves their own safety. If there is a situation that your staff feels needs more attention, they should follow the standard grievance procedures for the facility and with the approval of your own agency's management.

REMEMBER ▶ You are "a guest in their house" and you want to be invited back.

Correctional Setting Challenges and Barriers

There are many personal and public health rewards for working within a correctional setting. There can also be major challenges and barriers to working in this environment.

Just getting in and out of a facility on a normal day takes more time and effort than working with clients in the community. These extra efforts and roadblocks need to be accepted as a part of the "price of doing business" in a correctional setting.

The following are some examples of barriers to working in correctional settings and suggestions for how to overcome them:

Program Space

In almost every facility, program space is limited. Most correctional facilities were not built with programs as a priority or even a consideration. Working with a facility to find a space that is appropriate for your program can be one of your toughest challenges.

It is important to find a space that provides the most privacy the facility will allow you without endangering staff safety. This may mean being flexible about when you can deliver the program. For example, you may be able to use a classroom or counselor's office that is vacant during certain times of day.

Your program space may also change locations over the course of the program due to the changing needs of the facility. Once again, flexibility is a key to challenges with space.

Examples of possible program spaces within a correctional facility include:

- Counselor's office
- Classrooms
- Education classroom or office
- Correctional officer's office inside the housing units
- Medical staff office or lounge
- Medical treatment space
- Lawyer meeting rooms
- Laundry
- Recreation yards or private hallways
- Visiting rooms
- Chapels or other religious settings
- Closet space

Confidentiality

As mentioned earlier, confidentiality can be an issue within the facility. The issue of client confidentiality is very different in a correctional facility than it is in a traditional community-based organization. It is important to be honest with clients about the limits of confidentially of the program while inside the correctional facility. The facility may be concerned that confidential meetings between your staff and your clients can be a safety risk. It is important to stress the sensitive nature of the program and the importance of privacy and confidentiality to the facility.

Some options for resolving issues of confidentiality may include:

- Identify a space within the facility that has a glass door or window so that correctional staff can view the program without hearing the contents.
- Have correctional staff escort clients to see the Project START staff.
- Give correctional staff a list of clients and their meeting times.
- Suggest that the door remain slightly open so that correctional staff can hear if an incident occurs, but cannot hear details of a regular conversation.
- Stress to the facility that program staff will follow every safety precaution required by the facility (such as carrying whistles and personal alarms).
- Assure the facility that all program staff will complete all required safety trainings given by the facility *before* they begin their work.

If there is a phone in the facility that your staff would like to use during the program, make sure they know that the phone will probably be monitored by the facility. Decide whether or not to use a monitored phone or make calls on behalf of clients outside of the facility.

Client Materials

All materials inside a correctional facility are subject to search and seizure. It is good practice to take all materials out of the facility after every client meeting. This will help protect the clients' privacy. Clients should also be given the option to either keep copies of their paperwork with them in the facility or to receive their paperwork after release. When given the choice, many clients choose not to keep such sensitive materials in their housing units or cells. Instead they may prefer being given their written materials after release.

Lockdowns and Other Disturbances

At any given time, a correctional facility may restrict your staff's access to clients.

Examples of these restrictions include:

- Lockdowns
- Weather related restrictions (such as heat, snow, or fog)
- Recalls of all prisoners to their housing units
- Routine health screenings
- Quarantines

Your staff may or may not be told of a disturbance to service before they make an attempt to enter the facility. Either way, it is usually not a good idea to try to override the disturbance and see clients on restriction. The best approach - especially for an agency that is new to the facility - is to try to find out when the restriction will be lifted, leave the facility, and continue the program after the restriction has been lifted. Sometimes, correctional facilities will have a contact person or a hotline your staff can call before they arrive that will provide information on the access status of the facility.

Disruptions can be frustrating. It is important to keep your cool. Remember, the goal is to serve the clients.

Building a Relationship with Incarcerated Clients

Equally important to the success of the agency within a correctional facility is building a relationship with the clients themselves. Many of the same issues for working with the facility should be considered when working with the clients.

Issues of Trust with Incarcerated Clients

There will be issues of trust with incarcerated individuals just as there are with correctional staff. Potential clients may have seen programs come and go. They may also have been involved with other service providers who did not follow through, or may view your program as part of the correctional facility. All of these issues affect the level of trust potential clients will have for your program and your staff. One slip-up by program staff can damage the relationship between your clients and your program. Therefore it is important to hire the right staff and provide good supervision for the program.

You can begin to build trust in your staff and program by getting incarcerated individuals involved in the planning of your program, being consistent with your work, and delivering on what you promise. Once this trust has been established, the clients themselves will become one of your best program assets and help you to build trust with other potential clients. They can then become a great marketing tool to spread the word about your program.

Roles Incarcerated Individuals Can Play in the Start-Up Phase

One of the best ways to develop a solid relationship with incarcerated clients is to ask them to play a role in developing the program. As you learned in the "Getting Started" chapter, individuals who are incarcerated can and should serve as advisors to your program. While they may not be able to attend your formal Community Advisory Board meetings in the community, their feedback is still extremely valuable.

Some correctional facilities may have a Prisoner Advisory Board. Others may help you identify a few incarcerated individuals who can serve as program advisors on your Project START Peer Advisory Board.

These peer advisors can provide valuable input for your program, including:

- Identifying current client needs
- Giving feedback for marketing and outreach
- Providing prison or jail culture training for your staff
- Identifying 'dos and don'ts' for working in the facility
- Reviewing program material for language and readability
- Promoting your program
- Recruiting potential clients

Most important, the Peer Advisory Board gives a voice to the people who are incarcerated while helping your agency build a reputation and credibility within correctional setting.

Consistency and Follow-Through with Clients

Consistency and follow-through are probably the two most important elements to building a reputation with incarcerated clients. Your word and what you do with it will make or break your program on the inside.

It is much better to be conservative with your promises and follow through than to promise too much and not deliver. It is also important to be consistent in the level of service you provide from one person to the next, so that your program does not gain a reputation for favoritism (see next section).

Group Identities

Correctional settings are often divided by policies that require certain subgroups to be housed together (such as by ethnicity, health status, security level, or gang affiliation). Those who are incarcerated may further divide themselves into different subgroups by race or ethnicity, gang affiliation, age, religion, sexual orientation, language and/or geographic roots.

Do not expect your staff to become experts in understanding all of the subgroups and the complex subculture within a correctional facility. However, it is important for your staff to be aware that these cultural elements exist and to provide a program that is viewed as open and fair to all individuals who are eligible.

Group identities should be taken into consideration when:

- Preparing materials to be distributed to perspective clients
- Selecting incarcerated individuals for a peer advisory board
- Hiring a diverse program staff
- Conducting outreach within the facility

Finally, cultural groups may be different from facility to facility. Therefore it is important to work with people at your local correctional facility to help identify the particular cultural groups in your facility.

Working Effectively With Parole and Probation Departments

The role of parole and probation departments is important in a client's transition from a correctional setting back to the community. Some Project START clients releasing from a jail may be on probation. Some Project START clients releasing from a prison may be on parole. While other Project START clients may be on both probation and parole.

Clients on parole or probation will have certain restrictions placed on them, many times called the "conditions of their parole or probation." Examples of these restrictions include:

Curfews ▶ Parole officers have the right to drop by an individual's residence at any time during curfew hours to make sure the person on parole is there.

Travel bans ▶ People on parole may only be able to travel certain distances for work or for pleasure. Exceptions to these bans require pre-approval from parole officers.

Prohibitions on contact with other people on parole ▶ Parole officers can have a lot of authority over people on parole including with whom they can socialize. They also have a say in approving where people on parole live and what types of additional services they must be involved in (e.g. substance abuse services or mental health treatment).

Employment requirements ▶ Parole officers may require that people on parole are employed, are actively seeking employment, or have an approved reason if they are not (e.g. they are in a residential substance abuse treatment program).

Drug testing ▶ People on parole, even those without drug-related convictions, may be subjected to random drug testing.

It is important for you to identity if parole or probation systems are a part of your local criminal justice system. If they are, you should gain an understanding of how these systems work and how they might impact the work you do with your clients.

Finally, it is important that your agency determines what role (if any) you would like parole and probation to play in your program. In the original Project START research, parole and probation departments were used mostly as a source for locating or tracing clients.

The following is a list of things to consider:

- ▶ It is important to know and understand how the conditions of your client's parole and probation will affect a client upon release and how they may impact the service plan you are developing with your client. (e.g. Are there restrictions on where a client can live or work? Will they have required appointments they need to attend? Will there be other requirements such as mandatory drug abuse assessment or treatment?)

- Parole and probation officers may have access to resources or vouchers for service programs, substance abuse beds, or housing program that could be a real asset for your client.
- If there are conflicts between clients' parole contract and their personal goals (e.g. client want to live in a different community than where their parole officer says they can live), have an honest and open conversation with your clients about the consequences of these differences so that they can make the most informed decision.
- Depending on the culture of the local parole or probation department, you may wish to involve parole or probation officers more in the program. This may involve having joint meetings with the client, their parole or probation officer and Project START staff.

Expanding the role of parole and probation may have risks and benefits. For example, parole officers may be willing to support and include Project START goals in their parole plans. Risks may include some parole departments pressuring Project START staff to give out private information about their clients. Your decision should depend on each individual client and the relationship you have with your local department.

This determination should be made based on:

- Knowing the laws regarding parole and probation systems in your local community
- Knowing how the parole and probation systems work in your community
- Discussing the risks and benefits of working with parole and probation with your clients

No matter what role the departments will have in the program, be sure that all of your program staff knows how the parole and probation systems work in your area. Staff should understand the conditions of parole and probation that may apply to their clients once they are released. Your staff should also understand the impact these conditions may have on the transitional plans they will be developing with your clients.

Approaching a Parole or Probation Department

Before you begin your program, take the time to make specific contacts within your local parole and probation departments. Just as when approaching a correctional facility, try to find a "service-friendly" contact person in the parole or probation department. This contact may be a supervisor, a community liaison representative, or an officer who is involved with other community efforts. Ask other community-based service providers to see if they have a good contact in the department.

At this meeting, provide the department with written materials about your program. If you have already hired field staff, bring them with you to this meeting. Underline what you can

do to support the parole officer's job. This effort will show empathy for their work and will help them understand the value of your program for both the client and the department. Making contacts with officers now can greatly affect the way they will treat the program, your staff, and your clients once the clients are released.

If possible, attend a local or regional parole meeting so the program can be shared and discussed with all of the officers in that region. Also, just as you will do with the correctional facility, get a written approval for the program from the regional administrator that addresses issues of confidentiality and privacy. This can be helpful when dealing with new supervisors or new parole officers who are not familiar with your program.

Things to Consider Regarding Parole and Project START Clients

- Understand that a parole officer's first responsibility is to protect the public. Their next responsibility is to help parolees enter back into the community.
- Clients may request that your program staff members attend meetings with their parole or probation officer. When your staff is present at these meetings, parole officers may clearly see your client's participation in these programs and may treat the client with more respect overall.
- Most parole officers will ask parolees: what are they planning to do with their life? Are they willing to change their lifestyle and leave prison and the criminal justice system behind? Help your clients plan for these questions by setting small, realistic goals that give them something to work towards in successfully completing their parole.
- Encourage your clients to talk with the people they live with about the requirements of their parole. Encourage them to ask family and friends how they can help the client avoid situations that will put them at risk for doing more time.
- Make sure your clients understand their parole contract and all that is required of them. Encourage them to ask questions if they are not sure about something. (See Appendix V for an example from the State of California, Department of Corrections, Notice and Conditions of Parole.)
- Stress to your clients the importance of keeping all of their appointments with their parole officer, even if these appointments are unpleasant. Encourage them to plan their day so they can do something they enjoy after the appointment. Tell them to seek support from friends and family who know how important it is for them to keep their appointments.

ADDITIONAL INFORMATION AND TRAINING ▶ For more information about Project START including information on program training, go to the web site **www.effectiveinterventions.org** or contact:

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Appendices

Appendix I ▶ Research Articles

Primary Research Outcome Article, Wolitski R. J., et. al.

Science to Community: Research Fact Sheet

Appendix II ▶ CDC Disclaimer Statements

The ABCs of Smart Behavior

Male Latex Condoms and Sexually Transmitted Diseases Fact Sheet

Content of AIDS-Related Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention

CDC Statement on Nonoxynol-9 Spermicide, May 10, 2002

CDC Statement on Study Results of Products Containing Nonoxynol-9

Relative Efficacy of a Multisession Sexual Risk–Reduction Intervention for Young Men Released From Prisons in 4 States

Richard J. Wolitski, PhD, and the Project START Writing Group, for the Project START Study Group

Objectives. We compared the effects of an enhanced multisession intervention with a single-session intervention on the sexual risk behavior of young men released from prison.

Methods. Young men, aged 18 to 29 years, were recruited from US prisons in 4 states and systematically assigned to the prerelease single-session intervention or the pre- and postrelease enhanced intervention. Both interventions addressed HIV, hepatitis, and other sexually transmitted infections; the enhanced intervention also addressed community reentry needs (e.g., housing, employment). Assessment data were collected before intervention, and 1, 12, and 24 weeks after release.

Results. A total of 522 men were included in intent-to-treat analyses. Follow-up rates ranged from 76% to 87%. Unprotected vaginal or anal sex during the 90 days before incarceration was reported by 86% of men in the enhanced intervention and 89% in the single-session intervention (OR = 0.78; 95% CI = 0.46, 1.32). At 24 weeks, 68% of men assigned to the enhanced intervention reported unprotected vaginal or anal sex compared with 78% of those assigned to the single-session intervention (OR = 0.40; 95% CI = 0.18, 0.88).

Conclusion. Project START demonstrated the efficacy of a sexual risk–reduction intervention that bridges incarceration and community reentry. (*Am J Public Health.* 2006;96:1854–1861. doi:10.2105/AJPH.2004.056044)

The prevalence of HIV, hepatitis, and other sexually transmitted infections (STIs) is higher among incarcerated populations than among the general US population.[1,2] The number of confirmed AIDS cases was 3 times higher in 2003 among incarcerated individuals than in the general population,[3] and elevated rates of hepatitis and other STIs have also been reported.[4–10] Consistent with these data, men entering correctional settings often report behaviors that place them and their partners at considerable risk for HIV, hepatitis, and other STIs, including unprotected sexual intercourse with multiple and high-risk sexual partners, injection drug use, and needle sharing.[5,11,12]

These health disparities affect the more than 2 200 000 adults who were incarcerated in the United States as of the end of 2004.[13] Most of these adults are male (93%) and are members of racial/ethnic groups that are disproportionately affected by HIV and other STIs.[13] Although the lives of many incarcerated persons have already been affected by HIV, hepatitis C, or viral STIs, these lifelong infections can be prevented among younger men who are incarcerated. In 2004, 35% of men in state or federal prisons were aged younger than 30 years.[13]

The period before men are released from prison presents an important opportunity to reach this high-risk group and motivate them to avoid risk behavior after they are released from prison.[14] However, few published intervention trials for incarcerated men have assessed sexual behavior outcomes. Two studies described the ability of a 1-session and an 8-session sexual risk–reduction intervention (delivered before release from prison) to increase condom use at participants' first sexual encounter after release.[15,16] Another study found that 2 6-session prerelease interventions for young offenders reduced sexual risk, but the study failed to demonstrate that sexual risk–reduction skills training was superior to an anger management intervention that was provided to the comparison group.[17]

Additional research is needed to determine if the effects of a prerelease intervention can be enhanced by providing transitional support that continues after release from prison and addresses community reentry needs that may interfere with young men's ability to adopt safer sex practices. These competing needs can include unstable housing and employment, lack of access to primary and preventive healthcare, estrangement from family and relational supports, substance use, mental health and coping problems, poor self-esteem and self-acceptance, and other problems.[14,18–21]

Although there is evidence that transitional interventions can reduce substance use behavior among men leaving correctional settings,[22] the effect of a community reentry intervention on men's sexual risk has not been the subject of published reports. This article describes the results of Project START, a multisite study designed to test a multisession risk-reduction intervention for young men being released from prison.

METHODS

Eligibility and Recruitment

Participants were recruited in 2001 and 2002 from 8 state prisons in 4 states (California, Mississippi, Rhode Island, and Wisconsin). The sample consisted of men who were aged 18 to 29 years, incarcerated at least 90 days, scheduled for release within 14 to 60 days, able to provide informed consent and communicate in English, willing to provide postrelease contact information, and released to an unrestricted environment in site-specific catchment areas.

The correctional institutions provided a monthly list of men aged 18 to 29 years scheduled for release. When the number of potential participants exceeded the recruitment quota, potential participants were either sequentially approached according to their scheduled release date or randomly selected for approach. Participants were assigned to intervention groups on the basis of the month of recruitment (California and Rhode Island) or the month of anticipated release (Mississippi and Wisconsin).

Incentives

Reimbursements for completing all 4 assessments ranged from $180 to $200 across sites. In addition to monetary incentives, participants were offered free condoms, resource materials, and a $10 reimbursement for transportation or childcare costs for all activities conducted outside a correctional facility. To facilitate follow-up, all participants were offered a no-cost pager, which they were allowed to keep.

Interventions

The intervention trial was informed by extensive formative research.[5,7,20,23–25] On the basis of this research, 2 interventions—a single-session intervention and an enhanced intervention—were compared. Both interventions incorporated features of prevention case management,[26,27] motivational interviewing,[28] and harm reduction.[29]

The single-session intervention was based on a brief HIV-risk assessment and risk-reduction planning intervention for incarcerated men.[16] It consisted of a 60- to 90-minute individual session that was conducted approximately 2 weeks before release. The interventionist assessed the participant's HIV/AIDS, hepatitis, and STI knowledge and risk behavior and helped the participant develop a personal risk-reduction plan. The interventionist provided information, skills training, and referrals as required and worked with the participant to identify incremental steps toward risk reduction.

The enhanced intervention consisted of 2 scheduled individual sessions before release and 4 scheduled sessions at 1, 3, 6, and 12 weeks after release. The first in-prison session was the same as the single-session intervention. The second in-prison session focused on community reentry needs and included assessment, planning, and problem solving, and facilitated referral for housing, employment, financial problems, social relationships, substance abuse and mental health treatment, legal problems, and avoiding reincarceration. The postrelease sessions involved review and updating of the plan developed during previous sessions, including discussion of facilitators of and barriers to implementing the risk-reduction plan. In-prison sessions lasted 60 to 90 minutes; the postrelease sessions were 30 to 60 minutes. Additional sessions were offered to enhanced intervention participants as needed during the intervention period.

Assessment Procedures and Measures

Participants were assessed before release and 1 week, 12 weeks, and 24 weeks after release. In Mississippi, Rhode Island, and Wisconsin, assessments were conducted using the Questionnaire Development System audio computer-assisted self-interview technology (Nova Research Company, Bethesda, Md). Because prison policies in California prohibited the use of laptop computers, this site used interviewer-administered questionnaires. Separate staff conducted assessment and intervention activities in all sites.

Each assessment measured life circumstances, utilization of community resources and prevention services, substance use, sexual practices, HIV and STI beliefs, depression and coping, and demographic characteristics. The reporting period for most prerelease assessment items was the 90 days before incarceration. The 1-week assessment addressed the period since release from prison, and the 12- and 24-week assessments addressed the time since the previous assessment. The assessments were limited to risk behavior that occurred in the community. In-prison risk behavior was assessed only in a supplemental study that was conducted after the 24-week assessment.[30]

Primary outcomes, which were defined at the start of the study, were sexual practices with any, main, and nonmain partners and nonsterile injection drug use. Sexual practices were assessed separately for main and nonmain sexual partners. Main partners were defined as "someone you feel a special emotional attachment or commitment to." All other partners were considered to be nonmain partners. Partner-specific information was collected for the most recent main partner and the most recent nonmain partner during the reporting period. Aggregate information was collected for other main and nonmain partners. For each type of partner, the number of times each type of sex was performed (i.e., vaginal intercourse, insertive and receptive oral sex, insertive and receptive anal sex) and the number of times condoms were used for each type of sex were assessed. The questionnaire also assessed whether each type of partner was perceived to be an "at-risk" partner, which was defined as a partner who: (1) had ever injected drugs, (2) had ever smoked crack, (3) had ever traded sex for money or drugs, (4) had ever had an STI, (5) currently had other sexual partners, or (6) was HIV seropositive.

Responses to the sex behavior items were combined to form dichotomous variables representing unprotected vaginal or anal sex at last sex with any partner and with an at-risk partner. Separate dichotomous variables were calculated for unprotected intercourse during the entire recall period for any, main, and nonmain partners.

Lifetime history of injection drug use was assessed by asking participants if they had ever injected any drugs, including steroids. Recent use of injection drugs was assessed by first asking participants about the use of specific drugs and then asking if each drug had been injected.

Reincarceration was defined *a priori* as a secondary outcome. Reincarceration was assessed by asking participants whether they had been held in a jail or prison for at least 1 night. Reincarceration was also assessed by documenting whether follow-up assessments were conducted in a correctional facility.

Analyses

Intent-to-treat analyses were conducted that compared the 2 intervention groups at each postrelease follow-up. For the 1-week follow-up, outcomes were modeled with SAS Version 8.2 logistic regression (SAS Institute Inc, Cary, NC). The 12-week and 24-week follow-up data were analyzed separately from the 1-week data because of differences in the recall periods. Each outcome was modeled as either a binary or an ordinal variable with nonlinear mixed models. All models included indicator variables for intervention arm, site, assessment visit (12- and 24-week analyses only), and all 2-way and 3-way interactions. Analyses controlled for the number of days spent free in the community and, for risk behavior, preincarceration levels of the outcome behavior.

TABLE 1—Project START Recruitment and Study Participation Rates

	Total, No./ Denominator (%)	Single-Session Intervention, No./ Denominator (%)	Enhanced Intervention, No./ Denominator (%)
Recruitment			
Attempted to contact	830 (100)	400/400 (100)	430/430 (100)
Contacted	724/830 (87.2)	354/400 (88.5)	370/430 (86.0)
Screened–eligible	592/724 (81.8)	294/354 (83.1)	298/370 (80.1)
Consented	561/592 (94.8)	281/294 (95.6)	280/298 (94.0)
Prerelease activities			
Assessed and released[a]	522/561 (93.0)	259/281 (92.2)	263/280 (93.9)
Intervention session 1	503/522 (96.4)	244/259 (94.2)	259/263 (98.5)
Intervention session 2	...	...	233/263 (88.6)
Postrelease assessments			
Week 1	449/522 (86.0)	226/259 (87.3)	223/263 (84.8)
Week 12	414/522 (79.3)	198/259 (76.4)	216/263 (82.1)
Week 24	432/522 (82.7)	213/259 (82.2)	219/263 (83.3)
Postrelease intervention sessions			
Week 1	...	...	210/263 (79.8)
Week 3	...	...	173/263 (65.8)
Week 6	...	...	173/263 (65.8)
Week 12	...	...	196/263 (74.5)

Note. START = Sexually Transmitted Disease and AIDS Risk Reduction Trial.
[a]Satisfied inclusion criteria for intent-to-treat analyses.

RESULTS

Participants and Participation Rates

Of the 830 men selected for recruitment, 724 (87%) were contacted, and 561 (77%) were screened, determined to be eligible, and provided informed consent (Table 1). Of these, 522 (93%) initiated the prerelease assessment and were released from prison to a nonrestrictive environment, thus meeting criteria for inclusion in the intent-to-treat analyses. Characteristics of these men are shown in Table 2. Most had been tested previously for HIV (88%); 2 reported that they were HIV-seropositive. Almost all had 1 or more sexual partners during the 90 days before incarceration (M=5.0; SD=9.4), and unprotected sexual intercourse was common. Few (n=11) had sex with a male partner during this period. The single-session intervention and enhanced intervention groups were comparable, except that the single-session intervention group was more likely to have been tested for HIV (Table 2).

Table 1 presents attendance rates for both interventions. In the enhanced intervention, 67% received 5 or more of the 6 scheduled sessions. A total of 91 optional enhanced intervention sessions were delivered to 49 participants, of whom 61% received 1 additional session. Retention for follow-up assessments ranged from 76% to 87% (Table 1), and there were no significant differences between intervention groups at any follow-up. There were no significant differences in prerelease characteristics or risk behavior for men who returned for follow-up versus those who were lost to follow-up at any given postrelease assessment.

Sexual Behavior

No significant differences were observed between the single-session intervention group and the enhanced intervention group before the last enhanced intervention session was delivered after the 12-week assessment (Table 3). At 1 week, the enhanced intervention group reported slightly lower rates of unprotected intercourse compared with the single-session intervention group. At 12 weeks, this pattern was observed for all behaviors, but these differences did not achieve statistical significance.

Significant differences between groups were observed at the 24-week assessment, which was scheduled 12 weeks after the last enhanced intervention session. At 24 weeks, the enhanced intervention group was significantly less likely than the single-session intervention group to report unprotected vaginal or anal intercourse during their most recent sexual encounter (Table 3). They were also less likely than men in the single-session intervention group to report any unprotected intercourse in the reporting period. When sexual behaviors with main and nonmain partners were analyzed separately, the observed effects were explained by differences in unprotected intercourse with main, but not nonmain, sexual partners (Table 3).

An additional series of analyses was conducted to determine whether differences between the enhanced intervention and single-session intervention groups could be explained by differences in the amount of time that had elapsed since intervention. For the single-session intervention group, all follow-up assessments were conducted after the intervention was completed. The only assessment conducted after all enhanced intervention sessions were delivered was the 24-week assessment. Thus, additional comparisons were made with data collected at the 12-week assessment for the single-session intervention group and the 24-week assessment for the enhanced intervention group. These assessment periods best approximated a 3-month postintervention follow-up for both groups.

Results of these analyses showed that fewer men in the enhanced intervention group reported unprotected intercourse during their most recent sexual encounter compared with men in the single-session intervention group (Table 3). The enhanced intervention group was also significantly less likely to report unprotected intercourse during any sexual encounter since the last assessment than was the single-session intervention group. When analyzed by partner type, the enhanced intervention group was less likely than the single-session intervention group to report unprotected intercourse with a main partner, but there were no differences for nonmain partners.

TABLE 2—Selected Characteristics of Participants Assigned to Single-Session Intervention (SSI) or Enhanced Intervention (EI), Measured at Prerelease Assessment

	Overall No./ Denominator, n = 522	Intervention Group, No. (%) SSI No./ Denominator, n = 259	EI No./ Denominator, n = 263	χ^2 P
Site				
California	146/522 (28.0)	72/259 (27.8)	74/263 (28.1)	.99
Mississippi	65/522 (12.5)	31/259 (12.0)	34/263 (12.9)	
Rhode Island	152/522 (29.1)	76/259 (29.3)	76/263 (28.9)	
Wisconsin	159/522 (30.5)	80/259 (30.9)	79/263 (30.0)	
Age				
18–21 years	171/522 (22.6)	88/259 (34.0)	83/263 (31.6)	.69
22–25 years	249/522 (47.7)	124/259 (47.9)	125/263 (47.5)	
26–29 years	102/522 (19.5)	47/259 (18.1)	55/263 (20.9)	
Race/ethnicity				
White, non-Hispanic	118/522 (22.6)	58/259 (22.4)	60/263 (22.8)	.53
Black, non-Hispanic	271/522 (51.9)	135/259 (52.1)	136/263 (51.7)	
Hispanic, any race	72/522 (13.8)	40/259 (15.4)	32/263 (12.2)	
Other, non-Hispanic	61/522 (11.7)	26/259 (10.0)	35/263 (13.3)	
Education				
Less than high school	233/519 (44.9)	117/257 (45.5)	116/262 (44.3)	.78
High-school graduate/GED	286/519 (55.1)	140/257 (54.5)	146/262 (55.7)	
Marital status				
Single, divorced, widowed	486/513 (94.7)	242/254 (95.3)	244/259 (94.2)	.59
Married	27/513 (5.3)	12/254 (4.7)	15/259 (5.8)	
Type of sexual partners[a]				
No sexual partner	14/516 (2.7)	5/254 (2.0)	9/262 (3.4)	.52
Main only	135/516 (26.2)	67/254 (26.4)	68/262 (26.0)	
Nonmain only	71/516 (13.8)	31/254 (12.2)	40/262 (15.3)	
Main and nonmain	296/516 (57.4)	151/254 (59.4)	145/262 (55.3)	
Any at-risk partner	341/516 (66.1)	166/254 (65.4)	175/262 (66.8)	.73
At-risk main partner	195/516 (37.8)	95/254 (37.4)	100/262 (38.2)	.86
At-risk nonmain partner	270/510 (52.9)	135/252 (53.6)	135/258 (52.3)	.78
Unprotected sexual intercourse				
Unprotected vaginal/anal sex with any partner[a]	452/516 (87.6)	226/254 (89.0)	226/262 (86.3)	.35
Unprotected vaginal/anal sex with main partner[a]	390/511 (76.3)	201/252 (79.8)	189/259 (73.0)	.07
Unprotected vaginal/anal sex with nonmain partner[a]	248/513 (48.3)	119/252 (47.2)	129/261 (49.4)	.62
Unprotected vaginal/anal sex at last sexual intercourse[a]	404/509 (79.4)	206/251 (82.1)	198/258 (76.7)	.14
Unprotected vaginal/anal sex with at-risk partner at last sexual intercourse[a,b]	173/512 (33.8)	88/251 (35.1)	85/261 (32.6)	.55
Drug use				
Marijuana use[a]	409/518 (78.9)	198/256 (77.3)	211/262 (80.4)	.37
Other noninjection drug use[a]	256/519 (49.3)	124/256 (48.4)	132/263 (37.5)	.69
Injection drug use—ever used	41/519 (7.9)	19/256 (7.4)	22/263 (8.4)	.69
Injection drug use[a]	32/519 (6.2)	14/256 (5.5)	18/263 (6.8)	.52

Continued

Injection Drug Use

Few participants reported injection drug use at the 1-week (4/224 single-session intervention, 2/220 enhanced intervention), 12-week (7/194 single-session intervention, 5/207 enhanced intervention), or 24-week assessment (7/196 single-session intervention, 7/180 enhanced intervention). Given the low prevalence of injection drug use in both groups, outcome analyses were not performed.

Reincarceration

Reincarceration was common in both intervention groups—44% reported at 24 weeks that they had been in a jail or prison at least once since release. By contrast with the patterns observed for sexual risk, there was a significant difference between the single-session intervention and enhanced intervention groups for self-reported reincarceration previous to, but not after, the conclusion of the enhanced intervention. At 12 weeks, more men in the enhanced intervention group reported that they had been reincarcerated compared with the single-session intervention group (38.9% vs 26.9%; adjusted OR=2.60; 95% CI=1.09, 6.23). This difference was not significant at the 24-week assessment (49.1% enhanced intervention vs 39.8% single-session intervention; adjusted OR=1.19; 95% CI=0.81, 4.52).

Differences in self-reported reincarceration were qualified by an intervention group by site interaction that approached significance at 12 weeks (P=.061), and was not present at 24 weeks (P=.54). At 12 weeks, in California only, the enhanced intervention group was significantly more likely to report having been reincarcerated than the single-session intervention group (64.5% vs 27.9%, respectively; OR=12.26; 95% CI=2.58, 58.17). No significant differences in reincarceration rates between enhanced intervention and single-session intervention participants were observed in any of the other sites.

There was no significant difference between groups in the percentage of assessments that were conducted in jail or prison at either the 12-week (22.2% enhanced intervention vs 16.2% single-session intervention; adjusted OR=0.86; 95% CI=0.33, 2.29) or the 24-week assessment (31.5% enhanced intervention vs 23.0% single-session

TABLE 2—*Continued*

Ever tested for HIV	451/513 (87.9)	230/253 (90.9)	221/260 (85.0)	.04
Previous incarcerations—lifetime				
0	22/507 (4.3)	12/251 (4.8)	10/256 (3.9)	.71
1–3	123/507 (24.3)	61/251 (24.3)	62/256 (24.2)	
4–6	120/507 (23.7)	57/251 (22.7)	63/256 (24.6)	
7–9	102/507 (20.1)	56/251 (22.3)	46/256 (18.0)	
10 or more	140/507 (27.6)	65/251 (25.9)	75/256 (29.3)	

Note. GED = general equivalency diploma.
[a]During the 3 months before the current incarceration.
[b]Partner described by participant as having a history of injecting drug use, crack cocaine use, exchange of sex for money or drugs, sexually transmitted infection, HIV infection, or who currently has other sexual partners.

intervention; adjusted OR=2.22; 95% CI=0.71, 6.91). A significant intervention group by site interaction was present at 12 weeks ($P<.05$), but not at 24 weeks ($P=.86$). At 12 weeks, the enhanced intervention group in California was significantly more likely to have been assessed in jail or prison than the single-session intervention group (56.5% enhanced intervention vs 18.0% single-session intervention; adjusted OR=8.78; 95% CI=2.12, 36.34). No significant differences were observed in the other sites.

DISCUSSION

Project START demonstrated that a multisession community-reentry intervention can lead to lower rates of sexual risk behavior among young men who are released from prison. Significantly lower rates of unprotected intercourse were observed at 24 weeks for men assigned to the enhanced intervention compared with those assigned to the single-session intervention. These differences continued to be present even when differences in the amount of time since the last intervention contact were taken into account. This success is noteworthy given the difficulties inherent in working in correctional settings, including restricted access to participants, limited private space, negative attitudes toward prevention activities among some correctional staff, and restrictions on HIV-prevention materials in prison.[31]

Prerelease data from Project START support the need to provide HIV, STI, and hepatitis risk-reduction interventions to incarcerated men. The majority of men in both intervention groups reported unprotected intercourse before incarceration. Unprotected intercourse with main partners was reported by 76% of participants, and nearly half

TABLE 3—Postrelease Sexual Practices Reported by Scheduled Time of Postrelease Assessment for Single-Session Intervention (SSI) and Enhanced Intervention (EI) Groups, No. (%)

	1 Week			12 Weeks			24 Weeks			EI at 24 weeks vs SSI at 12 weeks
	SSI No./ Denominator, n = 226	EI No./ Denominator, n = 223	Adjusted OR[a] (95% CI)	SSI No./ Denominator, n = 198	EI No./ Denominator, n = 216	Adjusted OR[b] (95% CI)	SSI No./ Denominator, n = 213	EI No./ Denominator, n = 219	Adjusted OR[b] (95% CI)	Adjusted OR[b] (95% CI)
Unprotected vaginal/anal sex at last sexual intercourse	105/219 (47.9)	90/217 (41.5)	0.74 (0.48, 1.15)	128/181 (70.7)	123/203 (60.6)	0.57 (0.29, 1.13)	131/191 (68.6)	101/171 (59.1)	0.48 (0.24, 0.95)	0.45 (0.22, 0.91)
Unprotected vaginal/anal sex with any partner	114/223 (51.1)	95/218 (43.6)	0.64 (0.44, 1.04)	147/190 (77.4)	142/207 (68.6)	0.56 (0.26, 1.17)	151/193 (78.2)	122/179 (68.2)	0.40 (0.18, 0.88)	0.45 (0.20, 0.98)
Unprotected vaginal/anal sex with a main partner	86/219 (39.3)	82/217 (37.8)	0.99 (0.63, 1.54)	115/187 (61.5)	117/203 (57.6)	0.87 (0.40, 1.89)	126/191 (66.0)	94/173 (54.3)	0.30 (0.13, 0.71)	0.43 (0.19, 0.99)
Unprotected vaginal/anal sex with a nonmain partner	35/223 (15.7)	24/218 (11.0)	0.63 (0.33, 1.20)	64/188 (34.0)	58/207 (28.0)	0.62 (0.40, 1.89)	61/192 (31.8)	57/179 (31.8)	0.99 (0.50, 1.94)	0.73 (0.38, 1.40)
Unprotected vaginal/anal sex with at-risk partner at last sexual intercourse[c]	39/220 (17.7)	42/217 (19.4)	0.99 (0.58, 1.70)	61/182 (33.5)	51/203 (25.1)	0.53 (0.28, 1.02)	46/194 (23.7)	44/174 (25.3)	0.87 (0.41, 1.86)	0.42 (0.20, 0.90)

Note. OR = odds ratio; CI = confidence interval. Numbers for specific sexual practices may be lower than the total number of men interviewed at a given assessment because only sexual practices in the community were assessed. Questions about sexual practices were not asked of men who were continuously incarcerated during the follow-up period. Data are missing in only a small number of cases because a question was skipped or a participant declined to answer.
[a]Odds ratios estimated from a logistic model that included intervention group, site, covariates for days in community, and the outcome measured at the prerelease interview as well as 2-way arm by site interactions.
[b]Odds ratios estimated from a nonlinear mixed model that included intervention group, site, time (12 or 24 weeks), covariates for days in community, and the outcome measured at the prerelease interview as well as 2-way and 3-way interactions among arm, site, and time.
[c]Partner described by the participant as having a history of injecting drug use, crack cocaine use, exchange of sex for money or drugs, sexually transmitted infection, HIV infection, or who currently has other sexual partners.

(48%) had unprotected sexual intercourse with a nonmain partner. These rates of unprotected intercourse are of particular concern given that two thirds of participants believed that 1 or more of their partners had a risk factor for HIV, STI, or hepatitis. The rates of substance use observed in this sample represent another public health concern—49% of participants had used noninjection drugs during the 3 months before incarceration, and 8% had ever injected drugs. Together, these data support the need for a concerted public health effort to reduce the effects of risky sexual practices and substance abuse on the health of incarcerated young men and their sexual partners.

The enhanced intervention tested in this study addressed sexual risk within the context of competing issues affecting young men's ability to successfully reenter the community. These issues may limit the ability of at-risk persons to maintain safer sex practices, but few sexual risk–reduction interventions have addressed competing life issues. Exceptions include interventions for at-risk women[32] and injection drug users,[33] as well as prevention case management, which the Centers for Disease Control and Prevention endorses for high-risk populations with multiple needs.[26,27] Previous evaluations of case management interventions that addressed sexual risk either lacked a comparison group or found no difference in risk between those who received case management and those who did not.[27,34–36] The present findings contribute new evidence supporting the effectiveness of prevention case management and other individually tailored interventions that address sexual risk within the context of competing threats to health and well-being.

Although the enhanced intervention was associated with lower rates of sexual risk with all partners relative to the single-session intervention, the intervention effect was specific to sexual practices with main partners. This was an unexpected finding, given that other intervention trials have shown greater reductions in risk with nonmain partners than with main partners.[37–39] The lower rates of unprotected sexual intercourse with main partners in the enhanced intervention group may have substantial public health benefits. Given the increased burden of STIs among incarcerated men, reductions in risk behavior protect the health of these men's sexual partners. They also protect men with high-risk partners. Before incarceration, a third of study participants had a main partner who was described as having 1 or more risks for HIV, hepatitis, or other STIs.

The present findings are consistent with previous research, which showed that unprotected intercourse is more common with main than with nonmain partners.[38,40,41] The ability of the enhanced intervention to differentially motivate behavior change with main, but not nonmain partners, may be explained in part by the relatively low rates of unprotected intercourse with nonmain partners reported at prerelease and postrelease assessments. These rates were notably lower at follow-up in both the enhanced intervention and single-session intervention groups, suggesting that they may have been affected by potential influences that were common to both groups (e.g., HIV testing or other prevention services received during incarceration, the single-session intervention, free condoms).

It is unlikely that the between-group difference in self-reported reincarceration at 12 weeks was caused by the enhanced intervention. In previous studies, behavioral interventions and prerelease planning with follow-up after release have reduced reincarceration.[17,42] Significant differences in reincarceration rates were observed in only 1 of 4 sites, suggesting that this finding may be an artifact of site-specific differences in follow-up procedures. In this site, a community-based organization that works within local prisons (and is near the prison) was responsible for conducting intervention activities and following participants assigned to the enhanced intervention through the 12-week assessment. A university-based team with experience tracing community-based samples followed the single-session intervention participants. This team also was responsible for following the enhanced intervention participants *after* the 12-week assessment. The community-based organization was more familiar with prison personnel and procedures, which may have made it easier for its staff to gain access to men who were reincarcerated. This explanation is consistent with the differences in reincarceration that were observed at 12 weeks, but not at 24 weeks, when both intervention groups were followed by the university-based team.

A number of limitations should be noted. First, the enhanced intervention was compared with a single-session intervention that controlled for experimental demand but not attention, which raises the possibility that increased staff contact alone could explain differences between the enhanced intervention and single-session intervention groups. Second, the enhanced intervention group was followed for only 12 weeks after the last intervention session; thus, it is not known whether behavior changes were sustained over a longer period of time. Third, data on the risk characteristics of sexual partners were not available for all individual partners. Thus, we could not assess the number of risky partners or condom use specifically with these partners. Finally, it is not known whether results are generalizable to other incarcerated populations.

These limitations are offset by a number of strengths. The use of nonbiased assignment, the comparability of intervention groups at the prerelease assessment, high retention rates for follow-up assessments, and the lack of differential attrition bolster the study's internal reliability. The multisite nature of the project, low refusal rates, and nonbiased selection of research participants strengthen the external reliability of study findings.

Efforts to reduce HIV, hepatitis, and other STIs among incarcerated men can make an important contribution to community health, but the potential benefits of such efforts have not been fully realized.[19] The enhanced intervention tested in Project START provides an evidence-based strategy for reducing sexual risk and should be considered for use with other young men in correctional settings. Given the disproportionate burden of disease in this population, there is an urgent need for health departments and community-based organizations to work with correctional institutions to improve the health of these men, their partners, and their communities. ■

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This article was accepted October 31, 2005.

Note. *The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention.*

Contributors

R.J. Wolitski led the writing group for this article. Members of the Project START Study Group worked collaboratively to design the study, develop intervention and assessment materials, plan statistical analyses, and interpret study findings.

Human Participant Protection

All research activities were approved by institutional review boards at the Centers for Disease Control and Prevention (CDC) and each of the institutions funded under the cooperative agreement. As an additional safeguard, the project received a federal certificate of confidentiality.

Acknowledgments

This study was funded by the CDC through cooperative agreements with Jackson State University (CCU414879), Medical College of Wisconsin (CCU514804), Miriam Hospital (CCU114812), and the University of California, San Francisco (CCU914806).

The Project START Study Group consisted of principal investigators, investigators, and research staff from: Brown Medical School/Miriam Hospital, Providence, RI: Kathleen Morrow (principal investigator), Timothy Flanigan (principal investigator), Christine Fitzgerald, Jill Nealey-Moore, Deborah Kacanek, Ricky Lugo, Daniel Strother, Melissa Dispigno, Jaclynn Jurpewski, Michael Patterson, Jacki Hecht, Kellie Green, Gina Best, Meghan Woods, and Stephanie Paton; Centerforce, San Rafael, Calif: Barry Zack (principal investigator), Katie Kramer, Carolyn King, Annette Lerma, and Merjo Roca; CDC: Robin MacGowan (principal investigator), Richard Wolitski (principal investigator), Lisa Belcher, Andrew Margolis, Susan Moss, Ann O'Leary, John Williamson, Achintya Dey, and Kashif Iqbal; Jackson State University, Jackson, Miss: John Askew (principal investigator), Marty Fortenberry, Daryl Johnson, Moriba Lumumba, and Jerry Vardaman; Medical College of Wisconsin, Milwaukee: David Wyatt Seal (principal investigator), Tim McAuliffe, Barbara Reed, Rodney Simms, Jessica Berzowski, Don Bourque, Jeff Buckles, Mark Charles, Melanie Krapf, Kelly Malen, Ricardo Reed, and Noel Rosado; University of Alaska Anchorage: Gloria Eldridge (principal investigator); University of California, San Francisco: Olga Grinstead (principal investigator), Diane Binson, Bonnie Faigeles, Steve Gregorich, William Woods, Anthony King, Kathleen McCartney, and Jax McKee-Shapter; University of Wisconsin Medical School, Madison: James Sosman (principal investigator). Members of the writing group were: John Askew, Diane Binson, Gloria Eldridge, Timothy Flanigan, Olga Grinstead, Steve Gregorich, Robin MacGowan, Andrew Margolis, Kathleen Morrow, Susan Moss, David Wyatt Seal, James Sosman, and Barry Zack. Susan Moss and Steve Gregorich conducted the statistical analyses with input from the principal investigators and the data analysis subcommittee (Binson, Margolis, McAuliffe, Nealy-Moore, and Williamson).

The group thanks the study participants and the departments of correction in each of the states for their many contributions to the study. We would also like to acknowledge James M. Fitterling, Juarlyn Gaiter, Julie Lifshay, Mary McFarlane, and Raymond Niaura for contributions to the early development of this study.

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Science to Community

Project START: HIV/STD/hepatitis prevention for young men being released from prison

Prevention #12 July 2004

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Main Findings

- **Project START's Enhanced Intervention was successful: men in the Enhanced Intervention had lower rates of sexual risk 24 weeks after release compared to men in the Single Session Intervention.**
- Young men leaving prison are at risk for HIV, STD and hepatitis.
- Many young men leaving prison engage in unprotected sexual activity immediately after release from prison.
- Young men leaving prison are also at high risk for returning to prison.
- It is feasible to maintain contact with young men after they have left prison when there are sufficient resources for tracing.

Background

By the end of 2002, over 2 million adults were incarcerated in the US, and 93% of those were men. African Americans and Latinos were incarcerated at greater rates than Whites in the US, 7.6 times greater for African Americans and 2.6 times greater for Latinos. Nearly 40% of incarcerated men were under the age of 30. Young men of color are at high risk of incarceration and the health problems related to incarceration.

These young men also are our neighbors, frequently passing in and out of jail and prison and returning back to the community. Men who are incarcerated have disproportionate rates of HIV, sexually transmitted diseases (STDs) and hepatitis. Rates of HIV are 8-10 times higher for incarcerated persons than for the general US population; hepatitis C rates are 9-10 times higher, and STD rates among men entering jails are as high as 35%.

Men leaving prison face numerous challenges that may impede their ability to protect themselves against these diseases. Men often must re-establish relationships, find employment and housing and deal with addictions and mental health issues. Prisons present a unique opportunity for HIV/STD education and skills building to help men avoid risk after their release from prison.

Project START history

There are few services for men leaving prison and little research on HIV/STD prevention programs for men leaving prison. Recognizing the need to develop and test interventions specifically for incarcerated men, the Centers for Disease Control and Prevention (CDC) funded Project START to develop an HIV, STD and hepatitis prevention program for young men aged 18-29 who are leaving prison and to test the effectiveness of the interventions in reducing sexual risk after leaving prison. Study sites at state prisons were selected in four states: California, Mississippi, Rhode Island and Wisconsin.

The first three years of the study were dedicated to formative research. During the formative research period, all investigators engaged in a process of intervention development to create a Single Session Intervention (SSI) and Enhanced Intervention (EI). The intervention was implemented through a behavioral trial where the SSI and EI were compared and participants were followed for six months after their initial release from prison.

How is this project unique?

- The interventions were designed specifically for young men (18-29 years) leaving prison.
- The EI started pre-release and continued post-release.
- The interventions were based on extensive formative research with incarcerated men and providers both inside and outside of prison.
- The interventions focused on sexual risk, with reincarceration as a secondary outcome.

Formative Research

Our formative research included three studies. First, we conducted qualitative research with 71 service providers working inside the prison and 97 working outside the prison. Providers inside prisons included wardens, correctional officers, teachers, nurses, physician assistants and chief medical officers. Providers outside the prison included staff from various services including HIV/STD, homeless, halfway house, medical and mental health, substance use, parole officers, faith-based personnel and vocational counselors.

Second, we conducted qualitative and quantitative research with 106 men, recruiting them while incarcerated and conducting interviews prior to release and at 1, 4, 12 and 24 weeks after release.

Third, we collected urine and blood samples from these men when they had been out of prison for 24

weeks to assess the feasibility of testing for STD and hepatitis among this population.

Formative Research Key Findings

Provider perceptions of risk

- Providers believed most men were sexually active immediately after release. They did not believe abstinence was an effective intervention outcome for sexual behavior.
- The most likely reason for HIV/STD risk was believed to be sexual activity combined with drug use.
- Reasons for sexual risk behavior included: "making up for lost time," "being a man," degree of HIV/STD knowledge and vulnerability, desire to escape and lack of future orientation.
- Peers, partners and family had a strong influence on risk behavior, both positively and negatively.
- Factors that could help reduce risk were: stable housing, availability of jobs and economic self sufficiency; and positive community support including needle exchange services, drug treatment and condom distribution.

Conclusion: Providers believed that an intervention that focuses directly on sexual risk reduction in the context of men's lives as they reenter the community after release was most likely to be effective.

Risk behavior of men leaving prison

- Men engaged in unprotected sexual activity soon after release from prison, with 51% engaging in unprotected sex on the first day and 86% by the end of the first week.
- Rates of reincarceration were high: 72% had at least 4 prior incarcerations and 40% spent at least one day in prison or jail in the 24 weeks since their initial release.
- One-third of the young men reported they had ever been diagnosed with an STD, 2% were hepatitis C positive and 2% were HIV+.
- Most men had primary committed female partners. Only 8% consistently used condoms with their primary partners prior to incarceration.
- 1% reported sex with men.
- Almost 10% reported ever injecting drugs.
- After release, two-thirds used alcohol and half used marijuana, even though many were on probation or parole.
- Half of the men were unemployed prior to incarceration, 80% at 1 week post-release and 40% at 24 weeks post-release.

Conclusion: Young men faced many challenges after release. Programs should be comprehensive by focusing on HIV/STD and hepatitis risk as well as the context of risk and immediate needs of men post-incarceration.

Feasibility of STD and hepatitis testing

- Collecting specimens and providing results is feasible. Monetary incentives can increase participation.
- Of 33 men tested for STDs and hepatitis, 8 (24%) had Chlamydia, Trichomoniasis, HBV or HCV.

Conclusion: STDs are common among these men. Programs for men who have been incarcerated should be aware that many men acquire infections after release from custody and should be referred for screening, treatment and vaccination for STDs.

Behavioral Intervention Trial

Development

The intervention was designed based on the formative research we conducted with prison service providers and incarcerated men. Formative research helped us understand what the differences were in each state's prison system, what would work within the structure of the prisons and whether it was possible to recruit men in prison and maintain contact with them after release.

We formed a committee with representatives from each research site to develop the intervention and intervention materials, pilot-test the intervention and refine the intervention prior to the randomized behavioral trial. We also developed referral lists and community resource guides for each site.

We hired interventionists and interviewers who had experience working with incarcerated populations. Each project staff member had to be cleared by the state's Department of Corrections. We held two cross-site trainings prior to implementation. Intervention staff received follow-up trainings and regular supervisory meetings at each site.

Process

The Project START intervention trial involved 522 young men between the ages of 18 and 29 (52% African-American, 23% White, 14% Hispanic, 12% other). Men were recruited from eight state prisons in four states: California,

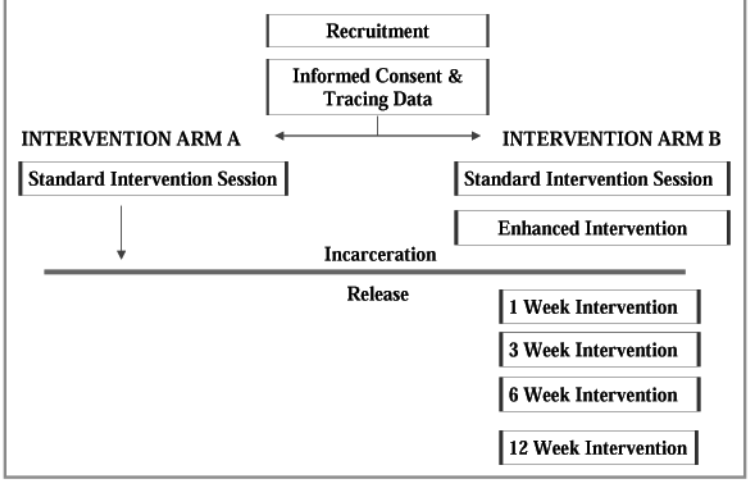
Sidebar 1: SSI composite case example

Joe Jones was recruited as he neared the end of his three-year sentence. He was 21 years old, unmarried and planned to return to live with his parents in a rural area of the state. Due to his recruitment date, he was assigned to the SSI. In the intervention session Joe worked with the interventionist to review his knowledge about HIV, STDs and hepatitis and to identify his own risk (risk assessment). After this review Joe and the interventionist agreed that his primary risk was through unprotected vaginal and anal intercourse with casual female partners, particularly when he had been drinking or using drugs. The interventionist worked with Joe to identify barriers to condom use and to make a specific behavioral plan to have condoms available when going out to meet women. Joe acknowledged that his alcohol and drug use contributed to his risk and although he was skeptical about needing alcohol or drug treatment services, he accepted referrals from the interventionist. At the end of the session, Joe received a written copy of his goals and risk reduction plan. At 24 weeks post-release, Joe reported using condoms more consistently.

Mississippi, Rhode Island and Wisconsin. We used non-biased assignment to either an SSI pre-release or an EI. The EI included the two pre-release sessions and four individual sessions post-release. See Diagram 1 for the intervention design.

Although men were not paid to attend intervention sessions, they were provided with transportation and/or child/elder care reimbursement up to $10 if applicable. Men were also offered free condoms and resource and educational materials at all post-release sessions that did not occur in a prison or jail. Participants were paid for completing each assessment session and were provided with pagers and voicemail to assist project staff in maintaining contact after release.

Diagram 1: Intervention design



The intervention was based on the following conceptual framework:

Harm Reduction: reducing harmful consequences to participant and others.

Problem Solving: generating possible solutions, determining consequences, choosing best solution, creating a realistic plan of action.

Motivational Enhancement: enhancing motivation for behavior change through a client-centered but directive approach.

Enhancing Access to Services: facilitating referral and reducing barriers to use of existing community services.

Single Session Intervention (SSI)

This intervention took place about 2 weeks prior to release and lasted 60-90 minutes. Young men met individually with a trained interventionist. Together, they assessed the young man's HIV/STD/hepatitis knowledge and risks, then devised a personalized risk reduction plan. See Sidebar 1 for a composite case example.

Enhanced Intervention (EI)

Two sessions of this multiple-session intervention took place in prison prior to release, and four sessions were planned after release at 1, 3, 6 and 12 weeks post-release. The first in-prison session was the same as the SSI. The second in-prison session focused on the participant's needs after release and included assessment, planning, problem-solving, and facilitated referrals for housing, employment, financial problems, social relationships, substance use and mental health treatment, legal problems and avoiding reincarceration. Together, they created a participant plan.

The post-release sessions continued the plan developed during the in-prison session. In each session, the participant and interventionist assessed previous plans and goals, problem-solved difficulties, and focused on new goals identified by the participant. Each session included a review and update of the HIV/STD/hepatitis risk reduction plan developed in the first session. All sessions ended with an updated plan that addressed post-release needs and used existing community resources where available. See sidebar 2 for a composite case example for the EI.

Evaluation

Young men answered survey questions to assess risk behavior prior to release and at 1, 12 and 24-weeks after release. Retention was excellent, with 83% of men completing the 24-week follow-up assessment. In three sites (MI, RI and WI), assessments were conducted using audio-computer-assisted self-interview (A-CASI) technology. In one site (CA), the use of laptop computers for research was prohibited in the prison and all assessments were conducted face-to-face. Young men were reimbursed for participating in the evaluation, with the amount varying by cost of living in each state ($180-$200 if all assessments were completed).

Some post-release assessments were conducted by telephone when it was not possible to conduct an in-person assessment. Assessments were conducted in prison for participants who were reincarcerated and at a variety of community sites for participants who were released. In-prison assessments did not include questions about sexual behavior or substance use that occurred during that incarceration. For each participant, one staff member delivered the intervention and a second staff member conducted the assessments.

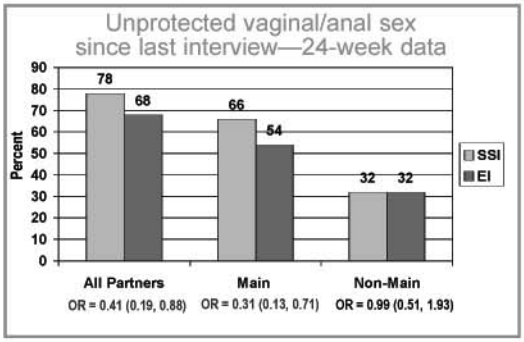
Sidebar 2: EI composite case example

John Smith was recruited 60 days prior to his release from a two-year sentence. He was 27 years old, unmarried and planning to return to live with a friend after release. Due to his recruitment date, he was assigned to the enhanced intervention. In the first intervention session Joe worked with the interventionist to review his knowledge about HIV, STDs and hepatitis and to identify his own risk (risk assessment). John and the interventionist agreed that his primary risk was through unprotected vaginal intercourse with the mother of his two children who was a regular but not committed sexual partner. They developed a plan to support John in introducing condoms into this relationship. In the second session prior to release John worked with the interventionist to define broader post-release goals. In this process John prioritized finding work and realized that renewing his drivers license and developing a resume were the first steps toward this goal. He developed a step-by-step plan toward these goals, discussed his immediate post-release plans and scheduled a time and place to meet for the first post-release session. John met with the interventionist three times post-release. He missed his third post-release session when he was briefly re-incarcerated due to a parole violation. By the final post-release session John has enrolled in an employment development program and had successfully negotiated condom use with his regular partner.

Intervention Key Findings

Project START is at the beginning of its analysis stage and these findings are just the beginning. We are continuing to analyze our results and expect to have more detailed data on sexual risk behavior and reincarceration by the end of 2004.

Reduction in sexual risk behavior



- At 24 weeks, men in the EI (68%) were significantly less likely than men in the SSI (78%) to report unprotected vaginal or anal sex with all partners since the last interview. This effect was driven by differences in risk with main partners (as opposed to non-main partners).
- Many men had main and non-main partners who were themselves at increased risk of HIV/STDs or hepatitis.

Conclusion: These men were at considerable risk for sexually transmitted infections before and after incarceration. Greater risk reduction occurred with main partners than with non-main partners, protecting not only the men but their partners as well. The Project START intervention was effective in reducing sexual risk behavior.

Lessons Learned - Challenges of Prison Research

Feasibility of Research in Prison Systems

- Working in prisons presents numerous challenges such as: postponing work during lock downs, needing clearance by the Department of Corrections for all project staff, locating an appropriately private space for interviews and interventions and complying with prison regulations.
- Despite all this, Project START conducted formative research, developed interventions, recruited over 500 men at 8 prisons across 4 states, conducted interventions both inside and outside the prison and had excellent retention rates.

Needs of Incarcerated Men

- HIV/STD intervention programs for incarcerated men who are being released should address strategies to reduce risk behaviors associated with HIV/STD transmission, and other needs like housing, employment, mental health issues and reintegration with family.
- These intervention programs should cover the period from pre-release to reentry into the community.
- The first weeks post-release are crucial. Risk behavior resumes soon after release.
- Programs need to go beyond simply providing community referrals, to making facilitated referrals (locate "friendly" agencies and staff, call the agency and make the appointment, follow-up to make sure appointment is kept).

Recruitment and Retention

- Recruitment and retention for research studies is feasible if you learn the prison system and work within it.
- It is possible to maintain contact with men post-incarceration. It is resource-intensive and requires dedicated, well-trained staff.
- Young men experience high rates of reincarceration. Programs should develop relationships with correctional institutions that allow them to maintain contact with participants who are reincarcerated

Selected Papers and Presentations

Grinstead O, Seal DW, Wolitski R, et al. HIV and STD testing in prisons: perspectives of in-prison service providers. *AIDS Education and Prevention*. 2003;15(6):547-560.

MacGowan RJ, Margolis AD, Gaiter J, et al. Predictors of risky sex of young men after release from prison. *International Journal of STD & AIDS*. 2003; 14(8):519-523.

Seal DW, Margolis AD, Sosman J, et al. HIV and STD Risk Behavior among 18-25 Year Old Men Released From US Prisons: Provider Perspectives. *AIDS & Behavior*. 2003;7:131-141.

Seal DW, Belcher L, Morrow K, et al. A qualitative study of substance use and sexual behavior among 18-29 year old men while incarcerated in the US. *Health Education & Behavior*. (in press)

Sosman J, MacGowan RJ, Margolis AD, et al. The feasibility of STD and hepatitis screening among 18-29 year old men recently released from prison. *International Journal of STD & AIDS*. (in press)

Wolitski RJ. Project START reduces HIV risk among prisoners after release. Presented at the XV International Conference on AIDS, Bangkok, Thailand. July 2004. Abstract #WeOrC1296.

Project web site

www.cdc.gov/hiv/projects/projectSTART

Copies of this report are available at
www.caps.ucsf.edu/publications/STARTS2C.pdf

The ABCs of Smart Behavior

To avoid or reduce the risk for HIV

A stands for abstinence.

B stands for being faithful to a single sexual partner.

C stands for using condoms consistently and correctly.

CENTERS FOR DISEASE CONTROL AND PREVENTION

For more information:
CDC's National Prevention Information Network
(800) 458-5231 or www.cdcnpin.org

CDC National STD/HIV Hotline
(800) 227-8922 or (800) 342-2437
En Espanol (800) 344-7432
www.cdc.gov/std

Fact Sheet for Public Health Personnel:

Male Latex Condoms and Sexually Transmitted Diseases

In June 2000, the National Institutes of Health (NIH), in collaboration with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the United States Agency for International Development (USAID), convened a workshop to evaluate the published evidence establishing the effectiveness of latex male condoms in preventing STDs, including HIV. A summary report from that workshop was completed in July 2001 (http://www.niaid.nih.gov/dmid/stds/condomreport.pdf). This fact sheet is based on the NIH workshop report and additional studies that were not reviewed in that report or were published subsequent to the workshop (see "Condom Effectiveness" for additional references). Most epidemiologic studies comparing rates of STD transmission between condom users and non-users focus on penile-vaginal intercourse.

Recommendations concerning the male latex condom and the prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are based on information about how different STDs are transmitted, the physical properties of condoms, the anatomic coverage or protection that condoms provide, and epidemiologic studies of condom use and STD risk.

The surest way to avoid transmission of sexually transmitted diseases is to abstain from sexual intercourse, or to be in a long-term mutually monogamous relationship with a partner who has been tested and you know is uninfected.

For persons whose sexual behaviors place them at risk for STDs, correct and consistent use of the male latex condom can reduce the risk of STD transmission. However, no protective method is 100 percent effective, and condom use cannot guarantee absolute protection against any STD. Furthermore, condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV and other STDs. In order to achieve the protective effect of condoms, they must be used correctly and consistently. Incorrect use can lead to condom slippage or breakage, thus diminishing their protective effect. Inconsistent use, e.g., failure to use condoms with every act of

intercourse, can lead to STD transmission because transmission can occur with a single act of intercourse.

While condom use has been associated with a lower risk of cervical cancer, the use of condoms should not be a substitute for routine screening with Pap smears to detect and prevent cervical cancer.

Sexually Transmitted Diseases, Including HIV

Sexually transmitted diseases, including HIV
Latex condoms, when used consistently and correctly, are highly effective in preventing transmission of HIV, the virus that causes AIDS. In addition, correct and consistent use of latex condoms can reduce the risk of other sexually transmitted diseases (STDs), including discharge and genital ulcer diseases. While the effect of condoms in preventing human papillomavirus (HPV) infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

There are two primary ways that STDs can be transmitted. Human immunodeficiency virus (HIV), as well as gonorrhea, chlamydia, and trichomoniasis – the discharge diseases – are transmitted when infected semen or vaginal fluids contact mucosal surfaces (e.g., the male urethra, the vagina or cervix). In contrast, genital ulcer diseases – genital herpes, syphilis, and chancroid – and human papillomavirus are primarily transmitted through contact with infected skin or mucosal surfaces.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Condoms can be expected to provide different levels of protection for various sexually transmitted diseases, depending on differences in how the diseases are transmitted. Because condoms block the discharge of semen or protect the male urethra against exposure to vaginal secretions, a greater level of protection is provided for the discharge diseases. A lesser degree of protection is provided for the genital ulcer diseases or HPV because these infections may be transmitted by exposure to areas, e.g., infected skin or mucosal surfaces, that are not covered or protected by the condom.

Epidemiologic studies seek to measure the protective effect of condoms by comparing rates of STDs between condom users and nonusers in real-life settings. Developing such measures of condom effectiveness is challenging. Because these studies involve private behaviors that investigators cannot observe directly, it is difficult to determine

accurately whether an individual is a condom user or whether condoms are used consistently and correctly. Likewise, it can be difficult to determine the level of exposure to STDs among study participants. These problems are often compounded in studies that employ a "retrospective" design, e.g., studies that measure behaviors and risks in the past.

As a result, observed measures of condom effectiveness may be inaccurate. Most epidemiologic studies of STDs, other than HIV, are characterized by these methodological limitations, and thus, the results across them vary widely--ranging from demonstrating no protection to demonstrating substantial protection associated with condom use. This inconclusiveness of epidemiologic data about condom effectiveness indicates that more research is needed--not that latex condoms do not work. For HIV infection, unlike other STDs, a number of carefully conducted studies, employing more rigorous methods and measures, have demonstrated that consistent condom use is a highly effective means of preventing HIV transmission.

Another type of epidemiologic study involves examination of STD rates in populations rather than individuals. Such studies have demonstrated that when condom use increases within population groups, rates of STDs decline in these groups. Other studies have examined the relationship between condom use and the complications of sexually transmitted infections. For example, condom use has been associated with a decreased risk of cervical cancer – an HPV associated disease.

The following includes specific information for HIV, discharge diseases, genital ulcer diseases and human papillomavirus, including information on laboratory studies, the theoretical basis for protection and epidemiologic studies.

HIV / AIDS

HIV, the virus that causes AIDS
Latex condoms, when used consistently and correctly, are highly effective in preventing the sexual transmission of HIV, the virus that causes AIDS.

AIDS is, by far, the most deadly sexually transmitted disease, and considerably more scientific evidence exists regarding condom effectiveness for prevention of HIV infection than for other STDs. The body of research on the effectiveness of latex condoms in preventing sexual transmission of HIV is both comprehensive and conclusive. In fact, the ability of latex condoms to prevent transmission of HIV has been scientifically established in "real-life" studies of sexually active couples as well as in laboratory studies.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Latex condoms cover the penis and provide an effective barrier to exposure to secretions such as semen and vaginal fluids, blocking the pathway of sexual transmission of HIV infection.

Epidemiologic studies that are conducted in real-life settings, where one partner is infected with HIV and the other partner is not, demonstrate conclusively that the consistent use of latex condoms provides a high degree of protection.

Discharge Diseases, Including Gonorrhea, Chlamydia, and Trichomoniasis

Discharge diseases, other than HIV
Latex condoms, when used consistently and correctly, can reduce the risk of transmission of gonorrhea, chlamydia, and trichomoniasis.

Gonorrhea, chlamydia, and trichomoniasis are termed discharge diseases because they are sexually transmitted by genital secretions, such as semen or vaginal fluids. HIV is also transmitted by genital secretions.

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. The physical properties of latex condoms protect against discharge diseases such as gonorrhea, chlamydia, and trichomoniasis, by providing a barrier to the genital secretions that transmit STD-causing organisms.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of chlamydia, gonorrhea and trichomoniasis. However, some other epidemiologic studies show little or no protection against these infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the discharge diseases. More research is needed to assess the degree of protection latex condoms provide for discharge diseases, other than HIV.

Genital Ulcer Diseases and Human Papillomavirus

Genital ulcer diseases and HPV infections
Genital ulcer diseases and HPV infections can occur in both male or female genital areas that are covered or protected by a latex condom, as well as in areas that are not covered. Correct and consistent use of latex condoms can reduce the risk of genital herpes, syphilis, and chancroid only when the infected area or site of potential exposure is protected. While the effect of condoms in preventing human papillomavirus infection is unknown, condom use has been associated with a lower rate of cervical cancer, an HPV-associated disease.

Genital ulcer diseases include genital herpes, syphilis, and chancroid. These diseases are transmitted primarily through "skin-to-skin" contact from sores/ulcers or infected skin that looks normal. HPV infections are transmitted through contact with infected genital skin or mucosal surfaces/fluids. Genital ulcer diseases and HPV infection can occur in male or female genital areas that are, or are not, covered (protected by the condom).

Laboratory studies have demonstrated that latex condoms provide an essentially impermeable barrier to particles the size of STD pathogens.

Theoretical basis for protection. Protection against genital ulcer diseases and HPV depends on the site of the sore/ulcer or infection. Latex condoms can only protect against transmission when the ulcers or infections are in genital areas that are covered or protected by the condom. Thus, consistent and correct use of latex condoms would be expected to protect against transmission of genital ulcer diseases and HPV in some, but not all, instances.

Epidemiologic studies that compare infection rates among condom users and nonusers provide evidence that latex condoms can protect against the transmission of syphilis and genital herpes. However, some other epidemiologic studies show little or no protection. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against the genital ulcer diseases. No conclusive studies have specifically addressed the transmission of chancroid and condom use, although several studies have documented a reduced risk of genital ulcers in settings where chancroid is a leading cause of genital ulcers. More research is needed to assess the degree of protection latex condoms provide for the genital ulcer diseases.

While some epidemiologic studies have demonstrated lower rates of HPV infection among condom users, most have not. It is particularly difficult to study the relationship between condom use and HPV infection because HPV infection is often intermittently detectable and because it is difficult to assess the frequency of either existing or new

infections. Many of the available epidemiologic studies were not designed or conducted in ways that allow for accurate measurement of condom effectiveness against HPV infection.

A number of studies, however, do show an association between condom use and a reduced risk of HPV-associated diseases, including genital warts, cervical dysplasia and cervical cancer. The reason for lower rates of cervical cancer among condom users observed in some studies is unknown. HPV infection is believed to be required, but not by itself sufficient, for cervical cancer to occur. Co-infections with other STDs may be a factor in increasing the likelihood that HPV infection will lead to cervical cancer. More research is needed to assess the degree of protection latex condoms provide for both HPV infection and HPV-associated disease, such as cervical cancer.

Department of Health and Human Services

For additional information on condom effectiveness, contact
CDC's National Prevention Information Network
(800) 458-5231 or **www.cdcnpin.org**

CONTENT OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS

Interim Revisions June 1992

1. Basic Principles

Controlling the spread of HIV infection and AIDS requires the promotion of individual behaviors that eliminate or reduce the risk of acquiring and spreading the virus. Messages must be provided to the public that emphasize the ways by which individuals can fully protect themselves from acquiring the virus. These methods include abstinence from the illegal use of IV drugs and from sexual intercourse except in a mutually monogamous relationship with an uninfected partner. For those individuals who do not or cannot cease risky behavior, methods of reducing their risk of acquiring or spreading the virus must also be communicated. Such messages can be controversial. These principles are intended to provide guidance for the development and use of educational materials, and to require the establishment of Program Review Panels to consider the appropriateness of messages designed to communicate with various groups.

a. Written materials (e.g., pamphlets, brochures, fliers), audio visual materials (e.g., motion pictures and video tapes), and pictorials (e.g., posters and similar educational materialsusing photographs, slides, drawings, or paintings) should use terms, descriptors, or displays necessary for the intended audience to understand dangerous behaviors and explain less risky practices concerning HIV transmission.

2. Written materials, audiovisual materials, and pictorials should be reviewed by Program Review Panels consistent with the provisions of Section 2500 (b), (c), and (d) of the Public Health Service Act, 42 U.S.C. Section 300ee(b), (c), and (d), as follows:

"SEC. 2500. USE OF FUNDS.

(b) CONTENTS OF PROGRAMS. - All programs of education and information receiving funds under this title shall include information about the harmful effects of promiscuous sexual activity and intravenous substance abuse, and the benefits of abstaining from such activities.

(c) LIMITATION. - None of the funds appropriated to carry out this title may be used to provide education or information designed to promote or encourage, directly, homosexual or heterosexual sexual activity or intravenous substance abuse.

(d) CONSTRUCTION. - Subsection (c) may not be construed to restrict the ability of an education program that includes the information required in subsection (b) to provide accurate information about various means to reduce an individual's risk of exposure to, or to transmission of, the etiologic agent for acquired immune deficiency syndrome, provided that any informational materials used are not obscene."

c. Educational sessions should not include activities in which attendees participate in sexually suggestive physical contact or actual sexual practices.

d. Messages provided to young people in schools and in other settings should be guided by the principles contained in "Guidelines for Effective School Health Education to Prevent the Spread of AIDS" (MMWR 1988;37 [suppl. no. S-2]).

2. Program Review Panel

a. Each recipient will be required to establish or identify a Program Review Panel to review and approve all written materials, pictorials, audiovisuals, questionnaires or survey instruments, and proposed educational group

session activities to be used under the project plan. This requirement applies regardless of whether the applicant plans to conduct the total program activities or plans to have part of them conducted through other organization (s) and whether program activities involve creating unique materials or using/distributing modified or intact materials already developed by others. Whenever feasible, CDC funded community-based organizations are encouraged to use a Program Review Panel established by a health department or another CDC-funded organization rather than establish their own panel. The Surgeon General's Report on Acquired Immune Deficiency Syndrome (October 1986) and CDC-developed materials do not need to be reviewed by the panel unless such review is deemed appropriate by the recipient. Members of a Program Review Panel should:

(1) Understand how HIV is and is not transmitted; and

(2) Understand the epidemiology and extent of the HIV/AIDS problem in the local population and the specific audiences for which materials are intended.

2. The Program Review Panel will be guided by the CDC Basic Principles (in the previous section) in conducting such reviews. The panel is authorized to review materials only and is not empowered either to evaluate the proposal as a whole or to replace any other internal review panel or procedure of the recipient organization or local governmental jurisdiction.

3. Applicants for CDC assistance will be required to include in their applications the following:

   (1) Identification of a panel of no less than five persons which represent a reasonable cross-section of the general population. Since Program Review Panels review materials for many intended audiences, no single intended audience shall predominate the composition of the Program Review panel, except as provided in subsection (d) below. In addition:

   (a) Panels which review materials intended for a specific audience should draw upon the expertise of individuals who can represent cultural sensitivities and language of the intended audience either through representation on the panels or as consultants to the panels.

   (b) The composition of Program Review Panels, except for panels reviewing materials for school-based populations, must include an employee of a State or local health department with appropriate expertise in the area under consideration who is designated by the health department to represent the department on the panel. If such an employee is not available, an individual with appropriate expertise, designated by the health department to represent the agency in this matter, must serve as a member of the panel.

   (c) Panels which review materials for use with school-based populations should include representatives of groups such as teachers, school administrators, parents, and students.

   (d) Panels reviewing materials intended for racial and ethnic minority populations must comply with the terms of (a), (b), and (c), above. However, membership of the Program Review Panel may be drawn predominately from such racial and ethnic populations.

   (2) A letter or memorandum from the proposed project director, countersigned by a responsible business official, which includes:

   (a) Concurrence with this guidance and assurance that its provisions will be observed;

   (b) The identity of proposed members of the Program Review Panel, including their names, occupations, and any organizational affiliations that were considered in their selection for the panel.

4. CDC-funded organizations that undertake program plans in other than school-based populations which are national, regional (multi state), or statewide in scope, or that plan to distribute materials as described above to other organizations on a national, regional, or statewide basis, must establish a single Program Review Panel to fulfill this requirement. Such national/regional/State panels must include as a member an employee of a State or local health department, or an appropriate designated representative of such department, consistent with the provisions of Section 2.c.(1). Materials reviewed by such a single (national, regional, or state) Program Review Panel do not need to be reviewed locally unless such review is deemed appropriate by the local organization planning to use or distribute the materials. Such national/regional/State organization must adopt a national/regional/statewide standard when applying Basic Principles 1.a. and 1.b.

5. When a cooperative agreement/grant is awarded, the recipient will:

   (1) Convene the Program Review Panel and present for its assessment copies of written materials, pictorials, and audiovisuals proposed to be used;

   (2) Provide for assessment by the Program Review Panel text, scripts, or detailed descriptions for written materials, pictorials, or audiovisuals which are under development;

   (3) Prior to expenditure of funds related to the ultimate program use of these materials, assure that its project files contain a statement(s) signed by the Program Review Panel specifying the vote for approval or disapproval for each proposed item submitted to the panel; and

   (4) Provide to CDC in regular progress reports signed statement(s) of the chairperson of the Program Review Panel specifying the vote for approval or disapproval for each proposed item that is subject to this guidance.

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MMWR Weekly

May 10, 2002 / 51(18);389-392

Nonoxynol-9 Spermicide Contraception Use --- United States, 1999

Most women in the United States with human immunodeficiency virus (HIV) become infected through sexual transmission, and a woman's choice of contraception can affect her risk for HIV transmission during sexual contact with an infected partner. Most contraceptives do not protect against transmission of HIV and other sexually transmitted diseases (STDs) (*1*), and the use of some contraceptives containing nonoxynol-9 (N-9) might increase the risk for HIV sexual transmission. Three randomized, controlled trials of the use of N-9 contraceptives by commercial sex workers (CSWs) in Africa failed to demonstrate any protection against HIV infection (*2--4*); one trial showed an increased risk (*3*). N-9 contraceptives also failed to protect against infection with *Neisseria gonorrhoeae* and *Chlamydia trachomatis* in two randomized trials (*5*,*6*), one among African CSWs and one among U.S. women recruited from an STD clinic. Because most women in the African studies had frequent sexual activity, had high-level exposure to N-9, and probably were exposed to a population of men with a high prevalence of HIV/STDs, the implications of these studies for U.S. women are uncertain. To determine the extent of N-9 contraceptive use among U.S. women, CDC assessed data provided by U.S. family planning clinics for 1999. This report summarizes the results of that assessment, which indicate that some U.S. women are using N-9 contraceptives. Sexually active women should consider their individual HIV/STD infection risk when choosing a method of contraception. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections.

CDC collected information on types of N-9 contraceptives purchased and family planning program (FPP) guidelines for N-9 contraceptive use. The national FPP, authorized by Title X of the Public Health Service Act, serves approximately 4.5 million predominantly low-income women each year. Program data for 1999 were obtained from all 10 U.S. Department of Health and Human Services (HHS) regions on the number of female clients and the number of female clients who reported use of N-9 contraceptives or condoms as their primary method of contraception. CDC obtained limited purchase data for 1999 for specific N-9 contraceptives and program guidelines from eight state/territorial FPPs within six HHS regions. State health departments, family planning grantees, and family planning councils were contacted to request assistance in collecting data on purchasing patterns of the 91 Title X grantees; of the 12 FPPs that responded, eight provided sufficient data for analysis.

In 1999, a total of 7%--18% of women attending Title X clinics reported using condoms as their primary method of contraception. Data on the percentage of condoms lubricated with N-9 were not available. A total of 1%--5% of all women attending Title X clinics reported using N-9 contraceptives (other than condoms) as their primary method of contraception (Table 1). Among the eight FPPs that provided purchase data, most (87%) condoms were N-9--lubricated (Table 2). All eight FPPs purchased N-9 contraceptives (i.e., vaginal films and suppositories, jellies, creams, and foams) to be used either alone or in combination with diaphragms or other contraceptive products. Four of the eight clinics had protocols or program guidance stating that N-9--containing foam should be dispensed routinely with condoms; two additional programs reported that despite the absence of a clinic protocol, the practice was common. Data for the other two programs were not available.

Reported by: *The Alan Guttmacher Institute, New York, New York. Office of Population Affairs, U.S. Dept of Health and Human Services, Bethesda, Maryland. A Duerr, MD, C Beck-Sague, MD, Div Reproductive Health, National Center Chronic Disease and Public Health Promotion; Div of HIV and AIDS Prevention, National Center HIV/AIDS, STDs, and TB Prevention; B Carlton-Tohill, EIS Officer, CDC.*

Editorial Note:

The findings in this report indicate that in 1999, before the release of recent publications on N-9 and HIV/STDs (*4,6,7*), Title X family planning clinics in the U.S. purchased and distributed N-9 contraceptives. Among at least eight family planning clinics, most of the condoms purchased were N-9--lubricated; this is consistent with trends in condom purchases among the general public (*8*). The 2002 STD treatment guidelines state that condoms lubricated with spermicides are no more effective than other lubricated condoms in protecting against the transmission of HIV infection and other STDs (*7*). CDC recommends that previously purchased condoms lubricated with N-9 spermicide continue to be distributed provided the condoms have not passed their expiration date. The amount of N-9 on a spermicide-lubricated condom is small relative to the doses tested in the studies in Africa and the use of N-9--lubricated condoms is preferable to using no condom at all. In the future, purchase of condoms lubricated with N-9 is not recommended because of their increased cost, shorter shelf life, association with urinary tract infections in young women, and lack of apparent benefit compared with other lubricated condoms (*7*).

Spermicidal gel is used in conjunction with diaphragms (*1*); only diaphragms combined with the use of spermicide are approved as contraceptives. The respective contributions of the physical barrier (diaphragm) and chemical barrier (spermicide) are unknown, but the combined use prevents approximately 460,000 pregnancies in the United States each year (*1*).

The findings in this report are subject to at least two limitations. First, data on specific products and patterns of contraceptive use were limited; CDC used a nonrepresentative sample of regions and states that voluntarily provided data, and specific use patterns of the contraceptives could not be extrapolated from these data. Second, data correlating use of N-9 contraceptives with individual HIV risk were not available.

Prevention of both unintended pregnancy and HIV/STD infection among U.S. women is needed. In 1994, a total of 49% of all pregnancies were unintended (*9*). Furthermore, 26% of women experience an unintended pregnancy during the first year of typical use of spermicide products (*1*). In 1999, a total of 10,780 AIDS cases, 537,003 chlamydia cases, and 179,534 gonorrhea cases were reported among U.S. women. Contraceptive options should provide both effective fertility control and protection from HIV/STDs; however, the optimal choice is probably not the same for every woman.

N-9 alone is not an effective means to prevent infection with HIV or cervical gonorrhea and chlamydia (*2,7*). Sexually active women and their health-care providers should consider risk for infection with HIV and other STDs and risk for unintended pregnancy when considering contraceptive options. Providers of family planning services should inform women at risk for HIV/STDs that N-9 contraceptives do not protect against these infections. In addition, women seeking a family planning method should be informed that latex condoms, when used consistently and correctly, are effective in preventing transmission of HIV and can reduce the risk for other STDs.

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Table 1

TABLE 1. Number of women using male condoms or nonoxynol-9 (N-9) products as their primary method of contraception, by Title X Family Planning Region — United States, 1999

Region*	No. of women served	Male condoms No.	Male condoms (%)	N-9 products† No.	N-9 products† (%)
I	179,705	27,726	(15)	1,251	(1)
II	404,325	73,069	(18)	21,515	(5)
III	487,502	73,088	(15)	4,807	(1)
IV	1,011,126	93,011	(9)	29,630	(3)
V	522,312	61,756	(12)	2,489	(1)
VI	478,533	40,520	(8)	11,212	(2)
VII	238,971	15,949	(7)	1,386	(1)
VIII	133,735	15,131	(11)	4,885	(4)
IX	672,362	109,678	(17)	14,547	(2)
X	186,469	17,320	(9)	1,275	(2)
Total	**4,315,040**	**527,248**	**(12)**	**92,997**	**(2)**

* Region I=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont; Region II=New Jersey, New York, Puerto Rico, Virgin Islands; Region III=Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia; Region IV=Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee; Region V=Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin; Region VI=Arkansas, Louisiana, New Mexico, Oklahoma, Texas; Region VII=Iowa, Kansas, Missouri, Nebraska; Region VIII=Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming; Region IX=Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, Palau; Region X=Alaska, Idaho, Oregon, Washington.

† Primary method of contraception reported by these women was one of the following: spermicidal foam, cream, jelly (with and without diaphragm), film, or suppositories.

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Table 2

TABLE 2. Number of nonoxynol-9 (N-9) contraceptives purchased by Title X Family Planning Programs in selected states/territories, 1999

State/territory	No. of clients served	Physical barrier method: Condoms with N-9	Physical barrier method: Condoms without N-9	N-9 chemical barrier methods: Gel	Vaginal: Film	Vaginal: Insert	Jelly	Foam
Puerto Rico	15,103	148,072	5,000	12,900	0	NA*	12,841	2,400
New York†	283,200	1,936,084	NA	0	73,788	NA	3,112	23,830
West Virginia	60,899	1,300,000	9,360	0	0	NA	1,200	9,900
Florida	193,784	3,920,000	560,000	0	468,720	NA	5,760	25,920
Tennessee	111,223	2,865,160§	717,088	0	94,500	12,528	756	2,758
Michigan	166,893	631,000	254,000	0	0	NA	1,000	1,200
Oklahoma	58,392	708,480	0	0	394,560	NA	1,200	0
Oregon	57,099	151,900	276,000	345	25,764	2,074	272	3,007

* Not available.
† 41 of 61 grantees responded.
§ Purchasing by family planning and sexually transmitted disease programs are combined and cannot be separated.

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This page last reviewed 5/9/2002

MMWR Weekly
August 11, 2000 / 49(31);717-8

Notice to Readers: CDC Statement on Study Results of Product Containing Nonoxynol-9

During the XIII International AIDS Conference held in Durban, South Africa, July 9--14, 2000, researchers from the Joint United Nations Program on AIDS (UNAIDS) presented results of a study of a product, COL-1492,* which contains nonoxynol-9 (N-9) (*1*). N-9 products are licensed for use in the United States as spermicides and are effective in preventing pregnancy, particularly when used with a diaphragm. The study examined the use of COL-1492 as a potential candidate microbicide, or topical compound to prevent the transmission of human immunodeficiency virus (HIV) and sexually transmitted diseases (STDs). The study found that N-9 did not protect against HIV infection and may have caused more transmission. The women who used N-9 gel became infected with HIV at approximately a 50% higher rate than women who used the placebo gel.

CDC has released a "Dear Colleague" letter that summarizes the findings and implications of the UNAIDS study. The letter is available on the World-Wide Web, http://www.cdc.gov/hiv; a hard copy is available from the National Prevention Information Network, telephone (800) 458-5231. Future consultations will be held to re-evaluate guidelines for HIV, STDs, and pregnancy prevention in populations at high risk for HIV infection. A detailed scientific report will be released on the Web when additional findings are available.

Reference

1. van Damme L. Advances in topical microbicides. Presented at the XIII International AIDS Conference, July 9--14, 2000, Durban, South Africa.

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