U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

National Institute of Justice
Centers for Disease Control and Prevention

Research in Brief

July 1998

NIJ CDC
Partners in Research on Correctional Health Care

Issues and Findings

Discussed in this brief: The extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB, based on responses to the 1997 NIJ/CDC national survey of correctional systems and site visits to six States and five city/county jurisdictions.

Key issues: Correctional populations have higher rates of HIV/AIDS, STDs, TB, and more risk factors for these diseases than the general population. Virtually all inmates return to the community, where they may place themselves and others in danger by engaging in high-risk behaviors. Collaborations between public health and correctional agencies may help fill gaps in programs for the prevention and treatment of HIV/AIDS, STDs, and TB, thereby benefiting an at-risk and underserved population as well as overall public health.

Key findings:

- According to NIJ/CDC survey responses, virtually all correctional systems have at least some collaboration with public health agencies.
- Site visits identified numerous collaborations in disease surveillance, testing and screening, followup, education and prevention programs, staff training, treatment services, and legislation and policy development, but found fewer collaborations in discharge planning and transitional services for people being released.
- Most existing collaborations involve public health departments providing funds, staff, or direct services in correctional facilities.
- Programs in Rhode Island and New York State exemplify more comprehensive collaborations.
- Key factors in successful collaborations include:

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Public Health/Corrections Collaborations: Prevention and Treatment of HIV/AIDS, STDs, and TB

by Theodore M. Hammett, Ph.D.

The missions of public health departments and correctional agencies are highly complementary: Correctional facilities and inmate populations are part of the larger community, and public health is integral to public safety. Public health and correctional agencies are increasingly working together to improve the health of inmates and, at the same time, the health of the larger community.

More than 1.75 million people are incarcerated in the prisons and jails of the United States—close to 1 percent of the Nation's population.[1] Inmates suffer disproportionately from infectious diseases, substance abuse, and a constellation of socioeconomic problems. In particular, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), sexually transmitted diseases (STDs) (such as syphilis, gonorrhea, and chlamydia), and tuberculosis (TB) are far more prevalent among incarcerated persons than the general U.S. population.

Figures from a 1994 survey cosponsored by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC) (the NIJ/CDC survey) reveal that AIDS is almost six times more prevalent among inmates than in the total U.S. population.[2] State and Federal inmates accounted for about 3 percent of the HIV-infected people in the country in 1995.[3] Incidence rates of gonorrhea in 1994 were 152 times higher among confined juvenile girls and 42 times higher among confined juvenile boys than among girls and boys of equivalent ages in the total population.[4] Comparisons are more difficult to make regarding TB, but the numbers in themselves are telling. Based on 1994 data from 31 State prison systems, the purified protein derivative (PPD) skin-test positivity rate (which indicates TB infection) among inmates was almost 14 percent, while 25 prison systems reported that more than 5,600 inmates converted from negative to positive PPDs in the 2 years prior to the NIJ/CDC survey.[5] In addition, risk factors for these infections are much higher in incarcerated populations than in the population at large.

Adult inmates and confined juveniles represent a large, highly at-risk population that could benefit greatly from health interventions. Such interventions could also greatly benefit overall public health.[6,7] Many correctional systems have

Issues and Findings *continued...*

– Availability of data on disease burden or dramatic events such as outbreaks demonstrating the need for collaborations.

– Organizational, legislative, or regulatory provisions such as health department responsibility for provision of health services in correctional facilities; or legislation or regulations requiring oversight mechanisms, screening, or disease reporting.

– Attitudes and philosophies such as commitment to collaboration at agency and facility levels; correctional agency willingness to open its facilities to outside organizations; and mutual sensitivity to concerns, priorities, and perspectives of corrections and public health personnel.

– Health department funding of programs in correctional facilities and operational features such as the presence of health department personnel in correctional facilities, liaison staff in correctional and public health agencies, formal agreements for collaboration (such as MOUs), and long-standing interagency relationships.

– Communication and information exchange such as correctional representation on HIV Prevention Planning Groups, service on joint committees, regularly held meetings at leadership and operational levels, and the exchange of important information about patients.

Recommendations: The key recommendations of the NIJ/CDC study involve implementing the following four key facilitators of collaboration:

- Public health agency collection and dissemination of data on the burden of infectious disease in inmate populations.
- Including correctional representation on all HIV Prevention Planning Groups.
- Public health agency initiation or expansion of funding for services and staff in correctional facilities.
- Public health and correctional agency recognition of the importance and potential benefits of interventions in correctional settings to the health of the larger community.

Target audience: Correctional administrators, public health agency administrators, correctional health services staff, public health agency staff, and legislators and other policymakers concerned with public health and criminal justice.

responded to this need and opportunity by instituting a variety of these interventions. However, the 1997 NIJ/CDC survey results reveal that numerous gaps remain. Less than two-thirds (61 percent) of State and Federal correctional facilities were providing instructor-led HIV/AIDS sessions, and only 13 percent were providing peer-led programs.[8] Other areas of insufficient services include discharge planning and continuity of medical services from correctional facilities to the community. Overall, more coordination is needed between services in these two domains.

Collaborations between public health and correctional agencies represent a potential means of filling these and other gaps in health-related services for inmates. Public health departments may have the funds, staff, expertise, and other resources to help prisons, jails, and juvenile facilities address the serious health needs of their inmates and thereby advance the cause of public health in their communities.

Consistent with their overall public safety and security missions, prisons and jails

Survey and Site Visit Methodologies

The ninth national NIJ/CDC survey of HIV/AIDS, STDs, and TB in correctional facilities was conducted in 1996 and 1997. Responses were received from all 50 State departments of correction, 41 of the largest city/county jail systems, and the Federal Bureau of Prisons. Following that, the survey was validated using an abbreviated version of the questionnaire with 50 individual facilities in 15 State correctional systems and the Federal Bureau of Prisons. The objective of the validation was to compare responses on key policy issues from individual facilities with responses from the central offices of their State departments of corrections.

As a followup to the national NIJ/CDC survey, a series of 11 site visits also was conducted in 1997 to determine the extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB.

Site visits were made to the following 6 States and 5 city/county-level jurisdictions by teams from Abt Associates, the Centers for Disease Control and Prevention, and the National Institute of Justice:

- States
  - Florida.
  - Illinois.
  - Missouri.
  - New York.
  - Rhode Island.
  - Washington.
- Cities and Counties
  - San Francisco, California.
  - Chicago (Cook County), Illinois.
  - Rochester (Monroe County), New York.
  - Memphis (Shelby County), Tennessee.
  - Houston (Harris County), Texas.

The sites were chosen based on telephone interviews with more than 20 jurisdictions that had been identified by CDC and Abt Associates. The final site selections were made with a view toward geographic diversity and having an even mix of State and city/county jurisdictions.

The 2-day visits included interviews with correctional and public health staff as well as visits to correctional and juvenile confinement facilities. Key public health staff in HIV/AIDS, STDs, and TB and correctional health services staff and others in the correctional systems who were involved in collaborations with public health departments were interviewed. The study team visited the major jail facility in each city/county and one or two facilities in each State.

Exhibit 1: ***Collaboration Between Correctional Systems and Public Health Departments, 1997***

Areas of Collaboration	Percentage of Systems Reporting Collaborations					
	HIV/AIDS		STDs		TB	
	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)	State/Federal Prison Systems (N=51)	City/County Jail Systems (N=41)
Educational Programs	78	63	67	53	75	49
Other Prevention Programs	69	59	55	39	61	41
Testing/Screening	73	68	69	73	71	71
Case Reporting	90	66	92	59	92	85
Counseling	78	61	53	46	47	37
Partner Notification	75	44	78	59	78	54
Outbreak Investigation	51	37	61	44	82	73
Treatment/Prophylaxis	65	59	65	63	80	85
Discharge Planning	84	71	65	54	84	83
Staff Training	82	68	73	59	82	76

Source: 1997 NIJ/CDC Survey

can create opportunities for interventions with underserved populations who are at high risk for HIV/AIDS, STDs, and TB. Correctional administrators can provide access to these populations and otherwise facilitate interventions by including language requiring early disease detection and treatment in their health protocols. Such language may be particularly important where health services are being provided through contracts with private organizations.

The study described in this report examined the extent and nature of public health/corrections collaborations in the prevention and treatment of HIV/AIDS, STDs, and TB. A description of the methodologies used for the survey and the site visits is found in "Survey and Site Visit Methodologies."

As expected, the study revealed that State health departments collaborated primarily with State correctional agencies, while city and county health departments worked primarily with county jails. However, there were numerous interactions between State health departments and county jails. In addition, collaborations between State correctional systems and county jails were very important, but sometimes inadequate, particularly in the area of information exchange.

The study occasionally touched on collaborations between corrections and other entities such as community-based organizations (CBOs) and academic medical centers. Indeed, a range of potential collaborators could be identified for future program development and research efforts.

This report first summarizes collaborations reported to the 1997 NIJ/CDC survey and those identified during site visits for this study. Two brief case studies are then presented, followed by a discussion of the factors important in successful collaboration. The report concludes with policy implications for improving and expanding collaborations.

Diversity of collaborative efforts

Collaborations between public health and correctional agencies encompass a wide variety of activities in the prevention and treatment of HIV/AIDS, STDs, and TB (see exhibit 1). Responses to the 1997 NIJ/CDC survey of correctional systems show that collaborative efforts are common and wide ranging. Virtually all State and Federal prison systems (98 percent) and city/county jail systems (90 percent) reported some collaboration with a public health department in the surveillance, prevention, and treatment of HIV/AIDS, STDs, or TB.

The appendix (pages 16 and 17) summarizes the diverse collaborative efforts identified during the site visits to 11 jurisdictions within the following broad headings:

- Administration and infrastructure.
- Policy development.
- Service delivery.

Many collaborations exist in disease surveillance, staff training, legislation and policy development, education/prevention programs, testing/screening/followup, and treatment services, as shown in the appendix. However, there are relatively fewer collaborations in quality assurance, clinical protocol de-

Rhode Island's Model of Collaboration

Rhode Island has developed a state-of-the-art model of collaboration involving the State Department of Health, the State Department of Corrections, an academic medical center (Miriam Hospital, affiliated with Brown University), and approximately 40 community-based organizations and service agencies. The organizational chart of Rhode Island's AIDS Services After Prison (ASAP) program, a centerpiece of the State's collaborative efforts, is displayed in exhibit 2.

Meetings and interactions between all of the organizational partners in the Rhode Island collaboration take place regularly. The partners also work together on disease surveillance, policies, legislative proposals, and union issues in the facilities. There is a demonstrable commitment to working together. In the words of the administrator of the Rhode Island health department's office of HIV/STDs, there is no sense of "our problem versus your problem."

The Department of Health provided much of the initial funding for staffing the program. However, over time, the program has been institutionalized and the Department of Corrections has picked up an increasing share of personnel costs, funding two public health educator positions from its regular budget.

In 1986 collaboration between the Rhode Island health and correctional departments led to the development of one of the first correctional AIDS policies in the United States. Early on, treatment and supportive services for inmates with HIV and continuity of care between providers in prison and in the community were important goals of this collaboration.[9] Subsequently, pretest and posttest counseling, discharge planning, transitional services, and community linkages for HIV-infected inmates and at-risk HIV-negative inmates were added.

The legislatively mandated implementation of HIV-antibody testing for incoming inmates in 1989 and the expansion of TB and STD screening in Rhode Island correctional facilities provided data that made a compelling case for health programming. The correctional department completes surveillance reports on HIV, STDs, and TB and provides those reports to the health department. The correctional department also notifies the health department's TB unit when a person with active or suspected TB or on TB prophylaxis is being released so continuity of care can be arranged.

Postrelease services for inmates with HIV infection or at risk for HIV infection include medical treatment, housing, substance abuse treatment, job development, psychosocial support, and long-term case management.[10] Evaluation results reveal reduced recidivism rates among female inmates who participated in these programs.[11] Compliance with postrelease medical and other appointments for services increased dramatically as well.

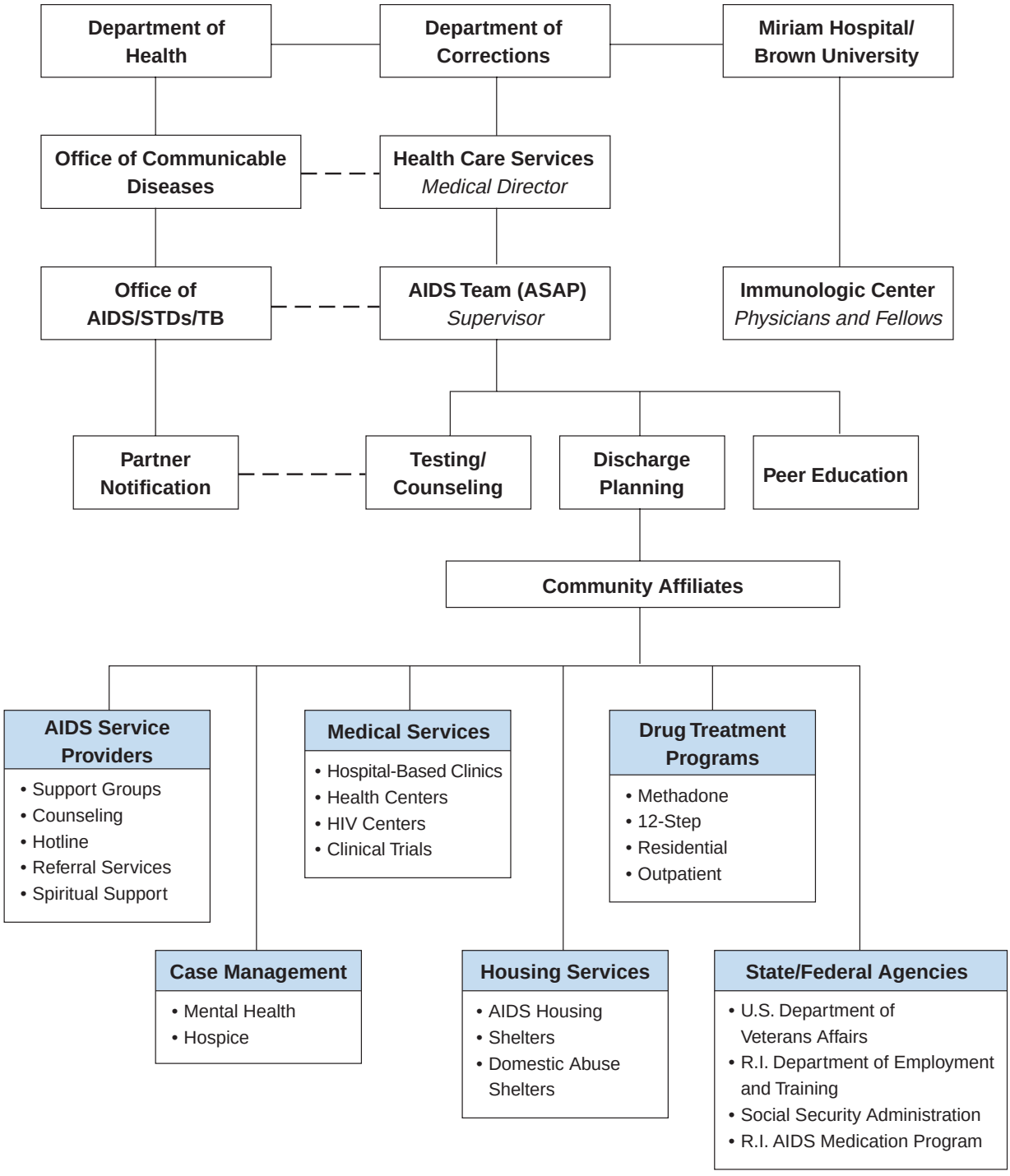
Program staff participate in a weekly case-assignment meeting to discuss community linkages and placements for inmates nearing release. Four key community-based organizations that specialize in the following populations and services participate in these meetings: 1) mentoring for employable women; 2) services for cocaine- and/or alcohol-involved persons; 3) services for long-term sex workers and/or injection drug users; and 4) services for HIV-infected persons.

A disease investigation specialist, whose position is funded by the Department of Health and who is based at the correctional facility, notifies inmates' sexual partners and performs outreach, primarily HIV. The specialist also locates HIV-positive individuals who have been released to the community before receiving their test results and links them to services at Miriam Hospital or a comparable provider of HIV services.

The CDC funding of two additional public health educator positions in the Department of Corrections has increased the overall program's emphasis on prevention. These educators orient incoming inmates on infectious diseases, provide multisession prevention programs for current inmates and educational sessions for staff, and coordinate inmate peer education programs.

Health department staff have met with the correctional officers' union to address issues surrounding disclosure of inmates' HIV status. The union favored disclosure to all correctional officers, but a compromise was achieved whereby disclosure may occur only in the case of potential transmission incidents, which are the primary concern of the union.

Exhibit 2: ***Rhode Island AIDS Services After Prison (ASAP) Organizational Chart***



velopment, discharge planning/transitional services, and laboratory services. Most of the collaborations identified in this study involve public health departments providing funding, staffing, and services to correctional departments. In order to succeed, such arrangements require interaction and cooperation between public health and correctional agencies as well as access to inmate populations. However, some collaborations go well beyond health departments providing services in prisons and jails. See "Rhode Island's Model of Collaboration" and "New York State's Model of Collaboration" for brief case studies of two such collaborations.

The following factors are common to successful collaborations between public health and correctional agencies:

- Data and events demonstrating a need for collaboration.
- Organizational, legislative, and regulatory provisions.
- Appropriate attitudes and philosophies.
- Program funding and operations.
- Communication and information exchange.

Data and events demonstrating a need for collaboration

Successful public health/corrections collaborations are much easier to develop and sustain when *data documenting the burden of disease* in the inmate population are readily available. Some might suggest that such data are a prerequisite for successful collaborations. Public health departments could be more proactive in disease surveillance among corrections populations. Better surveillance might produce a whole series of positive effects: more resources for correctional health programs, better services, a safer and healthier environment for inmates and staff, less disease returned to the community, and ultimately improved public health.

In Rhode Island, for example, the health and correctional departments demonstrated that 42 percent of all new HIV infections in the State were identified in correctional facilities. This convinced the State's HIV Prevention Planning Group to endorse substantial continued funding of collaborative HIV programs in prisons. Until these data were available, the planning group had expressed skepticism about the value and importance of prison-based programs. In Florida, data showing that 13 percent of the State's syphilis morbidity was identified in correctional facilities served as an important impetus for collaborative STD screening programs. In Washington, the State health department documents and publishes periodic reports on STD morbidity in adult and juvenile facilities, which helps justify the department's continued involvement in STD screening and followup programs in these facilities.

Because of low success in locating people released from Cook County Jail before syphilis treatment could be given, a rapid screening and treatment program for women in the jail was initiated. As a result, the percentage of Chicago's total syphilis morbidity identified at Cook County Jail increased from 17 percent in 1995 to 24 percent in 1996. The rapid screening and treatment program is a collaborative effort of CDC, the Chicago Department of Health, and the Cook County Jail.

Without hard data on the incidence and prevalence of HIV/AIDS, STDs, and TB, it is much more difficult to interest correctional and health departments in collaborating on interventions. It is also more difficult to justify requests for funding and other resources if the scope of the problem is unknown or undemonstrated. In some jurisdictions visited for this study, for example, jail medical services and public health department staff have no clear picture of morbidity among the inmates. The lack of this information is, in their view, a major stumbling block to more effective and better supported collaboration.

Dramatic events may call attention to the need for collaboration. For example, concern raised by the 1991 outbreak of multidrug-resistant TB in New York State and by other local outbreaks was mentioned in a number of jurisdictions as a factor promoting collaboration between public health and corrections. The New York outbreak prompted the formation of a city/county TB task force in Chicago.

In New York State, health department involvement in TB interventions that helped to protect correctional staff smoothed the way for other collaborations on HIV/AIDS and STDs. Staff in several jurisdictions identified collaborations in TB prevention, with their strong employee protection focus, as the "foot in the door" for other collaborative efforts.

Organizational, legislative, and regulatory provisions

In San Francisco and Memphis *the health department is responsible for providing health services in the correctional facilities*. Such arrangements require interaction and may help foster fuller collaboration. In San Francisco, for example, the director of forensic services, the health department unit responsible for jail health services, sits on several committees with sheriff's

department staff and, in turn, involves custody staff in health services committees. Nurses also meet regularly with custody captains to address issues in health services delivery.

Another important factor promoting collaboration is *legislative and regulatory provisions*. Strong State legislation in New York called for establishment of an interagency AIDS task force, which required that the commissioners of the State health and correctional departments and other agencies coordinate efforts in criminal justice settings. California law requiring notification to health departments of all TB cases was a spur to collaborations with correctional systems in the development of reporting procedures. Also in California, the legislatively created State Board of Corrections has the power to regulate local and county jails. The board's regulations require that each jail has a communicable disease control plan jointly created by jail officials and the local health officer. A Texas law enacted in 1993 requires all jails with 100 or more beds to submit TB control plans to the local health department.

The Memphis-Shelby County health officer used the powers granted him under Tennessee law to mandate PPD screening for TB in jails. Indeed, the jail director also favored PPD screening but asked the health director to require it in order to provide stronger justification and gain the cooperation of jail staff. A 1988 Washington State law provides for court-ordered HIV testing of inmates involved in potential transmission incidents, as well as convicted injection drug users, sex offenders, and sex workers. The correctional and juvenile agencies sought and obtained the involvement of the State health department in providing this mandated testing and reporting its results.

Attitudes and philosophies

Three important attitudes and philosophies of key actors in public health and corrections systems appear to facilitate successful collaboration:

- Strong commitment.
- Willingness to open facilities to outside agencies.
- Sensitivity to the concerns of both corrections and public health.

At the level of agency and facility leadership, there must be a *strong commitment* to collaborative approaches. This may involve a realization and declaration that infectious diseases among inmates represent both a correctional and a public health problem. As the county jail director in Memphis emphasized, public health is a part of the public safety that correctional facilities exist to protect. The Florida Department of Corrections' assistant secretary for health services stated that "the health problems of our inmates are public health problems because inmates go back to the community." In Illinois, the director of the correctional department endorsed an inmate peer education program sponsored by the health department and wrote to all facility superintendents encouraging their cooperation.

Correctional officials' commitment to collaborative approaches generally leads to their *willingness to open their facilities to outside organizations*. This is not always easy for correctional administrators to do, in view of their primary concern with security. They may also be wary of outsiders, based on their perceptions or experiences that outsiders' main purpose is to find and expose fault in correctional facilities. Even when central office leaders in a correctional system direct that there be open collaboration, individual superintendents may still attempt to prevent it in their facilities.

Numerous superintendents, however, are open to the involvement of outside agencies. Some, like the warden of Rhode Island's women's facility, see such involvement as essential. She welcomes outside medical providers, community-based organizations, student interns, and others to her facility. She believes that prisons are part of the community and that there should not be "impenetrable walls" between them. Moreover, she believes that outside providers are helpful to inmates in making transitions back to the community.

If correctional and public health agencies are to work together successfully, they must have *sensitivity to each other's concerns*. It is important, for example, that public health staff understand that security is, and always will be, the first priority of correctional systems. Public health activities must be accommodated within the overall correctional structure and procedures. As a public health investigator from the Houston health department's TB section commented, one must "ease in," work with security staff, abide by their rules, and try to build one-on-one relationships. Taking this approach, this public health investigator was accepted as "one of them [the deputies]" and enjoys their full cooperation. Similarly, the San Francisco health department's TB control staff person working in the jails has achieved good cooperation from custody staff by "requesting rather than demanding" assistance. In Washington State, the correctional department credited health department staff with being extremely collegial, focusing on finding solutions rather than finding fault.

New York State's Model of Collaboration

Collaborations between the New York State Department of Health (DOH) and the Department of Correctional Services (DOCS) on HIV/AIDS and TB involve almost constant interaction between the two agencies at both central office and facility levels. Collaborations on STDs have been primarily between DOH and county jails because DOH staff believe that the key opportunity for STD intervention is at the jail level and is essentially lost once inmates move on to DOCS facilities.

Beginnings of collaboration. The AIDS Institute of the New York State DOH and DOCS began their collaboration in 1987. The institute's Criminal Justice Initiative (CJI) involves a comprehensive array of HIV/AIDS services in DOCS facilities, such as HIV counseling and testing, education (including peer education programs provided by ex-offenders and current inmates), and supportive and transitional services for inmates living with HIV disease.

Facility-level cooperation. Institute staff emphasize that their involvement has been and remains dependent on the cooperation of individual facilities' superintendents, which, with the substantial assistance of DOCS central office staff, they have been quite successful in winning and maintaining.

State-level cooperation. The DOH Bureau of HIV/AIDS Epidemiology (AIDS Epi) and DOCS have collaborated on HIV/AIDS surveillance. The AIDS Institute and DOCS have also collaborated on the development of medical protocols and a quality review of HIV medical services. A memorandum of understanding between DOCS and the AIDS Institute for ongoing case-based quality review of HIV medical services was under development at the time of the site visit.

In 1989 the AIDS Institute and DOCS initiated a joint project in which DOCS funded positions in the institute to form regional teams to provide HIV counseling and testing for inmates and educational programs for inmates and correctional staff. This project was closely coordinated by the central offices of both agencies, and DOCS reviewed and approved the educational curriculums. Funding was also provided for AIDS Counseling and Education (ACE), a peer-based prevention and support program at the Bedford Hills women's facility. In 1992, the Women's Prison Initiative was established by the AIDS Institute to replicate the ACE peer education model at the other women's facilities and to provide a comprehensive continuum of care for HIV-infected females. Services provided at Albion, Taconic, and Bedford Hills correctional facilities include peer training, peer-delivered education on HIV/AIDS prevention and risk reduction, HIV counseling and testing, supportive services for HIV-infected inmates, and discharge planning and case management for inmates with HIV disease.

The AIDS in Prison Hotline project, funded by the AIDS Institute and operated by the Osborne Association in New York City, provides counseling, education, support, and referrals to community-based services for inmates. Inmate collect calls are encouraged.

CBOs brought in. In 1993 the regional teams serving DOCS facilities were expanded to include community-based organizations (CBOs). DOCS, CDC, the AIDS Institute, and other sources provide about $3 million per year for CJI activities. Most DOCS facilities now receive services through the AIDS Institute's CJI.

AIDS Institute staff reported that relations between the regional teams, the CBOs, and DOCS central office and facility staff are generally good. Although only about 25 percent of the funding for CJI activities comes from DOCS, interdepartmental communication and collaboration at the central office level are essential. At the facility level, the regional teams and CBOs are often accepted as part of the facility's staff. Initial and ongoing meetings on AIDS Institute programs at the facility level help ensure mutual understanding of roles and expectations and address emerging issues. Correctional officers' union representatives and inmate liaisons are included in these meetings.

HIV-seroprevalence studies. In the late 1980s, AIDS Epi began collaborating with DOCS on a series of blinded studies of HIV seropositivity among incoming inmates at the reception centers—Downstate and Ulster for men, and Bedford Hills for women. When it became clear that HIV seropositivity rates among inmates accepting voluntary testing were substantially lower than rates found in the blinded studies, the AIDS Institute and DOCS collaborated on a pilot study at Ulster to investigate these discrepancies. The 1994 study revealed that many inmates did not accept voluntary testing because they denied or underestimated the seriousness of their risk factors. Prior knowledge of HIV status was not a major reason for inmates to decline voluntary testing.

AIDS reporting extended. AIDS surveillance for DOCS inmates was essentially passive until 1996; inmate cases were not reported to DOH by DOCS. Only inmates admitted to a hospital for an AIDS-related illness were reported. In 1996, however, DOCS began providing DOH with an electronic database of case reports for all inmates known to have AIDS. This facilitated cross-checking case registries and helped increase the accuracy of case counts.

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New York State's Model of Collaboration

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Success in TB control. Since 1988, the New York State DOH Bureau of TB Control and DOCS have had extensive and, according to DOH staff, "exemplary" collaborations in screening, treatment, case management, surveillance, outbreak investigation, discharge planning, education and training of staff and inmates, and technical assistance to staff. TB cases in DOCS have declined steadily since reaching a peak in 1993. No TB outbreaks have occurred in DOCS facilities since 1993.

In 1988 and 1993, the New York State DOH's Bureau of Occupational Health assessed air-handling systems in DOCS facilities to better control TB. Training in environmental infection control measures and monitoring of negative pressure rooms was also given. DOH staff worked closely with DOCS and CDC staff to investigate and respond to a 1991 outbreak of multidrug-resistant TB. This included development and implementation of mandatory annual inmate and staff screening, education and training, and other measures to prevent recurrent outbreaks of TB.

HIV-related TB project. From 1991 to 1995, DOH collaborated with DOCS on the HIV-Related TB Project (HRTP). This established a demonstration screening and directly observed preventive therapy program at DOCS intake facilities. DOH conducted TB surveillance at DOCS facilities, and DOCS carried out all screening and treatment of inmates.

Two public health representatives (PHRs) from the DOH Bureau of TB Control are based at a DOCS reception center, where they are well integrated with health service staff. Another eight PHRs collectively visit each prison every 2 weeks to identify and report new suspected cases of TB and monitor treatment. In general, the PHRs work closely with the DOCS infection control nurses at the prisons on TB control, screening, and treatment issues. DOH staff conduct all surveillance and case tracking and consult on contact investigations and case management in DOCS facilities. PHRs report possible AIDS cases they identify to the AIDS Epi staff at DOH. The process of completing clinical records is automated so the appropriate PHR can be notified and receive case records immediately when an inmate is transferred to a facility in a different part of the State. Regular meetings and interactions between DOH and DOCS staff are devoted to surveillance, including reconciliation of case counts and other matters. DOH's TB nurse coordinator meets every 2 weeks with the DOCS director of communicable disease control who supervises the infection control nurses in the prisons. DOH's TB Bureau works with DOCS and the parole department on discharge planning for inmates with TB, as well as on community linkages and monitoring of adherence to treatment regimens following release.

STD control in county jails. As mentioned, collaborations on STD services have largely occurred between the State health department and county jails. In a demonstration project funded by CDC at the Nassau County jail, DOH staff provided rapid syphilis screening at intake and treatment of inmates with positive tests and no record of prior treatment. This intervention had a significant and positive effect on syphilis morbidity in the overall community. The STD control division of DOH is working on similar programs with jails in Monroe, Westchester, and Chautauqua counties, as well as in New York City.

Showing a willingness to compromise on policy issues is another way to demonstrate mutual concern and sensitivity. For example, the director of forensic services in the San Francisco health department compromised with the sheriff's department on the implementation of a State referendum on disclosure of inmates' HIV status to correctional officers. The compromise carefully restricted recipients of the information and provided for coding of the information to minimize the possibility of unauthorized disclosure.

Counterproductive factors. While the factors elucidated above can help facilitate successful collaborations, it is important to realize that there are *real differences between the philosophies, perspectives, and priorities of public health and correctional agencies that can make collaboration difficult if they are not sensitively handled*. For example, the medical staff in the jail may align with security staff rather than with public health staff. In Rochester/Monroe County, New York, health department staff reported that when they first began providing services in the jail, there seemed to be a "clash of cultures" between them and jail health staff. Since that time, however, a mutual respect for the different perspectives and challenges of each organization has led to collaborative and collegial relations. In Rochester, important improvements were made after a public health nurse spent time in the jail observing the work of her counterpart on the jail health staff. Through this experience, the public health nurse gained an appreciation of the danger, stress, and other challenges of working in the jail and developed great respect for the jail health staff.

The focus of the jail health staff is on emergency medicine and providing needed care within the context of maintaining safety and security. Public health activities and objectives such as disease tracking and followup are not as high a priority for jail health staff. By contrast, the health department staff who work in the jail place their highest priority on proactive public health activities such as screening, disease tracking, followup, and research. Nevertheless, the Rochester experience demonstrates that through mutual understanding, common ground can be discovered and effective collaborations achieved.

To be successful in the correctional environment, health department staff need to be able to work within the system and the rules. They cannot be confrontational and demand cooperation and then expect to succeed. According to the assistant health director in the Rochester health department, staff should beware of becoming inmate advocates and denouncing the system. Rather, they should focus on advancing the overall public health.

The director of medical services at the county jail in Houston described the differing perspectives by using the metaphor of a spoked wheel. To health services and public health staff, everything revolves around providing patient care and addressing health issues. To correctional staff, in contrast, health issues represent only one spoke of the wheel.

Lack of mutual respect and sensitivity can undermine collaborations. For example, health services and public health staff should not dismiss or ignore the concerns of correctional staff regarding occupational exposure to HIV and other diseases. As long as these concerns are based on actual risk of transmission, they should be addressed with respect and seriousness. Correctional officers' unions are often in the forefront on issues of occupational risk. These unions may oppose inmate peer education programs or other programs that involve ex-offenders entering jail facilities. A willingness to take these concerns seriously and to be open to compromise on them is essential. In New York State, a compromise was reached that allowed ex-offenders to present educational sessions for inmates but not for correctional staff.

Collaborations also suffer if public health staff devalue the skills and expertise of correctional medical staff and other correctional staff. In several jurisdictions, correctional health care staff reported being treated with disrespect by health department personnel. At one facility, the health services staff employed by the correctional department resent what they view as an *inappropriate supervisory and oversight approach taken by State health department staff who come into the prison*. In other words, the correctional health services staff want acknowledgment of and respect for their expertise—instead of concern that they will not perform properly unless closely supervised. The nurse administrator at this facility declared that "until you treat people as equals, you can't collaborate; you can only dictate." At the central office level in this jurisdiction, key health services staff expressed concern about language suggesting similar suspicious assumptions that was included in proposed terms of a memorandum of understanding between the departments of health and corrections.

Health services staff of several other State correctional systems reported county health department personnel, stigmatizing them as inferior practitioners who could not find jobs elsewhere, demanding cooperation, and refusing to work within correctional rules and regulations.

Conversely, *obstructionism and lack of cooperation by correctional staff can undermine collaborative efforts*. For example, security staff may hinder inmates' access to health services. In one jurisdiction, it was reported that the correctional officers who prepared the sick-call lists sometimes allegedly denied access to inmates needing services. Gate-clearance problems sometimes also allegedly have made it difficult for health department staff to provide services efficiently.

Program funding and operations

The following funding and operational factors were found to facilitate collaboration:

- Health department funding of programs in corrections.
- Presence of health department staff and programs in correctional facilities.
- Presence of a liaison person.
- Formal agreements for collaborations.
- Staff characteristics.
- Longstanding relationships.

Funding by health department. Funding is almost always a facilitating factor in collaborations. The director of medical services at the county jail in Houston said that collaboration could be based on the health department's ability and willingness to fill and pay for gaps in services and expertise. In Rhode Island, the health department provided much of the initial funding for the collaborative HIV/AIDS programs in the correctional facilities, but the Department of Corrections was

subsequently able to institutionalize the program and bring some of the costs into its budget.

In contrast, perhaps the most pervasive barriers to collaborative efforts are inadequate funding and resource constraints. Even the most powerful arguments for public health interventions, no matter how well grounded in data, may be denied adequate support in the current political climate emphasizing the punitive over the rehabilitative functions of corrections. Most of the collaborative programs observed in this study were working under serious constraints on funds, staff, and space. In one jurisdiction visited, the public health department suggested that jail health staff resisted more aggressive screening for HIV and STDs because sufficient funds were not available to treat all the patients who might be diagnosed.

Physical plant and staffing. One jurisdiction reported that *no infrastructure or space* was available in the city jail to expand disease screening and offer other health services in which the health department might collaborate. In addition, staffing shortages at this same city facility would prompt resistance to escorting inmates to health services even if such health services were available. A jail director interviewed for the study acknowledged that the staff and facilities were inadequate to support more proactive health services.

Public health staff working in several other correctional facilities reported *frequent problems with the callout and escort of inmates* to attend medical services. These problems were attributed to a combination of staff shortages and obstructionism or lack of interest on the part of security staff.

Presence of public health programs. The *physical presence of public health programs* and staff in correctional facilities has promoted—in many cases, necessitated—collaboration. As described earlier, jail teams and staff from public health departments regularly work in the correctional facilities of the jurisdictions visited for this report, performing a variety of functions including screening, surveillance, education and training, contact investigation and partner elicitation, and followup.

Liaison. A *liaison* at the central office or facility level often makes collaboration easier to manage and sustain. In New York State, each facility has designated a single liaison for State health department programs—usually the nurse administrator or deputy superintendent for programs. This individual arranges gate clearances, sets up appointments, and ensures inmate access to services. In Illinois, the department of corrections' public health coordinator serves as the liaison for all health department programs and helps the programs gain acceptance at the facility level. A similar correctional liaison to the State health department in Florida has proven to be very useful.

Formal agreements. Embodying collaborations in *formal agreements* has been helpful in several jurisdictions. Memorandums of understanding (MOUs) and similar instruments help to institutionalize collaborative efforts, making them less dependent on personal relationships. Rhode Island's broad-based HIV/AIDS collaborations involving the health and correctional departments, an academic medical center, and numerous CBOs are formalized in written agreements.

From 1990 to 1996, the New York State Department of Health had an MOU with the Parole Division to provide transitional services for HIV-infected inmates. Because the covered services were rolled into other contracts awarded in 1997, the MOU was not renewed. An MOU with the Division for Youth covering education, counseling, and testing services is still in place.

In Washington State, MOUs between the health and correctional departments and the juvenile agency specify roles and responsibilities regarding court-ordered HIV testing.

Other documents can also formalize collaborative efforts. For example, the strategic plan of the Florida department of corrections requires collaboration with the health department and other community resources.

Staff characteristics. In several visited jurisdictions it appeared that certain *staff characteristics* make collaborations easier to forge and maintain. For example, in Houston, both the director of medical services in the county jail and the supervisor of the health department's jail team mentioned that having a security background was useful for jail health services staff. The health department's jail team supervisor worked in corrections and criminal justice before assuming his current role and noted that this background helped him both negotiate the jail system and win quicker acceptance from security staff. The director of medical services in Houston worked for many years in security before taking his present position. He believes that when the director of medical services is a sheriff's department employee rather than an employee of another agency or a contracted organization, he or she has more leverage and authority to advance public health objectives in the jail setting.

In both New York State and Illinois, the key liaison to the health depart-

ment in the correctional department previously worked for the health department. This background helped the liaison not only to understand and commit to a public health approach but also to develop working relationships with health department staff more easily.

Relationships. Finally, *longstanding relationships* and the passage of time often are required to perfect collaboration. In Washington State, for example, the health and correctional departments were at one time part of the same State agency, so they have a long history of working together. In Rhode Island, the collaborative HIV/AIDS program was developed and refined over a period of 10 years.

Communication and information exchange

Opportunities to discuss issues and exchange information are important to developing and sustaining collaborations. The study identified four factors that improve communication and information exchange:

- Correctional representation on HIV Prevention Planning Groups.
- Health and correctional department service on other joint committees.
- Regular meetings at leadership and operational levels.
- Exchange of important patient information.

Representation on planning groups. Correctional representation on *HIV Prevention Planning Groups* is the most important factor in this category. These groups are mandated by CDC in all States and cities receiving CDC HIV prevention funds. The Prevention Planning Groups often have substantial influence on the allocation of HIV prevention funding.

In Rhode Island, a correctional staffer is a member of the State's Prevention Planning Group. In San Francisco, a representative of the health department's Forensic AIDS Project, which provides HIV prevention programs in the jails, serves in the HIV Prevention Planning Group.

In Chicago/Cook County, a representative of the city health department's STD program (who was an advocate for correctional needs) serves in the HIV Prevention Planning Group. This representative presented jail data to the planning group and successfully lobbied for allocation of resources to the jail, resulting in the hiring of two additional staff for the jail's STD program.

There also can be valuable teaching opportunities on these planning groups. The Florida Department of Corrections' infection control coordinator is a member of the statewide Prevention Planning Group, where she believes her most important function has been to educate the other members about the correctional environment and the needs of inmate populations.

On the other hand, the absence of correctional representation on HIV Prevention Planning Groups, which is the case in most of the jurisdictions visited for this study, almost inevitably means that programs in correctional facilities receive insufficient attention and support. In turn, a critical impetus for collaborative programs will be missing.

Joint committees. *Service on other standing committees* provides opportunities to develop and enhance collaborations. In Illinois and New York, the public health and correctional departments are both represented on State interagency AIDS task forces, while in Missouri, Washington, and New York, both departments serve on Governors' advisory councils on AIDS. New York's advisory council has a subcommittee on criminal justice that includes representatives of State corrections, health, and parole agencies. In Missouri, the health department's medical director serves on the department of correction's (DOC's) review committee for its health services contract.

The Florida DOC's medical director serves on the State TB Control Coalition and the department of health's (DOH's) medical director for HIV sits on the correctional department's medical ethics panel. A task force comprising staff from the jail, corrections center, and health department was convened in Memphis to address TB screening in jails. It has been proposed to keep this group in existence to provide a forum for discussion of other health issues in the jails and correctional center. In Rochester, a Jail Health Advisory Committee has brought together high-level managers at the jail and in the health department to address issues of common concern.

Regularly held meetings. In addition to serving together on standing committees, it is important for public health and correctional staff to conduct *regularly held meetings at both leadership and operational levels.* In Florida, there are quarterly coordination meetings of DOC and DOH staff on TB issues, as well as regularly scheduled collaborative TB case-review conferences. TB case-review meetings are also held in Missouri on a monthly basis. These meetings have identified errors, one involving a case in which treatment was wrongly terminated.

In contrast, a barrier to collaboration may have been the absence or infrequency of meetings at central office and facility levels. In one jurisdiction,

the lack of meetings between the heads and high-level management of relevant departments has led to a somewhat fragmented approach to the provision of public health interventions in the jails. The jurisdiction's approach has been characterized by overlapping functions, poor communication, and turf disputes.

Sharing information. Access to and *exchange of information about individual patients* is often critical to the success of collaborative efforts. This is particularly true when correctional or health department staff provide followup on test results or partner notification or continue patients on medications following their transfer or release. (Inmates may be transferred frequently from housing unit to housing unit within a facility as well as between different facilities. Inmates may also be released on short notice.)

In many of the visited jurisdictions, procedures have been developed to transfer medical records and provide interagency access to important clinical or locator information. In New York State, for example, health department staff have access to portions of the department of correctional services (DOCS) inmate information system so they can track transferred inmates within the system and ensure that HIV and PPD results and medication status are provided to the new facility. In Illinois, the health department was able to track and respond appropriately to a TB outbreak in the correctional system because their staff had access to the DOC database on inmate movements and transfers. The work of Missouri health department staff who conduct followup interviews in the prisons and elicit information about sexual partners is facilitated by access to the correctional department's HIV and syphilis case logs and to inmates' automated medical records. Similarly, Chicago health department staff who conduct STD screening and treatment in Cook County jail depend on the jail's database for the locations and court dates of inmates and on the Chicago health department registry for their treatment histories.

Under a grant from the Corrections Program Office, U.S. Department of Justice, Florida's prison and jail leadership is developing a partnership in TB control with the primary objectives of coordination of services and exchange of information as inmates move from county jails to State prisons.

Correctional department access to health department databases can also be very useful. In Washington State, when the DOC wishes to determine the status of inmates being transferred or released, it can check health department databases on patients receiving medications for TB and patients receiving preventive therapy.

On the other hand, *problems with the availability and exchange of information* have impeded collaboration and undermined inmate health care. In many instances, vital medical records, including test results and medication status of transferred or released inmates, were never sent to the new health care provider or sent only after long delays. HIV antibody tests and PPD skin tests have had to be readministered because there was no record of previous testing. At one juvenile detention facility, the county health department was responsible for HIV counseling and testing but did not furnish test results to the facility's medical director. Inmates receiving combination antiretroviral therapy for HIV may arrive at a new facility without written records of the specific regimen, and the new facility may be unable to obtain records from the previous facility within a reasonable period. Therefore, medications may need to be restarted.

Suggestions on how public health departments and correctional agencies can work together to expand and enhance health services for inmates are offered under "Policy Implications."

Conclusions

Collaborative efforts should be expanded to include organizations beyond public health and adult correctional agencies and to involve a broader range of criminal justice populations and organizations that offer needed services and linkages. Other types of organizations to include in comprehensive collaborations are probation and parole agencies, juvenile systems and facilities, community-based organizations, AIDS service organizations, substance abuse treatment programs, academic medical centers and universities, and other service providers.

Clearly, State and local government agencies and service providers in the affected communities bear the primary responsibility for development of collaborations. However, Federal agencies such as CDC and NIJ may be able to support expanded and enhanced collaborations in some ways. These include funding demonstration projects (such as CDC's enhanced STD screening and treatment efforts) and sponsoring conferences and forums that offer opportunities for staff of correctional and public health departments and other pertinent organizations to meet and discuss collaborations.

The development and distribution by appropriate government agencies of

Policy Implications

This study identified many effective and promising public health/corrections collaborations to address problems of HIV/AIDS, STDs, and TB in correctional facilities, as well as gaps, shortfalls, and weaknesses in collaborative efforts. In general, the study found that inmate services and collaborations in the following areas could benefit from expansion and enhancement:

- Behavioral prevention programs.
- Inmate peer-based programs.
- Discharge planning and transitional services, including continuity of care, adherence to medication regimens, and social services to ease the transition to the community.

The study also found that most current collaborations involve public health departments providing or funding services in correctional facilities. This is, to be sure, an important aspect of collaboration that requires granting access to the facility as well as some interchange and discussion between public health and correctional agencies. But several actions are required to achieve comprehensive relationships:

- **Collecting and disseminating data by public health departments to demonstrate the disease burden in correctional and criminal justice populations.** Without these data, it may be very difficult to convince decisionmakers of the need for more resources and expanded collaborations.
- **Including correctional representatives on HIV Prevention Planning Groups.** Such representation can help to ensure that correctional and criminal justice settings receive their fair share of attention and that their unmet resource needs receive appropriate priority.
- **Initiating or expanding funding by public health departments of services and staff in correctional facilities and other criminal justice settings.** Such funding support can be the first step in the development of full collaborations.
- **Recognizing the importance of interventions in correctional settings to the health of the larger community.** In particular, the importance of screening, early detection, and early treatment can be understood and reflected in program priorities.

Additional steps to consider

Additional, more specific steps may be taken to help ensure successful collaboration:

Improving the context for collaboration. Use administrative, legislative, and regulatory powers to require collaborations:

- Include specific roles and requirements for health departments and correctional agencies for collaborative efforts in appropriate legislation and regulations.
- Formalize collaborative relationships between health departments and correctional agencies in memorandums of understanding or other written agreements.
- Establish and use the legal powers of health directors to require disease screening and other interventions as appropriate and ethical.

Building collaborative attitudes. Promote the following attitudes and philosophies that facilitate collaboration:

- Establish a commitment by health departments and correctional agencies to the principle that public health is part of public safety.
- Recognize that correctional facilities are part of the community. Additionally, virtually all inmates return to the community.
- Open correctional facilities to outside organizations that can provide valuable resources and expertise to address health issues.
- Build mutual respect for each others' missions, priorities, concerns, and capabilities. For example, address the legitimate concerns of correctional employees regarding occupational exposure to HIV, STDs, TB, and other diseases.
- Be willing to compromise and work within the reasonable rules and constraints of the correctional facility in order to achieve larger public health goals.

Operationalizing collaboration. Establish the following operational features to foster collaboration:

- Locate health department programs and staff in correctional facilities.
- Establish single, regularly accessible liaisons for collaboration at the central office and facility levels.
- Resolve logistical issues by, for example, providing trouble-free gate clearance for health department program staff and expediting callout and escorts for inmates attending health programs.

Improving communication. Improve communication and information exchange among all staff members in the following ways:

- Develop and implement better systems for accessing and exchanging important clinical and inmate-locator information at all jurisdictional levels.
- Establish joint health department/correctional committees at the leadership and operational levels.
- Hold regular joint staff meetings at the central office and facility levels.

guidelines for the prevention of HIV/AIDS and STDs in correctional settings might be helpful in fostering collaborations between public health and correctional agencies. Guidelines such as those developed by CDC for controlling TB in correctional facilities could provide a framework for discussion of the benefits of appropriate prevention, control, and treatment procedures.

In sum, correctional facilities are important points to access high-risk, underserved populations and offer opportunities to reach these populations with important health interventions. As the examples included in this report demonstrate, collaborative efforts can be successful in improving the health of inmates and benefiting overall public health as well.

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Appendix: Summary of Collaborative

Sites	Administration and Infrastructure						
	Health Department Responsibility	Disease Surveillance	Database Support	Inspections and Assessments	Quality Assurance	Staff Training	Linkage Development
Rhode Island		DOC medical staff report HIV, STDs, TB, and all other reportable infectious diseases to DOH.	DOH provides computer equipment. DOC provides database.	DOC medical director contacts DOH TB coordinator in cases of active/suspect TB in discharged population.	DOH reviews treatment of all cases.		DOC attends DOH HIV Advisory Committee. DOC is part of HIV Prevention Planning Group.
New York		DOH collaborates on blinded HIV-seroprevalence studies and improved AIDS-case counting. DOH funded demonstration TB screening projects at DOCS intake facilities; 10 regional PHRs perform surveillance, case tracking, and contact investigations.	DOH access to DOCS database on inmate movements facilitates TB tracking and delivery of HIV-test results.	DOH assisted with investigation of MDR-TB outbreak in prisons. DOH assessed air handling in DOCS facilities and consults on specifications for negative-pressure rooms.	DOH and DOCS collaborates on HIV/AIDS case review. DOH monitors treatment of TB cases in DOCS facilities.	DOH provides TB training and technical assistance for staff of DOCS. DOH trains DOCS staff in HIV/AIDS transmission, prevention, workplace practices, and universal precautions.	Routine meetings are held between DOH and DOCS. DOCS participates in statewide meetings with contractors serving correctional facilities.
Washington		DOH collaborates on blinded HIV-seroprevalence studies. DOH documents STD morbidity in adult and juvenile facilities.	DOH provides DOC staff with access to TB treatment and prevention therapy databases.	DOH surveyed HIV/AIDS, STD, and TB services in prisons. DOH inspects prisons each year and helps justify requests for resources.	DOH reviews treatment of active TB cases.	DOH reserves slots for DOC staff at annual STD clinical updates. DOH trains DOC staff on HIV counseling and testing.	
Florida		DOH-funded staff prepares TB case reports on inmates.		DOH-funded staff monitor TB treatment logs in prisons.	Collaborative TB case-review conferences are held regularly.	DOH holds annual health update conferences, including training in HIV counseling and testing. DOC and DOH jointly sponsor TB workshops.	Quarterly meetings are held with DOC and DOH staff.
Missouri		DOC provides HIV-screening reports to DOH. DOH conducts surveillance for HIV, STDs, and TB.			DOH teams monitor HIV and STD testing and treatment in State prisons. TB case-review meetings are held monthly. DOH participates in review of DOC health services contractor.	DOH provides training to probation and parole staff in HIV risk assessment and community linkages.	Governors Council on AIDS provides linkage among many agencies, including DOC and DOH. Quarterly TB coordination meetings are held. DOC participates in HIV Prevention Planning Group.
Illinois		DOH collaborates with DOC on blinded HIV-seroprevalence studies.	DOH access to DOC database on inmate movements and locations facilitates TB tracking.		DOH reviews STD morbidity reports to assess treatment.	DOH trains DOC staff in TB and STD interviewing and counseling techniques.	
Houston (Harris County), Texas				DOH surveyed HIV/AIDS, STD, and TB services in jails.		DOH assists in providing and coordinating STD training to jail clinicians.	
Memphis (Shelby County), Tennessee	DOH is responsible for health services in jails.						
Rochester (Monroe County), New York						DOH trains clinicians at jail and juvenile detention center.	DOH funds women's jail committee. DOH serves with jail staff on Jail Health Advisory Committee.
San Francisco, California	DOH is responsible for health and mental health services in jails.	DOH provides HIV/AIDS, STD, and TB surveillance and disease tracking.				DOH TB control staff trained jail staff in placing and reading PPDs.	DOH launched and coordinated Bay-area TB control group, bringing together public health and correction staff.
Chicago (Cook County), Illinois	Cermak Health Services, a unit of county government, provides all jail health services.	DOH provides onsite STD surveillance.	DOH staff have access to jail computer and provide access to city syphilis registry.		DOH ensures appropriate STD treatment and participates in infectious disease quality-assurance meetings.	DOH provides TB training at correctional officer's academy and STD training to jail clinicians.	

DOH = Department of Health DOC = Department of Correction DOCS = Department of Correctional Services MDR = Multidrug Resistant

Efforts Identified During Site Visits

	Policy Development		Service Delivery				
	Legislation and Policy	Clinical Protocols	Education/Prevention Programs	Testing, Screening, and Followup	Treatment	Discharge Planning and Transitional Services	Laboratory Services
	DOH and DOC collaborated on DOC's HIV/AIDS policy. DOH and DOC jointly drafted legislation on HIV testing in response to incidents and disclosure of HIV status.		DOH (with CDC funding) funds prison prevention staff, who offer HIV orientation and multisession programs and coordinate inmate peer program.	DOH funds HIV pretest and posttest counseling and partner notification in prisons. DOH provides TB outreach and followup for persons released from jail and prison.	DOH and DOC jointly fund treatment, which helps ensure continuity of care. Academic medical center involved.	DOH and DOC jointly fund discharge planning and community linkage. DOC medical director contacts DOH TB coordinator in cases of active/suspect TB in discharged population.	State lab performs confirmatory HIV testing.
		DOH and DOCS jointly develop HIV/AIDS treatment protocols and TB control policy.	$3 million per year for HIV/AIDS services were provided to prisons, juvenile facilities, and parolees for peer-led programs. DOCS funds regional teams from AIDS Institute to present HIV educational programs.	AIDS Institute regional teams and funded contractors provide HIV counseling and testing. DOH (with CDC funding) supports STAT syphilis screening and treatment programs in selected county jails. DOH and DOCS developed and implemented mandatory TB screening for inmates and staff.	DOH funded a demonstration of directly observed preventive therapy for TB at DOCS intake facilities. DOH reps perform TB case management at DOCS facilities.	AIDS Institute supports Prisoners Hotline and transitional services for inmates with HIV/AIDS. DOH's TB bureau promotes collaborative planning between DOCS and Parole Department, links releasees and community providers, and monitors treatment in community.	DOH lab processes HIV and STD tests for DOCS inmates.
	DOH helped draft and review DOC infection control manual. DOH reviews other policies. DOH helped draft legislation on disclosure of HIV status.		DOH distributes STD prevention literature to State prisons. DOH funds a CBO to provide HIV prevention work in prisons.	DOH provides HIV/STD partner notification services in prisons. DOH provides special STD screening in two county juvenile detention centers. DOH offers chlamydia screening at women's prison.			DOH provides some HIV and STD testing for State prisons.
	DOC coordinates all HIV/AIDS, STD, and TB policy guidelines with DOH.		DOH funds peer-based HIV/AIDS prevention program at Lawtey Correctional Facility. Program is being expanded to other facilities.	State/county DOHs provide STD screening, followup, and partner notification in many State prisons, county jails, and juvenile facilities. DOH-funded staff do TB followup.	County DOH follows up on TB treatment of released inmates.	DOC coordinates with DOH on discharge planning and continuing care for inmates with HIV/AIDS and TB.	DOH provides STD testing for many county jails.
	DOH and DOC collaborated on point-scoring assessment of TB isolation, developed guidelines for TB screening and treatment, and compromised on condom distribution at release.	Governors Council on AIDS reviews HIV/AIDS treatment protocols for inmates.	DOH provides training for inmate HIV/AIDS peer educators in two DOC facilities.	DOH funds HIV/STD/TB screening and partner notification services in prisons. Three regional DOH teams conduct followup interviews with syphilis-positive inmates. DOH assists with TB screening and followup in prisons. DOH funds peer-based HIV prerelease programs.	Joint project with DOC/Parole Department provides incentives to refill TB prevention medication prescriptions.		
			DOH funds HIV/AIDS education programs at prerelease centers. DOH funds and provides training for peer HIV/AIDS prevention program in most facilities. DOH trained 100 peers, and peers made 17,000 contacts with inmates in 1996.	DOH staff conducts STD contact investigations.			State public health lab provides all STD testing for State prisons.
			CDC funds VCRs and TVs to show HIV prevention videos in city jail.	County DOH offers HIV counseling and testing. City DOH provides inmate followup for HIV/AIDS and STD treatment, and referral. City DOH provides partner notification to outside contacts. City DOH/jail team provides limited syphilis and HIV testing in several facilities. City DOH performs contact investigation on all active TB cases in jail.	City DOH/jail team provides some medications for STD treatment in jail. County provides directly observed therapy for jail releasees with TB.		
	Health officer mandated universal PPD screening in jails.		DOH/jail team offers HIV/STD educational services at county jails.	DOH/jail teams provide HIV counseling, testing and partner notification in jails. DOH/jail teams provide STD screening, followup interviews, partner notification, and evaluation of PPD-positive TB tests.			
			DOH provides jail inmates with education in TB preventive therapy.	DOH teams provide HIV counseling and testing, and STD testing and followup in jail and juvenile facilities. DOH TB staff follow up on PPD positives in jail and community.		DOH hired discharge planner to work in jail.	
	DOH and sheriff's department compromised on HIV testing and disclosure policy.		DOH's Forensic AIDS Project (FAP) offers HIV education and prevention programs and distributes condoms in jails.	FAP provides HIV counseling and testing. DOH screens for STDs in jail, follows up in the community, and performs TB screening and followup.	FAP provides medical and psychological services for inmates with HIV/AIDS.	FAP provides discharge planning and community linkages for inmates with HIV. Jail staff and DOH TB control staff coordinate discharge planning and followup of patients with active TB.	
	DOH and DOC medical director collaborated to initiate universal pregnancy screening at jail intake.		Chicago DOH provides $340,000 per year for HIV prevention programs, which funded 7 of 10 HIV educators in county jail.	DOH funds STD screening staff at jail (with CDC funding). DOH provides STAT (immediate) syphilis screening and treatment for women in jail. DOH follows up in community and provides PPD results.	DOH provides directly observed therapy to jail releasees with TB.		State DOH lab provides confirmatory syphilis testing.

CBO = Community-Based Organization

Theodore M. Hammett, Ph.D., a Vice President at Abt Associates Inc., was the principal investigator for this study. The project was supported by contract OJP–94–C–007 awarded to Abt Associates Inc. by the National Institute of Justice.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

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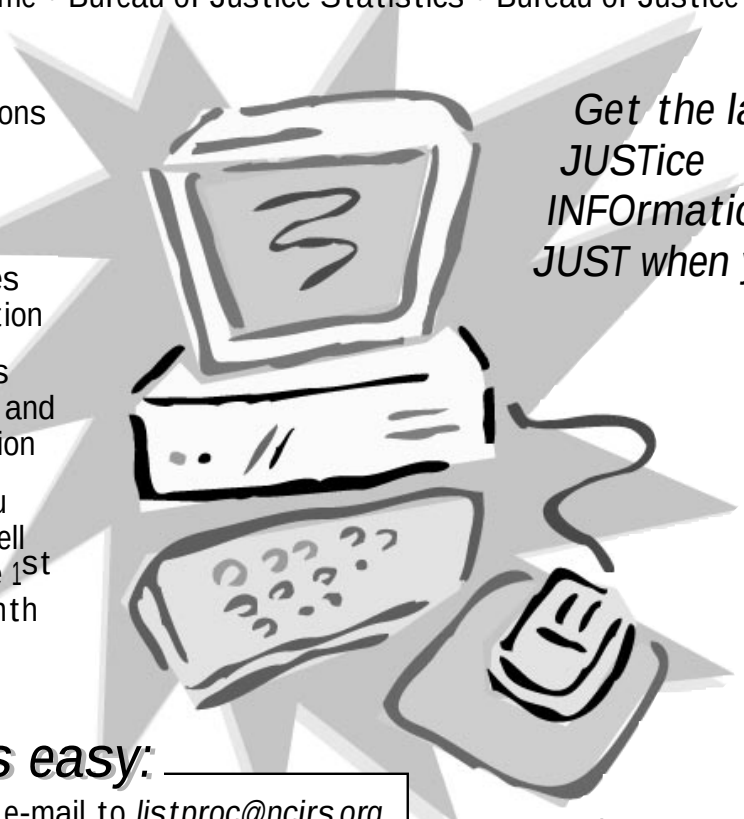

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