
AIDS Education in Correctional Facilities

A Review

Legislative Analyst's Office
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Introduction

This report is submitted in response to Chapter 1579, Statutes of 1988 (Senate Bill 1913, Presley). Chapter 1579 requires the Legislative Analyst's Office to determine whether the Department of Corrections (CDC) and the Department of the Youth Authority (CYA) have adequate education, prevention, and treatment programs related to acquired immunodeficiency syndrome (AIDS), and whether the programs are being properly implemented. Additionally, the law requires the Legislative Analyst's Office to assess the quality of AIDS education and prevention programs in county and city jails.

Throughout this report, we refer to human immunodeficiency virus (HIV) disease or infection, which encompasses the range of medical conditions resulting from HIV, including AIDS. This report is based on a review of the HIV education and prevention programs in a sample of CDC and CYA facilities, and local jails. This report reviews the HIV information and risk reduction skills that are provided in these correctional facilities, how and to whom they are provided, and provides our evaluation of program effectiveness. As used in this report, the term "HIV education program" encompasses those aspects of the education program that specifically address HIV disease prevention.

This report does not evaluate treatment programs. Such a review would have to be conducted by medical experts with clinical experience in HIV treatment.

Chapter I defines HIV disease and describes how it is transmitted. In addition, the chapter describes for California and the nation, the magnitude of HIV infection and HIV education programs in correctional facilities. It also includes information on HIV antibody testing policies and HIV housing policies in correctional facilities in California and nationwide. We provide information on these two policies because, in addition to education, they are the other methods used to manage HIV transmission in California's correctional facilities.

Chapter II describes the criteria used in this report to assess the HIV education programs in California's correctional facilities. Chapters III through V provide our findings, conclusions, and recommendations regarding HIV education programs in state prisons, CYA facilities, and local jails as required by Chapter 1579. Chapter VI discusses coordination issues between the Department of Health Services (DHS) Office of AIDS (OA) and correctional facilities which we identified during our review.

Appendix 1 provides a listing of the acronyms used throughout the report.

We would like to thank the staffs of the CDC and the CYA, the Board of Corrections (BOC), various counties and cities, community organizations, and medical and legal professionals for their assistance in providing information used in completing this report. We would like to especially thank Tom Voss and Christine Cummings of the CDC, Don Werkhoven of the CYA, and Jack Pederson of the BOC for their extensive assistance.

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Executive Summary

Chapter 1579, Statutes of 1988, requires the Legislative Analyst's Office to determine whether the Department of Corrections (CDC), the Department of the Youth Authority (CYA), and local jails have adequate acquired immunodeficiency syndrome (AIDS) education programs. To make this determination, we surveyed human immunodeficiency virus (HIV) education programs in 42 state and local correctional facilities within California. We reviewed these facilities using criteria that we developed based on a model from the United States General Accounting Office.

The criteria are based on research findings that indicate that an effective HIV education program is one that leads to behavior change--that is, individuals acting in ways that reduce their chances of HIV infection. However, as discussed below many of the elements needed to increase the likelihood of behavior change are missing from the state and local HIV education programs that we reviewed.

The policy decision facing the Legislature is whether it wants the HIV education programs in state and local correctional facilities to be designed to achieve the goal of changing behavior. We believe that the following recommendations would increase the likelihood of behavior change, thereby, helping to reduce the spread of HIV in California's correctional facilities. In addition, many of the recommendations would result in administrative improvements in current HIV education programs.

Findings and Recommendations

Finding 1. Not all state and local correctional staff, inmates, and CYA wards receive HIV education.

During our review, we found that:

- Not all correctional facilities conduct HIV education classes for staff, inmates, or wards. However, such

classes are provided far more consistently for staff than for inmates and wards.

- Not all staff, inmates, and wards attend HIV education classes that are provided by facilities. However, attendance at such classes is higher for staff than for inmates and wards.
- Not all staff, inmates, or wards routinely receive written HIV information.

Based on these findings, we conclude that staff, inmates, and wards are potentially at risk of HIV infection because: (1) they are not kept up-to-date with current information and procedures for decreasing their risk of HIV infection and (2) the value of an HIV education class as a means to reinforce information and procedures is lost.

These problems exist because: (1) not all facilities have identified staff, inmates, and wards as high-risk groups requiring HIV education programs and (2) attendance requirements are not enforced or attendance is voluntary. In addition, in some cases, classes for inmates and wards are not provided by facilities. Further, not all facilities routinely distribute written information to staff, inmates, and wards. These problems are also exacerbated by administrative weaknesses within facilities.

Recommendation. The CDC, CYA, and Board of Corrections (BOC) should ensure that all high-risk target groups are identified, and that staff, inmates, and wards attend HIV education classes and periodically receive written HIV information. (The BOC is responsible for establishing operating standards for local jails, including training standards for local corrections staff and health standards for local jail inmates.)

Finding 2. Not all facilities have centralized responsibility for their HIV education programs.

Within some facilities, no single individual oversees all HIV education efforts for either staff, inmates, or wards. Consequently, there is no operational mechanism for ensuring that: (1) HIV education is provided to all target groups, (2) consistent information is provided to individual target groups, and (3) duplicative HIV education efforts are minimized.

Recommendation. The CDC, CYA, and BOC should ensure that all HIV education efforts are coordinated within each facility.

Finding 3. Not all target groups receive the same basic factual information.

Numerous HIV training curricula are used for similar target groups throughout the three correctional systems. Consequently, staff who perform similar work--for example, custody staff in CDC, CYA, and local jails--do not receive the same factual HIV information. Also, inmates and wards within individual facilities may not receive the same factual information. Furthermore, state funds are being used to fund the development of multiple curricula through the CDC and CYA central offices, as well as the Department of Health Services (DHS) Office of AIDS (OA).

This problem exists because, in an effort to respond to the HIV health threat, the individual correctional systems and their individual facilities have developed their own solutions. Additionally, the OA has funded community-based organizations to provide HIV education in the community as well as in correctional facilities. In general, collaborative efforts have not been taken by these organizations to increase the uniformity of HIV education and to minimize unnecessary duplication of this education.

Recommendation. The CDC, CYA, and BOC should each improve its coordination efforts with the OA. In addition, each correctional agency and the OA should jointly evaluate the correctional agency's HIV education program. These evaluations should determine the goals of each program and the respective roles of each agency.

Finding 4. Although staff are taught risk reduction skills, not all inmates or wards are taught risk reduction skills.

Risk reduction skills, such as safety and equipment sterilization procedures, are consistently taught to staff. However, risk reduction skills, such as the proper use of

condoms, are not taught to all inmates or wards. Additionally, condoms are generally not available to inmates and wards. Consequently, these inmates and wards are at risk of HIV infection if they engage in high-risk activities.

Recommendations.

- Given the seriousness of HIV disease, and the importance medical experts have placed on the use of condoms to reduce the risk of HIV transmission, the CDC should examine its current policies on the demonstration and availability of condoms in prisons. Accordingly, the CDC central office should contract with an organization which has expertise in this area to: (1) evaluate the effects of the prison condom demonstration and availability programs that currently exist nationwide and (2) determine whether such programs should be tested and/or implemented in California. In addition, the contractor should assess the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission in prisons.
- The results of the studies recommended above should be used by the BOC to assess local jail condom demonstration and availability policies, and the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission in local jails.
- The CYA central office should review its current policies on the demonstration and availability of condoms in CYA facilities. Accordingly, it should contract with an organization which has expertise in this area to determine whether condom demonstration and availability programs for wards should be tested and/or implemented in California. In addition, the contractor should assess the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission in CYA facilities.

**Potential State
Mandated Costs**

As the preceding findings suggest, we identified a number of problems with the HIV education programs in local jails. If the Legislature intends to increase the effec-

tiveness and uniformity of these programs statewide, then additional standards must be identified for local jails. The Legislature has an option, however, as to whether compliance with these standards is mandatory or optional.

If the Legislature wishes to *mandate* a given level of HIV education on local jails, it could require the BOC to adopt such regulations. This option would require state reimbursement of local costs.

In contrast, the Legislature could require the BOC to establish guidelines for HIV education which would be merely advisory and, consequently, would not require state reimbursement. Clearly, however, the first option increases the likelihood that statewide uniformity would be achieved.

Chapter I

HIV Disease in Correctional Facilities: An Overview

This chapter provides a context for considering the HIV education programs in California's correctional facilities. Specifically, the chapter: defines HIV disease, which includes AIDS; describes how it is transmitted; and discusses the magnitude of HIV infection in correctional facilities in California and nationwide. In addition, the chapter provides an overview of HIV education policies and certain HIV management policies in correctional facilities in California and nationwide.

Human
Immunodeficiency
Virus Disease¹

What is HIV Disease? The term HIV disease is used to describe the spectrum of HIV infection, ranging from asymptomatic HIV seropositive (HIV-positive) to AIDS. A person is asymptomatic HIV-positive if he/she tests positive for the HIV antibody, but has no medical symptoms related to the infection. Such a person can transmit the virus to others whether or not symptoms are present. AIDS-related complex or condition (ARC) is the term used to describe some of the symptoms caused by HIV infection. These symptoms are generally less severe than those of AIDS. AIDS is the most severe stage of HIV infection. The general terms "HIV infection," "infected with HIV," and "HIV-positive" refer to those who test positive and are anywhere along the spectrum of the disease. Researchers believe that most (if not all) people who are HIV-positive will ultimately develop AIDS.

¹Department of Health and Human Services, Centers for Disease Control, *A Curriculum Guide for Public-Safety and Emergency Response Workers: Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus*. (Atlanta, GA: 1989), 3-2 through 3-18. Unless otherwise noted, information in the section entitled "Human Immunodeficiency Virus Disease" is from this document.

How is HIV Transmitted? HIV lives in blood and certain body fluids. It must enter the body quickly and then enter the bloodstream. There are several ways HIV is transmitted: (1) by having sexual contact with someone who is infected with HIV, (2) by sharing drug needles with someone who is infected with HIV, (3) an HIV-positive woman can transmit HIV to her unborn baby, (4) through needle-stick injuries, broken skin, or mucous membranes, and (5) by receiving contaminated blood products.

According to medical experts, HIV is not spread during casual everyday contact nor do insects transmit HIV. There are no documented cases of HIV transmission from contact with bodily fluids other than blood or semen.

How is HIV Infection Detected? Currently, a blood test is used to identify the presence of HIV antibodies. Antibodies against the virus usually develop within 6 to 12 weeks after a person is infected with HIV. According to the National Institute of Justice (NIJ), recent research indicates that the ELISA and Western Blot antibody tests--the laboratory tests most commonly used to detect antibodies to HIV--are highly accurate if quality control measures are maintained. At this time, there is no vaccine or cure for HIV infection.

How is HIV Transmission Prevented? Transmission of HIV can be reduced in the workplace by using prescribed precautionary equipment and measures such as using protective gloves if exposure to blood is likely. Medical experts agree that HIV transmission also can be reduced through a number of personal behavior changes, including eliminating unsafe sexual practices and needle sharing in intravenous (IV) drug use. Specifically, they recommend preventive measures such as using condoms during sexual activities and sterilizing needles before sharing them during IV drug use.

The Magnitude of HIV Infection in Correctional Facilities

State Prisons. There were about 86,600 inmates in California's 18 state prisons as of November 1989. (This includes slightly more than 80,600 males and almost 6,000

females.) Of these inmates, 372 (356 males and 16 females), or approximately 0.4 percent, have been *identified* as infected with HIV.

There is, however, some uncertainty as to how many California prison inmates are actually infected with HIV. A study by the DHS *estimates* that about 2.6 percent of male inmates and 3.1 percent of female inmates in California's state prisons are infected with HIV. If correct, then slightly less than 2,300 inmates (2,097 males and 185 females) may be HIV-positive. Based on these estimates, there are slightly more than 1,900 inmates that have not yet been identified as infected. The average number of inmates in state prisons is expected to increase to approximately 88,400 during 1989-90, presumably resulting in additional HIV-positive inmates.

Nationwide data are not available on the total number of HIV-positive inmates that have been reported in federal and state prison systems. However, the NIJ reports that HIV infection rates ranged from 0 percent in a number of state systems to 17 percent in the New York state prison system. The high infection rate in New York is believed attributable to high infection rates among IV drug users in New York City.

The CDC estimates that a cumulative total of 278 AIDS cases had been reported in California's state prisons through September 1988. The NIJ reports that a cumulative total of 2,047 AIDS cases had been reported in the federal and state prison systems through the same period.

Currently, little data exist on the rate of HIV transmission in correctional systems. However, according to the NIJ, "Fragments of information from several correctional systems suggest low rates of transmission, but these are not conclusive." It should be noted that the NIJ also reports that no cases of HIV infection among correctional officers have been linked to an incident in the workplace.

Youth Correctional Facilities. There were slightly more than 8,300 wards in the CYA's 10 facilities as of November 1989. (This includes about 8,000 males and 300 females.) Of these wards, 2 have been *identified* as infected with HIV. However, the CYA *estimates* that 0.6 percent, or about 50 wards, are infected with HIV. Comparable data are not

available for youth correctional systems outside of California.

County and City Jails. Currently, there are no data available on the actual number of inmates in California's county and city jails who are infected with HIV. (During 1988, California had 182 county jail facilities in 57 counties with slightly more than 64,000 inmates, and 90 city jails held almost 1,500 inmates pending their arraignment or release.)

Despite the absence of actual data, a DHS study *estimated* an HIV infection rate in California's county jails of 1.3 percent. Another DHS study found that inmates entering state prisons from the San Francisco Bay Area have a higher HIV infection rate (5.3 percent) than those entering from other parts of Northern California (1.2 percent) and Southern California (2.0 percent). Comparable data for cities or counties outside of California are not available.

HIV Education Programs

Experts agree that HIV education is critical for staff, inmates, and wards if the risk of HIV infection is to be reduced.

State Prisons. All new CDC correctional officers are required to attend HIV education classes during academy training. The CDC also requires that all staff attend HIV education classes on an annual basis. In addition, the CDC provides written HIV information (that is, pamphlets, information cards, etc.) and videos for staff and inmates. Although there is no CDC requirement that HIV education classes be provided for inmates, such classes are provided in a number of California's state prisons. The number of CDC staff and inmates that actually attend HIV education classes, watch videos, or receive written information varies from prison to prison in California. This variation is discussed in detail in Chapter III of this report.

According to the NIJ, virtually all correctional systems nationwide provide both written information and videos to staff and inmates. In addition, 49 of the 51 federal and

state prison systems provide HIV education classes to staff. However, the degree to which all staff and inmates in other states *actually* receive HIV written information, watch videos, or attend classes has not been determined.

Many of the HIV education materials provided to CDC inmates include discussions on the proper use of condoms although the CDC prohibits all inmates from receiving condoms with one exception. Spouses are allowed to bring condoms into a facility for use during conjugal visits. Our survey found that one CDC facility provides condoms to *pre-release* inmates.

According to the NIJ, two state prison systems (Mississippi and Vermont) make condoms available to *current* inmates, and several state prison systems make condoms available for conjugal visits and /or to pre-release inmates. In Vermont, condoms are only available through medical staff. In Mississippi, condoms are sold in the prison canteen. Both states discipline inmates found to be engaging in sexual activities.

The CDC does not provide HIV education materials which discuss how to clean IV needles. However, a few HIV education trainers we interviewed indicated that they discuss needle cleaning in HIV education classes.

According to the NIJ, almost 40 percent of the federal and state prison systems provide education to inmates on needle cleaning. However, no prison system provides bleach to inmates to clean needles.

Youth Correctional Facilities. New CYA correctional officers are required to attend HIV education classes during academy training. The CYA also requires that all staff attend annual update classes. All wards are required to attend six hours of HIV education classes. In addition, the CYA provides written HIV information and videos for staff and wards. Despite these requirements, the number of staff and wards that actually receive written information, watch videos, or attend HIV education classes varies from facility to facility. This variation is discussed in detail in Chapter IV of this report.

No *nationwide* studies exist on HIV education policies in youth correctional systems. However, a CYA survey of six other states found that five states provide some type of

HIV education to staff and one state provides information on sources of HIV education. Four of the states provide some type of HIV education to wards.

The CYA provides education to wards on the proper use of condoms. Our survey found that one CYA facility makes condoms available to wards being released; however, this practice is contrary to CYA policy. The CYA also provides education to wards on needle cleaning; it does not provide bleach to wards. We were unable to obtain information regarding condom or bleach policies in other state youth correctional systems.

County and City Jails. The BOC is responsible for establishing operating standards for local jails, including training standards for local corrections staff and health standards for local jail inmates. The BOC requires new local correctional officers to attend corrections training classes within one year of beginning employment and to attend annual update classes. While some of these classes include segments on HIV infection, there is no board requirement that custody staff attend classes that cover HIV. According to the BOC, however, most custody staff in local jails receive HIV training annually. In addition, most county and city jails provide HIV written information and/or videos to staff.

All of the *county jails* we reviewed provide some type of HIV education to inmates. However, none of the *city jails* we reviewed provide any HIV education to inmates. This variation in HIV education practices is discussed in detail in Chapter V of this report.

An NIJ survey of a small number of county and city jail systems throughout the country indicates that HIV education classes were provided to both staff and inmates. However, the study found that it is more common for these classes to be held for staff than for inmates.

Ten of the fifteen county jails we reviewed provide information on the proper use of condoms to inmates; three of these jails also provide demonstrations. San Francisco County jail provides condoms to *current* inmates on a request basis, and only if HIV counseling is received first. Furthermore, inmates are advised that engaging in sexual activities within the jail is a felony and against

county jail policy. San Francisco and Sacramento County jails make condoms available to *pre-release* inmates.

According to the NIJ, only two other local jails nationwide make condoms available to *current* inmates--New York City and Philadelphia. In New York City condoms are only available through medical staff, and inmates found to be engaging in sexual activity are disciplined. In Philadelphia new inmates are provided three condoms.

Seven of the fifteen county jails we reviewed provide instructions to inmates on needle cleaning. Two of these jails also show videos which include demonstrations on the use of bleach to clean needles. Bleach or IV needles are not provided to any inmates.

According to the NIJ, 50 percent of county and city correctional systems nationwide provide education to inmates on needle cleaning, although bleach is not distributed in any correctional facility.

HIV Management Policies

In addition to HIV education programs, there are two other methods used to manage HIV transmission in California's correctional facilities. They are HIV antibody testing and housing policies.

HIV Antibody Testing. California law prohibits *mandatory* HIV antibody testing of inmates or wards except when an employee, inmate, or ward requests that an inmate or ward be tested in response to a specific incident, such as a violent attack, and a court order for testing of the inmate has been issued.

State Prisons. Under current CDC policy, *voluntary* testing of an inmate is provided if requested by the inmate. The federal prison system and all state prison systems test inmates to some degree, as shown in Table 1. Current testing policies in other states include: mandatory testing of all new inmates or parolees; mandatory testing of inmates with a history of high-risk behavior; mandatory testing of inmates when medically indicated, in response to incidents, or for epidemiological studies; and testing on inmate request.

Table 1

HIV Antibody Testing Policies for Inmates in State and Federal Prison Systems^{a,b}

October 1988

Policy	Number	Percent
Mandatory Testing		
• Mass screening (all incoming or all released inmates)	15	29%
• Screening of "risk groups" (including pregnant women), but not mass screening	8	16
• Testing <i>only</i> in response to clinical indications, incident response, or epidemiological studies	22	43
Voluntary Testing		
• Testing <i>only</i> on inmate request	6	12
Total	51	100%

^aSource: National Institute of Justice^bIncludes actual and planned policies.

Youth Correctional Facilities. The CYA provides testing to wards on a voluntary basis. A CYA survey of six other states found that they all provide HIV testing when there is a history of high-risk behavior or if there are medical indications of HIV infection.

County and City Jails. Most county jails we reviewed indicated that HIV antibody testing is provided on inmate request. In addition, county jails have implemented one or more of the following policies for voluntary testing: (1) decisions are made on a case-by-case basis about whether to provide HIV antibody testing to inmates, (2) HIV testing is routinely conducted for inmates who show signs of HIV infection, and (3) HIV testing is routinely conducted

for inmates with a history of high-risk behavior (please see Appendix 2). Generally, none of the city jails we reviewed routinely test for HIV infection because inmates only remain in these facilities for short periods of time before they are released or transferred to county jails.

An NIJ survey of a small number of county and city jail systems nationwide found that testing when medically indicated is the most common practice.

HIV Housing Policies. California state prison inmates identified as infected with HIV (whether or not they have symptoms) are housed separately from general population inmates. According to the CDC, the purpose of its housing policy is to prevent HIV transmission, concentrate resources and staff to provide necessary specialized care, protect staff, and protect inmates infected with HIV from assault. The CDC requires that HIV-positive inmates be transferred as soon as possible to a state prison with an HIV special housing unit (HIVSHU). Until transfer is possible, these inmates are to reside in isolation in prison infirmaries. The HIVSHUs for males are located at the California Institute for Men at Chino and the California Medical Facility at Vacaville. Females infected with HIV reside in an HIVSHU at the California Institute for Women at Frontera.

Table 2 shows that 20 of the federal and state prison systems routinely separate all inmates identified with AIDS from the general inmate population. Eight states routinely separate all inmates identified with ARC, and six routinely separate all inmates identified as asymptomatic HIV-positive. Thirty-six of the federal and state prison systems routinely maintain asymptomatic HIV-positive inmates in the general population with or without restrictions. According to the NIJ, the New York state prison system has switched to a case-by-case policy of determining whether or not to segregate HIV-positive inmates. In addition, New York state is in the process of returning segregated inmates to the general population. Many of its inmates, however, are still segregated.

Table 2

Housing Policies for Inmates with AIDS, ARC, and Asymptomatic HIV Infection: State and Federal Prison Systems^{a,b}

October 1988

Policy	AIDS		ARC		Asymptomatic HIV Infection	
	Number	Percent	Number	Percent	Number	Percent
All inmates maintained in general population	--	--	8	16%	24	47%
All inmates maintained in general population with restrictions ^c	1	2%	9	18	12	24
All inmates segregated/separated ^d	20	39	8	16	6	12
Case-by-case determination	30	59	23	45	8	16
No policy	--	--	<u>3</u>	<u>6</u>	<u>1</u>	<u>2</u>
Total	51	100%	51	100%	51	100%

^a Source: National Institute of Justice. Detail may not add to totals due to rounding.

^b Includes policies in jurisdictions that as yet have no cases in a particular category.

^c Includes single-celling.

^d Includes hospitalization, infirmary housing, and administrative separation in medical or nonmedical units.

Youth Correctional Facilities. The CYA maintains known HIV-positive wards in the general population at the Ventura School until they require special medical attention at which time they are housed in the infirmary. A CYA survey of seven other states found that six states maintain HIV-positive youthful offenders in the general population unless their medical needs require infirmary care. One state places HIV-positive youthful offenders into foster care.

County and City Jails. County jail practices in California vary with respect to housing of HIV-positive inmates. Thirteen of the fifteen county jails we reviewed routinely

house asymptomatic HIV-positive inmates in the general population. Of the remaining two jails, one houses asymptomatic inmates with the general population in housing units that receive higher levels of supervision, and one houses asymptomatic inmates in a separate HIV housing unit. However, as regards inmates with symptoms of HIV infection, we found that the county jails place these individuals in separate housing. In city jails, we found that inmates who are ill remain in the jail for very short periods of time before they are either released or transferred to county hospitals or jails.

Chapter II

Criteria for Assessing HIV Education Programs

In this chapter we discuss the criteria we used to assess the HIV education programs in California's correctional facilities. (A copy of the survey document is included in Appendix 3.)

How Were the Review Criteria Developed?

We developed evaluation criteria to meet the statutory requirements of Chapter 1579 based on background research in three areas--health education programs in general, HIV education programs outside of correctional facilities, and HIV education programs within correctional facilities. Our basic premise in developing these criteria was that an adequate HIV education program must have as its primary goal changing individuals' behavior so as to avoid or reduce activities placing them at risk of HIV infection. According to the literature we reviewed, an effective HIV education program would include the following outcomes: (1) improved knowledge of the facts regarding the health threat--in this case HIV infection, (2) awareness of the seriousness of the health threat, (3) behavior changes that result in risk reduction or elimination, and (4) maintenance of risk-reducing behavior changes.

Researchers note that most health education programs which have been based on providing information alone have not significantly changed behavior. For example, smoking, cardiovascular disease, and seat-belt use are cited as some of the health areas where many individuals have not been motivated to change their behavior based on information alone. According to the research we reviewed, health education programs that lead to behavior change

include certain common factors. A recent United States General Accounting Office report on AIDS education programs provides a model which includes those common factors found to influence behavior change in other health programs. We modified this model and used it as the review criteria for evaluating California's HIV education programs in correctional facilities.

The Review Criteria

We used five criteria to assess the HIV education programs in California's state and local correctional facilities. The criteria are described in detail below.

Specify the Target Groups. We found that identifying the target groups for education efforts is critical to reaching the intended audience. Whom the education efforts are directed toward affects how, when, and what HIV information must be provided to assist behavior change.

In correctional facilities, target groups include inmates, wards, staff, and visitors. A number of secondary target groups also exist. For example, inmates and wards paroled from the correctional system need specific HIV information that will help them in their day-to-day lives outside of the facility. In addition, health staff need more detailed information--for example, on sterilizing laboratory equipment--than correctional officers.

Identify Characteristics Placing Target Groups at Risk. According to our research, an accurate assessment of why an individual is at risk is critical to developing a program which assists behavior change. Trainers who are conducting HIV education programs must identify and address which high-risk activities individuals are involved in, and why individuals engage in these activities, including how individuals' attitudes and beliefs influence their involvement in high-risk activities. Additionally, when developing an education program, trainers must consider the HIV information that individuals currently have and the ability of individuals to understand the education program.

In correctional facilities, staff, inmates, and wards have a variety of characteristics that should influence the devel-

opment of HIV education programs. For example, staff are involved in high-risk activities, such as responding to fights, as part of their day-to-day jobs. Inmates and wards may engage in high-risk activities such as unsafe sex for a variety of reasons, such as peer pressure and the belief that risk taking is seen as positive by others. The ability of staff, inmates, and wards to understand the education program will depend on their vocabulary and level of reading and verbal comprehension.

Select Methods to Reach Target Groups. The literature we reviewed—including the recent *Report of the Presidential Commission on the HIV Epidemic*--identified a number of important methods for presenting HIV education programs. These methods include using credible trainers (such as health staff and peers), a variety of media, small or medium group size, active participant involvement, and periodic follow-up or reinforcement. In addition, the NIJ has stressed the importance of regular and mandatory HIV education classes for both staff and inmates.

Select Factual Information to Provide to Target Groups. According to the literature we reviewed, factual information is important for assisting behavior change because it helps the individual assess the degree of risk involved and the steps needed to eliminate or reduce risk. In reviewing various HIV education curricula, we found that the following information is included in all of the curricula developed by major health organizations: the spectrum of HIV infection, symptoms and treatment, HIV testing, precautionary measures, and degree of risk of infection.

Identify Risk Reduction Skills. The literature stresses that without actual demonstration and practice, and without the necessary resources, individuals are unlikely to develop risk reduction skills. In correctional facilities, for example, staff must know how to correctly respond to blood spills and have the necessary safety equipment available in order to reduce their risk of HIV infection. Inmates and wards who engage in high-risk activities, such as unsafe sex or IV drug use, need to have both the skills and resources necessary to reduce their risk of contracting HIV infection and to increase the probability of behavior change.

How Were the Reviews Conducted?

We reviewed HIV education programs in 42 state and local correctional facilities in California as shown in Table 3. We interviewed the individuals at each facility who were most knowledgeable about HIV programs for staff, inmates, and wards. Typically this included training managers, staff trainers, and chief medical officers. The survey document, based on the review criteria, was the guide for these interviews. We also held discussions with a limited number of inmates and wards, and attended selected education classes. Relevant documents, such as policies, procedures, and HIV education materials were also reviewed.

Our reviews of the correctional facilities began in January 1989 and continued through July 1989.

Prior to the reviews, we interviewed BOC, CDC, and CYA staff to determine current state policies and procedures on HIV education in correctional facilities, and to determine what guidance and resources they provide to facilities.

Table 3

HIV Education Programs in Correctional Facilities Review Sites

State Prisons

California Institute for Men at Chino, California Institute for Women at Frontera, California Medical Facility at Vacaville, California Rehabilitation Center at Norco, Mule Creek State Prison at Lone, Northern California Women's Facility at Stockton

California Youth Authority Facilities

Karl Holton School at Stockton, Northern Reception Center Clinic at Sacramento, Preston School of Industry at Lone, Southern Reception Center Clinic at Whittier, Ventura School at Camarillo, Youth Training School at Chino

County Jails

Alameda County Jail, Fresno County Jail, Inyo County Jail, Lake County Jail, Los Angeles County Jail, Marin County Jail, Orange County Jail, Sacramento County Jail, San Bernardino County Jail, San Diego County Jail, San Francisco County Jail, Santa Barbara County Jail, Santa Clara County Jail, Sonoma County Jail, Sutter County Jail

City Jails

Alameda County: Berkeley City Jail, Hayward City Jail, Oakland City Jail

Fresno County: Coalinga City Jail, Selma City Jail

Los Angeles County: Burbank City Jail, Covina City Jail, Hawthorne City Jail, Los Angeles City Police Department (Parker Center), San Fernando City Jail, Santa Monica City Jail, Whittier City Jail

Marin County: Novato City Jail

Santa Barbara County: Lompoc City Jail

Santa Clara County: Santa Clara City Jail

Chapter III

HIV Education Programs in State Prisons

We reviewed HIV education programs in six state prisons as shown in Table 3 of Chapter II. These six state prisons represent facilities which are large and small, for men and women, are medical and nonmedical facilities, and with and without reception centers (that is, the entry points for inmates into the correctional system). Three of these facilities (CIM, CIW and CMF) have HIVSHUs for inmates infected with HIV.

Findings. The CDC has identified both staff and inmates as target groups who should receive HIV education. As regards staff, all CDC cadets in training to become custody staff receive HIV education at the department's training academy. In addition, all of the six facilities we reviewed include new and current staff in their HIV education programs. Additional HIV education is provided to custody staff, health staff, and HIVSHU staff.

As regards inmates, all six facilities include new, current, and pre-release inmates in their HIV education programs. Inmates residing in the three HIVSHUs also are included in the facilities' HIV education programs. HIV information in Spanish is available for Spanish-speaking inmates. Although written materials are placed in some visitor areas and in some family visiting trailers, visitors--including spouses--are not formally included in facilities' HIV education programs.

Findings, Conclusions, and Recommendations

1. Did CDC Facilities Specify the Target Groups?

Conclusions. The CDC has identified staff and inmates as target groups to receive HIV education. Such targeting enables the facilities to address the distinctly separate HIV education needs of the staff and inmates. The failure to target spouses in the family visiting program, however, places participating spouses and inmates at risk of HIV infection.

Recommendation. The CDC central office should ensure that spouses participating in the family visiting program are included in the facilities' HIV education programs.

**2. Did CDC Facilities
Identify Characteristics
Placing Target Groups at
Risk?**

Characteristics Placing Staff at Risk

Findings. The CDC central office provides or approves all HIV education materials (that is, written information, posters, videos, and training curricula) for staff. These materials are developed by the CDC, the San Francisco AIDS Foundation, the American Red Cross, and other organizations. These materials identify the high-risk activities that staff may be involved in as part of their jobs and explain how they can reduce the risk of HIV transmission.

The high-risk activities discussed in these materials are consistent with those identified by the Centers for Disease Control and the AIDS Education for Emergency Workers Project (AEWP) under the auspices of the American Red Cross. For health staff, high-risk activities include contact with contaminated needles, bodily fluids, and infectious waste. For custody staff, high-risk activities include contact with contaminated sharp objects during body searches and cell searches, and contact with bodily fluids during altercations.

HIV education materials are developed to take into consideration staff abilities--vocabulary, and reading and verbal comprehension.

Conclusions. Based on our review, we conclude that the CDC has identified the high-risk activities of staff, and

provides HIV education materials that discuss these identified high-risk activities. In addition, these materials are presented in a manner that is understandable to staff.

Recommendation. None.

Characteristics Placing Inmates at Risk

Findings. The CDC central office provides or approves all HIV education materials for inmates. These materials are developed not only by the CDC but by the San Francisco AIDS Foundation, the American Red Cross, and other organizations. These materials identify the high-risk activities that inmates may be involved in and explain how they can reduce their risk of HIV transmission. For inmates, high-risk activities include engaging in IV drug use and sharing needles, unsafe sex, tattooing, piercing ears, and sharing razors.

Although the high-risk activities of inmates are identified, generally we found that HIV educational materials do not address the *reasons* for inmates' involvement in high-risk activities, including how attitudes and beliefs influence high-risk involvement. Some trainers we interviewed, however, indicated that they address the reasons for high-risk activities. For example, they cited the following reasons for inmates engaging in high-risk activities: incarceration, habit, personal preference, peer pressure, and lack of information about HIV infection. Other trainers stated, however, that there is not enough time to include in a class both the basic factual HIV information, as well as the reasons for high-risk involvement.

Inmate HIV education materials are developed to take into consideration their abilities--vocabulary, and reading and verbal comprehension. For example, written HIV information and videos for inmates are provided in both English and Spanish, and they are generally developed for the third grade level. Furthermore, written information has become less technical over time, and common everyday language is used in most of the publications the central office provides. Nevertheless, some of the trainers and inmates we interviewed criticized the written HIV information as still too technical and not using vocabulary common to inmates.

Conclusions. Our review found that the CDC central office provides many HIV education materials that identify the high-risk activities of inmates and discuss how HIV transmission can be reduced or eliminated. However, these materials do not address the reasons why inmates are involved in high-risk activities, including how attitudes and beliefs influence high-risk involvement. Such information should be included in HIV education materials in order to increase the probability that inmates will modify their behavior thereby reducing their exposure to HIV infection.

Recommendations.

- The CDC central office should ensure that HIV education materials for inmates are nontechnical and easily understood.
- After the CDC central office and the facilities have ensured that all inmates receive basic factual HIV information, they should assess how the reasons for inmates' involvement in high-risk activities can be addressed in their HIV education materials.

**3. Did CDC Facilities
Select Methods to Reach
Target Groups?**

Methods to Reach Staff

Findings. The CDC central office requires that all CDC staff receive HIV education annually. Beginning in 1986-87, all cadets attending the department's training academy were required to receive two hours of HIV training. In addition, all custody staff at facilities were required to receive two hours of HIV training in 1986-87. Currently, all staff are required to attend a minimum of 30 minutes of HIV training annually. Health staff are required to receive training on HIV infection control procedures and policies during orientation and annually thereafter. Directives provided by the central office instruct the facilities to distribute written HIV information to staff and to post posters when received from the central office.

Our review found that all six facilities conduct HIV education classes for *new* staff. Attendance at these classes is mandatory, and those interviewed indicated that new

staff attend these classes with few exceptions. Three facilities provide HIV training for new staff within the first week of their arrival. The other three facilities provide HIV training to new staff as soon as there are sufficient personnel for a minimum class size, generally, within 30 to 90 days of staff arrival. However, written HIV information is either provided or available to these new staff within the first week of their arrival at the facility.

On the other hand, attendance at mandatory annual *update* classes varies. For the period from October 1987 through September 1988, the CDC found that attendance at these six facilities ranged from 28 percent at the NCWF to 78 percent at the MCSP. More recent data indicate that attendance at annual update classes is generally improving, but still ranges from 27 percent at the CRC to 100 percent at the MCSP.

At the six facilities we reviewed, classroom instruction generally includes lectures, distribution of written information, use of videos, and question and answer portions. Class sizes range from 5 to 200 staff, although the average class size is about 30 staff. The classes range in length from one hour to two and one-half hours. Generally, these classes are conducted by facility staff who have attended training classes sponsored or approved by the central office. (However, trainers from organizations working under contracts with the OA conduct some of the classes.) Facility staff that conduct classes include physicians, nurses, custody staff, and support staff.

Outside of HIV classes, the CIW and the CMF place written HIV information in staff mailboxes and the CIM includes information with paychecks. The other three facilities place information in various locations to be picked up by staff; however, this method does not ensure that staff in fact pick up this material.

The CIM, CMF, and CIW provide additional mandatory HIV training for staff of the HIVSHU over and above any other HIV training they receive. At the CIM, the goal is to provide this training before staff begin work in the unit. The CIW provided additional training to its HIVSHU staff in October 1988. At the time this report was prepared, planning for another training class for these staff was in

process. The CMF advises us that it provides additional HIV training to its HIVSHU staff periodically.

During our review, we generally found that several individuals in a facility were responsible for staff HIV education efforts and that their efforts were not always integrated. For example, at one facility we had to contact nine individuals in order to obtain a complete picture of the facility's HIV education program for staff.

Conclusions. Written HIV information is available to most new staff. Some new staff attend HIV education classes just prior to or soon after arriving at a facility. However, other staff may be involved in high-risk activities before receiving current HIV information because: (1) education classes are not scheduled upon arrival of new staff and (2) written HIV information is not always provided directly to new staff.

Although staff attendance at annual update classes has improved at some facilities, a high proportion of staff at other facilities are not attending annual update classes as required. As a result, some current staff may not receive updated HIV information, thereby preventing the reinforcement value of update classes. Additionally, written HIV information is not always distributed outside of HIV education classes in a manner that ensures that all staff receive or pay attention to it. As a result, staff may not receive updated written information, and this information loses its reinforcement value.

At the facilities we reviewed, responsibility for the staff HIV education was carried out by several individuals operating independently and generally on their own initiative. Consequently, there is no mechanism for ensuring that: (1) HIV education is provided to all staff, (2) consistent information is provided to staff, and (3) duplicative HIV education efforts are minimized.

Recommendations.

- The CDC central office should ensure that new staff who may be involved in high-risk activities receive HIV education.
- The CDC central office should ensure that all staff who may be involved in high-risk activities attend the required annual HIV update classes.

- The CDC central office should provide facilities with more specific guidelines for distributing written HIV information to staff to ensure that they actually receive the updated written HIV information provided by the central office.
- The CDC central office should assess its current distribution schedule to determine whether or not it distributes HIV materials in a manner that maximizes their reinforcement value and complements the information provided to staff in HIV education classes.
- The CDC central office should ensure that all HIV education efforts for staff are coordinated within each facility.

Methods to Reach Inmates

Findings. Although the CDC central office does not require facilities to conduct HIV education classes for inmates, all six facilities we surveyed conduct such classes for either new, current, and/or pre-release inmates. However, not all inmates attend these classes. As regards *new* inmates, four facilities (CIW, CMF, CRC, and NCWF) provide HIV education classes for these inmates within 48 hours to 5 weeks after their arrival. Although staff at these facilities indicated that attendance at these HIV classes is mandatory, we found that other inmate activities (such as medical appointments) are often scheduled at the same times as these HIV classes and that attendance requirements are generally not enforced. The CIM and the MCSP do not conduct HIV education classes for arriving inmates.

As regards *current* inmates, four facilities (CIM, CMF, MCSP, NCWF) periodically conduct HIV classes or informal information sessions for these inmates. The CRC periodically shows HIV videos only. Attendance is voluntary at all five facilities. The sixth facility, CIW, does not conduct classes for the existing general population. All six facilities conduct classes for *pre-release* inmates; however, only the CRC indicated that inmate attendance at these classes is mandatory. Little data are collected on inmate attendance at HIV education classes, so it is virtually impossible to determine actual inmate attendance.

Inmate HIV education is conducted by either facility staff or trainers from organizations working under contracts with the OA. Both staff and inmates expressed con-

cerns about trainer credibility at several facilities. Some inmates expressed concern that inmate advisory committees which provide input on HIV education do not actually have much influence on facilities' HIV education programs. In contrast, peer trainers (inmates) are involved in the HIV education classes at the CIW and the CMF, and staff and inmates interviewed at these institutions indicated that peer trainers have a high degree of credibility.

In general, classroom instruction includes lectures and question and answer portions. Videos are not shown in all classes, although the CDC provides a variety of videos to facilities and encourages that they be shown. Additionally, written materials are not distributed in all classes. Classes range in size from 1 to 50 inmates and in length from one-half hour to three hours.

Outside of classes, written materials may be given to inmates when they arrive at the facility, placed in various locations to be picked up by inmates, or not distributed at all. Both staff and inmates indicated that many inmates do not read these materials.

Both the CIW and the CMF provide HIV education sessions periodically to inmates in HIVSHUs. At the time this report was prepared, the CIM provided only written HIV information to HIVSHU inmates.

During our review, we found that responsibility for the inmate HIV education program was fragmented among many individuals within a facility (as well as contractors). No single individual in a facility or contractor was aware of all inmate education efforts. For example, at most facilities, we had to contact many persons in order to obtain information on HIV education programs. In addition, we found that the persons in charge of distributing written materials were entirely separate from the persons running the other HIV education efforts. We also found that contractors have little knowledge about a facility's HIV education program prior to conducting education classes in the facility.

Conclusions. Although the CDC does not require the facilities to provide HIV education classes for inmates, the six facilities we reviewed conduct such classes for either new, current, and/or pre-release inmates. Nevertheless,

not all inmates attend HIV education classes either on arrival, during incarceration, or prior to release. This is because: (1) attendance is voluntary in some cases or (2) when mandatory, attendance requirements are not enforced. Voluntary attendance requirements for HIV education classes result in: (1) inmates not receiving needed HIV information and (2) HIV classes sometimes being conducted for a small number of inmates.

Because HIV education classes or materials are not provided to inmates on a regular basis, there is little reinforcement of the information that has been provided. As a result, the probability of behavior modification is reduced. With the exception of the CIW and the CMF, facilities do not use inmates as peer trainers although they are a resource that could be used to improve the credibility of HIV education. In addition, the lack of visible inmate influence on facilities' programs reduces the credibility of the program.

Written HIV information reaches far more inmates than education classes, although not all inmates receive or read these materials. Additionally, there is no schedule for distributing written information to maximize its reinforcement value.

As with staff, responsibility for the inmate HIV education program was carried out by several individuals operating independently. Consequently, there was no mechanism for ensuring that HIV education efforts are coordinated, consistent, and timely.

Recommendations.

- The CDC central office should ensure that all new inmates attend HIV education classes or watch HIV education videos, and receive HIV written information within a few days of arrival at reception centers and that all inmates leaving prison attend pre-release HIV education classes.
- The CDC central office should provide facilities with more specific guidelines for distributing written HIV information to inmates to ensure that they actually receive the updated written information provided by the central office.
- The CDC central office should distribute HIV materials in a manner that maximizes their reinforcement

value and complements the information provided to inmates in HIV education classes.

- The CDC should place more emphasis on periodic reinforcement of information to effect behavior modification. This will increase the probability of HIV education leading to a reduction in inmates' involvement in high-risk activities.
- The CDC central office should assess if inmates can play a larger role in developing HIV education programs for inmates and if more inmates can be utilized as peer trainers.
- The CDC central office should ensure that all HIV education efforts for inmates are coordinated within each facility.

**4. Did CDC Facilities
Provide Factual
Information to Target
Groups?**

Factual Information Provided to Staff

Findings. Although the AEWB curriculum is used most often for staff HIV education classes, other curricula are also used. All of the curricula vary in their content although, in general, they contain much of the same basic HIV information. The curricula were developed with funding provided by either the CDC or OA.

The AEWB curriculum includes: (1) the definition of HIV disease (HIV-positive, ARC, AIDS), (2) how HIV is transmitted and not transmitted, (3) safety precautions and procedures for preventing HIV transmission in the workplace, (4) the symptoms of HIV infection, and (5) the reasons for obtaining an HIV antibody test.

Our review found that the information provided to staff during HIV education classes varies. This is because of differences in the curricula and trainer expertise, and because the number of questions received on one topic limits the time available for other topics.

Conclusions. The absence of standard curricula for the various staff target groups has two significant consequences. First, it means that not all staff within a target group receive the same basic factual information. Second, the state is paying for the development of comparable curricula more than once.

Many questions during an HIV education class may result in inadequate time to cover all topics fully and, consequently, staff may not receive the information they need to reduce their risk of HIV infection.

Recommendations.

- The CDC central office and the OA should jointly evaluate the HIV curricula to ensure that regardless of the curricula used, all staff receive consistent information.
- The CDC central office should ensure that there is enough time in a class to provide adequate HIV information.
- The CDC central office and the OA should jointly determine the model curricula that are necessary for the various staff target groups.

Factual Information Provided to Inmates

Findings. The CDC central office does not provide model curricula for the various inmate target groups. As a result, several curricula are used within the CDC. All of the curricula vary in their content although, in general, they contain much of the same basic HIV information. These curricula were developed with funding provided by either the CDC or OA.

In general, the curricula for inmates include: (1) the definition of HIV disease, (2) how HIV is transmitted and not transmitted, (3) precautionary measures, (4) the symptoms of HIV disease, (5) the reasons for obtaining an HIV antibody test, (6) the meaning of HIV antibody test results, and (7) the treatment of HIV infection.

Based on our review, the information provided to inmates during HIV education classes varies. Part of this variation is due to differences in the curricula, trainer expertise, and the number of questions received during a class. In addition, part of the variation is due to the trainers' own beliefs about what the inmates need to know about HIV infection.

Conclusions. The absence of standard curricula for the various inmate target groups has two significant consequences. First, it means that not all inmates within a target group receive the same basic factual information. In addition, it is not clear that inmates receive sufficient factual

information so they can assess their own risk of HIV infection. Second, the state is paying for the development of comparable curricula more than once.

Many questions during an HIV education class may result in inadequate time to cover all topics fully and, consequently, inmates may not receive the information they need to reduce their risk of HIV infection.

Recommendations.

- The CDC central office and the OA should jointly evaluate the HIV curricula to ensure that regardless of the curriculum used, all inmates within a target group receive consistent information.
- The CDC central office and the OA should jointly determine the model curricula that are necessary for the various inmate target groups.
- The CDC central office should ensure that inmates receive the factual information they need to assess their own risk of HIV infection.
- The CDC central office should ensure that there is enough time in a class to provide adequate HIV information.

**5. Did CDC Facilities
Provide Risk Reduction
Skills?**

Findings. Facilities teach a variety of risk reduction skills to staff. For example, staff receive instructions and demonstrations on the proper use of gloves, goggles, one-way airways for resuscitation, and jump suits; procedures for cleaning, sterilization, and waste disposal; and procedures for handling sharp items. Staff have available to them the equipment listed above.

As regards inmates, all six facilities provide information on risk reduction, including abstinence, safe sexual activities, and the use of condoms in their HIV classes and written materials. However, demonstrations of the proper use of condoms are provided in one pre-release program (CMF), contrary to CDC policy. Information on needle-cleaning is not generally provided to inmates although a few trainers indicated that they provide such information during HIV classes.

Conclusions. The risk reduction skills and equipment provided for staff are consistent with those recommended by the Centers for Disease Control and the AEWPP. However, risk reduction skills are not taught to inmates. For example, inmates are not actually shown how to correctly use condoms and how to clean IV needles, and condoms or bleach are not provided to inmates.

Recommendation. Although sex and IV drug use are both illegal activities within state prisons, few dispute that these activities occur in prisons. Currently, there is little information available on whether condom demonstration and availability programs would affect the transmission of HIV among inmates who engage in these practices. However, given the seriousness of the disease, and the importance medical experts have placed on the use of condoms to reduce the risk of HIV transmission, the CDC should review its current policies on the demonstration and availability of condoms in prisons. (Safety and legal considerations preclude distributing bleach to inmates for cleaning IV needles.) In order to facilitate such a review, the CDC central office should contract with an organization which has expertise in this area to: (1) evaluate the effects of the prison condom demonstration and availability programs that currently exist nationwide and (2) determine whether such programs should be tested and/or implemented in California. In addition, the contractor should assess the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission in prisons.

Chapter I

HIV Education Programs in California Youth Authority Facilities

We reviewed HIV education programs in six CYA facilities as shown in Table 3 of Chapter II. These six CYA institutions represent facilities which are large and small, for males and females, and with and without reception centers for wards admitted to the CYA. In addition, one of these facilities, the Ventura School, is the facility where HIV-positive wards reside. The average age of CYA wards is 18.8 years, with 68 percent of wards being 18 years of age or older. Behavior modification is emphasized in all CYA programs.

Findings. The CYA has identified some, but not all, of the target groups who should receive HIV education. As regards staff, all CYA cadets receive HIV education at the department's training academy prior to being assigned as an employee to a facility. However, only one of the six facilities we reviewed includes *new* staff in its HIV education program while all six facilities include *current* staff in their HIV education programs.

As regards wards, two facilities include *new* wards in their HIV education programs, and all six include *current* wards. Two facilities include *pre-release* wards in their HIV education programs. HIV information in Spanish is available for Spanish-speaking wards in southern California facilities. No HIV information is provided to visitors.

Conclusions. The CYA does not address the specific HIV education needs of certain staff and wards. Although HIV information is not provided to visitors, this does not

Findings, Conclusions and Recommendations

1. Did CYA Facilities Specify the Target Groups?

appear to present a problem because there are no extended visiting programs for wards and their spouses as there are in the state's prisons.

Recommendation. The CYA central office should ensure that all facilities include new staff, new wards, and pre-release wards in their HIV education programs. In addition, Spanish-speaking wards should be included in all facilities' HIV programs.

**2. Did CYA Facilities
Identify Characteristics
Placing Target Groups at
Risk?**

Characteristics Placing Staff at Risk

Findings. The CYA central office provides the majority of the HIV education materials (that is, written information, posters, videos, and training curricula) for staff. These materials are developed by the CYA, the American Red Cross, and other organizations. These materials identify the high-risk activities that staff may be involved in as part of their jobs and explain how they can reduce the risk of HIV transmission. The high-risk activities discussed in these materials are consistent with those identified by the Centers for Disease Control and the AEWPP.

For health staff, high-risk activities include contact with contaminated needles, bodily fluids, and infectious waste. For custody staff, high-risk activities include contact with contaminated sharp objects during body searches and cell searches, and contact with bodily fluids during altercations.

The HIV education materials provided by the CYA central office are developed to take into consideration the abilities of staff--vocabulary, and reading and verbal comprehension.

Other HIV materials that have not been approved by the central office are also used in individual facilities. (There is no requirement that such materials be approved by the central office beforehand.) Due to time constraints, we were unable to review these materials.

Conclusions. The CYA central office has identified the high-risk activities of staff, and provides HIV education

materials that discuss these identified high-risk activities in an understandable manner.

Recommendation. None.

Characteristics Placing Wards at Risk

Findings. The CYA central office provides the majority of HIV education materials for wards. In addition, it provides the HIV curriculum that is used in HIV education classes for wards. As regards the education materials, they are developed by the CYA, the San Francisco AIDS Foundation, the American Red Cross, and other organizations. These materials identify the high-risk activities that wards may be involved in and explain how they can reduce their risk of HIV transmission. For wards, high-risk activities include engaging in IV drug use and sharing needles, unsafe sex, tattooing, and piercing ears.

The HIV curriculum that is provided by the CYA central office discusses the reasons for wards' involvement in high-risk activities, including how attitudes and beliefs influence high-risk involvement. According to the trainers we interviewed, the reasons for wards' involvement in high-risk activities include age, peer pressure, and a false sense of invincibility. It is important to note that CYA teachers routinely address the reasons for wards' involvement in high-risk activities in their classes because behavior modification is emphasized in all CYA programs.

Written HIV information provided by the central office for wards, however, does not discuss the reasons for high-risk involvement. Rather, this information is intended to be short, and to focus on how HIV is transmitted and how transmission can be eliminated or reduced.

The HIV education materials provided by the CYA central office are developed to take into consideration the abilities of wards--vocabulary, and reading and verbal comprehension levels. For example, written materials and videos are provided in both English and Spanish for wards in southern California facilities. In addition, written HIV information is generally developed for the third grade level. However, during our interviews, many teachers who conduct HIV education classes for wards criticized the HIV curriculum provided by the CYA central office as being too technical and difficult for many wards to under-

stand. As a result, this curriculum is almost always modified by teachers at the facilities before it is used in HIV education classes for wards.

Other HIV materials that have not been approved by the central office are also used in individual facilities. (There is no requirement that such materials be approved by the central office beforehand.) Due to time constraints, we were unable to review these materials.

Conclusions. The CYA central office provides many HIV education materials and an HIV curriculum that identify the high-risk activities of wards and discuss how HIV transmission can be reduced or eliminated. However, the HIV curriculum is considered by many teachers to be too technical and difficult. Unfortunately, this curriculum is the only HIV education material provided by the central office which addresses the reasons for wards' involvement in high-risk activities. Because teachers often modify this curriculum to make it more useful to wards, the information that is actually provided to wards is unknown. There are no CYA central office guidelines for modifying the curriculum to ensure consistency among the programs.

Recommendations.

- The CYA central office should ensure that HIV education materials for wards are nontechnical and easily understood.
- The CYA central office should ensure that the HIV information provided to wards addresses the HIV education needs of wards.
- After the CYA central office and the facilities have ensured that all wards receive basic factual HIV information, they should assess how the reasons for wards' involvement in high-risk activities can be addressed in HIV education materials used outside of HIV education classes.

3. Did CYA Facilities Select Methods to Reach Target Groups?

Methods to Reach Staff

Findings. The CYA central office requires that all CYA staff receive HIV education annually. Beginning in 1987-88, all cadets attending the department's training academy were required to receive two hours of HIV training. In addition, all CYA staff at facilities were required to receive two hours of HIV training in 1987-88 and an update annually thereafter. Directives provided by the CYA central office instruct the facilities to distribute written HIV information to staff and to post posters when received from the central office.

Five of the six facilities we reviewed provide written HIV information or HIV training for new staff during orientation. The orientation is held within one to three months of new staff arrival, depending on when there are sufficient personnel for a minimum class size. We were unable to obtain attendance data for these orientation sessions. As regards update *classes*, the CYA central office advises that 98 percent of the CYA staff attended these mandatory classes in 1987-88. Written HIV information is generally not available outside of HIV classes at CYA facilities. In fact, during our visits to some CYA facilities we were unable to determine who in the facility was responsible for distributing written HIV information to staff.

All six facilities utilize similar formats for staff HIV training classes. These classes are conducted by facility staff who attended training classes sponsored by the CYA central office. These facility trainers include physicians, nurses, custody staff, counselors, and teachers. A standard HIV training module, provided by the central office, is used at all facilities. It includes lectures, distribution of written materials, use of videos, and question and answer portions. Class sizes range from 1 to 50 staff, although the average class size is about 25 staff. The training module is designed to be completed in two hours.

As with the CDC, we generally found that no one individual in a facility oversees all HIV education efforts for staff. At all CYA facilities, a number of people had to be contacted in order to obtain information about staff HIV education efforts.

Conclusions. New CYA staff may be involved in high-risk activities prior to receiving current HIV information. This is because new staff orientation sessions are not scheduled soon after new staff arrival, and because written HIV information is not provided directly to new staff outside of HIV education classes.

Based on the information provided by the CYA central office, most staff attend mandatory annual update classes. However, written HIV information is rarely distributed to staff outside of HIV education classes. Consequently, staff seldom receive updated written information, thereby minimizing the reinforcement value of this information.

At the facilities we reviewed, generally no one individual within the facilities had overall responsibility for the staff HIV education program. Consequently, there is no mechanism for ensuring that: (1) HIV education is provided to all staff, (2) consistent information is provided to staff, and (3) duplicative HIV education efforts are minimized.

Recommendations.

- The CYA central office should ensure that new staff who may be involved in high-risk activities receive HIV education.
- The CYA central office should continue to ensure that all staff who may be involved in high-risk activities attend the required annual HIV update classes.
- The CYA central office should provide facilities with more specific guidelines for distributing written HIV information to staff to ensure that they actually receive the updated written HIV information provided by the central office.
- The CYA central office should develop a distribution schedule for HIV materials that maximizes the reinforcement value of these materials and complements the information provided to staff in HIV education classes.

- The CYA central office should ensure that all HIV education efforts for staff are coordinated within each facility.

Methods to Reach Wards

Findings. Beginning in 1987-88, all wards were required to receive six hours of HIV education. Despite this requirement, our review found that not all wards attended these classes. For example, only two facilities (SRCC and YTS) provide HIV education classes for *new* wards. These classes are held within two weeks of a ward's arrival at the YTS and within six weeks at the SRCC.

As regards *current* wards, all six facilities conduct HIV education classes for these individuals. The CYA central office advises us that 65 percent to 85 percent of wards have attended HIV education classes, but we were unable to verify this information. Although attendance at these HIV classes is intended to be mandatory, other activities (such as medical appointments) are often scheduled at the same time as these classes. Only the PSI has a formal HIV education class in place for *pre-release* wards. The Ventura School indicated that informal HIV education sessions are held for pre-release wards.

The HIV education classes for wards are conducted by either facility staff or trainers from organizations working under contract with the OA. Only at the KHS are peer trainers involved in the HIV education classes. Staff interviewed at that facility indicated that peer trainers have been accepted in the facility as well as in the community where they sometimes make presentations.

In general, classroom instruction includes lectures, videos, and question and answer portions. Written HIV information is distributed in some classes. Class sizes range from 1 to 45 wards. Although the training curriculum is designed to be completed in 6 hours, the classes range in length from 3 to 13 hours.

Directives provided by the CYA central office instruct the facilities to distribute written HIV information to wards. However, we found that written information is seldom distributed to wards outside of HIV education classes. Facility staff indicated that wards often do not read this information.

Although the CYA central office requires that all wards receive HIV education, we found that responsibility for this education program was fragmented among many individuals within a facility (as well as contractors). For example, we found that: (1) no one ensures that wards attend the required HIV classes, (2) numerous individuals in each facility are developing HIV materials for wards and there is no approval process in place for these materials, (3) no one ensures that the HIV information provided to wards is consistent, and (4) HIV materials provided to facilities by the central office are often not distributed within facilities at all.

We also found instances where more than one contractor was conducting HIV classes for wards in a facility and that they were utilizing different curricula. In these cases, the OA has paid for the development of comparable curricula for the same target groups more than once. Additionally, contractors have little knowledge about a facility's HIV education program prior to conducting classes in that facility. As a result, contractors' efforts are not coordinated with other HIV education efforts in the facility.

Conclusions. Although the CYA requires that all wards receive HIV education, not all wards attend HIV education classes either on arrival, during incarceration, or prior to release. In addition, written information is often not provided to wards as required by the central office. This is a significant problem caused primarily by the lack of CYA central office coordination and monitoring. While a similar problem exists within the CDC, the progress made in developing an overall HIV education plan has been far less at the CYA than at the CDC. With the exception of the KHS, facilities do not use wards as peer trainers although they are a resource that could be used to improve HIV education for wards.

Recommendations.

- The CYA central office should develop a comprehensive implementation plan for its HIV education program for wards. This plan should specify the following provisions:
 - The CYA central office should ensure that all wards attend the required HIV education classes. We recommend that these classes be provided at

the reception centers so that wards will have adequate HIV information before they are permanently assigned to a facility. We also recommend that all pre-release wards attend HIV education classes prior to leaving a facility.

- The CYA central office should provide facilities with more specific guidelines for distributing written HIV information to wards to ensure that they actually receive the updated written information provided by the central office.
- The CYA central office should develop a distribution schedule for HIV materials that maximizes the reinforcement value of these materials and complements the information provided to wards in HIV education classes.
- The CYA central office should assess if wards can play a larger role in developing HIV education programs for wards and if more wards can be utilized as peer trainers.
- The CYA central office should ensure that all HIV education efforts for wards are coordinated within each facility.

4. Did CYA Facilities Provide Factual Information to Target Groups?

Factual Information Provided to Staff

Findings. A standard HIV training curriculum for staff, developed by Herbert Z. Wong and Associates, is provided by the CYA central office. The information included in this curriculum is consistent with certain information covered by the AEWPP curriculum which is used by the CDC and many local jails.

However, our review found that the information provided to staff during HIV education classes varies. This is because of differences in trainer expertise and because the number of questions received on one topic limits the time available for other topics.

Conclusions. Many questions during an HIV education class may result in inadequate time to cover all topics fully and, consequently, staff may not receive the information they need to reduce their risk of HIV infection.

Recommendation. The CYA central office should ensure that there is enough time in a class to provide adequate HIV information.

Factual Information Provided to Wards

Findings. Although the CYA central office provides a model training curriculum for wards, this curriculum is often modified. In addition, other comparable curricula which were developed with funding provided by the OA are used in facilities by contractors. The HIV training curriculum which is provided by the CYA central office includes much of the same information that is provided for inmates by the CDC and the local jails.

Based on our review, the information provided to wards during HIV education classes varies. This is because of differences in the curricula and trainer expertise.

Conclusions. The use of several standard curricula for wards has two significant consequences. First, it means that not all wards receive the same basic factual information. In addition, it is not clear that wards receive sufficient factual information so they can assess their own risk of HIV infection. Second, the state is paying for the development of comparable curricula more than once.

Recommendations.

- The CYA central office and the OA should jointly evaluate the HIV curricula to ensure that regardless of the curricula used, all wards within a target group receive consistent information.
- The CYA central office and the OA should jointly determine the model curricula that are necessary for the various ward target groups.
- The CYA central office should ensure that wards receive the factual information they need to assess their own risk of HIV infection.

5. Did CYA Facilities Provide Risk Reduction Skills?

Findings. Facilities teach a variety of risk reduction skills to staff. For example, staff receive instructions and demonstrations on the proper use of gloves, goggles, and

one-way airways for resuscitation; procedures for cleaning, sterilization, and waste disposal; and procedures for handling sharp items. Staff have available to them the equipment listed above.

As regards wards, the HIV curriculum provided by the central office includes information on risk reduction including abstinence, safe sexual activities, and instructions on using condoms and using bleach to clean IV needles. The CYA has no written policy on making condoms available to wards, although it has verbally informed staff that condoms are not to be provided. However, one facility makes condoms available to parolees.

Conclusions. The risk reduction skills and equipment provided for staff are consistent with those recommended by the Centers for Disease Control and the American Red Cross. However, condoms or bleach are not provided to wards.

Recommendation. Although sex and IV drug use are both illegal activities within CYA facilities, few dispute that these activities occur within facilities. Given the seriousness of HIV disease, and the importance medical experts have placed on the use of condoms to reduce the risk of HIV transmission, the CYA should review its current policies on the demonstration and availability of condoms for wards. (Safety and legal considerations preclude distributing bleach to wards for cleaning needles.) In order to facilitate such a review, the CYA central office should contract with an organization which has expertise in this area to determine whether condom demonstration and availability programs for wards should be tested and/or implemented in California. In addition, the contractor should assess the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission in CYA facilities.



Chapter V

HIV Education Programs in County and City Jails

Chapter 1579 contains legislative intent language recommending that every city and county correctional agency and law enforcement agency have a comprehensive HIV education program for staff and inmates in operation by March 31, 1989. During our review, however, we found that not all local jails have implemented comprehensive programs for staff and inmates. Additionally, we found that the programs that are in place vary because each local jail is responsible for developing its own HIV education programs. Consequently, the effectiveness of these HIV education programs, and therefore the probability of behavior change, varies throughout the state. Moreover, unnecessary costs are being incurred due to the duplicative development and implementation of numerous HIV education programs statewide.

If the Legislature intends to increase the statewide effectiveness and uniformity of the HIV education programs in local jails, then additional standards must be identified for local jails. The Legislature has an option, however, as to whether compliance with these standards should be mandatory or optional. If the Legislature wishes to *mandate* a given level of HIV education, it could require the BOC to adopt such regulations. (The BOC is responsible for establishing operating standards for local jails, including training standards for local corrections staff and health standards for local jail inmates.) This option would require state reimbursement of local costs. In contrast, the Legislature could require the BOC to establish guidelines for HIV education which would be merely advisory and, consequently, would not require state reimbursement. Clearly, however, the first option increases the likelihood that statewide uniformity would be achieved.

The findings and conclusions of our review of local jails follow below. Our recommendations are found at the end of the chapter. We reviewed HIV education programs in 15 county jails and 15 city jails as shown in Table 3 of Chapter II. These 30 local jails include facilities which are large and small, for men and women, and are in urban and rural areas of the state. We conducted on-site reviews at 7 county jails, and telephone surveys of the remaining 8 county jails and 15 city jails.

Findings, Conclusions and Recommendations

1. Did County and City Jails Specify the Target Groups?

Findings. The local jails have identified custody staff as a target group that should receive HIV education. Many *new* custody staff receive HIV education either at county and city departments' training academies prior to being assigned to a jail or upon arrival at a local jail. All of the 30 local jails we reviewed provide HIV education to their *current* custody staff.

As regards HIV education programs for county jail inmates, only three county jails (Sacramento, San Francisco, and Santa Clara) include new, current, *and* pre-release inmates in their HIV education programs. The remaining county jails include inmates in their HIV education programs as follows: two county jails include *new* inmates; five include only *new* inmates with a history of high-risk behavior; and nine include *current* inmates.

HIV information in Spanish is available in many county jails. Although written materials are placed in some visitors areas, visitors are not formally included in county jails' HIV education programs.

None of the city jails we reviewed include either inmates or visitors in their HIV education programs.

Conclusions. All of the local jails we reviewed provide HIV education to their custody staff. However, of the local jails we reviewed, most of the county jails and all of the city jails did not provide HIV education for all inmates. The lack of such education places these inmates at risk of HIV infection.

The failure to target visitors does not appear to present a problem because there are no extended visiting programs in local jails for inmates and their spouses.

2. Did County and City Jails Identify Characteristics Placing Target Groups at Risk?

Characteristics Placing Staff at Risk

Findings. The HIV education materials (that is, written information, posters, videos, and training curricula) used in local jails for custody staff are developed by the American Red Cross, the AEW, and other organizations. The materials we reviewed identify the high-risk activities that custody staff may be involved in as part of their jobs and explain how they can reduce the risk of HIV transmission. The high-risk activities discussed in these materials are consistent with those identified by the Centers for Disease Control and the AEW, and are the same activities discussed in the staff HIV education materials used by the CDC and the CYA.

The HIV materials that we reviewed take into consideration the abilities of custody staff--vocabulary, and reading and verbal comprehension.

Conclusions. Based on our review, we conclude that the local jails have identified the high-risk activities of custody staff, and provide HIV education materials that discuss these identified high-risk activities in an understandable manner.

Characteristics Placing Inmates at Risk

Findings. None of the city jails we reviewed provide HIV education to inmates. As regards county jails, the HIV education materials used for inmates are developed by the San Francisco AIDS Foundation, the American Red Cross, and other organizations. These materials identify the high-risk activities that inmates may be involved in and explain how they can reduce their risk of HIV transmission.

Although the HIV education materials identify the high-risk activities of inmates, generally we found that these materials do not address the reasons for inmates' involve-

ment in high-risk activities, including how attitudes and beliefs influence high-risk involvement. However, some of the trainers we interviewed at county jails indicated they address these reasons in their HIV education classes. Other trainers indicated, however, that there is only enough time to discuss the basic factual HIV information during an HIV education class.

The HIV materials that we reviewed take into consideration the abilities of inmates--vocabulary, and reading and verbal comprehension. For example, 11 county jails provide written HIV information in both English and Spanish. However, some of the trainers and inmates we interviewed criticized the written HIV information and the videos provided to inmates, stating that they are too technical and do not use vocabulary common to inmates.

Conclusions. All of the 15 county jails we reviewed provide some type of HIV education to inmates that identifies the high-risk activities of inmates and explains how HIV transmission can be reduced or eliminated. However, many of the HIV education programs in county jails do not consider the reasons for inmate involvement in high-risk activities. If the probability of behavior change is to be increased, the reasons inmates are involved in high-risk activities should be addressed.

3. Did County and City Jails Select Methods to Reach Target Groups?

Methods to Reach Staff

Findings. The BOC requires that local jail custody staff attend specified training within one year of employment. HIV education is integrated into this training. However, many new custody staff receive their first HIV training at county and city departments' training academies prior to beginning employment at a local jail or upon their arrival at a local jail.

The BOC also requires that custody staff attend annual update training. However, there is no requirement that, as part of this annual update training, custody staff choose an HIV-related class. Although the board does not require that current custody staff attend specific HIV update

classes, 11 county jails and 1 city jail required current custody staff to attend these classes during 1988-89. For 1989-90, however, it is unknown how many local jails will require current custody staff to attend specific HIV update classes.

During our review, we found that HIV education classes for custody staff at county and city jails utilize similar formats. Generally, these classes are conducted by sheriffs' and police department staff who have attended training classes such as those conducted by the AEWB. (However, trainers from organizations working under contracts with the OA conduct some of the classes.) Classroom instruction includes lectures, distribution of written information, use of videos, and question and answer portions. The class sizes range from 15 to 90 staff, although the average class size is about 25 staff. The classes range in length from two to eight hours.

Fourteen county jails and six city jails periodically distribute written HIV information to current custody staff outside of HIV education classes, although the BOC does not require that such information be provided outside of classes. Most local jails include this information in monthly, bimonthly, or quarterly staff bulletins that are placed in staff mailboxes, distribute it with paychecks, or place it in various locations to be picked up by staff.

As with the CDC and the CYA, generally no single individual within a jail oversees all HIV education for staff.

Conclusions. Our review found that many, but not all, new custody staff attend HIV education classes. In addition, we found that most current custody staff attended HIV training in 1988-89. Also, written HIV information is routinely provided to custody staff in many county jails and some city jails. Although many HIV education efforts were undertaken in local jails in 1988-89, it is not assured that these efforts will continue in the future due to the lack of specific HIV training requirements.

Methods to Reach Inmates

Findings. None of the city jails we reviewed provide HIV education to inmates. As regards county jails, only San Francisco County Jail periodically conducts HIV edu-

cation classes for *new* inmates. Seven county jails periodically conduct HIV education classes for *current* inmates. Attendance is voluntary at all of these classes. None of the county jails routinely conduct HIV classes for *pre-release* inmates. Seven county jails periodically show videos to inmates outside of HIV education classes. Few data are collected on inmate attendance at HIV education classes or video sessions, so it is virtually impossible to determine actual inmate attendance.

Inmate HIV education classes are generally conducted by either county health department staff or trainers from other organizations working under contracts with the OA. As with the CDC, some trainers and inmates expressed concerns about trainer credibility. Some inmates expressed concern that inmate advisory committees do not have much influence on HIV education programs. None of the county jails we surveyed utilize peer trainers, who tend to increase the credibility of the HIV education programs.

Classroom instruction includes lectures, use of videos, and question and answer portions. Written HIV information is not distributed in all classes. The classes range in size from 5 to 45 inmates and in length from one hour to three hours.

Written information is primarily distributed during HIV education classes. Outside of these classes, written materials may be given to inmates or placed in various locations to be picked up by inmates. Again, staff and inmates indicated that many inmates do not read these materials.

As with all of the HIV education programs we reviewed, generally no single individual in a jail oversees all HIV education efforts for inmates. Consequently, there is no mechanism for ensuring that: (1) HIV education is provided to all inmates, (2) consistent HIV information is provided to inmates, and (3) duplicative HIV education efforts are minimized.

Conclusions. City jail inmates do not receive any HIV education. Moreover, not all county jail inmates receive HIV education. There are three primary reasons for this. First, a high proportion of inmates remain in local jails for only short periods of time. Second, the BOC does not require local jails to provide HIV education to inmates.

Finally, in the county jails which provide HIV education classes or videos, inmate attendance is not mandatory. Voluntary attendance requirements result in some inmates not receiving HIV information.

The HIV education classes that are provided to inmates primarily focus on information sharing with little focus on behavior modification. Additionally, there is no schedule for distributing written information on a regular basis which would maximize its reinforcement value. Also, local jails do not use inmates as peer trainers although they are a resource that could be used to improve the credibility of HIV education.

Because no single individual in a jail oversees all HIV education for inmates (with the exception of San Francisco County), HIV education efforts do not result in coordinated, consistent, and timely HIV education for all inmates.

4. Did County and City Jails Provide Factual Information to Target Groups?

Factual Information Provided to Staff

Findings. As with the CDC, the AEWPP curriculum is most often used for custody staff, although other curricula are used. The curricula vary in content although, in general, they contain much of the same basic HIV information. Some of these curricula were developed with funding provided by the OA.

Our review found that the information provided to staff varies. This is because of differences in the curricula and trainer expertise, and because the number of questions received on one topic limits the time available for other topics.

Conclusions. The absence of standard curricula has two significant consequences. First, it means that not all staff receive the same basic factual information. Second, the state is paying for the development of comparable curricula more than once.

We question the need for the development of many comparable programs, particularly in light of the availa-

bility of the AEW P curriculum. This curriculum is considered a model for staff HIV education by many trainers, and it is currently used in many correctional facilities.

Many questions during an HIV education class may result in inadequate time to cover all topics fully and, consequently, staff may not receive the information they need to reduce their risk of HIV infection.

Factual Information Provided to Inmates

Findings. The city jails we reviewed do not provide HIV education to inmates. As regards the county jails, there are no standard curricula for inmates among the counties we reviewed. Consequently, numerous curricula are used in county jails that vary in their content; although, in general, they contain much of the same basic HIV information. Some of these comparable curricula used at local jails were developed with funding provided by the OA.

Our review found that the actual information provided to local jail inmates varies. Although part of this variation is due to use of various curricula, other factors include differences in trainers' expertise, and the number of questions received during a class.

Conclusions. The absence of standard curricula has two significant consequences. First, it means that not all inmates receive the same information. In addition, it is not clear that inmates receive sufficient information to allow them to assess their own risk of HIV infection. Second, the state is paying for the development of comparable curricula more than once.

Many questions during an HIV education class may result in inadequate time to cover all topics fully and, consequently, inmates may not receive the information they need to reduce their risk of HIV infection.

5. Did County and City Jails Provide Risk Reduction Skills?

Findings. The local jails teach a variety of risk reduction skills to custody staff. For example, staff receive instructions and demonstrations on the proper use of gloves,

goggles, and one-way airways for resuscitation; procedures for cleaning, sterilization, and waste disposal; and procedures for handling sharp items. Custody staff have available to them the equipment listed above.

The city jails we reviewed do not provide HIV education to inmates. As regards county jails, most facilities provide information on risk reduction, including abstinence and safe sexual activities. Ten of the fifteen county jails we reviewed provide verbal and/or written instructions to inmates on the proper use of condoms. Three of these jails also provide demonstrations of the proper use of condoms. One county jail (San Francisco) began providing condoms in July 1989 to *current* inmates who request them. Two county jails make condoms available to *pre-release* inmates.

In contrast to the state prisons, seven county jails provide verbal and/or written instructions on the proper use of bleach to clean IV needles to current inmates. Two of these jails also show videos which provide demonstrations on using bleach to clean IV needles. Bleach or clean IV needles are not provided, however, to any inmates.

Conclusions. As regards county jails, the risk reduction skills taught to custody staff and the equipment provided to these staff are consistent with those recommended by the Centers for Disease Control and the AEWB. Teaching of inmate skills, however, is lacking if behavior change is the ultimate goal of HIV education. Because not all inmates are actually shown how to correctly use condoms and to clean IV needles, and because condoms or bleach are not provided to inmates, some of the elements of a behavior change program are missing. City jails do not provide risk reduction skills to inmates.

Although sex and IV drug use are both illegal activities within local jails, few dispute that these activities occur. Currently, there is little information available on whether condom demonstration and availability programs would affect the transmission of HIV among inmates who engage in these practices. However, given the seriousness of the disease, and the importance medical experts have placed on the use of condoms to reduce the risk of HIV transmission, the BOC should review the current policies on the demonstration and availability of condoms in local jails.

(Safety and legal considerations preclude distributing bleach to inmates for cleaning IV needles.)

Recommendations.

Staff

- The BOC should issue regulations or guidelines regarding how local jails provide HIV education for new and current staff. Regulations which require local jails to take specific actions regarding HIV education would result in state mandates requiring reimbursement of local costs; guidelines which are merely advisory would not require reimbursement. These regulations or guidelines should assist local jails in ensuring that:
 - New custody staff who may be involved in high-risk activities receive HIV education.
 - Current custody staff who may be involved in high-risk activities attend annual HIV update classes.
 - Custody staff actually receive updated written HIV information.
 - HIV materials are distributed in a manner that maximizes their reinforcement value and complements the information provided to staff in HIV education classes.
 - HIV education efforts for staff are coordinated within a jail.
 - There is enough time in a class to provide adequate HIV information.
- The BOC and the OA should jointly evaluate the HIV curricula that are currently being used in local jails to ensure that regardless of the curricula used, all custody staff receive consistent information.

Inmates

- The BOC should provide guidelines or regulations to the local jails which address HIV education for new, current, and pre-release inmates. These guidelines or regulations should assist local jails in ensuring that:
 - New inmates receive HIV education upon arrival at a local jail and upon leaving a local jail after an extended period of time.
 - Inmates actually receive updated written HIV information.

-
- HIV materials are distributed in a manner that maximizes their reinforcement value and complements the information provided to inmates in HIV education classes.
 - Inmates receive the factual information they need to assess their own risk of HIV infection.
 - HIV education efforts for inmates are coordinated within a jail.
 - There is enough time in a class to provide adequate HIV information to inmates.
 - Any BOC guidelines or regulations should place an emphasis on behavior modification to increase the probability of HIV education leading to a reduction in inmates' involvement in high-risk activities.
 - The BOC should assess if inmates can play a larger role in developing HIV education programs for inmates and if more inmates can be utilized as peer trainers.
 - The BOC and the OA should jointly determine whether the continued development of multiple curricula for inmates in local jails is necessary and provide model curricula for inmates to the local jails.
 - The BOC should review condom demonstration and availability policies within the jails. In order to facilitate this review, the BOC should use the results of the studies recommended in Chapter III, relating to condom demonstration and availability in state prisons and the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission, to assess local jail condom demonstration and availability policies. (In Chapter III, we recommended that the CDC central office contract with an organization which has expertise in this area to: (1) evaluate the effects of the prison condom demonstration and availability programs that currently exist nationwide, (2) determine whether such programs should be tested and/or implemented in California, and (3) assess the extent to which abstinence and safe sexual activities are effective in reducing HIV transmission.)

Chapter VI

Coordination Between the Department of Health Services Office of AIDS and Correctional Facilities on HIV Education Programs

In this chapter, we discuss certain aspects of the OA's role with respect to HIV education programs in correctional facilities. In general, the OA's responsibilities include funding HIV education programs, providing technical assistance, and coordinating the activities of various state agencies.

Findings, Conclusions, and Recommendations

Findings. We found instances in which duplicate HIV education programs exist within individual CDC and CYA facilities. In these cases, trainers from community-based organizations working under contracts with the OA, were providing HIV education at CDC and CYA facilities that was separate from, although in many ways comparable to, the HIV education provided by CDC or CYA staff. These community-based programs sometimes are not coordinated with the correctional agencies' programs. As a result: (1) the state is paying more than once (through the correctional agencies and the OA) for comparable HIV programs for the same groups of inmates and staff and (2) staff, inmates, or wards within a given facility who attend an HIV education class conducted by one contractor may not receive the same information as others who attend a class conducted by another contractor, or by facility staff.

Duplicate HIV education programs and curricula exist because:

- The OA's policy is to encourage community-based organizations working under OA contracts, to develop HIV education programs that meet the needs and characteristics of their individual communities. The OA gives funding preference to community-based organizations for the development and operation of HIV education programs.
- The OA's contract process for HIV education programs does not take into consideration that HIV programs already exist in correctional facilities. The OA includes as target groups inmates, wards, and correctional facility staff, although the CDC, CYA, and many local jails already have HIV education programs in place for these target groups. The OA contract process has no mechanism for ensuring that supplemental rather than duplicative HIV education is provided to these target groups.
- The OA, generally, does not coordinate its contract process with the CDC or CYA.
- The OA does not review HIV education curricula for consistency within or among the various correctional facilities.
- As stated in earlier chapters, several individuals in a correctional facility were responsible for staff HIV education efforts and their efforts were not always coordinated.

The OA was unable to provide us with the amount of funds that are spent on the development of duplicate curricula for use in correctional facilities because the contracts do not specify this level of detail.

Conclusions. We believe that the practice of funding and using numerous curricula within the same target group is unnecessary because: (1) *custody* staff generally perform similar duties regardless of which correctional system or facility they are employed by and (2) the HIV education needs of state prison *inmates* or CYA *wards* do not vary from facility to facility within the CDC or CYA systems. Rather than independently developing HIV education programs for the same populations, the OA and correctional agencies should improve the coordination of their efforts.

Recommendations.

- The CDC, CYA, and BOC should each improve its coordination efforts with the OA. In addition, each correctional agency and the OA should jointly evaluate the correctional agency's HIV education program. These evaluations should determine the goals of each program and the respective roles of each agency.
- Outside organizations should not be granted contracts for providing HIV education classes in correctional facilities unless: (1) the correctional agency and the OA have jointly determined beforehand that there is a need for the organization's classes in a particular facility and (2) the contractors' classes are consistent with the correctional agency's overall HIV education goals.
- The OA should ensure that the appropriate correctional agencies participate in the contract process if it provides HIV education in correctional facilities.
- The OA, in cooperation with representatives of the correctional agencies, should designate model curricula and other HIV education materials for the various target groups.

Appendix 1

Acronyms Used in This Report

Acquired Immunodeficiency Syndrome	AIDS
AIDS Education for Emergency Workers Project	AEWP
AIDS-Related Complex or Condition	ARC
Board of Corrections	BOC
California Institute for Men	CIM
California Institute for Women	CIW
California Medical Facility	CMF
California Rehabilitation Center	CRC
Department of Corrections	CDC
Department of Health Services	DHS
Department of the Youth Authority	CYA
HIV Seropositive	HIV-positive
HIV Special Housing Unit	HIVSHU
Human Immunodeficiency Virus	HIV
Intravenous	IV
Karl Holton School	KHS
Mule Creek State Prison	MCSP
National Institute of Justice	NIJ
Northern California Women's Facility	NCWF
Northern Reception Center Clinic	NRCC
Office of AIDS	OA
Preston School of Industry	PSI
Southern Reception Center Clinic	SRCC
Youth Training School	YTS

Appendix 2

Appendix 2

Voluntary HIV Antibody Testing Policies for Inmates In Selected California County Jails

	<u>Routine Testing on Inmate Request</u>	<u>Routine Testing When Clinically Indicated</u>	<u>Routine Testing of Inmates with High-Risk History</u>	<u>Testing on a Case- By-Case Basis</u>
Alameda	X			X
Fresno				X
Inyo				X
Lake	X			X
Los Angeles	X	X		
Marin				X
Orange				X
Sacramento	X	X	X	
San Bernardino	X			X
San Diego	X	X		X
San Francisco	X ^a			X
Santa Barbara	X			X
Santa Clara	X			X
Sonoma		X	X	X
Sutter	X	X	X	

^aPregnant inmates only.

Appendix 3

LAO SURVEY DOCUMENT: CRITERIA FOR EVALUATING AIDS EDUCATION AND PREVENTION PROGRAMS

Date of Interview: _____

Name of Interviewee: _____

Title/Position: _____

Name of Facility: _____

Telephone Number: (____) _____

Name of Interviewer: _____

1. Specifying the Target Groups (Who must be reached?)

- a. Which primary target groups (e.g., male inmates) have been specified?
- b. Which secondary target groups (e.g., Spanish-speaking male inmates) have been specified?

2. Identifying Characteristics Placing the Target Groups at Risk (Why is an individual at risk?)

- a. Which high risk activities have been identified for each target group?
- b. Which reasons (e.g., lack of knowledge, habit) have been identified as factors in target group members engaging in high risk activities?
- c. Which abilities (e.g., reading level) have been identified as concerns in developing a message that is understood and accepted by target group members?
- d. Which attitudes or beliefs (e.g., desire to make a behavioral change, belief that one can successfully make a behavioral change, religious belief) have been identified as factors in developing a message that is understood and accepted by target group members?
- e. What AIDS information do target group members already have?
- f. What AIDS misinformation do target group members already have?

3. Selecting the Methods to Reach Target Groups (How will an individual be reached?)

- a. Is attendance at all educational/prevention sessions mandatory, and do inmates, staff, visitors actually attend the sessions?

- b. When are the initial education/prevention sessions held?
- c. Are the persons leading the initial sessions considered credible by the participants?
- d. Which media are used as part of the initial sessions?
- e. What size groups are used during the initial sessions and why were these group sizes chosen?
- f. How are the participants actively involved in the initial sessions?
- g. How long do the initial sessions last and why were these lengths chosen?
- h. Which positive and negative motivators (e.g., fear, consequences of AIDS, extra privileges) are incorporated into the initial sessions?
- i. How often are follow-up or reinforcement sessions held?
- j. Do follow-up or reinforcement sessions differ from the initial sessions in any way?
- k. How often are written materials distributed outside of education/prevention sessions?
- l. Is individual one-on-one counseling available?

4. Selecting the Factual Information to Provide to Target Groups (What information must be provided to an individual?)

- a. What information is provided about the spectrum of HIV diseases?
- b. What information is provided about how the HIV virus is transmitted and how it is not transmitted?
- c. What information is provided about symptoms and treatment?
- d. What information is provided about the purpose of HIV testing and the meaning of HIV test results?
- e. What information is provided about precautionary measures?
- f. Is information provided about the degree of risk associated with high risk activities and the degree to which risk can be reduced if precautionary measures are adopted?

5. Identifying Risk Reduction Skills (What skills does an individual need to reduce risk?)

- a. Are practical skills taught?
- b. Are interpersonal skills taught?
- c. Are any products or services (e.g., drug abuse treatment) provided?