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ABSTRACT

CLAIRE WILLEFORD

Effectiveness of a pre-release planning program for HIV-positive offenders exiting Georgia prisons: a qualitative evaluation approach

(Under the direction of Dr. Richard Rothenberg, Faculty Member)

Background: Two-year nationwide prison recidivism rates stand at over 60%, and minorities and the poor are at greatest risk both of first-time incarceration and of offending repeatedly over time. Initiatives that may address prison inmates' lack of resources and increase their success in their communities after release are now an important topic in the study of criminal justice policy. Over the course of the past two decades, the public health concern of HIV/AIDS has increasingly become a part of this discourse on re-entry, as the disease disproportionately affects minority communities both in and outside of prisons. Affected reentrants face not only the challenges associated with employment, education, housing, and other social infrastructure that impede their long-term re-entry into mainstream society, but must also navigate issues surrounding continuity of medical care and behavioral risk reduction.

In 2009, Georgia State University received funding to conduct an evaluation of Georgia's Pre-Release Planning Program (PRPP) for HIV-positive inmates, and conducted semi-structured interviews with 25 former inmates who had received services from PRPP. This thesis work attempts to assess the content of the interviews and the potential impact of such an evaluation on corrections policy, especially in light of other similar programs that have been funded nationwide.

Methods: A literature review was conducted to provide information on state and Federal pre-release programs for HIV+ prisoners that have been funded since the 1990s. A qualitative analysis of the GSU interview transcripts, consisting of coding for major themes, was completed. The goal of the analysis was to determine what program components had been most beneficial to participants, and also what needs had gone unfulfilled.

Results: Most participants (23/25) in receipt of pre-release planning services in Georgia felt that they had benefitted from the program. A majority (19/25) attended the appointments set up for them by the program coordinator. Respondents were generally satisfied with their medical care, though cases existed where respondents had been unable to access a stable provider or medication supply as planned. The greatest aid to participants from PRPP was in the area of medical care. Limitations were perceived in the areas of employment after release and the Department of Labor program to which PRPP referred participants, as well as housing to a lesser degree. Study participants acknowledged and appreciated the program coordinator's hard work with the resources that she had, and recommended transitional housing and work programs as ideal resources to improve their situations. Almost all (22/23) expressed interest in a community mentoring program to aid their progress post-release.

Conclusions: Literature showed a variety of education and prevention program models targeting HIV in prisons since the 1990s. The best program outcomes were associated with the longest period of intervention and the most intensive case management (Rhode Island), but further evaluation is needed, and funding for such programs is a real and consistent concern.

When combined with the literature on previous and existing programs nationwide, the voices of these participants provide a good idea of what may be next for a successful pre-release program in Georgia. 1) Planning services should begin sooner before release—possibly at the time of admission to prison—and should provide a longer period of follow-up, in order to capitalize on the time available for intervention with this vulnerable population and to more effectively prevent recidivism. The addition of support staff for the Georgia PRPP may allow this to occur. 2) Provision or expansion of the community mentoring program proposed in Spaulding’s 2009 study and supported by participants in these interviews, providing for matching of mentors with mentees by family and ethnic background, may be an important way to improve health outcomes among this population while facing a dearth of funding. 3) Securing and advocating for additional funding for vocational, counseling, and medical support services available to the general prison population is crucial, in order to support opportunities for skills advancement and true corrections in life path among a historically deprived incarcerated population. A cost-effectiveness analysis by state officials is recommended in order to measure the true economic value of such programs—especially in contrast to the public burden of unchecked recidivism. 4) A change in the Georgia laws that severely restrict the civil rights of ex-felons—including the right to vote, to be considered for many job opportunities, to be admitted to certain professional schools, and to receive state or federal financial aid for secondary education—is essential if former inmates are to be realistically expected to succeed outside of prison.

INDEX WORDS:

HIV, HIV/AIDS, inmates, release programs, Georgia, reentry, prison health, prisoners

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POSITIVE OFFENDERS EXITING GEORGIA PRISONS: A
QUALITATIVE EVALUATION APPROACH

by

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B.A., AGNES SCOTT COLLEGE

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of Georgia State University in Partial Fulfillment
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INTRODUCTION

The state of Georgia operates the nation's fifth-largest prison system at an approximate cost of \$1 billion per year (Teegardin 2010, Rensi 2009). Currently, one of every 15 Georgia adults is under some form of correctional supervision—incarceration, probation, or parole—placing the state in first rank nationally for proportion of population in the correctional system (Rensi 2009). These large numbers can be traced in part to longer sentences and stricter release regulations adopted in the 1990s by Georgia and many other states as part of the “war on drugs” and other political movements against crime (Welch 1999, Lynch 2007). While 2009 saw a slight downturn in prison populations in at least half of U.S. states—the first such trend in nearly four decades—as correctional departments sought to curb expenditures through seeking community alternatives to incarceration, Georgia's prison system grew by 1.6% during this year (Pew Center for the States 2010). Government officials expect current growth trends to continue under political pressure for tough punishments (Teegardin 2010).

As is true nationally, while incarceration numbers are large in Georgia, inmate statistics are not reflective of statewide demographic patterns. This phenomenon is perhaps most immediately apparent in the disparate state imprisonment rates across racial and ethnic groups. African-Americans experience incarceration at a rate over three times that of Caucasians; in fact, Georgia has one of the largest black prison populations of all states in proportion to its general statewide population (Sentencing Project 2007). While the Latino prison population currently equals less than five percent of the total, it is useful to note that this number quintupled between 1993 and 2003, and then doubled again by 2008. Hispanic inmates are expected to compose at least 10% of Georgia's total inmates

by 2013 if present trends continue. The contrast between state demographics by race and the state prison population may be examined in Table 2.

Outside of ethnic background, other sociological factors carry considerable weight in determining the role of criminal behavior and prison in consistently bringing a certain group of people together and shaping society through their repeated experience. Gender is one: while females make up 50.8% of Georgia's population, they compose only 6.6% of the state prison population (U.S. Census Bureau 2010, Georgia Department of Corrections 2010). These women prisoners, though a small group, are more likely to be white, to be incarcerated for drug offenses, to suffer from antisocial personality disorders, and to require treatment for both mental health and substance abuse issues while in prison than are males (Georgia Department of Corrections 2010, Young and Reviere (ed.) 2006). Age is another important factor for consideration, with the largest proportion of state prisoners consisting of men in their working and reproductive years, ages 20-49 (Georgia Department of Corrections 2010). The prison population is less likely than Georgia's overall population to have completed high school, less likely to have been employed before incarceration, less likely to be married, and more likely to abuse alcohol or drugs (Georgia Department of Corrections 2010, U.S. Census Bureau 2010, Krienert and Fleisher 2004). The disproportionate burden of infectious disease such as Hepatitis B and HIV/AIDS found in correctional facilities further skew the statistics for this population (Centers for Disease Control and Prevention 2002).

Table 1

Offenders in the Georgia prison system

In prison	54,420
On parole	23,091
On probation	159,000
TOTAL	236,511

Table 1

Offenders in the Georgia prison system. Source: Georgia Department of Corrections, September 2010.

Table 2

Demographic overview of Georgia inside and outside the prison system, by race

Race	Total Percent of Population (State)	Total Percent of Population (Georgia DOC Inmates)
White	65.0%	35.9%
Black	30.2%	62.4%
Asian	3.0%	0.2%
American Indian	0.4%	0.2%
Hispanic/Latino	8.3%	4%

Unknown/Other Race	9.7%	<1.0
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Table 2

Demographic overview of Georgia inside and outside the prison system, by race.

Numbers sourced from the U.S. Census Bureau and Georgia Department of Corrections.

Percentages may add up to more than one hundred due to self-identification with more than one ethnic group.

HIV as a Risk Factor of Interest

It has long been recognized that the impoverished and minority background of a majority of prison inmates, combined with complex related factors such as discrimination, a lack of educational opportunity, and a lack of service and resource infrastructure in home communities can lead to disillusionment with government support systems and with the idea of achieving productive participation in society. In 2000, more than half of state prisoners nationwide reported an annual income of less than \$10,000; although roughly 80% of U.S. working-age men were employed, only 55% of prison inmates reported employment at the time of their arrest. Only 33% of prison inmates had completed high school, compared with 85% of 20-29 year-old men nationwide (*Poverty and the Criminal Justice System* 2005). 69% of inmates released from Georgia prisons in 2002 had drug-related behavior problems (LaVigne & Mamalian 2005). Individual community members' pessimistic attitudes about the future and their life opportunities, together with a lack of investment in standard forms of social control and support—e.g.,

the police, the court system, social services, even schools and conventional forms of employment—influence criminal behavior and often lead to poor outcomes upon release from prison. Recidivism or the “revolving door” in and out of prison for a significant segment of the population is a compelling issue in the contemporary field of criminal justice, both at the state level and nationally. The time before a prisoner’s release, or re-entry into society, is increasingly viewed by researchers as a crucial window during which behavioral interventions may take place (McLean et al 2006, Draine & Herman 2007).

Over the course of the past two decades, the public health concern of HIV/AIDS has increasingly become a part of the discourse on re-entry, as the disease disproportionately affects minority communities both in and outside of prisons. Affected reentrants face not only the challenges associated with employment, education, housing, and other social infrastructure that impede their long-term re-entry into mainstream society, but must also navigate issues surrounding continuity of medical care and behavioral risk reduction. The federal government has worked with states in recent years to provide increased recognition and support for this doubly marginalized population in the form of Ryan White CARE dollars, many of which have led directly to the creation of pre-release counseling and other planning programs.¹

¹ The Ryan White CARE Act, created in 1990, provides HIV/AIDS-related medical assistance to those who are otherwise unable to procure it. Federal money is allocated to state and local agencies for diverse purposes (medication, support services, healthcare provider training, etc.) as specified by the clauses of the Act. Title II of the CARE Act covers all grants provided for services delivered directly by states.

Georgia finds itself near the forefront of this dialogue, with a current AIDS diagnosis rate of 19.7 per 100,000 persons and ranking sixth of the 50 states in cumulative reported AIDS cases through December 2008 (Kaiser State Health Facts 2010, Centers for Disease Control and Prevention 2010). Moreover, while Georgia has consistently been ranked in the top ten states for cumulative AIDS cases since the 1990s, the annual rate of reported AIDS cases jumped from ninth in the nation in 2004 to fifth place in 2009 (Georgia Department of Human Resources 2009). The specific need for a focus on HIV/AIDS in prison settings is also evident. The Centers for Disease Control and Prevention determined in 1996 that 17% of all U.S. HIV cases passed through a correctional facility (Smith et al 2010), and the U.S. Bureau of Justice reports that the rate of the disease is nearly six times higher among state prison populations than among the general public (Centers for Disease Control and Prevention 2006). In August 2010, HIV-positive inmates in the state of Georgia totaled around 900—approximately 2% of the total prison population (Georgia Department of Corrections 2010). Over 400 HIV-positive inmates are released back into their communities in Georgia each year (Rensi 2009). Because recidivism is high and the serving of short sentences for parole and probation violations is common, HIV-positive offenders may move frequently between correctional facilities and their home communities.

Since 1988, the Georgia Department of Corrections has conducted mandatory HIV screening of inmates upon entry, and has provided subsequent testing upon request or if clinically indicated (Centers for Disease Control and Prevention 2006). Furthermore, in 2009, with the passage of Senate Bill 64 into law in the state of Georgia, testing and counseling for HIV became required for incarcerated persons before release

from prison (Georgia General Assembly 2010). Both requirements further delineate the need for comprehensive and available services for HIV/AIDS-affected prisoners, many of whom may learn their HIV-serostatus for the first time in a correctional setting.

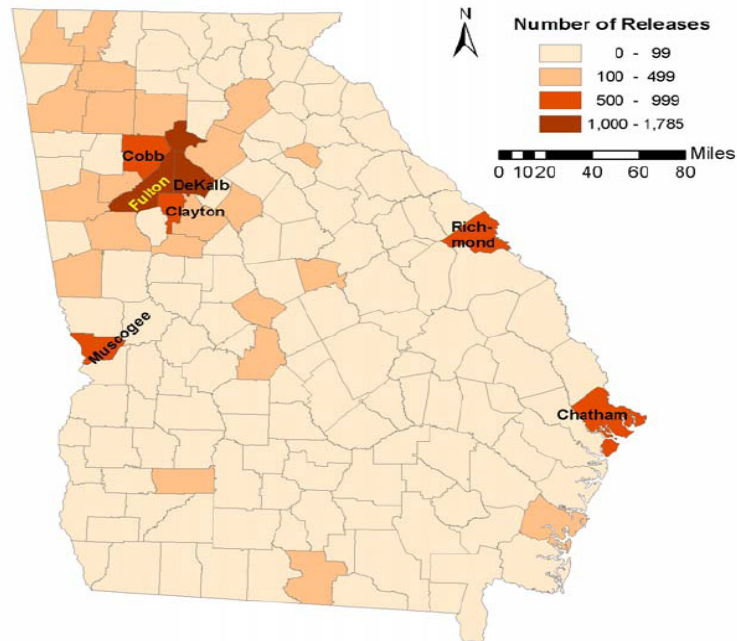
Background of Program and Study

Georgia's Pre-Release Planning Program for HIV-positive inmates received Ryan White Title II funding and began as a pilot project in early 2004. This program—known as PRPP—continues to exist as a collaboration between the Georgia Department of Corrections (DOC) and the Georgia Department of Human Resources (DHR), with a single pre-release coordinator overseeing services for all eligible inmates in the state. Due to lack of funding for expansion, only 14 of Georgia's 43 state prisons are included in the PRPP program's service area and may receive specialized pre-release planning. HIV-positive inmates of other prisons receive access to what resources general DOC medical staff may be able to provide them at the time of their release (Rensi 2009). In 2009, program coordinator Chayne Rensi estimated her active inmate caseload at around 115 individuals, with a total of 489 inmates served by the program since it began in 2004 (Rensi 2009). Over half of these inmates are released to the metro Atlanta area, with most remaining offenders released to smaller urban areas such as Savannah, Augusta, Macon and Columbus (Rensi 2009, Georgia Department of Corrections 2002).

Figure 1

Prisoner Releases by Georgia County, 2002

Figure 25. Number of Prisoner Releases by Georgia County, 2002



Sources: Offender Tracking Information System (OTIS), Georgia Department of Corrections, provided by Office of Planning and Analysis, GDC. Address level data provided by the Georgia Board of Pardons and Paroles

Note: Total releases to GA = 15,227; 434 (or 2.9%) are not shown on the map because of incomplete addresses.

PRPP case management for eligible clients in Georgia generally commences once a release date has been established. In the case of parolees, an approved residence plan or stable address must be on file; for offenders who have completed their entire sentence or “maxed out,” Georgia DOC must permit release regardless of living situation, and housing is often an issue. PRPP case management assists with housing referrals and with other needs such as help with ADAP (AIDS Drug Assistance Program), substance abuse and mental health treatment, public assistance, food and clothing, transportation, medical care, and other case management (Rensi 2009). Upon release all inmates are provided a

14-day supply of HAART medication, a copy of their medical records, a set of clothing, a bus ticket, and a debit card worth \$25.00 (Rensi 2009).

In 2009, Georgia State University's Institute of Public Health received funds to evaluate the effectiveness of the PRPP program and to identify ways to expand the scope of the existing program. In partnership with the Department of Corrections, the Georgia Department of Community Health (DCH) and the Georgia Bureau of Pardons and Paroles, Institute staff conducted 25 semi-structured interviews with recently released recipients of PRPP resources over a one-year period spanning from June 2009 to June 2010. Former prisoners were asked to speak on a variety of topics, with their perception of the PRPP program central to the interview. Greatest challenges since release from prison, experience of family and social support, struggles to procure necessities such as employment, housing and food, perception of HIV-related social stigma, the successes of the PRPP program and what could be done to improve PRPP services in participants' eyes were all important components of the qualitative interviews.

Such outcome evaluation research is relatively rare, due to the lack of available funding as well as of general popular interest surrounding services for the incarcerated population. The results of the research merit notice for their potential contribution to the evidence base supporting certain types of interventions for HIV-positive prisoners, and leading to new research. This paper will attempt to highlight and to explore some of the most important themes uncovered in Georgia State University's discussions with these 25 former prisoners.

Purpose of Current Work

Through a review of the extant literature on pre-release planning, HIV/AIDS issues in prisons, and most specifically HIV/AIDS-related issues post-prisoner release, I provide here an overview of several state and national pre-release prison programs, with the goal of placing Georgia's programming efforts in a historical and political context for the reader. This research is supplemented with a qualitative analysis of the 25 aforementioned interviews of HIV-positive former Georgia state offenders. My goal in presenting this work is to provide a working answer to the following questions:

- 1) To what extent is Georgia's Pre-Release Planning Program succeeding in addressing the needs of HIV-positive offenders upon their release from prison into the community? To what extent is it not succeeding?
- 2) Based on literature and the current qualitative study, what next steps are recommended for continued successful operation and expansion of the PRPP in Georgia?

The dual approach of examining the recent program evaluation alongside those of other similar programs is taken with the intent of providing the most complete recommendations possible for Georgia's young program, and with hopes of informing future similar research.

REVIEW OF THE LITERATURE

Current Issues in HIV-positive Exiting Inmate Populations

While HIV/AIDS is a formidable life challenge in itself, it is seldom the sole health issue experienced by incarcerated persons. Mental health problems and substance abuse, in particular, are issues that have been understood to go hand in hand with HIV/AIDS (National Governor's Association 2004, Conover 2009). In Georgia's pre-release program, 45% of HIV-positive women and 12% of HIV-positive men took mental health medications concurrently with HAART drugs in 2009, and pre-release coordinator Chayne Rensi categorized substance abuse treatment as a high-priority need for exiting participants (Rensi 2009). The link among these three issues may be somewhat complex and cyclical. It is known that a high percentage of prisoners are past or active drug users, and substance abusers are more prone to HIV-risk behaviors in the community than is the general population (Pettus-Davis et al 2009). The perceived stigma and long-term stress of dealing with HIV are also in themselves often cause for the onset of mental health disorders, conceivably contributing to a lower likelihood of adhering to medication regimens and a greater probability of exposing others to infection (World Health Organization 2008). HIV-positive inmates exiting prisons need access to comprehensive, confidential, multi-tiered systems of care that acknowledge the intersectionality of these major health issues. This is especially important given the high reincarceration rate of substance-using offenders (Pettus-Davis et al 2009).

As HIV-positive inmates cycle through the process of incarceration and release, the stigma experienced due to their medical condition is a lasting and significant burden. Derlega et al's (2010) qualitative study with former offenders in a Southeastern U.S. state found that medical confidentiality was difficult to maintain within the prison setting. HIV-positive inmates reported stereotypes and prejudicial attitudes about HIV/AIDS as

widely held among other inmates and prison staff, and felt devalued and mistreated; some study members stopped taking HAART medications while in prison in order to prevent widespread knowledge of their HIV-serostatus (Derlega et al 2010). These participants stated that their negative experiences with harassment and exclusion while in prison affected decisions about HIV disclosure (Derlega et al 2010). Since HIV-related stigma can be a debilitating problem in the outside world post-release, affecting ex-offenders' social support networks and access to resources as discussed above, the prison environment must strive to provide medical privacy to inmates in order to prepare them to continue with health management in the community.

Perhaps most gravely, survival in the “outside world” post-release has become steadily less of a practical possibility over recent decades with the realization of mandatory sentences (especially for drug crimes), the sanction of public benefits for drug offenders, and the curtailment of ex-felons' civil rights. In Georgia, such restrictions include the loss of the right to vote during the term of the sentence (including parole, probation, and payment of all restitution, which is often not completed by low wage earners); the preclusion from many job opportunities; the loss of driving privileges; the loss of the right to own a firearm for life; the loss of state and federal financial aid for secondary education, and the denial of admission to certain state professional schools and licensure (such as law) for life (Georgia Defenders 2008). Such aggressively punitive measures that remain in effect after the completion of prison time discourage the rehabilitation of offenders. Criminal recidivism rates are high throughout the U.S.: two-thirds of offenders are consistently expected to re-enter the prison system within three years of release (Bureau of Justice Statistics 2008), and Georgia's rate is reflective of the

national situation (Gingrich & Earley 2010). Moreover, only 16% of prisoners released by the Georgia DOC in 2002 reported participating in any educational, counseling, or vocational programs during their time in prison, including drug and alcohol risk reduction (Mamalian & Lavigne 2004). A combined lack of programming support within prisons and continued punishment post-release that does not permit successful community reintegration leave historically marginalized prison populations vulnerable.

Pre-Release Programs: Case Studies of the CDP and Other Local Initiatives

Over the past two decades, numerous state and national initiatives have emerged with the goal of linking HIV-positive offenders to services as they exit prison, improving health outcomes and reducing recidivism rates among this population. Funding sources, outcomes and evaluation of these programs have been varied. An overview in this section of selected national and state pre-release prison initiatives may give points of reference for the Georgia PRPP's successful program evaluation, growth, and future development of additional services.

In 1999, the Centers for Disease Control and Prevention (CDC) and the Health Resources Services Administration (HRSA) entered into a partnership to provide support for HIV case management and discharge planning for incarcerated individuals at the community level (Potter 2003). This initiative became known as the Corrections Demonstration Project (CDP). Six states were funded—along with one additional county jail system—to provide prevention and treatment for HIV-positive inmates. By definition, CDPs consisted of health departments who were able to forge strong working

relationships with corrections systems and with appropriate community resources for provision of services. Preference for funds was allocated based on morbidity rates of HIV: generally urban areas where the disease was, and is, concentrated (Potter 2003). California, Florida, Georgia, Massachusetts, New Jersey, New York, and Cook County, Illinois all received health department grants to create CDP programs in conjunction with their respective Departments of Corrections for a trial period of five years. The goals, target populations and special issues of the seven CDC-HRSA programs, summarized in Appendix B1, provide a good basic idea of the common issues addressed by most pre-release interventions.

At the creation of the CDP, an Evaluation and Program Support Center (EPSC) was created and funded by CDC and HRSA for the duration of the pilot project at Emory University's Rollins School of Public Health (Potter 2003). The EPSC conducted a multi-site longitudinal evaluation with focus on the case management and discharge planning services received by clients. While a more complete list of evaluation objectives may be observed in Appendix B3, the overall goal of EPSC's evaluation research was to measure inmates' lasting connections to key services, as well as the level of effort on the part of community staff needed to connect offenders to these services (Emory School of Public Health n.d.). Some of EPSC's findings of special issues as noted in Appendix B1—housing, mental health, special needs of women prisoners, need for improved training of program staff—are worth noting for successful continued implementation of Georgia's PRPP, while EPSC's set of evaluation criteria may in itself be a useful tool for further program development. Evaluation is often costly, staff-intensive and practically difficult to implement, and the Emory-CDP model may serve as

an ideal for newer programs such as Georgia's. Practical information maintained on CDP programs by its administrators (available through presentations, publications and program records) may in itself prove useful in executing successful state programs today.

Several state programs dedicated to the HIV-positive prison population have merited recognition since (and some even before) the CDP. The state of Florida, in addition to its original Linking Inmates to Needed Care (LINC) CDP—discontinued in 2004—has created a Pre-Release Planning Program (Florida PRPP) with the help of HRSA and Ryan White Title II funding. This program serves approximately five times as many inmates as the LINC program and is able to reach all correctional facilities, with five pre-release planners divided among the four regions of the state (Florida DOH Corrections Programs 2010). Planning services begin six months prior to the end of an inmate's sentence; follow-up meetings then commence every two to four weeks for discussion of referrals, receipt of health education, and completion of applications for case management and housing. Upon exit, prisoners receive a 30-day supply of medication plus medical records (upon request) and emergency phone numbers. Follow-up is conducted at one month by the PRPP program to verify whether former inmates have kept their medical appointments (Florida DOH Corrections Programs 2008, Rechline 2004). While more current information exists on Florida's state programs than on others, through publications maintained by the Department of Health and the Department of Corrections, the program has not been subject to significant outside evaluation.

Rhode Island, a state typically at the forefront of preventive community health measures, has had a pre- and post-release planning program in place for HIV-positive

inmates of all state prisons since 1996 (Zaller et al 2008). Project Bridge, a collaboration among doctors and social workers at Miriam Hospital in Providence, RI, has been a recipient of HRSA funding since October of that year in order to provide intensive case management and continuity of medical care for HIV/AIDS-affected inmates exiting state prisons (Zaller et al 2008). While the program has undergone periodic refinements, as of 2008 its key components consisted of pre-release planning 30-90 days prior to release; social stabilization of offenders based on an Eco-behaviorism model (built into social work services which are provided for 18 months post-release); provision of specialty HIV care at the Miriam Hospital Clinic; referrals to other necessary services, and follow-up and data analysis by research staff throughout the 18-month period (Zaller et al 2008). Zaller et al's retrospective analysis of Rhode Island client records showed that virtually all clients (95%) maintained medical care throughout their enrollment in Project Bridge, while 45.8% secured housing, 71% were linked to mental health care, and 51% sustained linkage to addiction services (Zaller et al 2008). While these high numbers—especially for health care—suggest a successful model worthy of emulation, it is important to consider that Rhode Island's relatively small state population and number of HIV/AIDS-affected prisoners may be part of what make such a complete program possible.

Maryland, a state whose AIDS prevalence is among the nation's highest², has also operated a pre-release case management program since the mid-1990s. The program, titled Prevention Case Management (PCM), consisted in 2002 of two mandatory modules: health education training with a focus on personal HIV risk reduction and

² 2007 rate of 24.8 cases per 100,000 population, as compared to the general U.S. 12.5 cases per 100,000. This ranked Maryland third after the District of Columbia and New York. Source: Henry J. Kaiser Family Foundation (2009)

linkage to services for a successful transition into the community (Bauserman et al 2003). Case management is not limited to HIV-positive inmates, but rather is based on a risk-reduction model that targets the vulnerable incarcerated population as a whole. Health department staff and private contractors hired by the state administer state-mandated HIV/AIDS prevention curriculum in the prisons and jails in addition to case management curriculum designed especially for PCM (Bauserman et al 2003). One-on-one planning sessions are combined with group counseling, and an individualized case plan is created for each inmate based on the results of a risk behavior pre-test upon entry to PCM (Bauserman et al 2003). Planning sessions around condom use and substance abuse became mandatory parts of the PCM in 1998 (Bauserman et al 2003). Participants in the Maryland PCM program have not been evaluated with regard to success in the community after release; however, *t*-test analyses of the pre- and post-tests administered by PCM revealed statistically significant changes in attitudes, self-efficacy, and intentions related to HIV risk reduction (Bauserman et al 2003). In light of funding difficulties, though, further investigation has questioned whether or not case management is the most efficient way to reduce risk (Cohen et al 2006).

Texas and New Mexico, perhaps heeding this economic logic, have more recently begun implementation of slightly different risk reduction models in their correctional systems. In 2002, the AIDS Foundation of Houston received one of four HRSA state grants made available for Prevention and Education Training Sites (PETS); the funds were used to train staff and implement curriculum for what is now Project Wall Talk, a peer education program targeting minority offenders within 36 Texas state prison units and the areas where offenders legally reside (Ross et al 2006). Peer educators undergo

intensive HIV risk reduction and health education training and subsequent annual conferences to update their education, and are charged with delivering their knowledge to other inmates (Ross et al 2006). In July 2009, 1,200 peer educators worked within the Texas Department of Criminal Justice and over 100,000 prisoners had received health training since the inception of the program (New Mexico Peer Education Program 2009). In a 2006 evaluation of the Texas program, peer educators and their students showed significant increases in HIV-related knowledge as well as significant narrowing of the gap in risk behavior awareness across categories of race/ethnicity and educational background (Ross et al 2006).

New Mexico's Project ECHO was modeled after Project Wall Talk, using funds from the Agency for Health Research and Quality (AHRQ), Robert Wood Johnson Foundation, the New Mexico Health Department and the New Mexico Legislature which had been allotted for work on health disparities (New Mexico Peer Education Program 2009). The program's focus is on STI risk reduction, addictions, hepatitis C, and general health literacy, with the added intent of increasing job skills and potential for employment for inmates as community health workers or health educators after release (New Mexico Peer Education Program 2009). Physicians and social workers of the Project ECHO organization work with the New Mexico Corrections Department, the New Mexico Reentry Bureau and Central New Mexico Correctional Facility to provide these services (New Mexico Peer Education Program 2009). No formal evaluation of the New Mexico program is available to date.

As a final note on Georgia's prison programming, Spaulding et al's (2009) Emory study uses survey and qualitative data to make the case for a community life-coach

program, to operate in Atlanta and Macon, Ga., which could supplement the PRPP for increased success. This approach recognizes the general lack of public funding for large, comprehensive state-based re-entry case management, and would draw on volunteers from existing prison community service groups to be matched to exiting offenders of similar demographic background (Spaulding et al 2009). The interviews showed strong interest in such a program among convenience samples of ex-offenders and potential community mentors, as well as matching between the two groups in areas such as age, family background, and religious belief (Spaulding et al 2009). While sustained funding, training of volunteers, and the question of statistically significant differences in life outcomes for mentees are all factors requiring further research, this initial study shows a community mentor program for ex-offenders to be a promising area for further investigation (Spaulding et al 2009).

Summary of Program Literature

Much of the decisive information on pre-release programs for HIV-positive state offenders is still forthcoming. For each of the programs outlined here, only one outcome evaluation study was available at best for review; for some, no evaluation had been completed to date. Further investigation is required to determine which models are truly most cost-effective and successful in reducing risk. Funding is also a constant limitation for states seeking to create, maintain and evaluate pre-release programs. However, the available information on other programs does provide some valuable lessons on the special issues encountered and the various models available when serving this population.

Georgia can take advantage of this developmental stage to learn from other states' early experiences and to implement evaluation measures that may ensure quality with expansion. When combined with Georgia State University's qualitative evaluation research on the PRPP, the literature on other programs may be used to make concrete recommendations about next steps for Georgia's PRPP.

METHODOLOGY

Study Population

The 25 participants in Georgia State's qualitative evaluation of the PRPP were recruited using contact information obtained from the PRPP coordinator. They resided at the time of interview either in the Atlanta metropolitan area (20), Macon/Bibb County (four), or Rome, Ga. (one). Ethnicity was predominantly African-American (22) and gender overwhelmingly male (24). Three participants were Caucasian and one was female, also white. None reported Hispanic or Latino ethnicity. Ages of participants ranged from 27 to 60 years, with a median age of 46. This figure was consistent with the mean age served by the Georgia PRPP.

The date of participants' release from Georgia prisons ranged from summer of 2008 to February 2010, with most release dates occurring during 2009. Interviews occurred from two to eighteen months post-release, depending on the release date and recruitment of each participant. Prior to release, participants had served sentences ranging from 12 months to 15 years, with a median and mode sentence of 24 months.

Research Design

Georgia State University's evaluation tool consisted of a semi-structured interview that sought to explore participants' perceptions of the Georgia PRPP. Two experienced research staff from Georgia State's Institute of Public Health—one of them an African-American man who had spent years in state prison—initiated contact with potential participants, then met with them either at respondents' homes or at Georgia State University to conduct in-person, individual interviews. Verbal and written consent were obtained and the conversations were recorded and transcribed. Interviews generally lasted about one hour, and \$50 compensation was provided to participants.

Evaluation interviews began with a collection of general demographics, and moved on to more open-ended questions about participants' general feelings and greatest concerns in the time just before and just after release from prison. Some of these questions addressed family and social support, housing, work and income, and health status since release. The core questions of the interview dealt with participants' experience with the PRPP and with Georgia's pre-release coordinator, Chayne Rensi: quantity and quality of case management received while in prison; most helpful resources, least helpful, how participants would improve the program or create their own; and whether or not they would be interested in a community mentoring program to expand upon the services they received in prison pre-release. The question guide for these interview sessions is included as Appendix B2.

An informal follow-up telephone interview was conducted at the end of the year-long evaluation period, with the purpose of gathering information on participants' overall state of being at that time. A total of 17 of the original participants (or 68%) were contacted at year's end for this conversation. Of the participants lost to follow-up, three were incarcerated, two were deceased, and three could not be located.

Analysis

A qualitative analysis of the interview data, consisting of coding for major themes, was completed. While inductive coding—the development of codes after direct examination of the data—was important in providing an idea of ex-offenders' psychosocial context (for example: “sense of injustice,” “feeling like an outsider,” “relief,” “trying to reshape patterns of behavior”), I used a priori codes based on the literature and on the interview guide to develop the major themes of interest. These categories include “PRPP helped most,” “PRPP helped least,” “housing,” “mental health,” “medication,” “interest in a mentor program after release,” and “what will keep me from going back to prison?”

As peer review to assure intercoder reliability was not possible, I attempted to ensure validity by using a straightforward, low-inference coding system for the core themes. For example, all items coded under “PRPP helped least” respond directly to the corresponding question in the interview guide; all items coded under “medication” or “housing” must contain verbatim references to those topics by participants. Text from

the transcripts is used throughout my own interpretation of results in order to allow the voices of the study participants to be heard.

RESULTS

Descriptive Overview of the Sample

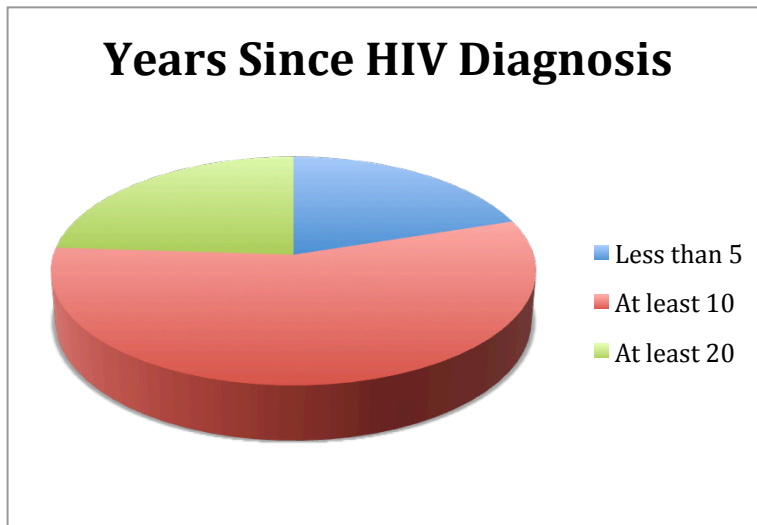
In addition to the basic demographic variables discussed above, this study provided insight on several other descriptors that are useful to interpreting respondents' experiences. Seven male participants identified as gay or bisexual, while the remaining 18 participants reported no same-sex sexual contact. Additionally, at initial interview or follow-up, eight participants stated that they had spent one night or more in jail since their release from prison. (Smith et al 2010)

Descriptive information on respondents' life experience with HIV/AIDS was provided by the Georgia State study. Only five participants of the 25 had tested positive for HIV in the five years immediately preceding the interview. All remaining sample members had known of their HIV-positive status for at least 10 years, and some for more than 20 years (see Figure 2). Experiences of HIV-related stigma—whether in the form of internal conflict and shame or overt discrimination by family, friends and community—were reported by all but two study participants. 18 of 25 participants were taking anti-retroviral drugs (ARVs) in prison, and had had no difficulty accessing medication upon their release. Of the remaining seven respondents, three had been prescribed medication but had not been able to take it due to access issues, while four had not been told by a physician that they needed to begin an ARV regimen (Smith et al 2010).

Figure 2

Time since HIV diagnosis for study participants, in years

Source: Smith et al 2010

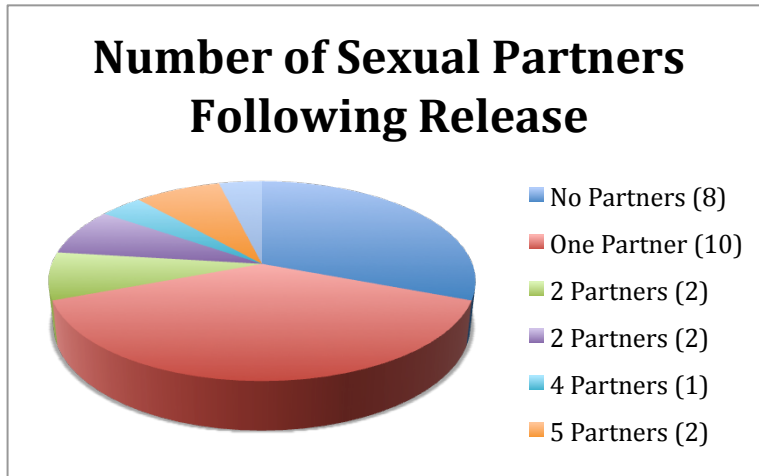


Participants experienced a variety of health issues in addition to HIV, including concerns related to substance abuse and mental health. 14 sample members reported chronic or serious medical conditions other than HIV, including heart (2) and orthopedic conditions (3), respiratory disease (3), and cancer (2). The two deaths in the sample between initial interview and follow-up were attributed to a heart attack and liver cancer. 12 respondents also reported diagnoses of mental health conditions; nine were receiving some form of treatment. 18/25 reported abstinence from drugs since release, while 7/25 admitted to drug use. Drugs of choice included crack cocaine (3), marijuana (3), metamphetamine (1) and powder cocaine (1). Intravenous drug use was not reported.

Figure 3

Number of sexual partners since release as reported by participants

Source: Smith et al 2010

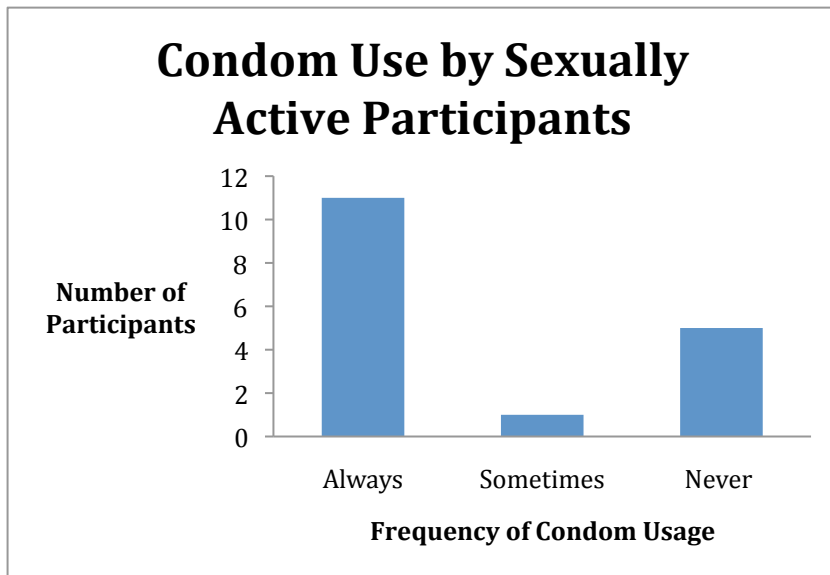


Sexual risk behaviors were also addressed by the Georgia State interview instrument. 17 sample members (68%) reported engaging in sexual activity with at least one partner since release. The number of sex partners for each participant ranged from 0-10, with 9/17 participants reporting a single partner as their primary sexual contact (see Figure 3 for a more detailed distribution). Of the 17 respondents who reported sexual activity, 11 stated that they always used condoms, while five reported that they never did (see Figure 4). Seven of the 17 sexually active participants reported engaging in sex acts with partners who were also HIV-positive. Three respondents admitted to having paid money for sex since their release from prison.

Figure 4

Use of condoms by sexually active participants since release

Source: Smith et al 2010



Overview of the PRPP; Benefits

24 of 25 participants recalled or were able to estimate the number of times they had participated in pre-release planning sessions in prison. The number of sessions ranged from two to 18, with a mean of 4.1 and a median and mode of three. While two participants specifically indicated that they worked with Ms. Renzi during the last six months of their sentences—and this would seem to be the most common scenario, given that most inmates received around three visits from her—a smaller number indicated that

she worked with them for a year or more (1/25) or even for the entire time of their incarceration (3/25).

A vast majority of the sample (23/25) could identify one or more PRPP-related resource that had been directly beneficial to them since release. Most participants (20/25) stated that Ms. Rensi had made appointments for them in the community before release, and while the interviewer did not consistently inquire about specific appointments, many participants went on to list such definite referrals as medical (18/20), housing (13/20), food stamps and disability (12/20), the AIDS Drug Assistance Program (12/20), case management (9/20), and Department of Labor employment programs (6/20). A majority of the respondents mentioning referrals (19/20) kept at least some of their appointments. Proclaimed one participant, “I don’t miss one. Parole, medical, whatever is set up for me, that’s where I go” (African-American male, 55 years old, 11/09/2009). These respondents were connecting to community resources in the way that was ultimately the PRPP’s goal, though the change in long-term health outcomes remains to be measured. Other study participants stated that they selectively kept those appointments that they needed, or that they thought would provide useful services: “[I kept] all of them except for the ones I knew, like the food stamps, like I knew that was out of the question, so I didn’t even bother with that” (58-year-old African-American male, 12/12/09).³

³ Section 115 of the 1996 welfare reform act (Personal Responsibility and Work Opportunity Reconciliation Act) prohibits anyone convicted of a drug-related felony from receiving federally-funded cash assistance or food stamps unless individual states opt out of or modify the ban. Currently, 16 states—including Georgia—completely deny benefits on the basis of a drug conviction; 21 states have modified the ban; and 16 other states have eliminated the ban (*The Lifetime Ban on TANF Cash Assistance...*, n.d.)

Table 3. Participants' voices: How did the PRPP help most?

Component of the PRPP that helped most	# of participants
Medical linkages	10
Appointments	9
Chayne Rensi's support and counseling	6
Housing referrals	5
Support groups	1
Referral to veterans' Department of Labor program	1
Help with disability/labor pool options	1
Prison ministry referral	1

Table 3. Participants' voices: How did the PRPP help most?

When asked how the PRPP had most helped them, 10 of 25 participants responded that the greatest assistance had been with medical needs in the form of referrals to ADAP, clinics and other healthcare providers. (Table 4 may be examined for a quantitative breakdown of the responses to this question.) Housing was also considered a need met by a few program participants (5/25), as were the appointments made for inmates before release, together with information provided on community resources (9/25). One participant admitted,

“all the appointments that she made, that was a big thing [that] I didn't have to do when I got out 'cause if I did, I probably wouldn't have . . . I would have had other things that I was trying to get done and I probably just would have pushed it off and pushed it off and pushed it off” (27-year-old white male, 02/22/10).

Although three of the participants answered that “none” of their needs had been met by the program, many of the remaining responses revolved around the support in staying focused, motivated and in learning to navigate resources that the PRPP had provided them. One man described Ms. Rensi’s personal support as instrumental in “knowing how to do [the things I needed] and the places to go to get them” (50-year-old African-American male, 01/11/10). Another stated that

“she helped me a lot because . . . I wasn’t used to talking about the situation, trying to adapt to it and she kind of broke things down to me on how to deal with . . . being HIV status. If you worrying and carrying around all that, that’s messing up your immune system . . . between her and my case manager at AID Atlanta, I think I talked to her more than I talked to my case manager” (40-year-old African-American male, 03/17/2010).

The above quote illustrates the personal connection that most evaluation participants appeared to feel was forged with the pre-release coordinator, facilitating—and perhaps crucial to—both linkage to services and to a healthier life perspective that would increase likelihood of service usage upon release. Almost all participants (23/25) struggled with varying degrees of social and internalized stigma associated with their HIV-positive status, inside of prison and out, and Ms. Rensi had the opportunity to serve as a neutral counselor and resource provider. Her relatively brief intervention with participants appeared to be sufficient in some cases to provide hope, motivation, and perhaps even a reevaluation of attitudes and behavior. One PRPP participant, also citing the inspiration provided by Ms. Rensi’s counseling, believed that “she helped [me] with getting through prison. I say she helped me by enlightening me to just stay focused and

to never give up on nothing that I believe in that is good” (51-year-old African-American male, 05/24/10).

In a similar vein, over half of the study sample (13/25) mentioned instances in which Ms. Rensi took extra pains to help them with the details of their life situations, making them feel valued and supported in the hard work they faced upon release. Three participants reported that when they were unexpectedly transferred to other prisons, Ms. Rensi succeeded in reversing the transfers so that they could continue under her planning service jurisdiction. Others reported her help with toiletries, phone calls, job referrals in their areas, and general concern for their wellbeing. One reported, “when she come . . . I was looking forward to meeting with her and that would last me until the next month because she always had words of encouragement. She was resourceful, very resourceful” (48-year-old African-American male, 04/19/10). Others reported having depended on Ms. Rensi’s support and effective assistance even after release from prison:

“I call her constantly. Well, I haven’t called her in a while, but when I first got home, she had everything set up for me, as far as my going to the clinic and all that. Everything I needed was set up when I got home so she kept her word about what she was going to do. It was done when I got home” (50-year-old African-American male, n.d.)

In line with the participant who admitted that he might not have accessed important services if Ms. Rensi had not taken care of appointment details, this quote is telling of sample members’ reliance on the coordinator’s careful guidance both pre- and post-release. In light of the double marginalization that this population has experienced

through incarceration and HIV-positive status, and the fact that many may be generally unacquainted with the resources available to serve them, it seems reasonable to posit that simply providing inmates with information would not be not enough to improve their health outcomes. The one-on-one counseling with inmates, ensuring that appointments were in place, and even support past release date that Ms. Rensi was occasionally able to provide were among the aspects of the program most valued by participants.

Limitations of the PRPP

When asked how the program had helped them least, the largest group of respondents answered that all aspects of the program had been helpful. (A breakdown of responses to this question may be viewed in Table 5.) The greatest limitation named, however, related to employment. Many former inmates stated that this had been their biggest challenge (15/25); some had specific issues with the Department of Labor program to which the PRPP referred them (4/25), although this was not something asked about specifically by interview staff. Said one man who had been unable to procure steady employment since his release: “She never mentioned employment, you know. She just talked 'Department of Labor,' and I been down there and they got like a lot of people going for the same job” (54-year-old African-American male, 11/10/2010). This critique implies that Ms. Rensi did not sufficiently address the issue of employment for exiting prisoners, but whether participating inmates ever asked Ms. Rensi about services that were not explicitly offered to them seems doubtful from the small body of participant

commentary that addresses this topic.⁴ Respondents reported worries about employment before exit and arduous struggles to find work after release, but none reported in-depth discussions with Ms. Reni on this topic during planning sessions. For a variety of reasons, clients of planning services may not be ready to voice their precise needs and preferences at the time of service provision, and for this reason outcome evaluation is valuable. As political will and public support for providing these services are admittedly weak, the creation of an evidence base in their favor is especially important.

Table 4. Participants’ voices: How did the PRPP help least?

Component of the program that helped least	# of respondents (total of 17 participating)
Nothing—everything helped	6
Employment—needed more access to job programs	4
Public assistance (TANF, food stamps, SSI)	2
Housing	1
Clothing	1
Case management (AID Atlanta)	1
Preparing to disclose HIV status outside of prison	1
Lack of housing for women (female participant)	1

Table 4. Participants’ voices: How did the PRPP help least?

⁴ See section titled “How Participants Would Improve the PRPP” for specific participant quotations on this topic.

Another respondent made the following recommendation:

“Somebody was just recently telling me that they got a class every morning [for] ex-offenders . . . and they teach you typing, and stuff like that. I think [Chayne Rensi] should have a packet . . . even if it’s just going on [the computer] that week before you out, on HotJobs and printing out some jobs, because a lot of us don’t have the smarts to go on the computer and lots of guys are just computer illiterate. Now, she did have the Georgia Department of Labor . . . everybody that get out go there. But when I went there, the second day I was out, they told me that there is no jobs” (38-year-old African-American male, 05/11/10).

This man echoed the frustrations of the other study participants who felt that the Department of Labor (DOL) program to which PRPP referred them did not meet their needs. In spite of the fact that Ms. Rensi referred exiting prisoners to Top Step, a DOL program that works with employers and convicted felons to match the latter with suitable jobs, these participants did not report success using the program. To the contrary, they reported frustration with the inadequate employment resources available to a large client pool: the men quoted above expressed a perception that all exiting prisoners were sent straight to the Department of Labor, and that competition was too stiff for them to have much hope of interacting with prospective employers. The second man quoted suggested that it would be more effective to acquaint exiting inmates with online job search techniques rather than referring to the DOL. Of the participants who had found part-time work at the time of interview (15/25), none reported having located their employment through the DOL program. (No participants had found full-time work that would cover all of their living expenses.)

Many of study participants' additional comments on their unfulfilled needs post-release did not relate so much to shortcomings of the PRPP *per se* as to what the program could accomplish within its larger political, legal and social contexts. For example, individuals convicted of drug offenses became ineligible for food stamps and certain other state and federal benefit programs. This affected at least four members of this sample who mentioned being denied applications for public assistance. Medical treatment was also a problem for some individuals who had secondary health problems unrelated to HIV/AIDS. One participant summarized the limitations of PRPP's medical referrals:

“They were only limited to do so much. They couldn't really refer me to a specialist which I needed to see. Before I was incarcerated, I was seeing a pain treatment doctor and I haven't seen her since I been released and can't get into a clinic because I don't have any insurance. The Hope Center, they can't refer me because Ryan White only pays for only certain types of treatments, but I've been trying to see a neurologist and that's impossible” (47-year-old African-American male, 12/12/09).

While PRPP did provide medical referrals, the program was for the most part powerless to address insurance and other outside policy matters, as this man correctly assesses. Medicaid is not available to single, able-bodied people of working age, but those who are approved for disability benefits may be eligible for medically-needy Medicaid or benefits for the aged, blind or disabled (Georgetown University Health Policy Institute 2009, McGuffey 2004). This loophole notwithstanding, applying for disability and Medicaid benefits can be a long and uncertain process, and private

insurance for this largely unemployed population is unlikely. The sample members who dealt with medical conditions outside of HIV/AIDS (14/25) often faced difficulty securing needed care for these illnesses. More accessible health insurance policies (both public and private) and real government and industry action to curb escalating health care costs would allow PRPP to connect clients to services in an exponentially more effective way.

Another contextual limitation of the PRPP is the disconnect of many prison inmates—who are often from historically marginalized and poor communities—from the criminal justice system and many meaningful sources of social service delivery. These inmates are, of course, participating involuntarily in the judicial system as they serve a prison sentence; however, this contact may further reduce trust in the legal system among disadvantaged populations by merit of the very fact that minorities and the poor make up such a disproportionate number of arrests and have received such historically inferior treatment by law enforcement. Knowledge and utilization of available health, education and other social services may also be low among the urban poor (Hansen 2004, O’Toole et al 1999). The small number of participants (6/25) who did not follow through with PRPP appointments appeared in their comments to reflect this lack of connection with the social service system and how it worked, demonstrating indifference and confusion even after having received guidance from Ms. Rensi:

Interviewer: Now, did Chayne make any community appointments for you in order for you to access support services upon your release?

Participant: I think she did, but I didn’t follow up on ‘em.

I: So you didn't keep any of the appointments?

P: Nope.

I: And why was that?

P: 'Cause, first of all, man, I had missed a appointment and my mama set another appointment and she said that I had to go down there with some ID and I ain't have no ID. So they won't be trying to do nothing, get my ID. 'Cause I got to get a birth certificate. I got to get a birth certificate from Detroit, Michigan. You know what I'm saying. My little brother send my birth certificate and then I be able to get some ID.

I: So you can't . . . go to those appointments without ID?

P: That's what my mother told me.

I: So you didn't call to check and see?

P: No. My mother did it for me.

I: When you got out, didn't they give you a prison ID?

P: Yeah.

I: So you could have probably taken that, man.

P: Oh.

I: Yeah, so if I was you, I would suggest you maybe call and tell them you got your prison ID, there may be some services that they can't provide you with, but

some of the services you can [use]. And you haven't been to see a doctor since you been out?

P: No.

I: And why is that?

P: 'Cause I ain't have no ID. (28-year-old African-American man, 05/20/10)

This respondent had not followed up on any of the appointments provided by the PRPP program, despite a need for medical and other services. Why, if he needed services and had information on available resources, would he refuse to look into treatment, relying on his family to handle all communications and adhering faithfully to the idea that seeking care without an ID would be useless? Depression and the internalized stigma associated with incarceration and HIV-positive status may play a major role in his reluctance to seek help. So, too, might his life experiences with institutions and service providers. Like many other urban, impoverished black men, he may feel too alienated from normative society to trust conventional support systems or to readily respond to any behavioral intervention. While these belong in part to the realm of larger social issues that PRPP cannot fully address, such a person might be more effectively motivated to follow up on referrals by a pre-release coordinator of similar socioeconomic background, combined with extended follow-up contact post release.

Interviewer: Why didn't you keep these appointments [provided by PRPP]?

Participant: Let's see. I ain't feel like meeting with the mental health if she did.

The housing was, I already had housing. ADAP [the AIDS Drug Assistance Program], I ain't know nothing about so I ain't go.

I: So some of the stuff that you didn't know nothing about, you just didn't go?

P: Right.

I: Okay, um, so [did] any of it conflict with transportation problems or you just didn't go?

P: Just didn't go. (35-year-old African-American male, 11/05/09)

This participant also demonstrated indifference and inertia in utilizing and seeking out necessary resources. Like the previous respondent cited, he may have experienced psychological distress related to his HIV status and incarceration; his apathy might also be traceable to lifelong environment-informed experience, or even a cognitive condition. This respondent did have a place to go upon his release, and did not need to ask Ms. Rensi for a referral to transitional housing (usually a waiting list in any case, due to limited resources). However, his statement that he did not know anything about ADAP is telling: applications for the program were filled out for respondents by Ms. Rensi or another caseworker before release, and respondents had only to follow up with the local health department in order to enroll. He was not alone in expressing ignorance about ADAP. Another participant also admitted: "I probably did not go to ADAP because I didn't really know where to go, you know, at that time" (51-year-old African-American male, 05/24/10).

Of the six total sample participants who did not attend community

appointments provided to them by PRPP, three conceded that referrals had probably been made, but they could not remember for sure, or had trouble linking appointments they had attended to the PRPP referrals without considerable interviewer probing. Two participants maintained that no appointments had been made for them by Ms. Rensi. Again, more extensive post-release follow-up may be effective in reminding participants of their appointments and in continuing to wear away the psychosocial barriers that may prevent individuals in such unique health, social, and economic condition from keeping up with these obligations.

How Participants Would Improve the PRPP

When asked what services they would like to have provided to them in an ideal world upon release, participants had a range of ideas. The top-ranking need was housing, or a place to stay (14/25), followed by a comprehensive job or work-release program (13/25). Several participants also needed additional help linking to all needed health resources (8/25), while smaller numbers suggested that they would like to provide counseling (4), additional community support (4), and education (3) resources to create an effective program. All numbers relating to this question may be viewed in Table 6.

Table 5. Participants’ voices: How would you improve the PRPP?

Ideal services to be provided by a pre-release planning program	# of respondents
Transitional housing	14

Job program	13
More health resources	8
More community support resources (appointments, etc.)	4
Counseling (mental health, life skills, substance abuse)	4
Education (GED, etc.- in or outside of prison)	3
Support group	2
Clothing	2
Transportation	1

Table 5. Participants' voices: How would you improve the PRPP?

Outside of this question, several participants had constructive suggestions about how the PRPP could be improved within the parameters of its current structure and resources. These comments were volunteered by participants and not solicited specifically by interviewers. The suggestions included a longer time period of case management (2/25), or possibly just an increased number of the planning sessions, before release:

“the state need[s] to [allow more] pre-planning [to take place], getting a person accustomed. A person in prison, a lot of the guys that have been locked for a while . . . their mind is not set on pre-planning. They going back to the old habits of what they used to do. They might say one thing, but they going [to] do another. So counselors [should be] be assisted [in] prison to where they can . . . sit down and talk to you about some of the things that

you need to be doing to prepare. Not just waiting ‘til you get, okay, you go home next month and then you call me in two weeks before I go home and tell me such and such. No, let’s talk about some of them things before then, you know what I mean?” (46-year-old African-American male, 02/02/10)

This man’s quote supports Florida’s and Rhode Island’s pre-release models of initiating planning services at least six months before inmates’ release date. (While this is the goal in Georgia, the actual time of service initiation may currently depend on many factors outside of the service coordinator’s control.) The longer duration of services serves an important purpose considering the lack of counseling and vocational training available in correctional facilities, and the high numbers of exiting inmates who will soon return to prison. If prison is truly to serve as a corrective experience, educational and preventive programs must not only provide for a longer time window of preparation before inmates’ release—as this respondent suggests—but must take place throughout the length of a prison sentence. Providing more comprehensive services may certainly require a larger upfront investment of resources, but the longstanding disregard of this area has resulted in neglect of a crucial time window during which offenders may be effectively reached by behavioral interventions. Taxpayers, our general public safety, and the poor communities who bear the economic and psychological consequences of mass and repeated incarceration all pay the price of these shortsighted policy decisions.

Two other interviewees opined that support groups for HIV-positive inmates would have been beneficial both pre- and post-release. One expressed his experience this way:

“see, the mindset of an [HIV-positive] individual, when he gets out . . . I did everything I could to get somebody to kill me. I didn’t have the heart to do it myself and commit suicide, but I did these things, because I felt like my life was over with and I didn’t have anything to live for anymore. I wish before we get to that part about getting out, that we would have some type of support group within the system to let people know what they’re dealing with and how to live with it instead of entertaining the thought of ‘I’m going to die’” (58-year-old African-American male, 12/12/09).

This respondent did not elaborate on the specific nature, whether figurative or literal, of his attempts to harm himself. His limited remarks are nonetheless revealing of his and other respondents’ struggle with the social stigma they faced as HIV-positive individuals. Not only might they operate on incomplete medical knowledge of their disease, but many might also face rejection or unkind treatment from their family and other social support networks after release. Support groups in and outside of prison could help foster self-esteem and empowerment among exiting inmates, and possibly facilitate the circulation of useful information pertinent to common medical and family situations, as per the Texas and New Mexico peer education models.

As delineated in the section on limitations, several participants felt that the Department of Labor program to which the PRPP referred them was less than adequate in

meeting their employment needs post-release. Recommendations indicated a preference for a stronger focus on employment during case management sessions. One participant stated that although employment had been his most serious concern pre- and post-release, he had not asked Ms. Rensi about job resources because he believed that those referrals were not a part of her job responsibilities:

“I think she just did the best she could with what she had to work with, you know. It (employment) was on my mind, but I didn’t mention it ‘cause I felt that was all she was there for: just for the health part you know” (54-year-old African-American male, 11/10/2010).

This quote may be key to understanding the missing link between general satisfaction with the PRPP and discontent with the employment component of the program. In general, if participants in the program are not explicitly listing all of their release needs at the time of pre-release planning and discussing with the service coordinator what may be missing from the sessions, evaluation (such as the Georgia State study) is crucial to understanding what is being left out and to advocating for funding and support for these missing pieces.

Openness to a Mentoring Program to Expand PRPP Services

Of the 25 original participants, 23 were questioned about their openness to participating in a hypothetical partnership that would pair them with mentors in their communities upon release. This design could strengthen the foundation of the PRPP. Of those questioned, all but one (22/23) agreed that they would like to participate in such a program.

“[This program would] give me a person who hopefully is nowhere near associated [with] the life that I had before prison and is somebody who I can probably emulate, somebody I could go after and say this is what they did, this person is there to help me and I can tap into everything that they had and get,”
(50-year-old African-American male, 01/16/10)

said one participant. “The main stress part of HIV [is] not knowing where to go and who to turn to,” added another (40-year-old African-American male, 03/17/10). While these responses set the tone for most others, one interviewee stated that such a program would be useful for the simple purpose of filling and structuring his time outside of prison: “yeah, I go for help because you know, it’s something to keep me occupied. That’s what I’d be looking for. Something to keep my time occupied” (54-year-old African-American male, 04/29/10). Literature indicates that supervision and structure after release can be vital in determining released prison inmates’ ability to maintain a crime-free lifestyle and avoid returning to prison (Gideon 2009).

The respondent who said that he would not be interested in being paired with a mentor said that he was not confident enough in his social skills to participate in such a program. “I’m not a good talker and to me, you have to have the gift of gab and I don’t have the gift of gab. [It would be] very, very awkward for me” (53-year-old African-American male, 08/20/09).

Additional Issues

Near the close of the interview, participants were asked what additional issues needed to be addressed by researchers in order to improve their post-prison experience, and what services would be most useful to them in an ideal world. The sample tended to agree that while PRPP had assisted them where it was able, they faced huge barriers to gainful employment, stable housing, and sustained access to food, clothing and transportation which would permit them to integrate successfully into mainstream society. A successful state program would need to do much more to address root causes of poverty, crime and recidivism than current budget and resources allow.

Former inmates' criminal history was a huge factor in preventing obtainment of stable employment, even through the DOL Top Step program. While 18 of 25 subjects expressed frustration with their employment situation, nearly half the sample (10/25) discussed a totally futile search for work, almost assuredly made so by persistent background checks. The only female participant related,

“I felt like what was the use, they're not going to hire. Top Step really didn't have anywhere for me to go. . . once they learn you have a record, ah, you just may as well throw your hands up and quit cause once they see that you're a convicted felon . . . they're not going to hire you” (51-year-old white female, 12/28/09).

Interviewees discussed experiences of anger, injustice and feeling devalued by their fruitless searches for work. Said one participant,

“Convicted felons [are] people too. Before they went to prison, they had skills and so forth, some of them. . . [and] just putting that title on a piece of paper changed the whole scenario of how people look at you. It angers me 'cause of the

fact that they don't even know you. They don't even know you. They ain't even looked at your name" (46-year-old African-American male, 02/02/10).

Admitted another, "I fill out applications and never hear from them. [I feel like] shit. But who, who can I blame then? Nobody, but me" (55-year-old African-American male, 11/09/09). Of the commentary on employment, the thread that should perhaps be most compelling to policy decisions is that relating to the potential to fall back into illegal forms of monetary gain which could lead back to prison. Multiple participants referred to their attempts to hold on to good behavior, to stay away from old neighborhoods, and to earn income by legal means. Many were leaving prison for the second, third or fifth time. Not all were sure that this could be accomplished.

"I went to the Department, I go to the Department of Labor like once a week. I go online, put in job searches, send my resume to 'em . . . I'm a certified heating and air technician. I got universal certification, you know. 'Y'all hiring?' 'Well, we ain't hiring, we taking applications.' So I fill out the application online, send it in and go from there. I might call the company like every other week.

"[The wait] get real frustrating 'cause I'm use to doing and by me not doing it . . . I know that if I just stop doing this, I'm going back. I already know that. [And] I don't want to go back in the streets. I don't want to go back to selling drugs. I don't want to go back to robbing. I don't want to do none of that no more 'cause it's nothin' to it no more" (35-year-old African-American male, 11/05/09)

Housing was also a major issue for the sample, with 16 of 25 participants voicing some concern about their housing situation. Many interviewees (17/25) stayed with relatives or friends after release, but family tensions, as well as issues related to HIV/AIDS stigma and acceptance, often made these situations tenuous. While PRPP referrals to transitional and other housing resources were made, waiting lists often existed at available facilities. Resources in more rural areas were also a problem. The sole female interviewee shared that transitional housing resources for women in her situation were scarce.

As one participant summarized, “when you step out the door, you ain’t got nothing but \$35 . . . you can’t buy nothing but a hamburger and that’s it. And then the hardest times of the year with no jobs and stuff” (50-year-old African-American male, 01/16/10). Even with referrals and health resources from the pre-release program, men and women who have spent years behind bars are poorly positioned to hit adult life running as productive citizens. As an ideal solution, a number of interviewees visualized a transitional release program that would provide access to housing and income. One described this as

“a transitional place or something where . . . you can get a job and not have to worry about people turning you down and you know, you can’t do it because you’ve done this and you’ve done that . . . Not having to run around everywhere and figure out how you’re going to get there and try to keep appointments and all that kind of stuff” (27-year-old white male, 02/22/10).

Another defined in further detail:

“I would give every individual getting out of prison six months from the time that you get out. I would have them come through the halfway house and work for minimum wage [at] a car wash, construction work, paint houses or cut grass, just simple jobs, you pay them minimum wages and then turn around and have them a spot where they [can rent] houses, get them a place a stay, rent them out and then turn around and . . . keep the same job” (50-year-old African-American male, 01/16/10).

A smaller number of additional participants prioritized employment, saying that a job available upon release was all that they really needed to stabilize their situations. Possible mechanisms for this included a work-release program or one that taught work skills in prison. However, individuals who mentioned the need for a job upon release qualified their statements with reminders that employment in itself would not change life circumstances; exiting inmates had to decide for themselves that they did not want to return to prison: One man stated, “A couple of companies might be interested in hiring you; [inmates would] know you can check ‘em out. That what I would give them, something to start out. It would be up to them to follow through [on] that.” (41-year-old African-American male, 01/27/2010) Another man emphasized the importance of personal motivation in light of the lack of vocational training opportunities inside prisons. While the numbers he mentions may not be quite accurate, Georgia DOC statistics (cited in the section titled *How Participants Would Improve the PRPP*) support his and most others’ experience of being effectively barred from such programs:

Participant: When [inmates] get out, they [need] a job. 25 dollars and a bus ticket, what can you do with that?

Interviewer: So you feel like, somebody just need a job?

P: They got to have that mindset that when they get out, [that] they don't want to go back. And the majority of the folks that actually say they getting out, you know . . . it's so messed up.

I: When you say messed up, what you mean?

P: Trade-wise [inside the prison]. You know, something to better yourself-wise.

I: No stuff like that.

P: You got to be, it's a select group. I ain't going say select group, a select few that can actually get into these little trades that they got in there, you got to be a warden boy, a good one just to get in there, into these trade, trying to get in one of these trade thing. And it's what, almost 60,000 folks that's locked up.

I: And how many spots do you think they got?

P: At the most, they might have 5.

I: 5 for 60,000 people?

P: Yeah. (35-year-old African-American male, 11/05/2009)

Certain phrases, surfacing throughout the body of interviews, were arresting in their ability to convey participants' raw need for information and support, and their lack of preparedness for the stable life that they desired to create for themselves outside of prison. "I was on the street. . . I was suspected of 30 burglaries, was caught for one," said one participant, recounting a conversation with Chayne Rensi. "The last thing that you want to do is give me \$25 and some state clothes and drop me off at Greyhound with nothing. Do not do that. Because if you do, I know I will come back" (42-year-old African-American male, 01/16/10). Other participants echoed his sentiments of frustration.:

"What is it that the system need to do to keep me from going back to prison?

[is] the question that we need to be asking. Because . . . even though I've

been [in] that game and know what it's all about . . . after a year after I had been out, I really got frustrated and I thought okay, maybe I can just go do one and make me a little money in my pocket. But I realize you know, it's the same thing, the same game out there, the same results: prison. So what more resources do the state need to give to people coming out of prison?" (47-year-old African-American male, 12/12/09).

The plight of exiting inmates, non-specific to HIV status, was summarized by one participant's remarks on the need to provide more resources to others in his situation:

"My concern would be for the people that are getting out of prison because that was my hardest struggle there. There's nothing that nobody can do about the HIV that come. Nobody can do nothing about that. That was within myself. But with the prison system and getting out of prison—I think it should be something better" (50-year-old African-American male, 01/16/10).

DISCUSSION AND CONCLUSION

Working with qualitative data such as this set has both advantages and limitations. Although the voices of real people provide an important and irreplaceable window on the status of programs and policy, and are one important method of evaluation, there are bias issues to consider here as in all other types of research. For recently released offenders meeting face-to-face with researchers, impression management is an issue that cannot be discarded. Many of the paramount issues and obstacles shaping exiting inmates' experiences probably do, indeed, shine through in these data; however, sensitive and

illegal behaviors such as drug use, mental health issues, and sexual risk behaviors may have been underreported in this study, possibly more so than if a more confidential instrument had been used.

The sample size of 25 does not, of course, permit any conclusions drawn from these data to be generalizable to all HIV-positive inmates or even to all HIV-positive inmates in Georgia. However, the number of respondents did constitute approximately 22% of Chayne Rensi's PRPP caseload in 2009. With this number in mind, it is reasonable to suppose that results of this qualitative evaluation provide a fairly accurate picture of inmates' perception of the Georgia PRPP program as managed by Ms. Rensi at that point in time.

Summary and Recommendations for the Georgia PRPP Program

Most participants in receipt of pre-release planning services in Georgia felt that they had benefitted from the program. A majority attended the appointments set up for them by the program coordinator. Respondents were generally satisfied with their medical care (20/25), though cases existed where respondents had been unable to access a stable provider or medication supply as planned; the greatest assistance from PRPP was felt by recipients in the areas of medical care (10/25) and appointment referrals (9/25), with general life support and motivation (6/25) and housing assistance (5/25) reported in smaller numbers. Some limitations were perceived in the areas of employment and the Department of Labor program to which PRPP referred participants. Study participants acknowledged and appreciated Ms. Rensi's hard work with the resources that she had,

and recommended transitional housing and work programs as ideal resources to improve their situations. Almost all approved of the idea of a community mentoring program to aid their progress post-release.

When combined with the literature on previous and existing programs nationwide, the voices of these participants provide a good idea of what may be next for successful pre-release programs. Where Florida's growing pre-release program now provides multiple case planning sessions every two to four weeks for the last six months of incarceration—and is able to provide at least one follow-up contact after release—so, too, did respondents in this sample request more frequent and intensive planning sessions. If planning sessions begin with the purpose of readying long-incarcerated inmates for release, they may be unlikely to succeed; the same programs taking place throughout a prison sentence may capitalize on a valuable time window for intervention, and may much more effectively prevent recidivism. If one considers that most prison sentences (as demonstrated by this sample) last around two years, the most effective pre-release program would begin at the time of an inmate's entrance to prison rather than at the time a release date is determined. Adding another pre-release coordinator to provide for more intensive case management and successful interventions utilizing the structure of the existing PRPP may be an important first step for Georgia.

The 2009 Emory University study that introduced the idea of mentoring partnerships for HIV-positive former inmates (Spaulding et al) provided an important foundation for the questions posed on this topic in the Georgia State study. Two studies have now been completed in Georgia showing strong interest among released offenders in such a program. A logical next step would be for one of the two universities, or for

another institution, to use these results to gauge interest for funding and to attempt creation of a pilot program. Matching exiting inmates with mentors for ethnic and family background may maximize compatibility and increase chances of effectiveness.

A third, broader recommendation is for the Georgia Department of Corrections to create or to seek additional funding for all vocational, counseling and health services provided to inmates and especially those affected by special conditions such as HIV/AIDS. I strongly urge the direction of a cost-benefit analysis by (or for) state officials in order to measure the true economic value of such programs against the taxpayer burden of unchecked recidivism. As noted in previous sections of this paper, most people who enter prison are poor, uneducated, and dealing with addictions, yet only 16 percent of inmates recently had access to educational and vocational services within prison (Mamalian & Lavigne 2004). This lack of investment in a substantial sector of society results in escalating costs as more crimes are committed, families and communities are left without providers, and the prison system continues to grow.

A final recommendation concerns Georgia's felony laws. These restrictions of civil rights, curtailing inmates' ability to drive, vote, be hired for a job, and receive an education, severely inhibit the most earnest attempts to live an honest and crime-free life after prison. Surfacing again and again throughout the interviews was frustration about the futility of securing employment, as well as many doubts about the conceivability of a life outside of prison. Georgia's regulations must be amended in order to give a true chance at a new start to these citizens who are, in fact, returning to our communities every day in a restricted and ill-prepared capacity.

Participants' frustration with their experience of a one-sided society was palpable

throughout these interviews. The men and woman making up this sample were not able to depend upon stable housing, a way to get around, food to eat, or minimum income employment as the everyday survival tools that many take for granted, but rather often viewed these things as distant possibilities that they might never attain through legitimate means. Broad social and political questions of discrimination, education, employment and government had determined these men and woman's lives far beyond the scope of any pre-release planning program. Until many of these racial, educational and economic injustices are resolved, the U.S. and Georgia may continue to see a two-year 60% recidivism rate in prisons. In the meantime, amendment to the felony laws described, more support for educational and work training within the corrections system, and more comprehensive state- and federally-funded release programs for special populations may serve as secondary preventive measures.

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Appendix A

Overview of study participants' responses to key indicator questions

<u>Participant</u>	<u>Trouble securing food? (Y/N)</u>	<u>Trouble with clothing? (Y/N/ Unclear*)</u>	<u>Shelter? (Stable, Ambivalent, Unstable)</u>	<u>Had problems with access to medical care? (Y/N)</u>	<u>Been able to find work? (Y/N/ Ins.**)</u>	<u>Arrest or jail time since release? (Y/N)</u>
1	Yes	No	Ambivalent	No	No	No
2	No	Unclear	Stable	No	No	Yes
3	No	Unclear	Unstable	No	No	No
4	Yes	Unclear	Stable	No	Ins.	Yes
5	No	No	Stable	No	Ins.	No
6	No	No	Stable	No	Yes	Yes
7	Yes	Yes	Unstable	Yes	Ins.	Unclear
8	No	Unclear	Stable	No	Ins.	No
9	No	Unclear	Stable	No	Temporary	No
10	No	Unclear	Ambivalent	Yes	No	No
11	No	Unclear	Ambivalent	No	Ins.	Yes
12	No	Unclear	Ambivalent	No	Ins.	No
13	No	Yes	Stable	No	Ins.	No
14	Yes	Yes	Ambivalent	No	No	Unclear
15	No	Yes	Stable	No	No	No
16	No	Unclear	Stable	No	No	No
17	No	Unclear	Unstable	Yes	No	Yes
18	No	No	Stable	No	Ins.	No
19	No	Yes	Unstable	No	No	No
20	No	Unclear	Stable	No	Ins.	No
21	No	No	Unstable	No	Ins.	No
22	No	No	Stable	No	No	No
23	Yes	No	Ambivalent	Yes	Ins.	Yes
24	Yes	Yes	Stable	No	Ins.	Yes
25	No	Unclear	Stable	Yes	Ins.	Yes

*Unclear indicates that respondent did not mention clothing during his or her interview. Participants were not asked about their ability to procure clothing, but a number spoke on the subject without interviewer prompting.

**Insufficient=Participant has been able to perform some odd jobs for money or find some part-time work, but insufficient to cover all living expenses

Food: reasons for food insecurity included low wages and non-qualification for food stamps. One man mentioned that his transitional housing program provided a daily hot meal, but he was not often able to eat it because he was out looking for work.

Clothing: participants were not directly asked about clothing, but a good number mentioned a concern with securing it, or an experience receiving help. It is difficult to quantify the number who truly faced this concern since the question was not asked, and “unclear” here generally means that the item was not mentioned at all during the corresponding interview.

Shelter: The most common reason for classifying a respondent as “ambivalent” was a situation in which he was staying with family members, but expressed the knowledge that eventually he would be asked to leave the home. Other living situations included transitional housing, temporary lodging with friends, and hotel rooms.

Access to medical care: Issues affecting access included a lack of transportation and a lack of insurance that would cover care for non-HIV-related conditions.

Employment: Most evaluation participants had found only temporary or part-time work. Two of those who had found no work were not actively seeking employment, and were hoping for state disability benefits to be approved. One man, though he assessed himself as medically unable to work, was working part-time while he awaited decision on his disability.