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The Impact of ASO Prison Services on the Quality of Life of Inmates

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ABSTRACT

Background

In federal and provincial prisons the number of prisoners with HIV or AIDS is on the rise and these rates are much higher than in the general population. In response to these trends, a collaborative effort between Correctional Services Canada (CSC), two Ontario AIDS Service Organizations (ASOs) and one Hospital-based Clinic with HIV medical specialists was initiated to augment prevention education and support services to inmates infected/affected by HIV/AIDS. These services were provided in prison, on-site at the ASO office and by telephone.

Purpose of the Study

The primary objectives of this study were to measure 1) inmates' perceptions of the accessibility, acceptability and satisfaction with the services provided by ASO personnel and 2) to determine the impact of these services on inmates' quality of life. In addition, key staff of the CSC and the ASOs were interviewed to determine their knowledge and evaluation of the effectiveness of the ASO services provided.

Design and Methods

This was a one-time survey of current users (inmates) of prison support services provided by HARS and PARN and the separately contracted services of a prison HIV clinic. Thirty-six participants were recruited from the inmate population of 8 of the 11 federal penitentiaries serviced by HARS and PARN. A structured, one hour, face to face or telephone interview was conducted to detail their satisfaction with services provided, health related quality of life, coping strategies, depression and their use of prison support services. Respondents were assembled in two groups by their amount of prison support service use and compared on the above variables.
In addition, CSC staff and Prison Support Workers were invited to be interviewed to determine their perceptions of the effectiveness of the ASO provided Prison Support Services Program

Results

High and low inmate users of ASO support services differed on a number of variables with high users imprisoned longer, with better cognitive functioning and more active behavioural coping through information seeking. At the same time, high users had higher levels of depression and a pattern of more health distress. Depressed respondents tended to engage in more risk behaviours. Overall, ASO prison support services were endorsed positively by inmates as well as CSC personnel.

Conclusions

The importance of responding to the needs of this at risk population with prevention education and support services is indicated in the findings of this study, particularly to those individuals with mental health issues. These vulnerable inmates are accessing the right resource for the right needs but resources need to respond to issues like depression and addiction which are highly related to risk behaviour with more specific interventions.

INTRODUCTION

Ford & Wobeser (2000) attribute the recent increase in HIV and Hepatitis C seropositive rates in federal prisons (2% and 33%, respectively) to a high number of infected drug users who are bringing the diseases into the prison, as well as their continuation of risky behaviours, such as sharing of injection drug equipment, during their incarceration. They report that 24% of inmates inject drugs while in prison and 19% of inmates share injection equipment due to the unavailability of clean injection equipment. The trend of higher prevalence of HIV infection among inmates compared to the general population is unlikely to change since drug-related convictions continue to be widespread and generally new inmates have had little screening or treatment prior to incarceration (Calzavara et al., 1995; Ford & Wobeser, 2000). It is difficult to get an accurate estimate of the prevalence of HIV/AIDS in federal prisons due to the unavailability of anonymous testing. Many inmates do not know they are HIV+ and many of those who are HIV+ are unwilling to disclose this information (McAlpine, 2000).

Correctional institutions, community-based organizations, and health-care providers acknowledge that education and treatment programs must be provided during incarceration in order to reduce the physical illnesses (including the spread of communicable diseases such as HIV) and psychosocial problems that spill out into the community when inmates are released (Boudin et al., 1999; Conklin et al., 1998). In fact, recent studies have demonstrated a significant decrease in recidivism rates for inmates offered health and education programs during incarceration and continuity of care following release (Conklin et al., 1998; Flanigan et al., 1996). However, it is recognized that for health promotion programs to be successful, there is a need for greater collaboration between correctional services and community-based organizations (Zack et al., 2000; Hammett et al., 1998; Polonsky et al., 1994).

In Ontario, Canada, a collaborative effort was initiated between Correctional Services Canada (CSC), two AIDS Service Organizations (ASOs), and a hospital-based HIV Clinic. Generally, inmates in the federal and provincial penitentiaries surrounding Kingston and Peterborough can access HIV/AIDS-related health care from in-house institutional physicians and nurses in the prison Health Services Department and/or from the visiting HIV specialists (contracted by CSC) associated with the HIV Clinic at Kingston General Hospital. In addition, two ASOs (HIV/AIDS Regional Services or HARS, and Peterborough AIDS Resource Network or PARN) provide prevention education and support services to inmates infected/affected by HIV/AIDS. These services are provided on a part-time basis to Kingston area prisons by a prison support coordinator and an education coordinator from HARS, while a prison support worker from PARN provides both services to Peterborough area prisons. The primary purpose of this study was to evaluate the impact of these ASO prison services on the quality of life of the inmates.

Service Interventions

Prison Services provided by HARS and PARN

HARS and PARN are community-based AIDS service organizations that offer support and educational services to the inmates at federal penitentiaries. These services are provided by a prison support coordinator/worker and/or an education coordinator to current and former inmates infected or affected by HIV/AIDS, as well as limited support to an HIV+ inmate's personal community. These services are provided in the prisons, on-site at the HARS or PARN office, and by telephone (collect calls are accepted).

The role of the *prison support coordinator/worker* is 1) to provide advocacy services, treatment information, and supportive counselling (client driven and goal focused, which includes problem solving; addictions and relapse prevention planning; drug and sexual harm and risk reduction, grief and loss, past sexual abuse, trauma, institutional adjustment/transition; pre/post HIV test counselling; preparation of living wills; medication related pain and symptom control; Hepatitis C compensation); 2) to develop and maintain good working relationships with the administrators of the correctional institutions, as well as other relevant prison staff (e.g., health care professionals); 3) to support the development of peer health education training; 4) to network with other organizations who work with the prison population; 5) to reduce barriers to support, care, and treatment of HIV+ inmates; 6) to provide pre-release planning and to facilitate transition into the community of HIV+ inmates upon release from prison through appropriate referrals and pre-release fairs; 7) to coordinate and provide training to ASO volunteers who choose to work with inmates; 8) to establish a community-based support group for HIV+ inmates on escorted or unescorted temporary absence (ETA/UTA) programs. More recently and when resources permit, the coordinator has provided the same services to Hepatitis C positive inmates on request. Since July 1989, the HARS prison support coordinator has provided direct services to 53 federal prison inmates, of which 35 inmates were HIV+ (91% of visits/telephone calls involved difficulties accessing appropriate medical care; 54% involved compassionate release issues; and 71% concerned pre-release planning). Last year, the PARN prison support worker provided services to 14 federal prison inmates all of whom were HIV+.

Group education sessions in the prisons are conducted by both HARS and PARN. Sessions conducted by HARS are provided by the *education coordinator* who, in addition to broader educational responsibilities within the ASO, co-ordinates and delivers prison-specific

educational presentations, workshops, consultations, and information displays for inmates; provides ongoing training to education volunteers who choose to work with inmates; provides in-services to CSC staff, when requested; assembles education packages; and outreaches, networks, and consults with correctional institutions. The education sessions conducted by PARN are provided by the prison support worker who is also involved in training sessions in affiliation with the Centre for Addiction and Mental Health regarding HIV and addiction.

HIV Clinic

Upon request or by referral from the attending physician at Prison Health Services, inmates receive medical consultations/treatment from an HIV specialist from the HIV Clinic at the Kingston General Hospital. Generally, these services are received in the prison Health Services Department, or if necessary, inmates are transported to the hospital. This medical service operates independently and is not operationally connected with the services provided by the ASOs.

METHODS

Study Design

This study was a one-time survey of current users (inmates) of prison support services provided by HARS and PARN, and of non-users, inmates who used the prison HIV Clinic Specialist services only. Participants were recruited from the inmate population of 11 federal penitentiaries serviced by HARS and PARN: Kingston Penitentiary, Regional Treatment Centre, Bath Institution, Millhaven Institution, Collins Bay Institution, Joyceville Institution, Frontenac Institution, Pittsburgh Institution, Isabel McNeil House, Warkworth Institution and Sainte Anne

des Plaines (Quebec). Users of HARS/PARN services were recruited through the ASO prison support coordinator/worker, whereas, users of the HIV Clinic were recruited through the physician and clinic staff.

Evaluation Objectives

1. To measure inmate satisfaction with the services provided by the ASO prison support coordinator/worker, the education coordinator, and the HIV Clinic Specialist.
2. To assess inmate quality of life, coping ability, presence of depression and risk behaviour.
3. To examine if there was an association between inmate's quality of life, risk behaviour and the high and low use of ASO-provided prison health and support services.
4. To determine the perceptions of key staff at the ASOs and CSC concerning the effectiveness of ASO-provided prison support and education.

Measurement

Inmate satisfaction

A customized study-specific inmate satisfaction questionnaire was designed to capture the intensity of health, support, and education services utilized by the inmate and his/her opinions and satisfaction with the services provided. The CSQ-8 (Attkisson, 1987), a reliable client satisfaction questionnaire, was also administered.

Health-related quality of life, coping ability, depression

Previous studies have shown that a person's quality of life and ability to cope with HIV infection can be influenced by a multitude of psychosocial variables (Grassi et al., 1998). In addition, depressed mood is common in HIV-infected patients and is known to greatly impact quality of life (Savard et al., 1998). We were interested in examining if there was a relationship between the use of the ASO-provided prison support and education services and an inmate's quality of life, coping ability, and/or the occurrence of depression.

Administrative staff perceptions and feedback

Hammett et al., (1998) point out that it is critical for administrators, wardens, and other correctional staff to support pre-release planning, case management, and continuity-of-care programs if these programs are to be effective in assisting inmates with HIV/AIDS to make the transition from prison to the community. For this reason, we interviewed consenting correctional staff to elicit their perceptions and opinions about the ASO-provided prison services.

Description of Measures

The questionnaire package was administered using one-on-one interviews (in-person or by telephone) by an independent interviewer hired specifically for this study. As recommended in Correctional Service Canada's Forum on Corrections Research (Gaes, 2000), this study employed a mixture of quantitative and qualitative questions. While the standardized questionnaires provided scores to measure the impact that the program had on inmates, the qualitative component was designed to capture the nature of the gains by the inmates so as to

provide a better understanding of the satisfaction or shortcomings of the ASO-provided prison services program. See Appendix A for the complete inmate questionnaire package.

Demographics

Inmate demographics were collected including: age; gender; language and culture, education, length of incarceration (date of intake/release); HIV status.

Client Satisfaction

Inmate satisfaction was measured using the Client Satisfaction Questionnaire (CSQ-8) (Attkisson, 1987) and customized study-specific questions, including open-ended questions designed to collect information about:

- Services viewed as most helpful and/or useful and why.
- Needs, wants, issues, predicaments not currently being addressed by HARS/PARN services or the HIV Clinic Specialist.
- Ideas about additional services that could help address the above needs.

The CSQ-8 is an 8-item measure designed to assess clients' satisfaction with services. Questions range from "To what extent has our program met your needs?" to "Have the services you received helped you to deal more effectively with your problems?" and are answered on a scale of 1-4. This standardized satisfaction questionnaire was used to provide a mechanism to validate the customized satisfaction questionnaire.

Risky Behaviours

Risky behaviours were measured with a questionnaire that had been previously used in other Ontario prison studies to measure drug use before and after incarceration, injection practices, and tattooing (Ford et al., 2000). Additional questions were added about sexual practices.

MOS-HIV Health Survey (Quality of Life)

The MOS-HIV Health Survey is a brief, comprehensive measure of health-related quality of life (HRQoL) used extensively in diverse groups including people with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) (Wu et al, 1997). The 35-item questionnaire assesses ten dimensions of health including general health perceptions, pain, physical functioning, role functioning, social functioning, mental health, energy/fatigue, health distress, cognitive function, quality of life and takes approximately 15 minutes to complete. Subscales are scored on a 0 – 100 scale (a higher score indicates better health) and physical and mental health summary scores can be generated. The MOS-HIV Survey has been shown to be internally consistent, correlates with concurrent measures of health, discriminates between distinct groups, predicts future outcomes and is responsive to changes over time. Some questions have been re-worded in a minor way to reflect a typical day in prison.

Coping Ability

Ways of coping were measured using the Indices of Coping Responses by Moos et al., (1984) which focuses on the cognitive and behavioral coping responses that individuals use when a stressful event has occurred. They were asked to rate their frequency of use, on a 4-point

scale, of 33 different coping measures. Responses were categorized into cognitive, behavioral and avoidance methods of coping and problem solving, logical analysis, emotional distress, affective regulation and information seeking foci of coping.

Depression

Depression and anxiety were measured using the Center for Epidemiologic Studies Depression Scale CES-D8 (Radloff, 1977). It is a self-report questionnaire that assesses the client's report of the frequency of depressive and anxious symptoms. Respondents were asked to indicate how frequently they experienced 8 different symptoms on a scale of 0 (rarely) to 4 (most of the time). This questionnaire can be administered in 3-5 minutes.

Administrative Perceptions of ASO-provided prison services

CSC staff were invited to be interviewed, using open-ended questions, to determine their perceptions of the effectiveness of the ASO-provided Prison Support Services program, as were the ASO Prison Support personnel (see Appendices B & C for interview guides).

Study Process

A number of challenges exist when designing a study for a prison population. Literacy problems, access to the population for recruitment and confidentiality issues pose major barriers. The Canadian Expert Committee on AIDS and Prisons (ECAP) found very low response rates from both inmates and staff during their 1996 study (Jurgens, 1996).

Access to the population of interest was obtained through the Prison Support Workers who generated a list of known addresses of all current and past users of the ASO provided

services. This list was given to the study interviewer who assigned a distinct code number to each user. To protect the confidentiality of potential respondents, the interviewer was the only person to have the list of names and matching code numbers which was kept in a secure place. The interviewer then sent to potential respondents a mailing envelope containing an information sheet, consent form (Appendix D) and a telephone number with preferred calling times to arrange an appointment for their interview. Follow-up reminders were sent to inmates who had not arranged an interview time. No one except the interviewer knew who did or did not participate in the study.

To encourage a higher participation rate, respondents were interviewed directly using a structured questionnaire rather than being asked to independently complete a self report questionnaire and were provided with a $25 cash honorarium for participation in the study. To assist the respondents during the interview, they were provided with a copy of the questionnaire to follow.

Additional in-person or telephone interviews were conducted with consenting CSC staff and community based Parole Services staff to obtain their perceptions about the effectiveness of the ASO provided prison support services for inmates.

Sample Size Calculation

A 10-point difference in the mental health summary score (MSS) of the MOS-HIV Survey is considered a clinically important difference and a moderate effect (Ware, 1994). To detect a between-group post-intervention difference of 10 points on the scale of 100 between 2 groups (less intense and more intense use of services) a sample size of 17 per group was required

(alpha error of 0.05 (2-sided), a beta error of 0.20; SD of 15, intertemporal correlation of .70). This size sample was obtained.

Analysis

Descriptive analysis using means, SD's and proportions were used to describe proportions of persons exposed to different amounts of use of the prison support coordinator, mean sociodemographics, depression scores, coping scores, and SF-36 scores.

Scores on quality of life, coping and depression were compared using independent t-tests between those having high and low use of the services of the prison coordinator and high and low depression scores. Frequency rates and proportions were calculated to report rates of satisfaction with ASO prison support services.

Confidentiality and Ethics

Participation in this study was entirely voluntary. Methods to maintain confidentiality are summarized in Figure I. An envelope containing an information sheet describing the study and a consent form was mailed to or hand delivered to potential participants. Two copies of the informed consent form were provided in the envelope – one to be signed and returned to the interviewer, and one for the participant to sign and retain for their own reference. The name of a study contact person at the research unit was provided to the participant so that any questions they might have had could be answered to their satisfaction. During the interview, participants could refuse to answer specific questions or they could withdraw from the study at any time. Inmates were assured that they could refuse participation in the study without affecting services or care they would normally receive from the prison, HIV Clinic Specialist, or HARS/PARN.

The interviews took place in a private area in the Health Services department. Administration and security staff were not informed which inmates participated or not in the study. The study results are completely confidential and anonymous. CLEAR Unit staff who conducted the analysis at no time could connect participant names with study code numbers.

The Research Ethics Committees at McMaster University and Correctional Services Canada approved the study proposal and the consent form.

Figure 1

STUDY ROLE	ACTIVITY	CONFIDENTIALITY CHECKS
Prison Support Worker and HIV Clinic Specialist →	Obtain list of current/past inmate users of ASO prison support services (sends to Interviewer)	
↓		
Interviewer →	Assigns study code number to potential participant's name	Interviewer is only one to have names and matching code numbers
↓		
Interviewer →	Sends out study information letter and consent form to potential participants to participate in study	Interviewer is only one to know who does and does not participate in study
↓		
Interviewer →	Consenting inmate calls interviewer to arrange interview time and place	Interview arrangements same as for prison visits in health services
↓		
Interviewer →	Interview conducted	Participant can refuse to answer questions or withdraw at any time
↓		
CLEAR Research Investigator	Completed questionnaire couriered to CLEAR for data entry/analyses/write up	Only code numbers on returned Questionnaires: Only group data reported

Significance of the Evaluation

The study results were used to assess the value of this program as perceived by this unique population, to raise the visibility of the work done by HARS and PARN, and to guide the future development of the ASO prison support and education program.

RESULTS

Sampling

The HARS prison support coordinator generated a list of 70 clients to whom they had provided services during the year prior to the study. Of these clients, 45 were able to be contacted by letter and the remaining 25 had been released and their contact information was no longer accurate. Hence, we were unable to contact ex-inmates. The HIV Clinic Specialist estimated approximately 40 inmates used HIV clinic services during the past year, many of whom were assumed to also have used the ASO services. Since the user lists are confidential, it was not possible to determine the amount of overlap in use of services. The PARN prison support coordinator generated a list of 10 clients serviced during the year prior to the study who were not able to be identified separately from the HARS or clinic respondents.

Respondents came from 8 of the 11 federal prisons with Joyceville providing the most respondents (27.8%) and HARS services being used at least once by 28 of the 36 (78%) respondents. The results are shown in Table 1.

Table 1
Sample Prison Source (N=36)

Prison	%	
Joyceville	27.8	
Kingston	16.7	
Bath	16.7	
Warkworth	16.7	
Millhaven	11.1	
Regional Treatment Centre	5.6	
Frontenac	2.8	
Sainte Anne des Plaines (Québec)	2.8	
ASO/HIV Clinic Use	**# Respondents/**	**%**
Inmates		
HARS/PARN	30/55	54.5
HIV Clinic/Specialist	19/40	47.5
Ex-inmates	0/0	0.0
Administrative	14/14	100.0
Support Workers	2/2	100.0

Demographic Characteristics

Of the 36 respondents, 35 were male and 1 transgender with 89% identifying themselves as straight (heterosexual) and 11% as bisexual. The majority (70%) were between 26 and 40 years of age, primarily (75%) white racial background with minimal education (58.5%) (some high school or less). The results are shown in Table 2.

Table 2
Demographic Characteristics of Respondents (N=36)

Variable	%
Gender	
Male	97.2
Female	0.0
Transgender	2.8
Gender Identity	
Heterosexual (Straight)	88.9
Bisexual	11.1
Age	
26-30	16.7
31-35	13.9
36-40	38.9
41-45	16.7
46 and over	13.9
Ethnic Background	
White	75.0
Aboriginal	8.3
African Canadian	5.6
Other (1 of Hispanic, European, Metis, Mulato)	11.1
Level of Education	
Grade 8 or less	11.1
Some high school	47.2
High school diploma	25.0
Trade certificate	2.8
College diploma	5.6
Some university	8.3

Prison Background

All respondents (N=36) had been an inmate in a federal prison with 78% having been there at least one other time. Eighty-nine percent had been an inmate in a provincial prison with 53% having been there at least six or more times. For eight of the respondents (22%), the range of the length of their current sentence was 16 to 25 years. The results are shown in Table 3.

Table 3
Prison Background (N=36)

Variable	%
Ever inmate in federal prison?	
Yes	100.0
No	0.0
Number of other times	
0	22.2
1	33.3
2	13.9
3	16.7
4+	13.9
Ever inmate in provincial prison?	
Yes	88.9
No	11.1
Number of times	
1	15.6
2	21.9
3	3.1
4	3.1
5	3.1
6+	52.5
Length of current sentence (years)	
2-4 years	36.1
5-7 years	11.1
8-10 years	19.4
11-15 years	11.1
16+years	22.2

HIV Status

Fifty-six percent of the respondents were HIV positive, with 75% of them knowing about their status prior to this time in prison. Ninety-four percent of all the respondents had had an HIV blood test, 65% of whom had been tested 1 to 3 times. The results are shown in Table 4.

Table 4
HIV Background

Variable	%
HIV positive	**N=36**
Yes	55.6
No	36.1
Not sure	2.8
Missing	5.6
When status known	**N=20**
Before this time in prison	75.0
Since this time in prison	25.0
Ever had HIV blood test?	**N=36**
Yes	94.4
No	5.6
How many times?	**N=34**
1-3	64.7
4-7	17.6
8-11	0.0
12-15	8.8
Do not know	2.9
Missing	5.9

Health Related Quality of Life

Forty-two percent of the sample's average CES-D depression score was 12 (S.D. 4.9) where a score ≥ 7 suggests a clinically significant level of distress (Melchior, Huba, Brown & Rebach, 1993). When health status was analyzed by being depressed or not, they demonstrated statistically significantly lower scores (poorer) on the mental health scale (50 vs. 78) and the mental health summary scale (56 vs. 76) of the SF-36. In addition, those with higher depression had statistically significantly less energy (51 vs. 72), more health distress (55 vs. 86) and a lower quality of life (42 vs. 64). While not statistically significant, the more depressed had a pattern of lower health perceptions (46 vs. 62) and poorer overall physical health (58 vs. 70). The results are shown in Table 5.

Table 5
Demographics and Quality of Life by Depression

	Depressed (CESD >= 7) (N=15)		Not Depressed (CESD < 7) (N=21)		Test Statistics	
	Mean	**S.D.**	**Mean**	**S.D.**	**T-test**	**p-values**
Demographic						
Age	36.93	5.16	38.95	8.27	-0.835	0.410
Length of incarceration in years	6.38	4.77	4.58	4.98	1.086	0.285
Depression						
Depression score (CESD-8) (0-24)	12.13	4.94	3.04	1.92	7.693	<0.001**
Quality of Life Index score (0-100)						
Overall Health Perception	46.00	22.77	62.38	30.81	-1.744	0.090
Physical Function	80.56	21.52	74.21	34.25	0.633	0.531
Role Function	63.33	35.19	66.67	42.82	-0.247	0.806
*Social Function	*75.71	*32.51	80.00	37.42	-0.349	0.729
Cognitive Function	80.33	12.46	83.81	19.87	-0.598	0.554
Pain function	62.22	22.54	70.90	29.08	-0.966	0.341
Mental Health	50.40	19.41	77.52	18.26	-4.281	0.000**
Energy/Fatigue	51.00	24.29	72.62	24.78	-2.602	0.014**
Health Distress	54.67	34.82	86.43	17.69	-3.594	0.004**
Quality of Life	41.67	18.09	64.29	23.15	-3.154	0.003**
Physical Health Summary	57.94	16.63	70.03	25.35	-1.612	0.116
Mental Health Summary	56.26	14.42	76.32	17.20	-3.682	0.001*

*N=14
**p<0.05

Coping Measures

There was no statistically significant difference between the depressed and not depressed in their style or focus of coping. As a whole, they tended to be active behavioural copers with a focus on information seeking (Table 6).

Table 6
Comparison of Styles and Focus of Coping of Depressed and Not Depressed Respondents

	Depressed (CES-D ≥7) (N=15)		Not Depressed (CES-D <7) (N=21)		Test Statistics	
Coping Measures	**Mean**	**S.D.**	**Mean**	**S.D.**	**t-test**	**p-values**
Cognitive Coping (0-33)	24.07	4.71	23.05	3.89	0.706	0.485
Active Behavioural Coping (0-39)	25.09	7.72	24.95	8.26	0.263	0.794
Avoidance Coping (0-24)	6.87	3.27	5.95	3.09	0.854	0.399
Logical Analysis (0-12)	9.20	2.51	9.10	2.57	0.122	0.904
Information Seeking (0-21)	13.47	5.91	10.50	4.32	1.741	0.091
Problem Solving (0-15)	10.80	3.17	11.29	3.32	-0.441	0.662
Affective Regulation (0-18)	11.07	3.20	12.43	3.75	-1.141	0.262
Emotional Discharge (0-18)	5.73	2.96	5.05	2.99	0.681	0.501

Prison Support Coordinator: Health Services Use

Whereas the use of health resources can be a marker for poor adjustment to illness (Browne et al, 1995), we used respondents' reports of the frequency of talking to the Prison Support Coordinator (0-5 = low use; more than 5 = high use) as a proxy measure of service use since actual service use was not available for this survey. Those high users of the Coordinator had been in prison longer (mean 7.1 years vs. 3.4 years), had statistically significantly higher cognitive function (88 vs. 76) and tended to use statistically significantly more active behavioural strategies with statistically significantly more information seeking approaches. They tended to have overall better physical health with a pattern of less pain (63 vs. 73) and less health distress (68 vs. 79) than lower users. However, they had lower mental health (61 vs. 72) on the SF-36, which shows a clinically important difference and moderate effect (Ware, 1994). In addition, high users of Prison Support Coordinators had a mean score of 8.3 (6.2) on the CES-D scale which is indicative of a significant level of distress (Table 7), and is congruent with the mental health summary score on the SF-36.

Table 7
Comparison of High and Low Users of Prison Support Coordinators on Demographics, Quality of Life, Coping and Depression

	0-5 times (N=17)		5 + times (N=19)		Test Statistics	
	Mean	S.D.	Mean	S.D.	T-test	p-values
Demographic						
Age	38.35	8.09	37.89	6.35	0.190	0.850
Length of incarceration in years	3.36	2.95	7.09	5.67	-2.435	0.018**
Quality of Life (Index Score)						
Overall Health Perception Index score	60.29	30.59	51.32	26.76	0.939	0.354
Physical Function index score	80.88	29.13	73.25	29.99	0.773	0.445
Role Function index score	64.71	42.44	65.79	37.46	-0.081	0.936
*Social Function index score	77.50	36.42	78.95	34.94	-0.120	0.905
Cognitive Function index score	75.88	18.98	88.16	13.04	-2.283	0.029**
Pain function index score	72.55	27.25	62.57	25.72	1.130	0.266
Mental Health Index score	71.76	23.04	61.26	22.23	1.391	0.173
Energy/Fatigue index score	65.59	28.83	61.84	24.96	0.418	0.679
Health Distress index score	78.82	25.03	68.16	34.17	1.057	0.298
Quality of Life index score	52.94	24.82	56.58	23.34	-0.453	0.653
Physical Health Summary Index score	68.08	25.73	62.23	19.86	0.768	0.448
Mental Health Summary index score	69.97	20.23	66.16	17.75	0.602	0.551

*N=16
**p<0.05

Table 7 (Cont'd)
Comparison of High and Low Users of Prison Support Coordinators on Demographics, Quality of Life, Coping and Depression

		0-5 times (N=17)		5 + times (N=19)		Test Statistics	
		Mean	S.D.	Mean	S.D.	T-test	p-values
Coping Strategies							
Methods	Cognitive Coping (0-33)	22.24	3.67	24.58	4.46	-1.704	0.097
	Active Behavioural Coping (0-39)	21.38	8.06	28.25	6.52	-2.825	0.008**
	Avoidance Coping (0-24)	6.59	3.68	6.11	2.69	0.454	0.653
Focus	Logical Analysis (0-12)	8.76	2.56	9.47	2.48	-0.843	0.405
	Information Seeking (0-21)	8.74	4.78	14.42	3.98	-3.893	0.001**
	Problem Solving (0-15)	10.47	2.92	11.63	3.45	-1.083	0.286
	Affective Regulation (0-18)	11.41	3.81	12.26	3.35	-0.714	0.480
	Emotional Discharge (0-18)	5.65	3.55	5.05	2.37	0.597	0.555
Depression							
Depression score (CESD-8) (0-24)		5.18	4.77	8.31	6.18	-1.687	0.101

**p<0.05

Characteristics of Risk Behaviour in Prison

Drug Use

Fifty percent of respondents' convictions were related to drugs. Sixty-six percent of respondents reported that they had injected drugs outside of prison, whereas 53% reported injecting drugs inside any prison and 33% reported injecting drugs since they had been in prison this time. Seventeen percent of respondents reported injecting in the last 6 months. Cocaine was the most frequently reported drug used in prison this time by 10 respondents, followed by heroin (N=8) and morphine (N=4). Marijuana (N=19), hash (N=13), morphine (N=11) and crack/cocaine (N=9) were the most frequently reported non-injection drugs used by respondents in prison this time (Table 8).

Care of Injection Equipment

Fifty-one percent of respondents reported sharing injection equipment while outside of prison; 37% had shared works while in any prison and 25% had shared works with someone while in this prison this time. Five respondents had shared works in the last 6 months and thought that numerous other people had been using that particular set of works. All 5

respondents cleaned the equipment with bleach before taking their turn. The results are shown in Table 8.

Table 8
Risk Behaviour in Prison: Drugs

	%
Was your conviction drug related?	**N=36**
Yes	50.0
No	50.0
Have you ever injected drugs outside of prison?	**N=35**
Yes	65.7
No	34.3
Have you injected drugs in the last 6 months?	**N=36**
Yes	16.7
No	83.3
Did you ever inject drugs while you were in any prison?	**N=36**
Yes	52.8
No	47.2
Have you injected drugs since you have been in prison this time?	**N=36**
Yes	33.3
No	66.7
What drugs have you injected this time? (multiple answers)	
Cocaine	76.9
Heroin	61.5
Speed	7.7
Speedball\goofballs	7.7
Steroids	7.7
Other	61.5
Specify other drugs used	
Methadone	2.8
Morphine, dilaudid, crack	2.8
Morphine, dilaudid	2.8
Morphine - cottons	2.8
Morphine	5.6
Morphine, oxycontin	2.8
Numerous others	2.8
What other drugs (non-injection) have you used in prison (this time)? (multiple answers)	
None	38.9
Dilaudid	16.7
Morphine	30.6
Percocet	19.4
Codeine	22.2
Ecstasy	8.3
Marijuana	52.8
Hash	36.1
Downers	16.7
Acid	5.6
Crack/cocaine	25.0
Amphetamines	5.6
Nitrate inhalants	2.8
Other drugs	13.9
Specify other drugs used	
cigarettes	2.8
everything, lots	2.8
Heroin, PCP	2.8
tall ones	2.8
valium, morphine, THC	2.8
Valium/Benzo	2.8

Table 8 (Cont'd)
Risk Behaviour in Prison: Drugs

	%
Have you ever shared injection equipment (works/paraphernalia)* with anyone outside of prison?	**N=35**
Yes	51.4
No	48.6
Have you ever shared works with anyone while in any prison?	**N=35**
Yes	37.1
No	62.9
Have you ever shared works with anyone while in this prison?	**N=15**
Yes	60.0
No	40.0
Have you shared works with anyone in this prison in the last 6 months?	**N=11**
Yes	45.5
No	54.6
How many people do you think were using that set of works?	**N=5**
Two other people	20.0
Three other people	20.0
Five other people	20.0
Seven other people	20.0
Eight other people	20.0
Did you clean the works with bleach before your turn?	**N=5**
Yes	100.0

* works/paraphernalia includes needles, syringes, cookers, spoons, rinse water, filter, cotton

Tattoos/Body Piercing/Alcohol

Fifty percent of respondents (N=18) had a tattoo done while outside prison, 79% (N=27) when they were in any prison and 43% (N=13) had one done in prison this time. Nineteen percent (N=7) of respondents had body piercing done in this prison this time. Forty-four percent (N=16) of respondents used alcohol in this prison this time. The results are shown in Table 9.

Table 9
Risk Behaviour in Prison: Tattoos, Body Piercing and Alcohol

	%
Tattoos	
Did you ever get a tattoo when you were outside of prison?	**N=36**
Yes	50.0
No	50.0
Did you ever get a tattoo while inside any prison?	**N=34**
Yes	79.4
No	20.6
Did you get a tattoo while inside this prison this time?	**N=30**
Yes	43.3
No	56.7
Body Piercing	
Have you had any body piercing done while inside this prison this time?	**N=36**
Yes	19.4
No	80.6
Alcohol	
Have you ever used alcohol while inside this prison this time?	**N=36**
Yes	44.4
No	55.6

Sexual Activity

Twenty-two percent (N=8) of the respondents were sexually active in this prison this time, 8% (N=3) of whom engaged with multiple partners and all had unprotected sex. One respondent had a male main sex partner, with whom they had sex twice; 3 respondents had a male casual sex partner with whom they had sex 1 to 2 times; 2 respondents had sex with a female main sex partner on multiple occasions; 2 respondents had oral sex with a male main sex partner and 2 had oral sex with a male casual partner; 2 had oral sex with a female main sex partner on multiple occasions.

Alcohol or drugs were used by 2 of the 8 sexually active respondents when they had sex. Three respondents had unprotected sex with an injection drug user this time in prison and 1 respondent had unprotected sex with someone whom they did not know if they injected drugs. Two respondents had unprotected sex with someone they suspected or knew was HIV positive this time. One respondent had unprotected sex in exchange for drugs or money; 1 respondent was forced to have sex that was unprotected. The results are shown in Table 10.

Table 10
Risk Behaviour in Prison: Sexual Activity

		%
Since you came to this prison, how many different people have you had sex with? (This could be vaginal, anal, or oral sex with a male or a female.)		**N=36**
None		77.8
One		13.9
3-5		2.8
More than 10		5.6
Have you ever had unprotected sex while in prison this time? (Protection could be a condom, dental dam, or other protection such as saran wrap)		**% N=8**
Yes		100.0
vaginal/anal sex with a:	**# of times**	**f**
male main sex partner	2	1
male casual sex partner	1-2	3
female main sex partner	20+	2
oral sex with a:		
male main sex partner	1-4	2
male casual sex partner	2+	2
female main sex partner	20+	2
		%
When you had sex in prison this time, how often did you use alcohol or drugs at the same time?		**N=8**
Never		75.0
Almost always		25.0

Table 10 (Cont'd)
Risk Behaviour in Prison: Sexual Activity

	%
Have you ever had unprotected sex with a needle user (IDU) while in prison this time?	**N=8**
Yes	37.5
No	50.0
Don't know	12.5
Have you ever had unprotected sex with someone you suspect or know is HIV+ while in prison this time?	**N=8**
Yes	25.0
No	75.0
Have you ever had unprotected sex in exchange for money/drugs while in prison this time?	**N=8**
Yes	12.5
No	87.5
Have you ever been forced to have sex against your will while in prison this time?	**N=8**
Yes	12.5
No	87.5
If yes, was protection used?	**N=1**
No	100.0

Risk Behaviours by HIV Positive Inmates

Forty-eight percent (N=10) of the sample of HIV positive inmates (N=20) versus 15% (N=2) of HIV negative inmates had injected drugs this time in prison; seven of the HIV positive inmates (versus 2 HIV negative) had shared their works with someone else. In addition, 7 HIV positive inmates versus 5 HIV negative inmates had obtained a tattoo in this prison, 4 versus 2 had body piercing done and 9 versus 6 used alcohol. Five of the HIV positive inmates had unprotected sex, 4 with 1-2 people, and 1 with someone more than 10 times, whereas 2HIV negative inmates had unprotected sex with 2 people multiple times. Unprotected sex with a needle user and someone known or suspected of being HIV positive was reported by 2 HIV positive inmates and 1 HIV negative inmate. Unprotected sex for money or drugs was reported by 1 HIV positive inmate. The results are shown in Table 11.

Table 11
Risk Behaviours by HIV Positive or Not

	HIV Status		Test Statistics	
	Positive %	Negative %	Chi-square	p-values
Have you injected drugs since you have been in prison this time?	**N=21**	**N=13**		
Yes	47.6	15.4	3.653	0.056*
No	52.4	84.6		
Have you ever shared works with anyone while in this prison?	**N=10**	**N=4**		
Yes	70.0	50.0	0.498	0.480
No	30.0	50.0		
Did you get a tattoo while inside this prison this time?	**N=17**	**N=12**		
Yes	41.2	41.7	0.001	0.979
No	58.8	58.3		
Have you had any body piercing done while inside this prison this time?	**N=21**	**N=13**		
Yes	19.1	15.4	0.074	0.785
No	81.0	84.6		
Have you ever used alcohol while inside this prison this time?	**N=21**	**N=13**		
Yes	42.9	46.2	0.035	0.851
No	57.1	53.9		
Since in prison this time, how many different people have you had sex with?	**N=21**	**N=13**		
None	76.2	84.6		
1-2	19.1	7.7	3.010	0.390
3-5	0.0	7.7		
More than 10	4.8	0.0		
Have you ever had unprotected sex while in prison this time?	**N=5**	**N=2**		
Yes	100.0	100.0		
When you had sex this time, how often did you use alcohol/drugs at the same time?	**N=5**	**N=2**		
Never	80.0	50.0	0.630	0.427
Almost always	20.0	50.0		
Have you had unprotected sex with a needle user (IDU) while in prison this time?	**N=5**	**N=2**		
Yes	40.0	50.0		
No	40.0	50.0	0.467	0.792
Don't know	20.0	0.0		
Have you had unprotected sex with someone you suspect or know is HIV+ while in prison this time?	**N=5**	**N=2**		
Yes	40.0	0.0	1.120	0.290
No	60.0	100.0		
Have you had unprotected sex in exchange for money/drugs while in prison this time?	**N=5**	**N=2**		
Yes	20.0	0.0	0.467	0.495
No	80.0	100.0		
Have you been forced to have sex against your will while in prison this time?	**N=5**	**N=2**		
Yes	20.0	0.0	0.467	0.495
No	80.0	100.0		
If yes, was protection used?	**N=1**	**N=0**		
Yes	0.0	0.0	0.000	0.000
No	100.0	0.0		

*p = <0.05

Risk Behaviours and Depression

Depression appears to have played a role in the risk behaviour of inmates related to injection of drugs, in that 7 of the 15 depressed inmates (47%) as compared to 5 of the 21 not depressed inmates (24%) had injected drugs since they had been in prison this time as well as had used more non-injection drugs than the not depressed inmates including dilaudid, oral

morphine, percocet, codeine, ecstasy, marijuana, hash, and a variety of other drugs. Tattoos were obtained by a higher proportion of depressed (47%) versus non-depressed inmates (29%) as well as more body piercing (33% vs. 10%). Alcohol was used by more depressed inmates (60%) than non-depressed (33.3%). Five of the depressed inmates had unprotected sex while in prison this time (33%), compared to 3 of the not depressed group (14%), and 1 from each group used alcohol or drugs when having sex. Two of the 5 depressed inmates had unprotected sex with a needle user as well as someone they suspected or knew was HIV positive versus none in the not depressed group. The results are shown in Table 12.

Table 12
Risk Behaviours by Depressed or Not

	Depressed (CES-D >7) %	Not Depressed (CES-D <7) %	Test Statistics	
			Chi-square	p-values
Have you injected drugs since you have been in prison this time?	**N=15**	**N=21**		
Yes	46.7	23.8	2.057	0.151
No	53.3	76.2		
What other drugs (non-injection) have you used in prison this time? (multiple answers)				
None	26.7	47.6	1.616	0.204
Dilaudid	26.7	9.5	1.851	0.174
Morphine	40.0	23.8	1.081	0.298
Percocet	26.7	14.3	0.856	0.355
Codeine	33.3	14.3	1.837	0.175
Ecstasy	13.3	4.8	0.842	0.359
Marijuana	66.7	42.9	1.990	0.158
Hash	46.7	28.6	1.242	0.265
Downers	13.3	19.1	0.206	0.650
Acid	6.7	4.8	0.061	0.806
Crack/cocaine	26.7	23.8	0.038	0.845
Amphetamines	6.7	4.8	0.061	0.806
Nitrate inhalants	6.7	0.0	1.440	0.213
Other drugs	26.7	4.8	3.510	0.061
Have you ever shared works with anyone while in this prison?	**N=5**	**N-10**		
Yes	100.0	40.0	5.000	0.025*
No	0.0	60.0		
Did you get a tattoo while inside this prison this time?	**N=13**	**N=17**		
Yes	53.9	35.3	1.033	0.310
No	46.2	64.7		
Have you had any body piercing done while inside this prison this time?	**N=15**	**N=21**		
Yes	33.3	9.5	3.167	0.075
No	66.7	90.5		
Have you ever used alcohol while inside this prison this time?				
Yes	60.0	33.3	2.520	0.112
No	40.0	66.7		
Since you came to this prison this time, how many different people have you had sex with?				
None	66.7	85.7	6.260	0.100
One - two	26.7	4.8		
3-5	6.7	0.0		
More than 10	0.0	9.5		
Have you ever had unprotected sex while in prison this time?	**N=5**	**N=3**		
Yes	100.0	100.0		

Table 12 (Cont'd)
Risk Behaviours by Depressed or Not

	Depressed (CES-D >7) %	Not Depressed (CES-D <7) %	Test Statistics	
			Chi-square	p-values
When you had sex this time, how often did you use alcohol or drugs at the same time?	**N=5**	**N=3**		
Never	80.0	66.7	0.178	0.673
Almost always	20.0	33.3		
Have you ever had unprotected sex with a needle user (IDU) while in prison this time?	**N=5**	**N=3**		
Yes	40.0	33.3	0.889	0.641
No	40.0	66.7		
Don't know	20.0	0.0		
Have you ever had unprotected sex with someone you suspect or know is HIV+ while in prison this time?	**N=5**	**N=3**		
Yes	40.0	0.0	1.600	0.206
No	60.0	100.0		
Have you ever had unprotected sex in exchange for money/drugs while in prison this time?	**N=5**	**N=3**		
Yes	0.0	33.3	1.905	0.168
No	100.0	66.7		
Have you ever been forced to have sex against your will while in prison this time?	**N=5**	**N=3**		
Yes	20.0	0.0	0.696	0.408
No	80.0	100.0		
Was protection used?	**N=1**	**N=0**		
Yes	0.0	0.0	0.000	0.000
No	100.0	0.0		

*p = <0.05

Summary of Respondents (inmates) Characteristics

Thirty-six respondents (inmates) who completed this survey and who had used ASO prison support services, came from 8 of the 11 federal penitentiaries serviced by PARN, HARS and the HIV Clinic. The majority were white male, heterosexual, between 26 and 40 years of age with a long history of multiple incarcerations. Fifty-six percent (N=20) reported being HIV positive, plus 1 respondent who was uncertain of his status, with 75% aware of their status prior to this time in prison, 48% (N=10) reported being current injection drug users, sharing equipment (N=7) having a tattoo (N=7), body piercing (N=4), and unprotected sex (N-5). Injection drug use reflects the predominant transmission risk seen in HIV positive prisoners in other studies of federal prisons (Ford & Wobeser, 2000), while tattooing has been recognized as a risk factor for transmission of hepatitis C inside prison (Thompson et al, 1996; Holsen et al, 1993). Forty-two percent of the sample screened positive for depression. Thirty-six percent of respondents had a

sentence of between 2 and 4 years, 11% had a sentence of between 5 and 7 years, 19% 8 to ten years and 33% had a sentence 11 years and more.

Risky behaviours outside and inside prison relating to drug use, tattooing and sexual behaviour were high in the total group of inmates with 66% having injected drugs outside of prison, 53% injecting in any prison and 33% injecting in prison this time. Sharing works, while common outside of prison (51%) and in any prison (37%), was importantly reduced in the last 6 months (13.9%) in this prison. Five of the six respondents who shared their works reported using bleach before taking their turn. Fifty percent of respondents obtained a tattoo outside of prison, 79% in any prison, and 43% in prison this time. Body piercing was not as common (19%) and alcohol use was less than half the group (44%). While sexual activity was low, risky sex behaviour was high with 8 respondents (36%) reporting unprotected sex 100% of the time with a main partner (N=7) or casual partner (N=5) of both genders.

While 56% of respondents were HIV positive (N=20), they had brought not only their risky behaviours with them to prison, including injection drug use, sharing works, tattoos and unprotected sex, but in addition were suffering from depression which appears to have further enhanced these same risky behaviours. Depressed inmates were twice as likely to inject drugs, 1½ times more likely to have a tattoo, 3½ times more likely to have body piercing, and 1½ times more likely to use alcohol than non depressed inmates.

Inmate Evaluation of Prison HIV Services

HIV Clinic Specialist: Use

Over 50% of the respondents had used the HIV Clinic with all of them having seen the HIV specialist MD. The majority had learned about this service from the other health services staff and regular prison doctor (Table 13).

Table 13
Evaluation of Prison HIV Services: HIV Clinic: Use

	%
Use of HIV Clinic Services	**N=36**
Yes	52.8
No	47.2
Which staff did you see? (multiple answers)	**N=19**
HIV specialist (MD)	100.0
Chaplain	42.1
Nurse	31.6
Social Worker	15.8
Other (clinic staff)	5.3
How did you learn about the clinic? (multiple answers)	**N=19**
Regular prison doctor	47.4
Other health services staff	47.4
Friend outside prison	10.5
Other workers at an ASO	10.5
Other inmate	5.3
Other (doctor, PSAN, AIDS Resource book, Street Health,	26.3

HIV Clinic Specialist: Accessibility

The group was approximately evenly split on the ease of making a first appointment with the HIV Specialist at the clinic, while the majority (89%) reported having to wait more than a week for the appointment. Respondents reported that "*the physician only comes to the prison at a set time… every month to six weeks*". Once they had their appointment, all reported being seen by the HIV specialist (MD or nurse) within 45 minutes, with the majority (58%) reporting a wait of only 10-15 minutes. For those who had a blood test, the group was almost equally divided on whether or not they received their results back quickly enough. Some indicated a wait of 2-4 weeks (43%), while one respondent indicated he did not receive his results at all. Similarly, slightly over half of those who were prescribed medicines (53%) indicated they had no trouble

obtaining their medicine, whereas 42% indicated they did have trouble (Table 14). These troubles included getting HIV medications late *"so I don't take the cocktail because I am worried that that person will be late with the meds;"* or *"health services only carry a certain amount…so if they are not informed that someone with HIV is coming, they may not have enough drugs;" … "going to court and different jails…so didn't have the meds...gave wrong meds at different courts…screwed up whole regimen… ".*

Table 14
Evaluation of Prison HIV Services: HIV Clinic: Service Accessibility

	%
Ease of making first appointment	**N=19**
No problem	52.6
Harder than expected	47.4
How long to wait for appointment?	**N=19**
2-3 days	5.3
6-7 days	5.3
Over 1 week	89.5
Once you were at Health Services, how long did you wait to see the HIV specialist/nurse?	**N=19**
10-15 minutes	57.9
16-30 minutes	26.3
31-45 minutes	15.8
Of those who had blood tests, did you get the results back quickly enough?	**N=19**
Yes	52.6
No	47.4
How long did you wait?	
2-4 weeks	15.8
2 months	5.3
3 months	5.3
Did not get results	5.3
Slow	5.3
Not Stated	63.2
Any problems getting prescribed medicines?	**N=19**
Yes	42.1
No	52.6
Do not take medicine	5.3
Staff available evenings/weekends?	**N=19**
Yes	10.5
No	73.7
Don't know	15.8
Have you ever needed them on weekends/evenings?	
Yes	31.6
No	47.4
Not Stated	21.1

HIV Clinic Specialist: Acceptability

The HIV Clinic Specialist was overwhelmingly acceptable to the majority of respondents in terms of time spent (95%), comfort with clinicians (95%), asking questions (100%), getting information (84%) and follow-up (84%) (Table 15).

Table 15
Evaluation of Prison HIV Services: HIV Clinic: Service Acceptability

	%
Did doctor/nurse spend enough time with you?	**N=19**
Always/most times	94.7
Never	5.3
Were you comfortable talking with doctor/nurse?	**N=19**
Always/most times	94.7
Never	5.3
Were you able to see requested doctor/nurse?	**N=19**
Always/most times	73.7
Never	15.8
Missing	10.5
Could you ask all the questions you wanted to ask?	**N=19**
Always/most times	100.0
Did you get the information you needed?	**N=19**
Always/most times	84.2
Never	15.8
When you asked a question, were you given a complete answer?	**N=19**
Always/most times	100.0
If there was something they did not know, did they find out for you?	
Never asked what they could not answer	36.8
Always/most times	47.4
Never	15.8

HIV Clinic Specialist: Satisfaction

Satisfaction with the HIV Clinic Specialist by the respondents (N=19) was high (74%), with the majority (74%) willing to recommend these services to a friend (Table 16). One respondent would not tell anyone because he would not want others to know his status and others believed that fear of discrimination was the major reason that anyone infected or at risk of infection would not use these services.

Table 16
Evaluation of Prison HIV Services: HIV Clinic: Satisfaction with Services

	%
Overall satisfaction with HIV specialist/nurse	**N=19**
Excellent/good	73.7
Fair/poor	26.3
Are services good enough to recommend to a friend?	**N=19**
Yes	73.7
No	26.3
If no, why not?	
Not applicable	89.5
Better on street	5.3
No emotional support	5.3
Do you know of a PHA who did not use general prison health services?	**N=19**
Yes	26.3
No	73.7
Do you know of a PHA who did not use the HIV Clinic/specialist?	**N=19**
Yes	21.1
No	73.7
Not applicable	5.3
Do you know why they may not be using services? (N=4)	
Not stated	50.0
Discrimination	16.7
Fear/denial/uneducated	33.3

When data obtained from the Client Satisfaction Questionnaire (CSQ-8) was analyzed by high and low users of health resources (using the Prison Support Coordinator as a proxy measure), there were no statistically significant differences between the two groups on 7 of the 8 items, wherein the 7 items of satisfaction with the clinic services were strongly endorsed by both groups. The one item of difference was the question of whether respondents would come back to the HIV clinic should they ever need help again and there was one low user who did not think so. This respondent's lack of satisfaction had an impact on all of the low user group's responses due to the small sample size. The pattern of responses showed the low user group to be less endorsing of the items than the high user group (Table 17).

Table 17
Client Satisfaction: HIV Clinic by High and Low Users of Prison Support Coordinator

	0-5 times	5 + times	Test Statistics	
	N=6 %	N=12 %	Chi-square	p-values
How would you rate the quality of service you have received?				
Poor	0.0	0.0	0.532	0.767
Fair	16.7	8.3		
Good	33.3	25.0		
Excellent	50.0	66.7		
Did you get the kind of service you wanted?				
No, definitely not	0.0	0.0	0.554	0.457
No, not really	0.0	0.0		
Yes, generally	16.7	33.3		
Yes, definitely	83.3	66.7		
To what extent has the program met your needs?				
None of my needs have been met	0.0	0.0	2.986	0.225
Only a few of my needs have been met	16.7	8.3		
Most of my needs have been met	33.3	75.0		
Almost all of my needs have been met	50.0	16.7		
If a friend were in need of similar help, would you recommend the program to him or her?				
No, definitely not	16.7	0.0	2.550	0.279
No, I don't think so	0.0	0.0		
Yes, I think so	16.7	8.3		
Yes, definitely	66.7	91.7		
How satisfied are you with the amount of help you have received?				
Quite satisfied	0.0	0.0	2.563	0.278
Indifferent or mildly dissatisfied	16.7	0.0		
Mostly satisfied	50.0	41.7		
Very satisfied	33.3	58.3		
Have the services you received helped you to deal more effectively with your problems?				
No, they seemed to make things worse	0.0	0.0	5.625	0.060
No, they didn't really help	33.3	0.0		
Yes, they helped somewhat	50.0	41.7		
Yes, they helped a great deal	16.7	58.3		
*p = <0.05				
In an overall, general sense, how satisfied are you with the service you have received?				
Quite dissatisfied	0.0	0.0	3.343	0.188
Indifferent or mildly dissatisfied	16.7	0.0		
Mostly satisfied	66.7	50.0		
Very satisfied	16.7	50.0		
If you were to seek help again, would you come back to the program?				
No, definitely not	0.0	0.0	7.200	0.027*
No, I don't think so	16.7	0.0		
Yes, I think so	33.3	0.0		
Yes, definitely	50.0	100.0		
*p = <0.05				

Group Talks: Accessibility

Twenty-eight percent of the respondents had attended group talks put on by Community HIV/AIDS Workers. Respondents learned about the talks from a variety of sources including internal advertising, health services personnel, other inmates and external contacts such as

friends and an ASO (Table 18). Several respondents indicated that they would not attend the talks because *"there is a lot of discrimination in here…heard talks were happening but don't want people to know because they'll stop talking to you"*.

Group Talks: Acceptability

Respondents rated the talks highly in terms of the topics, the quality of the speakers, how comfortable they felt to ask questions and the opportunity for follow-up. The absence of information about "Hep C" and that the talks *"were not long enough"* were the only criticisms given of the talks (Table 18).

Table 18
Evaluation of Prison HIV Services: Group Talks

Accessibility	**%**		
Attended group talks put on by Community HIV/AIDS workers	**N=36**		
Yes	27.8		
No	72.2		
How did you fin out about these talks? (multiple answers)	**N=10**		
Poster	30.0		
Pamphlet	40.0		
Regular Prison MD	20.0		
HIV Clinic specialist	20.0		
Other health service staff	30.0		
Prison Support workers from ASO	30.0		
Another inmate	50.0		
Friend outside prison	10.0		
Other (OSAP, PARN, Peer Health Council)	40.0		
Acceptability (multiple answers)	**Yes %**	**No %**	
Did the speakers talk about the thing you were interested in?	80.0	20.0	
Did you get enough information?	70.0	30.0	
Was the speaker easy to understand?	100.0	0.0	
Did you feel comfortable enough to ask questions?	90.0	10.0	
Were you please with the way your questions were answered?	90.0	0.0	
Did they give handouts to take away with you?	80.0	20.0	
Did they give the name of someone to call for more information?	90.0	10.0	
Did you find the talks good enough to tell a friend to go?	100.0	0.0	
Follow-up			
After the talk, did you call the ASO for help?	90.0	10.0	
Were you unhappy about anything to do with the talk?	Lack of information		
Overall rating:	**Excellent %**	**Good %**	**Fair %**
Talk A (AIDS awareness, safe sex, drug use, health services of HARS)	30.0	60.0	10.0
Talk B (AIDS awareness, support groups, hygiene, transmission) **(N=5)**	100.0		
Talk C (NTC, relationships, condoms, birth control) **(N=4)**	75.0	25.0	

Group Talks: Satisfaction

There was no statistically significant difference between the two user groups in satisfaction with ASO prison support services on any of the satisfaction items (Table 19) with both groups rating the group talks as highly satisfying. The small sample size limits the ability to generalize.

Table 19
Client Satisfaction with Education Services by High and Low Users of Prison Support Coordinator

	0-5 times	5 + times	Test Statistics	
	%	%	Chi-square	p-values
How would you rate the quality of service you have received?	**N=2**	**N=8**		
Poor	0.0	0.0	1.875	0.392
Fair	50.0	12.5		
Good	0.0	37.5		
Excellent	50.0	50.0		
Did you get the kind of service you wanted?				
No, definitely not	0.0	0.0	0.833	0.659
No, not really	0.0	25.0		
Yes, generally	50.0	25.0		
Yes, definitely	50.0	50.0		
To what extent has the program met your needs?	**N=2**	**N=7**		
None of my needs have been met	0.0	0.0	1.768	0.413
Only a few of my needs have been met	0.0	42.9		
Most of my needs have been met	50.0	14.3		
Almost all of my needs have been met	50.0	42.9		
If a friend were in need of similar help, would you recommend the program?				
No, definitely not	0.0	0.0	1.148	0.284
No, I don't think so	0.0	0.0		
Yes, I think so	50.0	14.3		
Yes, definitely	50.0	85.7		
How satisfied are you with the amount of help you have received?				
Quite satisfied	0.0	0.0	1.286	0.257
Indifferent or mildly dissatisfied	0.0	0.0		
Mostly satisfied	0.0	42.9		
Very satisfied	100.0	57.1		
Have the services helped you deal more effectively with your problems?				
No, they seemed to make things worse	0.0	0.0	0.321	0.571
No, they didn't really help	0.0	0.0		
Yes, they helped somewhat	50.0	71.4		
Yes, they helped a great deal	50.0	28.6		
Overall, how satisfied are you with the service you have received?				
Quite dissatisfied	0.0	0.0	0.032	0.858
Indifferent or mildly dissatisfied	0.0	0.0		
Mostly satisfied	50.0	42.9		
Very satisfied	50.0	57.1		
If you were to seek help again, would you come back to the program?				
No, definitely not	0.0	0.0	1.148	0.284
No, I don't think so	0.0	0.0		
Yes, I think so	50.0	14.3		
Yes, definitely	50.0	85.7		

Prison Support Coordinator: Coordinator Use

Over 83% of respondents had talked with the Prison Support Coordinator with 19 of the 36 respondents talking with her/him more than 5 times. Respondents learned about the Coordinator from a variety of sources including internal advertising (posters, pamphlets), health services personnel, group talks, other ASO workers, other inmates and external sources including friends, street health as examples (Table 20).

Prison Support Coordinator: Accessibility

Eighty-six percent of respondents had "no problem at all" booking their first appointment with the Coordinator with 76% having to make only one phone call the first time to talk with the Coordinator.

Fifty percent of respondents obtained an appointment within 3 days of their request but 21% had to wait over 2 weeks for their appointment. Sixty-seven percent reported that there was no way to reach the Coordinator on evenings and weekends and 40% of these respondents said that they had needed them at these times but were unable to contact them. Respondents said that it was possible to leave a message when they called (90%).

Seventy percent of respondents who had spoken with the Coordinator had met with the Coordinator in person and that it had taken less then 10 minutes for 86% of them to go from their place to meet her (Table 20).

Table 20
Evaluation of Prison HIV Services: Prison Support Coordinator: Accessibility

	%
Talked with Prison Support Coordinator	**N=36**
YES	83.3
NO	16.7
How many times did you talk to the Prison Support Coordinator?	**N=36**
None	16.7
1-2	5.6
2-3	22.2
4-5	2.8
More than 5	52.8
How did you find out about the Prison Support Coordinator?	**N=30**
Poster	20.0
Pamphlet	6.7
Regular Prison MD	16.7
HIV Clinic specialists/nurse	23.3
Other health services staff	30.0
Group talk/presentation	13.3
Other ASO Worker (HARS)	16.7
Other inmate	26.7
Friend outside prison	6.7
Other*	43.3
How easy was it to book your first appointment?	**N=28**
No problem at all	85.7
Harder than expected	14.3
How many times did you have to call to talk with the Prison Support Coordinator the first time?	**N=29**
Once	75.9
Twice	13.8
Three times	3.5
Four times	6.9
How long was the usual wait for an appointment?	**N=28**
Within 3 days	50.0
4-7 days	3.6
1-2 weeks	10.7
Over 2 weeks	21.4
Don't know	14.3
Was there a way to reach the Prison Support Coordinator?	**N=30**
Yes	10.0
No	66.7
Don't know	23.3
If there was no way to reach them, did you ever need them on evenings/weekends?	**N=20**
Yes	40.0
No	60.0
If you did not know how to reach them, did you ever need them on evenings/weekends?	**N=7**
Yes	14.3
No	85.7
If the Prison Support Coordinator is not in when you call, can you leave a message?	**N=30**
Yes	90.0
No	3.3
Don't know	6.7
Did you ever meet with the Prison Support Coordinator in person?	**N=30**
Yes	70.0
No	26.7
Missing	3.3
How long did it take to get from your location?	**N=21**
Less than 10 minutes	85.7
10-30 minutes	4.8
31-45 minutes	4.8
More than 45 minutes	4.8

*Other = Health Fair (2); OSAP (1); list (1); worker (1); pre-release fair (1); PSAN (1); street health (1)

Prison Support Coordinator: Acceptability

Respondents rated the Coordinator highly in terms of time spent, comfort, freedom to ask questions, completeness of information obtained, follow-up, effectiveness of help provided and making other connections for them (Table 21). Half the group reported using other prison health services less as a result of using the Coordinator.

Seventy-three percent of respondents gave a "very pleased" overall rating of the services from the Coordinator, with 93% rating her/him as friendly, 97% "helpful" and 87% "interested in you". Eighty-three percent would recommend the Coordinator to a friend and 90% would use the Coordinator Services again (Table 21).

Table 21
Evaluation of Prison HIV Services: Prison Support Coordinator: Acceptability

	%
Did the Prison Support Coordinator spend enough time with you?	**N=30**
Always	76.7
Most times	20.0
Never	3.3
Did you feel comfortable talking to the Prison Support Coordinator?	
Always	80.0
Most times	13.3
Never	6.7
Were you given a chance to ask all the questions you wanted to ask?	
Always	83.3
Most time	16.7
Did you get all the information you needed?	
Always	66.7
Most times	23.3
Never	10.0
When you asked a question, did the Prison Support Coordinator give you a complete answer?	
Always	66.7
Most times	33.3
If there was something they did not know, did they find the answer and get back to you?	
Always	73.3
Most times	13.3
Never	3.3
Never asked anything they could not answer	6.7
Not stated	3.3
Was the Prison Support Coordinator able to help you solve the problem you called about?	
Always	40.0
Most times	40.0
Never	16.7
Missing	3.3
Did the Prison Support Coordinator ever connect you with someone else to help?	
Yes	60.0
No	40.0

Table 21 (Cont'd)
Evaluation of Prison HIV Services: Prison Support Coordinator: Acceptability

	%
What type of worker?	**N=18**
John Howard	11.1
CHOICES program	5.6
PARN (counseling)	5.6
HALCO, PASAN	44.6
HARS (volunteer)	5.6
Social services	5.6
Legal (Toronto)	5.6
Dr. McBride	5.6
Phone #/address	5.6
Because you used the Prison Support Coordinator, did you use other prison health services less?	**N=30**
Yes	46.7
No	46.7
Not sure	3.3
Missing	3.3
Was the Prison Support Coordinator:	
a) friendly?	93.3
b) helpful?	96.7
c) interested in you?	86.7
What is your overall rating of the services from the Prison Support Coordinator?	
Very pleased	73.3
Somewhat pleased	23.3
Not pleased at all	3.3
Would you recommend the Prison Support Coordinator to a friend?	
Yes	83.3
No	13.3
Not sure	3.3
If not, why not? (N=3): got bad vibes (1); lost faith in services (1); not helpful at all (1)	
Do you know someone with HIV who has never called the Prison Support Coordinator?	**N=29**
Yes	34.5
No	65.5
Reasons not to call (N=10):	**N=10**
Fear and denial (because of status)	20.0
Embarrassed	10.0
Do not know/not stated	50.0
Very private people/not want to	20.0
Would you use the Prison Support Coordinator services again?	**N=30**
Yes	90.0
No	10.0
Suggested other services you would use if offered by the Prison Support Coordinator:	
Not stated	50.0
No suggestions	33.3
Suggested services: (multiple answers)	
Methadone information	6.7
Needle Exchange	3.3
Release Plan	3.3
Sex education	3.3
Help in getting Social Insurance	3.3
More/in person counselling	6.7
Any complaints about the Prison Support Coordinator?	
None stated	76.7
No	16.7
Lack of information about Hep A	3.3
"No talk about suicide"	3.3

Table 22 displays the variety of reasons that respondents indicated they had for talking to the Prison Support Coordinator. ASO treatment (ways to treat, questions about ASO medicines) was endorsed by 97% of the respondents; getting information about Hep C by 73%; relationship

issues regarding speaking with health services staff such as prison MD, ASO specialist, other staff by 77%; and missing life outside of prison by 67%.

Table 22
Evaluation of Prison ASO Services: Prison Support Coordinator

Reasons for Talking to Prison Support Coordinator/worker	%
ASO:	**N=30**
Prevention	43.3
Diagnosing (blood test)	46.7
Treatment (ways to treat; if should start)	96.7
Getting results	46.7
Getting medical help	33.3
Hep C:	
Getting information	73.3
Drugs:	
Ways to stay safe while taking	40.0
Ways to get off drugs	43.3
Ways to stay off drugs	53.3
Feelings:	
About someone who had died from ASO	33.3
Other historical issues	53.3
Sexual abuse	
In the past	20.0
Presently	10.0
Relationships:	**N=30**
With other inmates	20.0
Medical personnel	76.7
Prison staff	36.7
Other ASO people	43.3
Someone outside prison	40.0
Family	20.0
Missing life outside prison	66.7
Help with:	
Making a living will	30.0
Planning for release	53.3
Moving to another place	30.0
Filling out government forms	26.7
Information about:	
Prison Support Groups	50.0
Peer Health Education	33.3
Becoming a Volunteer at the ASO	30.0
Pre-release fair	20.0
Other	33.3

Prison Support Coordinator: Satisfaction

When the satisfaction data were analyzed by user groups of Coordinator Services (high and low), there were statistically significant differences between high and low users in satisfaction ratings of the prison support services with the high users statistically significantly more satisfied: with the quality of services they had received (p=0.04); with the extent to which the program had met their needs (p=0.05); and with the amount of help they received (p=0.02). Although not statistically significantly different, high users as a group (89%) felt the support services had helped them deal more effectively with their problems, versus 64% of the low user

group; overall they were more satisfied with the services received (95% vs. 73%) and were definitely more likely to come to the program should they need help again (89%) vs. 64%). The results are shown in Table 23.

Table 23
Client Satisfaction by High and Low Users of Prison Support Coordinator/worker

	0-5 times	5 + times	Test Statistics	
	N=11 %	N=19 %	Chi-square	p-values
How would you rate the quality of service you have received?	**N=30**			
Poor	0.0	5.3	8.298	0.040*
Fair	36.4	0.0		
Good	18.2	26.3		
Excellent	45.5	68.4		
Did you get the kind of service you wanted?				
No, definitely not	0.0	5.3	3.351	0.341
No, not really	27.3	5.3		
Yes, generally	18.2	21.1		
Yes, definitely	54.6	68.4		
To what extent has the program met your needs?				
None of my needs have been met	18.2	5.3	7.936	0.047*
Only a few of my needs have been met	27.3	0.0		
Most of my needs have been met	27.3	57.9		
Almost all of my needs have been met	27.3	36.8		
If a friend were in need of similar help, would you recommend the program?				
No, definitely not	9.1	5.3	2.268	0.519
No, I don't think so	9.1	0.0		
Yes, I think so	9.1	5.3		
Yes, definitely	72.7	89.5		
How satisfied are you with the amount of help you have received?				
Not satisfied	0.0	5.3	9.792	0.020*
Indifferent or mildly dissatisfied	27.3	0.0		
Mostly satisfied	45.5	21.1		
Very satisfied	27.3	73.7		
Have the services you received helped you to deal more effectively with your problems?				
No, they seemed to make things worse	0.0	5.3	6.070	0.108
No, they didn't really help	36.4	5.3		
Yes, they helped somewhat	36.4	31.6		
Yes, they helped a great deal	27.3	57.9		
Overall, how satisfied are you with the service you have received?				
Quite dissatisfied	9.1	5.3	4.600	0.204
Indifferent or mildly dissatisfied	18.2	0.0		
Mostly satisfied	27.3	21.1		
Very satisfied	45.5	73.7		
If you were to seek help again, would you come back to the program?				
No, definitely not	0.0	5.3	5.419	0.144
No, I don't think so	9.1	0.0		
Yes, I think so	27.3	5.3		
Yes, definitely	63.6	89.5		

*p = <0.05

Other Health and Social Services

Respondents were asked if they had used any other community-based services inside or outside the prison, and what these services were. A small number (N=6) had used other services

inside the prison, mostly initiated by themselves (N=4), whereas a number of respondents (N=16) had used services outside the prison, initiated by other referrals (N=10).

When asked if they could think of other services they would use if offered by the ASO program, several suggested a needle exchange program, one a methadone program, sex education in general, and a few would like more supportive counselling and contact.

Forty-seven percent of the respondents had used the prison infirmary with 23% having had 1-2 visits in the past 3 months. One respondent visited the infirmary daily over the past 3 months while 3 others averaged 8-12 visits during the 3 month interval (Table 24).

Table 24
Use of Other Services

	%
Have you used any other Community-based services inside the prison?	**N=24**
Yes	25.0
No	75.0
Type of Referral (N=6)	**N=6**
Self referral	66.7
Other	33.3
Have you used any other Community-based services outside the prison?	**N=36**
Yes	66.7
No	33.3
Missing	
Type of Referral	**N=16**
Self referral	31.3
Other referral	62.5
Not sure	6.3
Number of prison infirmary visits in the past 3 months:	
0	37.5
1	6.3
2	18.8
4	6.3
8	6.3
10	6.3
12	6.3
95	6.3
Missing	6.3
Number of overnight stays in prison infirmary in the past 3 months:	
0	50.0
1	6.3
Missing	43.8
If not pleased about any of these other services, what would you do about it?	**N=36**
Not stated	63.9
Tell them	11.1
Call corrections	2.8
Cal HALCO	5.6
Lodge a complaint	13.9
Nothing: “want no one getting into trouble”	2.8

Overall Summary of Inmates' Evaluation of ASO Prison Support Services

ASO prison support resources (Prison Support Coordinator, Group Educational talks and HIV Clinic Specialist) were endorsed positively by inmate respondents in the survey. Over 50% of respondents used the HIV Clinic Specialist, 83% used the ASO Prison Support Coordinator, and 28% had attended group talks put on by the ASO workers.

Accessibility, acceptability and satisfaction were high among different types of users as well as by different frequencies of users. Those who used the ASO supported services reported they had reduced their use of other health services as a consequence. In addition, the topics discussed one to one with the Coordinator and in the group education talks were endorsed by respondents and were relevant to the objectives of the ASO prison support program (prevention/health promotion/advocacy). High users of the prison support services (who were more satisfied with the prison support program than low users) were inmates who were more likely to engage in risky behaviours, probably mediated by their depressed mood. It would appear that the right people, that is, those who have the most need for supportive care and education, in spite of the risk for discrimination, were attracted to the right resource for the right purpose. Given the lower use of injection drugs and sharing works in prison this time, it may be that this type of service has contained these high risk behaviours.

Prison inmates reflect high risk populations who prior to and after incarceration may form *"a bridge of infection"* between high HIV prevalence/risk and low prevalence/risk populations (Rapposelli et al, 2002). Thus HIV and AIDS education in prison and jail settings is a public health priority and an opportunity to reach members of an at-risk and disenfranchised population (Gyarmathy et al, 2003). Given the role that depression appears to play in risky behaviours, it is fundamentally important to assess for and treat depression in this at-risk

population. Proactive care may need to begin with the management of depressive symptoms before health promotion and illness prevention strategies will be effective.

Administrative Personnel Evaluation of ASO's Prison Services

Administrative Feedback

Fourteen Administrative personnel, including nurses, Health Services personnel and parole officers, representing 8 federal and 1 provincial prison, responded to the request for an interview. The interview questions related to knowledge of the role of the outside prison support workers, educational sessions and HIV Specialist, perceptions of services and recommendations for improvements or change.

1) *Can you describe what the ASO-provided Prison & Support Coordinator/worker does?*

All of the 14 respondents were able to describe aspects of the role of the Coordinator, 1 was uncertain and 1 did not know.

The Coordinator role was described as: "*a link to the community'*… "*she talks to the offenders with HIV concerns…is there for moral support…understands the disease process and how it affects them…provides educational material and some supplies"*… "*there are a number of components: support, a shoulder to talk to* (sic), *information/educational…discharge-transitional, referral, advocacy"*… "*helping to deal with the harsh reality of lack of control and privacy"*.

2) *Have you ever talked with the current ASO-provided Prison Support Coordinator about the services provided? If not, why not?*

Thirteen of the 14 respondents reported that they had spoken to one of the PSWs (one answer was missing). Respondents reported a variety of reasons for contact including: *"We are in contact by fax/e-mail/phone and visits, always exchanging information;"…"to learn about services they provide;"… "gives advice about medical issues"… "community resources;" … "sometimes we can prepare the PSW for the person who is going to see them…how to handle an angry, flammable inmate;"… "the community release strategies are wonderful…we (CSC) do not have the resources ourselves…don't have the community links;"… "Keeps us informed about what information she gives 'to the group'…so that we are on the same page".* Several of the respondents did not think the PSW was visible enough with wardens, parole officers, etc.: *"as if it is an area of health care that is a bit hidden…like a secret…and it shouldn't be".*

3) *In your opinion, do the inmates seem to be using the program? Any feedback from inmates or other stuff?*

Nine of the respondents believed that inmates were using the program, while two believed that *"because inmates' experience shame and embarrassment, their pride does not encourage use of the PSW; nor is HIV a huge priority in the federal facilities".* The remaining 3 respondents were in a position where *"never had an inmate ask for the service;"… "because we are a maximum security institution we aren't doing a lot of releases to the street so we aren't needing her to do a lot of pre-release training;"… "I don't do direct patient care…therefore I only hear about her work from time to time;"… "I don't know…if they are using it by phone…I wouldn't have access to that knowledge".*

Fifty percent of respondents reported positive feedback from the inmates about the program, that: *"they are happy to talk to the PSW…the inmates are asking where she is because*

they look forward to it…this guy was very happy with the services and what she did for him…very positive feedback…respectful, reliable and helpful;"… "they keep coming back to see her…everything I've ever heard is that the inmates are really appreciative;"… "if there was something going on I would be brought into the conversation….nobody went away mad…the system was working". The remaining respondents had not heard any feedback from inmates either because of their role or *"in here it is a need to know basis…so I don't need to know!"*

Staff feedback for the most part was positive: *"there has been nothing but good comments…there aren't many people who can work with these issues and still be upbeat, hopeful;"… "staff are pleased, especially those without a medical background because they are overwhelmed by the medical stuff…there is a high stigma about the disease that people are happy to have the PSW take a leadership role;"… "the staff are thrilled that she is here…she is a wealth of information".* From other points of view, several respondents wondered if other staff were aware of the PSW and what she does; others heard of the PSW *"only through rumour…if there is a situation where we get stuck (to get an offender to take meds), we call the PSW;"… "don't hear staff talk about anyone from the community offering services;"… "we can't discuss inmates' issues and medical problem unless given permission…we don't talk about these things…there isn't much interaction between other staff".* Several respondents commented on the challenge that this role has in that if *"an inmate is seen talking to the PSW, that implies that he's HIV+…is an issue for inmates feeling like they are disclosing indirectly"*; on the other hand, one respondent felt that *"most offenders viewed it as positive to speak to someone from the outside…saying people do care about them".*

4) *Do you think the program is useful to the inmates – is it making a difference? How do you know?*

All of the respondents were supportive in their opinion of the usefulness of the program. *"Absolutely it is useful to the inmates and to everyone within the institution;"… "it is quite specific and people use it and know it as a resource and take advantage of what it has to offer…get to talk to someone who is very knowledgeable;"… "the knowledge that there are people that care;"… "providers offer resources from outside people without the stigma"… "the links with the community are good in terms of release planning;"… "because the PSW doesn't work here on a permanent basis…it is like having someone who is totally objective;"… "I think we'd be a lot worse off without it…now with the clustering, I don't have as much time to do the infectious diseases anymore;"… "it is an excellent confidential service…with a clear mandate;"… "we try to make Health Care the inmates' issues because we are trying to prepare them for the street…it encourages ownership to have them talking to someone outside in the community".*

All respondents thought the program was making a difference in that *"it cuts through the medical bureaucracy, the provincial bureaucracy by working with the PSW;"… "there is increased communication amongst staff, concrete plans, action plans being completed;"… "I guess it is, because people keep coming back to see the PSW;"… "in as far as management goes it makes a great deal of difference to the wellbeing of the offender, staff and it is financially sound;"… "an inmate disclosed to me that he was HIV positive…which affected the planning such as medical follow-up and this self disclosure had a lot to do with the PSW;"… "I've seen tangible connections to the community…the follow-up on discharge stuff, that promises made are followed through"… "I can see the offender has picked up additional information"… "the other*

reason we know it is going well is because the people she sees come back again"… "we haven't had one verbal complaint and usually everyone shows for appointments;"… "did the inmates want to come down and see them?...they did…even (if) only seen by (increased) compliance rates – yes it worked".

***5)** Do you think the program should be continued? If not, why not? In current format, or not?*

All respondents agreed that the program should be continued and most respondents felt it could be enhanced in a variety of ways, such as… "*Definitely continued and expanded…accredited with medical accreditation to improve its legitimacy in the eyes of people in Corrections"… "need to raise the profile of the program…it is a unique agency dealing with specific issues;"… "maybe have it more often…come before inmates are released so they know the community resources;"*. Others wanted more information before making suggestions…*"like to see someone go to a chief's meeting so that we have more knowledge of what they are facing in other institutions;"… "would be nice to review the mandate before saying if it should be changed;"… "I think the program is more relevant to medium and minimum security institutions in terms of discharge planning;"… "it would be good if they were more a part of our team…the contact between me and the PSW is limited;"… "to what extent does this program make sure that the PSW stays up to date with the CSC reality?"… "I don't know if I see changes in delivery…more frequently would be valuable if she could come every 3/4/6 months and run almost an open clinic"… "I don't know if there is a stigma because this is so small a joint, everyone know everyone else's business!"… "it would be good to set down…to clarify their role and lines of communication".*

6) *Have you ever attended one of the education sessions? If not, why not? What did you think?*

Fifty percent of respondents had attended an educational session provided by the PSW and had positive responses. *"The HARS staff did an awesome job…were clear, succinct, everyone could understand…they are competent…adept in their field…they get us to do evaluations…the openness is always the incredible thing…they encourage people to access information…none of them have put themselves at a distance from us;"… "he was an excellent speaker – I remember it quite well;"… "I look for connections outside the area…and they can help with that".*

The reasons for non-attendance at these sessions are similar and include: "*no opportunity…no mention of them by inmates;"… "I have no time and it hasn't been offered…I think it would be useful for me to attend but that would be organized through health care;"… "it is difficult work…I really respect them;"… "there is lots of stuff I should go to but with 600 men and decreases in staff, its difficult to do my own job;"… "I look for connections outside…and they can help with that…there is definitely a need for pre-release planning, OHIP cards and housing… ".*

7) *Do you think these services are useful to the inmates? Why?*

There was little agreement that the education sessions were useful to the inmates. Respondents either "*didn't know anything about them;*" or the sessions "*were targeted at staff not inmates;"… "if an inmate walks into the gym and sees HIV stuff there then they turn right back around and walk out because of the stigma;"… "there is a problem with stigmatization so there aren't any group therapy sessions…".* For those who believed they were useful to the inmates, they felt that "*anything that dispels myths, education…it is all under the harm reduction*

umbrella;"… "any time we can give offenders people and the knowledge to make more informed choices"… "the more information inmates get, the better off they are…even if they are not infected we want to keep them that way"… "the symposium was trying to impress on people who don't know if they are positive…trying to promote being tested especially with the prevalence of Hep C"… "since the symposium, the Hep C testing requests doubled and people are asking for and HIV test every 6 months".

8) *Who should do the presentations about HIV/AIDS prevention and treatment (from the outside? trained inmates? staff from Health Services?)? Outsiders, inmates, or Health Services Staff?*

The majority of respondents felt that a combination of all 3 approaches (outside resources, health services and inmates) was the best because "*there is more trust and credibility from the community, more up to date"; "help the offender understand what is happening outside"… "Health Services also knows the inmates better than people from the outside"; "peer counsellors are a good idea if they are non-judgemental and have good listening skills"… "the inmates base values on their peers".*

On the other hand, respondents raised issues to be addressed when considering who to be involved; "*outsiders have to be familiar with the environment, the do's and don'ts of CSC…some medications we don't provide and they need to be familiar with the policies"; "it does put people at risk if they ask questions that identify them as being HIV positive…not just at risk from other inmates but also staff who are frightened of HIV"… "when people come from the outside it is hit and miss".*

As for having peer counsellors, *"they need to be supervised to ensure the info is correct;"… "inmates shouldn't be talking about it because of the privacy and safety issues…the other inmates would wonder how he knows about this stuff"… "people who have HIV are shunned in other institutions…their safety would be at risk;"… "there's a culture inside about who gets what from whom".* As for Health Services, one respondent felt since Health Services is still CSC, *"inmates don't trust us 100%"… "HARS has the street workers…knowing they can access services when they are on the street makes it (HARS) more credible to inmates"… "need to talk street talk, give experiences they are familiar with…teach to the level;"… "any Health Services education is best done with someone from the outside…if it is only HS staff there needs to be accountability that they are up to date with the material"… "I don't think Health Services staff should give the presentation but it should be known that we have the info…we can provide the information and can be accessed for testing and we are their clinic…if the guys are afraid to ask us about this stuff, then we lose a grip on what is going on".*

9) *What do you think about the HIV specialist/nurse coming in to the prison to see HIV+ inmates?*

The majority of respondents thought it was a good idea to have an HIV/AIDS specialist/nurse be on site at the prison to visit inmates; *"people need to be well trained about the progression of the disease…a medical specialist would be the one to explain symptoms, how to deal with them."* On the other hand they offered advice; *"if you are going to have any specialist, they need to know the parameters set by CSC because sometimes there is a tug of war;"… "all MD orders have to be approved by the Health Services MD…sometimes there is conflict between the MD and, for example, the dietician over whether or not Ensure supplements are*

necessary;"… "people who are incarcerated are in a different context than on the street and this is not always recognized by the clinic;"… "it's a good idea…I'm not territorial, I just want the courtesy, then I don't get surprised with something…and information doesn't go out that I can't follow through".

***10)** Any other comments/suggestions?*

A number of respondents added further support for these ASO prison support services. *"I have a positive feeling about the program…it is very practical and useful…when guys are going into Kingston or Toronto there is good support in the community;"… "I think there is a niche for that service and it is good for offenders to have other options so they aren't dealing just with us (Health Services);"… "I think the community services are important…provides an excellent service and is different than what we offer (Health Services).*

Several respondents suggested this service needed "*more funding and more information with easy accessibility to that info"…* that it *"would be nice if they (PSWs) had more time to come in"… "that there could be more advertisement of the service among the general population…like posters in different living units;"… "Few people show up for the education talks because they are after hours."*

Evaluation of ASO Provided Prison Support Services by Support and Education Workers

***1)** Can you describe what the ASO provided Prison Support Coordinator/Worker does?*

Counselling, support, advocacy, education and practical assistance to make the link to the outside community for HIV positive people and some limited services for people with Hep C were seen as the major purposes of the role of the Prison Support Coordinator/Worker. For

example such services could include *"making sure someone has a winter coat… helping them get a water filter… arranging for SIN numbers… helping with discharge… and making sure they get their meds"*.

2) *Are the inmates using the program? Any feedback?*

Respondents reported a variable amount of use, with some inmates *"expecting us to do everything for them and other see us as working on health related issues…so I don't think users understand the scope of what we do"*.

As far as feedback went, respondents felt the strength of the program was dependent on the quality of the worker, which had varied over time…but *"while generally the feedback had been positive, usually they tended not to hear from inmates when things were going well"… "Feedback from staff has been good…really supportive staff…who give good feedback to us"… "staff appreciate the pre-release planning and support"… "Health Services staff…bridge the gap…and the PSW work makes that easier."*

3) *Do you think the program is useful to the inmates and making a difference? How do you know?*

Support and education workers believed that the program was useful to inmates particularly in terms of advocacy; *"inmates seem to trust people from outside better"… "is important for them to ask questions and get an answer they believe is true"… "inmates don't have access to resources that we have easy access to just by dialling a number;"* A further difference that the program has made was that *"people are less isolated, more listened to, and*

for pre-release planning the inmate is going out with better supports already there in the community".

Signs of success for Support Workers were new efficiencies in the system such as *"when someone gets methadone on the first day out… or has an appointment with welfare on the first day out;"* or is having *"more success getting ID or finding a specialist…and there is not the recidivism rate".*

4) *Do you think the program should be continued or not? Explain.*

Respondents agreed that the program should be continued and required some changes but were uncertain how to make those changes. Hep C is a struggle *"because we really are supposed to be doing only HIV"… "it would be good to openly see people who only have Hep C and ones who are co-infected…"… "we don't call inmates down when we are inside because that is not in our official mandate…because so many people incarcerated are diagnosed with both (Hep C and HIV) we should be able to freely do that…".* The real challenge is access to inmates: *"would be good to have better access for inmates to us…for example we can't call them…and if they are in segregation they can only use the phone once per day".* As a result there can be a significant period of time in which there is no contact. In addition, the phone calls are not private; *"they make them from the range where everyone can hear".*

Respondents felt they needed more space and privacy and a way for advocating for needle exchange and *"stuff around tattooing".*

5/6) *Have you ever provided one of the education sessions? What did you think?*

Respondents felt the education sessions were beneficial and provided the opportunity to introduce the PSW to the inmates as well as to orient the inmates to what services are available in the community. *"It is a way to get information without inmates being singled out and gives inmates a point of contact"*.

7) *Who do you think should do the presentations (outsiders? inmates? staff from Health Services?)?*

Respondents endorsed education provided from all sources with some caveats. Having the support workers come in creates *"that link to the community"*, and *"avoids the mistrust of CSC"*. They felt that *"there is also power in training inmates"*… but recognize however, that *"people might not feel safe with a peer counsellor"*… *"while some HIV people feel really safe with other people who are also HIV… others want that distance"*. Similarly, *"having the staff from Health Services…would improve the inmates' connection to Health Services"*… but *"then there is the trust issue…some people just won't trust others…"*.

8) *What do you think about the HIV specialist/nurse coming into the prison to see HIV positive inmates?*

There were mixed opinions about this service and while respondents agreed on the importance of inmates receiving appropriate specialist care, they differed about how to protect inmates' privacy when the process results in *"singling out on individual for a special clinic"*. In addition there are the security issues whereby inmates require *"2 guards per inmate"* and *"if there are lockdowns or security checks they wouldn't be allowed to go to the services"*.

9) *Other comments/suggestions.*

Respondents outlined the challenges for them to carry out their role including *"more money to do the Hep C stuff"* and the lack of respect they feel they receive for the work that they do; *"I don't think we should have to fight to do this…it should be seen as a right"… "there needs to be a needle exchange program". "These suggestions aren't so much about us but about the prison…there needs to be some kind of anonymity about giving out medication…I don't know what we can do about that except advocate about it…that is why the inmates need us".*

Summary of Administrative Personnel and Prison Support Workers' Evaluation of ASO Prison Support Services

Overall, Administrative personnel were informed of the role of the ASO prison support program, believed that it was being used by inmates and was making a difference with tangible results. They supported the program and recommended continuing it with a few recommendations for expanding services and making them more visible.

There were 3 major interconnected issues for staff and support workers alike that they felt interfered with service provision. These included a) prison (CSC) parameters; b) HIV and stigmatization; c) access to prisoners. The "do's and don'ts of CSC" require good communication between support workers and Administrative personnel to avoid conflicts such as promising services that cannot be provided in prison (e.g. types of medications, special foods, clinic MD orders); an inherent distrust by inmates of CSC sponsored activities; and the barriers that prison rules create for support workers to accessing inmates or inmates being able to access support workers, and being able to provide their services and follow-up care (cannot call inmates, phone calls not private, etc.). For inmates the risk of stigmatization is enhanced by

attending special sessions on HIV or attending the special HIV Clinic or visiting the ASO Support Worker. For support workers the "rules" interfere with the opportunities to be responsive to health needs such as Hep C infected inmates, to reduce risk for injection drug users through needle exchange programs, tattooing safety and safer sex approaches.

Certainly the prison support workers were aware of the positive support of Administrative staff but acknowledge the variability in support among different institutions. When each participant in the system (CSC administration, inmates and Support Worker) can recognize the asset that each component brings to this complex system of service provision, then respect and trust may be nourished and grow in a process that could lead to earlier detection, health promotion and illness prevention.

SUMMARY AND DISCUSSION

Similar to other studies which indicate that prison inmates are at-risk of acquiring and transmitting HIV due to their risk behaviours and risk network (Estebanez et al, 2002; Stark et al, 1990), this study lends further evidence to support these findings and indicates, as well, the possible role that depression may play in mediating some of the risk behaviours. While there is a consensus that HIV disease carries unique psychosocial ramifications, health care delivery systems are still struggling with what services should be offered to patients (Murphy et al, 1992). From the results of this survey, it is apparent that the ASO provided support services are relevant to and used by the most vulnerable of PHA inmates, including those with a significant level of emotional distress, who injected drugs, shared works, had body piercing and used more alcohol than the not depressed inmates. HIV/AIDS education and support in prison and jail settings must

be a health priority as it provides an opportunity to reach these members of an at-risk population and address not only risky behaviours but also the underlying depression that may mediate it.

Despite the continuing efforts of prison systems to prevent drug use by prisoners, the reality is that drugs can and do enter. This study is further confirmation of this fact. The majority of inmate respondents were in prison in the first place on drug related offences and drug use and drug injection were widely practised by them outside (66%) or within the prison setting (33%). Incarceration may by the only opportunity to counsel, test and treat their addiction and their other health problems (Brook et al, 1998). Although sexual activity in prison is considered to be a less significant risk factor for HIV and Hep C transmission than sharing injection equipment (Canadian Strategy on HIV/AIDS, 2001/02), inmate respondents in this survey indicated a low level of sexual activity but a high rate of risky behaviour.

One of the important observations in the analysis of Prison Administrative personnel was how aware they were of the ASO prison support workers role and activities and their overwhelming support for these services.

Nonetheless, the unique circumstances of the prison system with its necessary rules and regulations, confidentiality and HIV issues and access to inmates, created barriers and challenges to providing support and education services from all points of view no matter how positive the attitudes. There was a general sense from staff, inmates and support workers that additional resources were needed to provide adequate services. Many indicated that the support program needed to be expanded with more frequent visits and support workers advocated the introduction of recognized risk reduction measures such as methadone programs and needle exchange programs.

Similar to other area of health services delivery, there appears to be a need for integrating health care resources (CSC, peer support, ASO workers) to enhance the effects of each dimension and to take advantage of the opportunity that incarceration affords to this at-risk population.

REFERENCES

Attkisson C. (1987). Client satisfaction questionnaire (CSQ-8). In K. Corcoran & J. Fischer (Eds.). Measures for clinical practice: A sourcebook (pp. 120-122). New York: The Free Press.

Browne G, Roberts J, Gafni A, Weir R, Watts S & Byrne C. (1995). More Effective and Less Expensive: Lessons from 5 Studies Examining Community Approaches to Care. Health Policy, 34(2):95-112.

Boudin K, Carrero I, Clark J, Flournoy V, Loftin K, Martindale S, Martinez M, Mastroieni E, Richardson S. (1999). ACE: a peer education and counseling program meets the needs of incarcerated women with HIV/AIDS issues. Journal of the Association of Nurses in AIDS Care, 10(6):90-98.

Brook D, Taylor C, Gunn J, Morden A. (1998). Substance misusers remanded to prison: A treatment opportunity? Addiction, 93:1851-6.

Calzavara L, Major C, Myers T, Schlossberg J, Millson M, Wallace E, Rankin J, Fearon M. (1995). The prevalence of HIV-1 infection among inmates in Ontario, Canada. Canadian Journal of Public Health, 86:335-339.

Canadian Strategy on HIV/AIDS. (2001/2002). HIV/AIDS in prisons 2: High Risk Behaviours behind Bars.

Conklin T, Lincoln T, Flanigan T. (1998). A public health model to connect correctional health care with communities. American Journal of Public Health, 88(8):1249-1250.

Estebanez P, Zunzunequi MV, Aguilar MD, Russell N, Cifuentes I & Hankins C. (2002). The role of prisons in the HIV epidemic among female injecting drug users. AIDS Care, 14(1):95-104.

Flanigan T, Kim J, Zierler S, Rich J, Vigilante K, Bury-Maynard D. (1996). A prison release program for HIV-positive women: linking them to health service and community follow-up. American Journal of Public Health, 86(6):886-887.

Ford PM, Pearson M, Sankar-Mistry P, Stevenson T, Bell D, Austin J. for the Queens University HIV Prison Study Group (2000)a. HIV, Hepatitis C and Risk Behaviour in a Canadian medium security federal penitentiary. Quarterly Journal of Medicine, 93:113-119.

Ford PM, Wobeser WL. (2000)b. Health care problems in prisons. Canadian Medical Association Journal, 162(5):664-665.

Gaes G. (2000). Guidelines for asking the right questions and communicating results [Online]. Available: http://www.csc-scc.gc.ca/text/pblct/forum/v12n2/indexe.shtml [2000, December 19].

Grassi L, Righi R, Sighinolfi L, Makoui S, Ghinelli F. (1998). Coping styles and psychosocial-related variables in HIV-infected patients. Psychosomatics, 39(4):350-359.

Grinstead O, Seal D, Wolitski R, Flanigan T, Fitzgerald C, Nealy-Moore J, Askew J & the Project START Study Group. (2003). AIDS Education and Prevention, 15(6):547-560.

Gymarthy VA, Neaiqus A, Számadó S. (2003). HIV Risk Behaviour History of Prison Inmates in Hungary. AIDS Education and Prevention, 15(6):561-9.

Hammett T, Gaiter J, Crawford C. (1998). Reaching seriously at-risk populations: health interventions in criminal justice systems. Health Education and Behaviour, 25(1):99-120.

Holsen DS, Harthug H, Myrmel H. (1993). Prevalence of antibodies to Hepatitis C virus and association with intravenous drug use and tattooing in a national prison in Norway. European Journal of Clinical Microbial Infectious Disease, 12:673-6.

Jurgens R. (1996). HIV/AIDS in prisons: final report. Montreal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society.

Melchior LA, Huba GJ, Brown VB, Rebach CJ. (1993). Reliability of the CES-D scale in different contexts. Psychiatry Research, 2: 125-134.

Moos RH, Conkite RC, Billings AG, Finney JW. (1984). Indices of coping. In Health and Daily Living Form Manual (pp.16-18). Palo Alto: California: Social Ecology Laboratory, Veterans Administration and Stanford University Medical Centre.

Murphy DA, Bahr R, Kelly JA, Bernstein BM, Morgan M. (1992) A Needs Assessment Survey of HIV-infected patients. Wisconsin Medical Journal, June:291-95.

Polonsky S, Kerr S, Harris B, Gaiter J, Fichtner R, Kennedy M. (1994). HIV prevention in prisons and jails: obstacles and opportunities. Public Health Reports, 109(5):615-625.

Radloff L.S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. Applied Psychological Measurement, 1:385-401.

Rapposelli K, Kennedy M, Miles J, Tinsley M, Rauch K, Austin L, Dooley S, Aranda-Naranjo B & Moore R. (2002) HIV/AIDS in correctional settings: A salient priority for the CDC and HRSA. AIDS Education and Prevention, 14(5, Suppl. B):103-13

Savard, J., Laberge, B., Gauthier, J.G., Ivers, H., Bergeron, M.B. (1998). Evaluating anxiety and depression in HIV-infected patients. Journal of Personality Assessment, 71(3): 349-367.

Stark K, Muller R, Guggenmoos-Holzmann I, Deininger S, Meyer E & Bienzle U. (1990). HIV Infection in intravenous drug abusers in Berlin: Risk factors and time trends. Klinische Wochenschrift, 68(8):415-20.

Thompson SC, Hernberger F, Wale E, Crofts N. (1996) Hepatitis C transmission through tattooing: a case report. Australian and New Zealand Journal of Public Health, 20:317-8.

Ware JE. (1994). SF-36 physical and mental health summary Scales: a user's manual. Boston: Health Assessment Lab, New England Medical Center.

Wu AW, Revicki DA, Jacobson D, Malitz FE. (1997). Evidence for reliability, validity and usefulness of the Medical outcomes Study HIV Health Survey (MOS-HIV). Quality of Life Research, 6:481-493.

Zack B, Flanigan T, DeCarlo P. (2000). What is the role of prison in HIV, Hepatitis, STD, and TB prevention? San Francisco: Centre for AIDS Prevention Studies (CAPS) at the University of California.

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APPENDICES

APPENDIX A

Inmate Questionnaire Package

APPENDIX B

Interview Guide for CSC Administrative Personnel

ADMINISTRATIVE QUESTIONNAIRE
(INTERVIEW FORMAT)

Preamble

Hello, my name is Marney McDiarmid and I am working with the Community-Linked Evaluation AIDS Resource (CLEAR) Unit on a study of the impact of AIDS Service Organizations' (ASOs) prison services on the quality of life of inmates. I understand that you are _____ (insert applicable job title) and I would like to ask you some questions about your perceptions of the effectiveness of the services being provided to the inmates by the ASOs. This interview should last about 45 minutes.

We are asking these questions so that we can get an overall feel for how useful you think the services are and to get any suggestions from you about how the program could be improved. Everything that you tell me is completely confidential. You will never be identified in connection with any statements that you make to me. Once all the interviews are completed, a summary of the recommendations will be put together into our report but no names will ever be published.

Question Guide

1. Briefly, can you tell me what the ASO-provided Prison Support Co-ordinator/Worker does?

2. Have you ever talked with the current ASO-provided Prison Support Coordinator/Worker about the services (s)he provides? If no, is there any reason why you haven't?

3. In your opinion, do the inmates seem to be using the program? Has there been any feedback from the inmates about the program? From other staff? Probes: Positive, negative, anything good/bad.

4. Do you think that the program is useful to the inmates? Do you think that it is making a difference? How do you know whether it is working or not? Probes: What signs of success do you look for?

5. Do you think the program should be continued? If so, do you think it should continue in the current format? A different format? If not, why do you think it should be discontinued?

6. Have you ever attended one of the education sessions put on by the ASO-provided Education Coordinators? If so, what did you think? If not, is there any reason why you haven't?

7. Do you think that these sessions are useful to the inmates? Why?

8. Do you think it is better for people from the outside to come in to the prison to do presentations about HIV/AIDS prevention and treatment OR do you think that it would be better to train inmates to do these types of presentations OR do you think it is better to have staff from Health Services conduct these presentations? Do you think it is a good idea to have peer counsellors?

9. What do you think about the idea of having the HIV specialist/nurse come into the prison to see HIV+ inmates?

10. Any other comments/suggestions?

APPENDIX C

Interview Guide for ASO Administrative Personnel

ADMINISTRATIVE QUESTIONNAIRE
(INTERVIEW FORMAT)

Preamble

Hello, my name is Marney McDiarmid and I am working with the Community-Linked Evaluation AIDS Resource (CLEAR) Unit on a study of the impact of AIDS Service Organizations' (ASOs) prison services on the quality of life of inmates. I understand that you are _____ (insert applicable job title) and I would like to ask you some questions about your perceptions of the effectiveness of the services being provided to the inmates by the ASOs. This interview should last about 45 minutes.

We are asking these questions so that we can get an overall feel for how useful you think the services are and to get any suggestions from you about how the program could be improved. Everything that you tell me is completely confidential. You will never be identified in connection with any statements that you make to me. Once all the interviews are completed, a summary of the recommendations will be put together into our report but no names will ever be published.

Question Guide

1. Briefly, can you tell me what the ASO-provided Prison Support Co-ordinator/Worker does?

2. In your opinion, do the inmates seem to be using the program? Has there been any feedback from the inmates about the program? From other staff? Probes: Positive, negative, anything good/bad.

3. Do you think that the program is useful to the inmates? Do you think that it is making a difference? How do you know whether it is working or not? Probes: What signs of success do you look for?

4. Do you think the program should be continued? If so, do you think it should continue in the current format? A different format? If not, why do you think it should be discontinued?

5. Have you ever provided one of the education sessions? If so, what did you think? If not, is there any reason why you haven't?

6. Do you think that these sessions are useful to the inmates? Why?

7. Do you think it is better for people from the outside to come in to the prison to do presentations about HIV/AIDS prevention and treatment OR do you think that it would be better to train inmates to do these types of presentations OR do you think it is better to have staff from Health Services conduct these presentations? Do you think it is a good idea to have peer counsellors?

8. What do you think about the idea of having the HIV specialist/nurse come into the prison to see HIV+ inmates?

9. Any other comments/suggestions?

APPENDIX D

Information Sheet & Consent Form

The Impact of ASO Prison Services on the Quality of Life of Inmates
Inmate Information Sheet

Who is doing the interview?
We are with a group at McMaster University called the CLEAR Unit which stands for Community-Linked Evaluation AIDS Resource Unit. We help AIDS Service Organizations, or ASOs for short, to assess how well their programs work.

Why are we doing the survey?
The staff of HIV/AIDS Regional Services, PARN – Your Community AIDS Resource Network, and the HIV Clinic staff from Kingston General Hospital have asked us to do a study to take a look at the services they bring to inmates. Some examples of these services are the Prison Support Coordinator/Worker and group education presentations.

What are we asking you to do?
You have been given this sheet because you have used one or more of these services. We would really like to send someone to talk to you about what it was like. If you are an inmate and you agree to take part in the study, an interviewer will come to visit you at the prison in a private area. If you are an ex-inmate, you can meet with the interviewer at HARS or PARN or you may decide to talk to the interviewer by telephone. When you talk together, the interviewer will write down your answers on a form. You will receive $25 to compensate for your time after completion of the interview.

Confidentiality
All answers you offer in the interview are confidential. Your name will not be recorded on the form. The form will then be sent to us so that we can look at the answers to the questions. This is a way for you to help us get true answers to the questions that we are asking and you can be sure that none of your answers can be traced back to you. **Your name will never be used in any report about this study.**

You do not have to take part in this study. If you don't take part, we will not tell anyone that you said no. If you do agree to go ahead but you don't want to answer a question, then you can just skip that question or stop the interview. **IF YOU ARE AN INMATE, YOU WILL NOT LOSE ANY RIGHTS IN THE PRISON IF YOU DO NOT TALK WITH US.** The talk could last from 30 minutes to 1 hour depending on how many of the services you have used. If you used the Prison Support Co-ordinator/worker and the HIV Clinic, you will likely be asked by both to be in this study; but **you will only need to talk with our interviewer once.**

Participation
If you are willing to have the interviewer come and talk to you, **please call collect to Marney McDiarmid at (613) 545-3698 on Tuesdays between 1:00 and 4:30 p.m. to arrange a convenient time**. If you have any questions that you want to ask someone on the research team, then call collect to the CLEAR Unit at (905) 525-9140 ext. 22293 during the days Monday to Friday.

We will be talking to a lot of inmates and ex-inmates and it should take us a couple of months to do all the interviews. When we are finished we will be able to give the ASOs some ideas about what inmates like or dislike about the services and ideas to make changes.

CLEAR UNIT: MCMASTER UNIVERSITY, FACULTY OF HEALTH SCIENCES AT FRID
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www.fhs.mcmaster.ca/slru/clear
Funded by: AIDS Bureau, Ontario Ministry of Health & Long-Term Care

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Telephone: (905) 525-9140 Ext. 22293

The Impact of ASO Prison Services on the Quality of Life of Inmates

INMATE CONSENT FORM

I, _____ consent to be in a study conducted by researchers from the Community-Linked Evaluation AIDS Resource (CLEAR) Unit of McMaster University to assess how effective the ASO provided prison services are for inmates.

I understand that I will take part in a 45-minute interview at my convenience. This will be arranged with the project interviewer. The interviewer will ask questions concerning what ASO services I have used and how useful they were and any suggestions I have about how these services could be improved. They will ask me questions about my health and coping.

I understand that my name will not be recorded with my answers and that I will not be personally identified in any discussion or written report.

I have had all my questions answered and I consent to take part in this study, knowing that I may withdraw from the study at any time, even after signing the form.

_____ _____
Signature Date

_____ _____
Interviewer Signature Date

If you wish additional information about this study, please call Marney McDiarmid at 613-545-3698 or Karen Auld, CLEAR Unit, McMaster University at (905) 525-9140 Ext. 22293.