Implementation of a Peer-Based Risk-Reduction Program in the Prison Setting

Richard Feffer, MS¹, Michael Ninburg¹, Lara Strick MD, MS²,³

¹Hepatitis Education Project, Seattle WA; ²Washington State Department of Corrections, Tumwater WA; ³University of Washington, Seattle WA

Prevalence of Human Immunodeficiency Virus (HIV) & Hepatitis C (HCV) is higher in the correctional setting compared to the general community. Risk factors for acquiring HIV & HCV are more common among prisoners, including injection drug use (IDU), non-professional tattooing, & unsafe sexual encounters.

Objective:
To implement an evidence-based program to reduce drug, tattoo, & sexual risk factors among prisoners of the Washington State Department of Corrections (WA DOC) both during incarceration & after release.

The SHIELD Model
After reviewing various risk-reduction models, the best way to reach the target population while working with limited resources was to use the evidence-based SHIELD (Self-Help in Eliminating Life-Threatening Diseases) model that relies on communication within peer networks to reduce risk behaviors.

- 1-2 facilitators train inmate peer educators during 6 interactive small-group sessions that involve role-plays, group discussions, & demonstrations
- Participants improve their own health behaviors & promote risk reduction within their social networks
- Original intervention trained low-income IDUs in the community to promote HIV risk reduction among peers

Modifications to SHIELD
1) Hepatitis C prevention added: HCV risk reduction was integrated into the curriculum. (e.g. HCV education & safe tattooing risk ladder activities – See Figure 1)
2) Goal of intervention expanded: Addresses risk reduction within their communities upon release as well as behind the walls during incarceration
3) Scenarios made applicable to prison: The interactive scenarios & role-plays in the curriculum were re-written to be applicable in the prison setting
4) Target population modified:
   a. The focus on active IDU was changed to a history of IDU to avoid the need to disclose IDU during incarceration & associated repercussions.
   b. To diversify group of participants, additional eligibility criteria included prison-specific characteristics like living unit, gang affiliation, etc.

Results at a Glance

1 SHIELD Cycle
4 Facilities
6 Sessions per Cycle
28 Trained Inmate Peer Educators

Excellent Participant Feedback
“I am more actively seeking out opportunities to do outreach.”
“I am more confident in discussing sensitive issues with those outside of my normal peer group.”
“It has made me more aware & made me want to help others be safer.”
“It’s given me a drive. I would like to help others know more, I really think about risk reduction.”

Figure 1. The risk-reduction ladders used during SHIELD sessions

Implementation Challenges
Buy-In for a Risk-Reduction Model:
SHIELD is based on “harm reduction,” emphasizing a spectrum of options for safer IDU, tattooing, & sex as opposed to more traditional abstinence-focused prevention. It was stressed that SHIELD does not promote nor condone risk behaviors, it just gives participants the tools to do it safely. The focus was on the reduced transmission of blood-borne pathogens after release, although many of the same principles could be used during incarceration. Decreased transmission of blood-borne pathogens, creates a safer work environment.

Staffing:
The suggested use of multiple FTE for implementation of SHIELD was not feasible with the limited staffing resources in WA DOC. Without additional funding, WA DOC was able to recruit participants & implement SHIELD using just one RN or counselor at each facility with the help of a co-facilitator from HEP. The intervention required the coordination & support from custody, administration & health services.

Custody Issues:
A facility hold was placed on some offender participants to ensure program completion. Facilitators worked with prison staff to allow some offenders to be excused from work or programming in order to attend a SHIELD cycle. Other custody issues considered for implementation included availability of safety & security personnel, class time & location.

Connecting Lessons to Practice:
Facilitators provided demonstrations of correct condom use & safe IDU when allowed or alternatively showed diagrams/photos. Only one facility did not allow the use of injection equipment as a teaching tool. Given the current lack of condoms & safer injection equipment available for use in prison facilities, not all lessons learned could be practiced prior to release, though they may impact post-release behavior.

Conclusions
The implementation of SHIELD demonstrates the feasibility of a peer-based risk reduction model for HIV & HCV prevention in the correctional setting despite many of the institutional challenges. Given IDU relapse rates & high risk sexual behaviors after release, the integration of harm reduction programs into the correctional setting is important to prevent ongoing transmission of HIV & HCV in the community & can also be of benefit behind bars.