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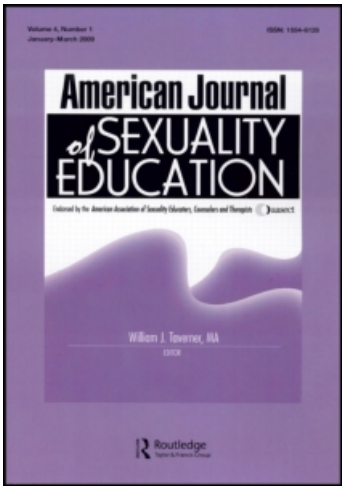

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Effective Resources Supporting Healthy Sexual Behavior in Formerly Incarcerated Persons

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Effective Resources Supporting Healthy Sexual Behavior in Formerly Incarcerated Persons

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The sexual health behavior of formerly incarcerated persons (FIPs) not only affects the FIP, their sex partners, and their significant others, but also affects their families and the communities in which they live. Certain health conditions, which are overrepresented in incarcerated populations, are directly impacted by sexual health behavior. These conditions include HIV infection and other sexually transmitted infections (STIs), which can have dramatic effects on the communities accepting the FIPs. FIPs of all ages need access to comprehensive resources that support healthy sexual behavior. Effective prevention and management of these pressing health conditions can positively influence family structure, employment, financial stability, and demand for health care services. In this article, we will examine the impact of sexual health behavior on the male FIP aged 14 years and up, as well as their communities. We evaluate what resources are available to inform and support healthy sexual behavior. In addition to assessing the effectiveness of resources, we provide our point of view on enhancing the effectiveness of these efforts. These insights will be particularly relevant for individuals who design, execute, and evaluate efforts designed to affect the health of any individual impacted by the sexual health behavior of male FIPs.

KEYWORDS *Behavioral health, formerly incarcerated persons, offender health, offender sexual behavior, sexual health behavior*

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INTRODUCTION

The United States has the highest documented incarceration rate in the world, as well as the world's highest total documented prison and jail population (Walmsley, 2009). In 2008, more than 7.3 million people, 3.2% of all U.S. adults, were on probation, parole, or in jail or prison (U.S. Census Bureau, 2010; U.S. Department of Justice, Bureau of Justice Statistics, 2010). In 2009, the U.S. prison and jail population was nearly 2.4 million individuals, including 81,000 juvenile offenders (Sickmund, 2010).

This incarcerated population is at increased risk for HIV/AIDS and other sexually transmitted infections (STIs). HIV infection and STIs are more prevalent among men who have been incarcerated than among men who have not been incarcerated (Adimora et al., 2003). There is strong association between HIV infected individuals and incarceration longer than 24 hours within the past 10 years (Adimora et al., 2003; Adimora et al., 2004). Although HIV infection rates have declined among U.S. inmates in the past few years, the prevalence of HIV/AIDS inside U.S. prisons is more than five times that of the general population (Centers for Disease Control and Prevention, 2009; Maruschak, 2009), and 15,000 HIV-positive inmates are released every year into communities across the country (Hammett, Harmon, & Rhodes, 2002). It is critical that public health professionals and others working with incarcerated and formerly incarcerated persons (FIPs) address the medical needs and health behaviors of these individuals to help reduce the spread of HIV/AIDS and other STIs, both in the prison system and in the communities to which FIPs are released.

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FIPS AND SEXUAL HEALTH BEHAVIOR

The high rates of HIV/AIDS and other STIs among formerly incarcerated men are largely driven by their sexual health behaviors, which tend to have distinct characteristics when compared to men who have never been incarcerated. Male FIPs tend to have less stable sexual relationships than men who have never been incarcerated. Incarceration disrupts relationships, causing physical separation, as well as loneliness and emotional isolation, and frequently results in broken relationships (Browning, Miller, & Lisa, 2001; Rindfuss & Stephen, 1990; Visher, LaVigne, & Travis, 2004). During incarceration, the inmates' partners often seek other partners to fill the void. In general these relationships are pursued for emotional and/or financial reasons. These new relationships significantly jeopardize the re-establishment of bonds with the FIP upon his release, and many FIPs engage in risky sexual behavior due to the absence of their formerly stable partner (MacGowan et al., 2003).

Incarcerated and formerly incarcerated men also have a higher prevalence of multiple new sex partners than do men without a history of incarceration. In the 12 months following release, FIPs are four times more likely than men who have never been incarcerated to engage in transactional sex, defined as sexual relationships where the giving of gifts, money, or services is a significant factor (Khan et al., 2008b). Men who have spent one night or more incarcerated are also more likely to have these concurrent sexual relationships (Manhart, Aral, Holmes, & Foxman, 2002). The disruption of relationships caused by incarceration may provide some explanation as to why FIPs tend to have more sexual relationships.

FIPs are also more likely to establish sexual relationships with high-risk partners, which tend to lead to other high-risk behaviors. For example, some men who have sex with men while incarcerated continue to have sex with men after release, but they do not self-identify as gay or bisexual, which limits their access of appropriate support services (Conklin, Lincoln, & Flanigan, 1998). Some men who have sex with men do not access support services targeted toward this population because these services are commonly perceived for gay or homosexual men. There is a belief among some FIPs that men who have sex with men, either during or after incarceration, are not gay or homosexual therefore these services are not for them. Furthermore, the male FIP's partner's incarceration status is highly correlated with a number of risky behaviors. Among male FIPs who self-report any incarceration history of a recent partner, 72% had a partner who used crack cocaine. Conversely, for male FIPs who did not report incarceration of a recent partner, only 19% reported they had a partner who used crack cocaine. Both male and female FIPs who report a recent sexual partner with a history of incarceration are much more likely to report multiple new sexual relationships and transactional sex *within the past 4 weeks* than those who have sexual partners without a history of incarceration (Khan et al., 2008b).

Duration of incarceration appears to be a more important predictor of risky sexual behavior than the amount of time that has passed since the FIP has been released. High risk sexual behavior is more common among FIPs who report short-term incarceration than long-term incarceration. Examining recidivism shows shorter sentence length correlates to shorter times between incarceration (DeJong, 1997; Gainey, Payne, & O'Toole, 2000). Therefore the relatively high association between short-term incarceration and high-risk sexual behavior may be due to frequent travel in and out of corrections facilities. Also, inmates serving long sentences are those who commit more serious crimes and may be more disconnected from social networks from which sexual partners are available. Furthermore, inmates with long sentences may exhibit greater antisocial behaviors which limit their social networks, and subsequent selection of sexual partners, upon release (Khan et al., 2008a).

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FIP DRUG USE AND SEXUAL BEHAVIOR

The authors have observed three distinct phases of drug use as it relates to sexual activity among FIPs: the period leading up to use, the period during drug use, and the period after the binge is over when the initial drug supply is used up. These phases are observable for users of street drugs like crack cocaine, whether smoked, snorted, or taken intravenously. Each phase has its own characteristics and drivers of sexual activity.

Often the FIP's drug use, and the sexual activity that surrounds it, is triggered by money, specifically the very significant event of *getting money* (J. Reed, personal communication, March 26, 2010). Getting paid, whether through criminal activity or legal means, comes with a certain degree of peril as it can serve as a trigger for a cycle of drug use and sexual activity. Money can be an even more significant trigger of sexual behavior than pornography and social environments (e.g., nightclubs, street corners, other areas of town). Money is often the center of drug use and can trigger a cycle of unhealthy sexual behavior.

> *If I'm out making money, even legally, obsessing about having money in my pocket, even if it is two weeks out, starts a desire. This feeling is powerful, the trouble can start days before I actually get paid, and I feel it. It is a very definite response to an anticipated event—money in my pocket*.—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

The FIP may experience a Pavlovian response that includes a familiar "rush" in the days leading up to the actual receipt of a paycheck. It triggers heightened sexual desire and resulting behavior days in advance. This rush is a distinct feeling corroborated by both recent users and those who have been in recovery and "clean" for years.

> *Oh yeah, it is a definite feeling of desire and anticipation. It comes from deep in my gut, in my bowel, the closest thing I can equate it to is . . . well the feeling you get when you have to go, you know not to be disgusting but a bowel movement. It is difficult to describe, but very real man. I've heard other guys talk about it in group. Something is going on, the chemicals are flowing*.—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

The Male FIP may engage in increased sexual activity in this initial phase, which can start 48 hours prior to the arrival of the paycheck. Sexual activity and drug use are very much tied together in part because the male FIP communicates his upcoming pay with his network, which creates temporary and money-driven relationships with certain sexual partners. The male FIP, again feeling the rush of upcoming pay, also experiences a heightened desire

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for sexual activity which is easily accommodated by certain people who make themselves available to him sexually, largely because of the prospect of participating in the drug use that will soon follow his acquisition of money. Once the pay arrives, drug acquisition and use can begin very shortly after and the male FIP enters the second phase, which is actually characterized by lower sexual drive.

> *My sexual desire and activity can actually go down as I'm using, sure there's sex, however my focus is getting and staying high. It drives everything.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

Crack is particularly dangerous because of its high addictiveness and relatively short lasting effects. Crack tends to be a social drug, and FIP crack cocaine users will often use with others. FIPs report this is primarily due to the paranoia that often comes with the crack cocaine high. The user anticipates this and wants people around.

> *When you're getting high and dealing with that paranoia, the last thing you want is to be alone.... that can ruin the high.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

Often, the women the FIP user has been having sex with prior to the paycheck are among the people the FIP user uses drugs with. The crack cocaine user also will use until the drugs, and subsequently the money, are gone. This dynamic can go a long way to explaining why the FIP who finally lands steady work is often at high risk for relapse after receiving his "first check."

Phase 3 of sexual behavior begins when the drugs are used up and the male FIP–female relationships can involve prostitution, conducted by the woman and encouraged by the FIP male, in an effort to earn more money to continue to use. This third phase also involves heightened sexual activity, perhaps brought upon by the desire on the part of the male FIP to manipulate the woman, as well as the woman's desire to manipulate the FIP male.

> *Everything revolves around the desire to get more money to get more drugs. The fussing, fighting, and the "making up" are fueled by the desire to use.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

Further research should be conducted with the male FIP drug user to validate these three fairly distinct phases. We recommend sexual health behavior interventions that incorporate these insights into their specific outreach, program design, and program execution.

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BARRIERS TO HEALTH CARE AND SUPPORT SERVICES FOR INCARCERATED AND FORMERLY INCARCERATED PERSONS

For some HIV-positive inmates, a corrections facility is the place where they are initially diagnosed with HIV and first receive treatment. Some HIV-positive FIPs feel they have better access to health care when incarcerated than in the "free world" (Hutchins State Jail Health Class, personal communication, March 23, 2010; J. Reed, personal communication, March 26, 2010). This is in part due to the ability to access resources when the inmate is not actively using drugs and may be in a period of sobriety. The authors have observed some inmates feel they get their best health care while incarcerated, but others report experiencing many difficulties accessing health care and preventing disease within the penal system. Despite the risk of HIV infection and frequent public health recommendations to incorporate resources designed specifically to reduce risky behavior, prevention practices are not widely utilized in United States corrections facilities. Proven risk reduction activities and tools, such as distributing condoms and clean needles or providing intensive drug treatment and addiction counseling, remain rare inside of prisons and jails (Association of State and Territorial Health Officials, 1999; Dolan, Wodak, & Penny, 1995; Gainey, Payne, & O'Toole, 2000; Gaiter & Doll, 1996).

Although state and federal prisons are required to provide medical and behavioral health treatment to inmates who request it or are determined to need it, the quality and use of these services is inconsistent, and comprehensive data collection on the impact of these services is not known (American Psychiatric Association, 2000; Anno, 2001). For example, about one in eight state prison inmates participate in formal, structured counseling (Beck & Maruschak, 2001). Counseling specifically focused on drug abuse is often not accessed by the inmates who may need it most. One in four state inmates participates in substance abuse counseling and treatment, but 50% of inmates self-report substance use in the year prior to their offense Similarly, necessary support services are not adequately utilized by FIPs upon their release. Nearly three out of four state prison systems provide referrals for inmates who wish to access psychosocial support, substance abuse, and other public assistance upon release, but only one in three FIPs schedule an initial appointment for these services (Hammett et al., 2002). Several factors, including lack of trust, inmate denial of their need for help, and lack of comprehensive case management, drive this gap in access to care. Many male FIPs mistrust and are intimidated by the health care delivery system because they are not familiar with it, subsequently they do not seek care as readily as men who have not been incarcerated (Hammett, Gaiter, & Crawford, 1998). Offenders, during incarceration and after release, frequently define and describe the majority of their relationships with low levels of trust and intimacy. This low level of trust often also applies to their relationships with various

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service providers, like counselors and case workers, who are initially viewed with great skepticism and mistrust. Some of these relationships never evolve past this initial mistrust, rendering ineffective programs that may be well designed and otherwise executed. Effective "skilled helper" relationships that can influence healthy sexual behavior must start with rapport, which is difficult to establish in an environment of mistrust. Only through consistency over time can trusting relationships be formed, and these are necessary to influence sexual health behavior (Egan, 1975).

Issues associated with race and ethnicity, including racial disparities with respect to incarceration, often exacerbate the mistrust felt by FIPs toward support service providers. African American men comprise 6% of the US adult population but make up about 35% of all inmates in prison or jails in the United Sates (Sabol, West, & Cooper, 2009). Criminal justice data consistently show that African American men do not commit a disproportionate number of crimes, but when compared to White men they are consistently incarcerated at higher rates (Mauer, 1999; Miller, 1996; Tonry, 1995). Changes in the Sentencing Reform Act of 1984, which increased the penalties for drug possession and use, dramatically increased the number of people convicted and sent to prison. African American men have been disproportionally negatively affected by this legislation, which has contributed to their disproportionate share of the U.S. prison population (Mauer, 1999; Miller, 1996; Tonry, 1995). African American men are incarcerated at rates up to seven times that of White men, and in some urban centers one in three African Americans is connected to the corrections "system" in some form, either in local (county) jails, prisons, or the parole system (Mauer, 1999; Miller, 1996). Despite African American men comprising 6% of the U.S. adult population, they make up 30% of those individuals with a felony conviction (The Sentencing Project, 2005). Nearly 8 in 10 African American men will be incarcerated at some time in their lives (Lotke, 1998). These facts are apparent to incarcerated persons, and African American inmates, in particular, may view them as indicators of a larger effort to target them for a life of incarceration. This perception makes them reluctant to seek necessary care upon release, and is important to consider when developing services for groups that include African American FIPs.

The culture of incarceration presents additional barriers to FIPs accessing needed counseling and support services. During incarceration, seeking support from a variety of sources is perceived as "weak," and refusing physical or mental health treatment is positively reinforced. This perspective extends beyond the facility walls and interrupts the desire and ability to seek care within a reasonable amount of time after release (Weissman, Stern, Fielding, & Epstein, 1991). Furthermore, FIPs experience significant stigma associated with incarceration. Even when an FIP wants help, this stigma, which is often self-perceived, can keep the FIP from actively seeking out support services.

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Support system training, resources, and policies may also be factors in the degree to which an inmate seeks treatment. For example, at the system level, enhanced discharge planning can improve FIP access to care. A San Francisco County Jail study found that HIV positive inmates who received discharge planning were six times more likely to access a continuity of care than inmates with chronic conditions who did not receive discharge planning upon release (Wang et al., 2008). In contrast, a lack of training among sexual health professionals can negatively affect FIPs' ability to access care. For example, FIPs with convictions for violent crimes—those who may most need behavioral health resources—experience greater difficulty in participating in these behavioral health programs because staff may not be trained to work with FIPs with violent behavior in their past. In addition, some agencies are not willing to deal with liability issues concerning their staff working with individuals with a history of violence (Lamb, Weinberger, & Gross, 1999).

In addition to the system level policies, broader public policy can have a great impact on FIPs' ability to access health and support services. For example, American courts consistently reject the right to substance abuse treatment in the interpretation of the Constitutional right for all offenders to have adequate health services and treatment during incarceration (Peters & Matthews, 2003). Also, FIPs generally cannot access sexual behavior risk reduction resources during their incarceration, which tends to reinforce behavior upon release. Furthermore, "tough on crime" public policy has limited FIP access to public benefits like food stamps and public housing (Pogorzelski, Wolff, Pan, & Blitz, 2005). These restrictions can last a lifetime, significantly impacting the FIPs' options for successful reentry. For example, many community-based resources that support FIPs have trouble consistently reaching this population because the FIPs do not have stable, adequate housing. In some areas 80% of FIPs report living in a place "other than their own" upon release (Rich et al., 2001). Providing any type of counseling or case management services to individuals with unstable housing presents considerable issues. Each of these barriers must be taken into account in designing effective sexual health behavior interventions among FIPs and the communities in which they live.

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EFFECTIVENESS OF AVAILABLE SERVICES

Effective Approaches to FIP Sexual Health Behavior Change

Formal evaluations of the broad array of interventions that focus on sexual health behavior both pre- and postrelease are scarce. Therefore, it is difficult and perhaps unfair to lump the various interventions together and assess their effectiveness when evaluated in terms of specific sexual health behavior change. These programs can have very different approaches, outcome measures, and, for community-based interventions, various collaborations

with health care providers and services. Examples of program diversity include:

- Some begin prerelease, some postrelease.
- Many do not measure outcomes as defined by specific health behavior change, a majority measure impact based on clients served.
- Programs may not effectively track the FIP long enough to measure sexual health behavior change.
- Faith-based programs may not teach and evaluate certain healthy sexual behaviors, such as using condoms, which are emphasized and evaluated in other programs.

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One comprehensive evaluation found no reductions in risky behaviors such as drug use while engaging in sexual behavior or participation in transactional sex, which led the evaluators to conclude the program was not effective in modifying sexual health behavior to lower risk of HIV infection.

> *We conclude that while a well-executed case management program can make modest differences in a few short-term outcomes of FIPs, this one did not change the life course or basic health status of most of its clients.*—Evaluation of a Case Management program for FIPs and HIV Risk (Needels, James-Burdumy, & Burghardt, 2005)

However, when examining comprehensive programs that focus on behavior change to reduce HIV risk that begin prerelease and track these same inmates postrelease, we find they can be effective and result in positively impacting sexual risk behaviors of the FIP. These programs offer valuable perspectives on effective risk reduction for FIP sexual behavior. FIPs that participate in prerelease programs report decreases in risky sexual behavior, injection drug use (IDU), and needle sharing after release. Participants also report higher utilization of community-based health support services and improvement in key drivers of healthy sexual behavioral such as self-efficacy for condom use and resistance to substance use, increased motivation to practice safer sex, and improved attitudes toward condom use (Bauserman, Richardson, Ward, Shea, Bowlin, Tomoyasu, Solomon, 2003).

Inmates report that peer-led education and counseling can be especially effective, in both pre- and post-release program activities. Inmates also report that specific teaching approaches, specifically pictures and videos, are more likely to affect their behavior. They report that when a peer counselor shares personal vignettes about their experiences or those of their friends or family, this makes a profound impression and may better position the FIP for behavior change upon release.

> *Men or women that have been down can relate on a real level. We can tell if someone has been on the street, they know the troubles we face. They can get on our level in ways others can't. They also tend to not talk down to us, I appreciate that they're really trying to help . . . and it makes a difference.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

Also, graphical tools especially have an impact, in part because they are easily understood by inmates with relatively low education levels. It is important for counselors to consider that only 2.4% of state prison inmates are college graduates or have advanced degrees, while 21% are high school graduates, 29% have a GED, and 26% have only some high school education (Harlow, 2003). More importantly, perhaps the graphical images, when coupled with effective peer instructors who share personal accounts, can be dramatic and lasting.

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> *The more personal they get the more I listen to them. I remember when TDCJ (Texas Department of Criminal Justice) had this lady talking to us about how her brother died, and dying from AIDS is no joke man . . . Man I can still remember these pictures of a guy's, you know, private area. Man I definitely kept the condoms with me when I got released after seeing that, I don't think I used them all, but I kept them.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

Interestingly, the student's sentiments may align with addiction research around intravenous drug users (IDUs) and their motivation to reduce HIV/AIDS high-risk behavior. In a study of 200 IDUs who were not in treatment, successful interventions targeted individuals with cognitive readiness to address AIDS-related issues at a "personal level." Also, participant-specific motivations should be incorporated to tailor intervention strategies (Camacho, Williams, Vogtsberger, & Simpson, 1995). Interventions that rely on peer-led programming and education produce additional ancillary benefits. Inmates who serve as peer educators tend to continue this role outside the formal classes and may influence other inmates as well as family members and friends outside the corrections facility (Ehrmann, 2002; Scott, Harzke, Mizwa, Pugh, & Ross, 2003). Despite the impact of peer-led interventions, some inmates report little knowledge of peer-led programs available in the areas where they will be released.

> *There are some pretty good classes they make us go through in here. They cover HIV/AIDS, sharing needles, and sex. They even give us condoms when we get out, however I don't know if they have this type of stuff for us when we get to the free world.*—(Anonymous, Hutchins State Jail Health Class, personal communication, March 23, 2010)

RECOMMENDATIONS

Any intervention focused on sexual health of FIPs must consider the wide diversity of the inmate population in terms of education, health literacy, race, age, criminal history, and drug use. When reviewing approaches that best position the intervention for the impact on healthy sexual behavior, three characteristics emerge.

First, the intervention should utilize peer-led sessions as much as possible. Incarcerated and formerly incarcerated men consistently tell of the impact that peers have on supporting the various challenges faced during their transition. The diversity of the inmate population presents particular challenges when developing peer-led interventions. This diversity should be considered in peer selection as well. Project Wall Talk, one comprehensive study of an intervention conducted inside Texas State prisons, found that a robust comprehensive training program compensates for the large variety in education levels among inmates, sexual health knowledge and skills, as well as gender and racial differences in baseline evaluations (Scott, Harzke, Mizwa, Pugh, & Ross, 2003).

Second, the intervention should begin prior to release. Establishing a relationship with the inmate prior to release is consistently shown to result in sustained behavior impact when compared to programs that begin after release. This approach is extremely challenging, however, as it requires an established relationship with the corrections facility, specifically the warden.

Third, any program that endeavors to address FIP sexual behavior must recognize the three distinct phases of drug use and sexual activity: the period leading up to use, the period during drug use, and the period after the binge is over when the initial drug supply is used up. Effective FIP reentry programs have been extensively researched and studied. In terms of effective interventions focused on behavior, the following guiding principles persist (Gendreau, 1996):

- Services should be intensive and behavioral in nature.
- Behavioral programs should target specific needs of high-risk offenders and should begin prerelease.
- Characteristics of offenders, therapists, and programs should be carefully matched.
- Program contingencies and behavioral strategies should be enforced in a firm but fair manner.
- Interpersonally sensitive and constructive communication should be used in relating to FIPs.
- Program structure and activities should be designed to disrupt delinquency networks.
- Relapse prevention strategies should be provided in the community.

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Addiction, which includes the environmental factors surrounding it, is the single greatest barrier to continuity of care and social stabilization faced by most FIPs (Rich, Holmes, Salas, Macalino, Davis, Ryczek, & Flanigan, 2001). To effectively connect FIPs with necessary resources, it is crucial to emphasize that substance abuse recovery is *not* a condition of program participation. Programs need to reinforce the importance of substance abuse treatment but not eject the FIPs if they relapse. Prerelease components are stressed because the initial 24 hours after release is the most important period in determining if an individual will participate in high-risk behaviors such as substance abuse and unsafe sex. This period presents the most significant challenges in practicing healthy behaviors that may be new to the FIP. Male FIPs state that a strong motivator upon release is reconnecting with a spouse or girlfriend in order to establish or return to a "provider" role in supporting the household; however, these may be roles that the FIPs never really played and, if they did, returning to them is often more challenging than anticipated because of fractured relationships, lingering addiction issues, and limited employment options. FIPs often return to familial circumstances and environments worse than what they left and worse than they anticipate. FIP programs, across various support services, must establish contact and a relationship as close to release as possible, preferably in the months prior to release.

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SUMMARY

The diversity of interventions around sexual health behavior, which are tied to other support areas such as addiction, counseling, and employment training, often mirror the diversity of the inmates they serve. Various community-based, faith-based, and government-based programs are at work to serve the needs of not just the FIPs but also the larger communities to which the FIPs return to live. Their health status, especially that influenced by risky sexual behavior, affects not only the FIP's proximal social network but also the larger community. There is certainly no one effective approach to affecting the sexual health behavior of FIPs in their difficult transitions from incarceration. Interventions should be flexible enough to seek to understand what is effective and work to craft initiatives that align with the goals of the program, the organization, and the needs of the FIP.

> *Because of my faith, which plays a tremendous role in my personal recovery, the Faith Based Collaborative emphasizes that having sex should come with a (wedding) ring, however regardless of if and to what degree religion or spirituality is part of a program, it must address the linkages between drug use and sexual activity. It is impossible to separate the two.*—Rev. J Reed, an FIP currently in his 24th year of recovery from crack cocaine and heroin

GLOSSARY

- **Adult Offender**: A person 25 or older who commits a crime.
- **Closeted**: activities or aspects of one's life that the individual chooses to keep private or completely secret.
- **Down**: incarcerated.
- **Free World**: anywhere outside of a corrections facility.
- **Juvenile**: In the United States, definitions and age limits of juveniles vary, the maximum age being set at 14 years in some states and as high as 21 in others.

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