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**Service Category Definition - DSHS State Services Grant
September 1, 2012 - August 31, 2013**

| | |
|---|--|
| Local Service Category: | Early Intervention Services – Incarcerated |
| Amount Available: | To be determined |
| Unit Cost | |
| Budget Requirements or Restrictions (TRG Only): | Maximum 10% of budget for Administrative Cost. No direct medical costs may be billed to this grant. |
| Local Service Category Definition: | This service includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client’s health literacy, establishment of THMP/ADAP <u>post-release</u> eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning. |
| Target Population (age, gender, geographic, race, ethnicity, etc.): | Services are for all HIV/AIDS infected individuals incarcerated in The Harris County Jail. |
| Services to be Provided: | Services include but are not limited to CPCDMS registration/update, assessment, provision of client education, coordination of medical care services provided while incarcerated, medication regimen transition, multidisciplinary team review, discharge planning, and referral to community resources. |
| Service Unit Definition(s) (TRG Only): | One unit of service is defined as 15 minutes of direct client services or coordination of care on behalf of client. |
| Financial Eligibility: | Due to incarceration, no income or residency documentation is required. |
| Client Eligibility: | HIV-positive incarcerated resident of the Harris County Jail. |
| Agency Requirements (TRG Only): | Agency must execute Memoranda of Understanding with Ryan White funded Outpatient Ambulatory Medical Care providers. The Administrative Agency must be notified in writing if any OAMC providers refuse to execute an MOU. |
| Staff Requirements: | Not Applicable. |
| Special Requirements (TRG Only): | Must comply with the State Services Standards of Care. |

FY 2013 RWPC “How to Best Meet the Need” Decision Process

| | | |
|---|---|--|
| Step in Process: Council | | Date: |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: Steering Committee | | Date: |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: Quality Assurance Committee | | Date: |
| Recommendations: | Approved: Y_____ No: _____ Approved With Changes:_____ | If approved with changes list changes below: |
| 1. | | |
| 2. | | |
| 3. | | |
| Step in Process: HTBMTN Workgroup #1 | | Date: 04/19/12 |
| Recommendations: | Financial Eligibility: | |
| 1. | | |
| 2. | | |
| 3. | | |

**DSHS STATE SERVICES
12-13 HOUSTON HSDA SERVICE-SPECIFIC STANDARDS OF CARE**

EARLY INTERVENTION SERVICES FOR THE INCARCERATED

| # | STANDARD | MEASURE |
|--|---|--|
| 9.0 Service-Specific Requirements | | |
| 9.1 | <p><u>Scope of Service</u> Early intervention Services for the Incarcerated includes the connection of incarcerated in the Harris County Jail into medical care, the coordination of their medical care while incarcerated, and the transition of their care from Harris County Jail to the community. Services must include: assessment of the client, provision of client education regarding disease and treatment, education and skills building to increase client’s health literacy, establishment of THMP/ADAP eligibility (as applicable), care coordination with medical resources within the jail, care coordination with service providers outside the jail, and discharge planning.</p> | <ul style="list-style-type: none"> • Program’s Policies and Procedures indicate compliance with expected Scope of Services. • Documentation of provision of services compliant with Scope of Services present in client files. |
| 9.2 | <p><u>Client Eligibility</u> In order to be eligible for services, individuals must meet the following:</p> <ul style="list-style-type: none"> • HIV-positive status <p><i>Due to client’s state of incarceration, this service is excluded from the requirement to document income and residency.</i></p> | <ul style="list-style-type: none"> • Documentation of HIV status is present in the client file. • Documentation in compliance with TRG Policies for SG-03 DOCUMENTATION OF HIV STATUS. |
| 9.3 | <p><u>CPCDMS Update/Registration</u> As part of intake into service, staff will register new clients into the CPCDMS data system (to the extent possible) and update CPCDMS registration for existing clients.</p> | <ul style="list-style-type: none"> • Current registration of client is present in CPCDMS. |
| 9.5 | <p><u>Assessment of Client</u> Staff will complete an intake assessment form for all clients served. The assessment will include identified needs upon release, assessment of support system upon release, and desired provider to receive referral information on.</p> | <ul style="list-style-type: none"> • Intake assessment form is present in the client file. |
| 9.6 | <p><u>Provision of Client Education</u> Staff provide client with education regarding the disease and its management, risk reduction, medication adherence and other health-related education.</p> | <ul style="list-style-type: none"> • Documentation of client education is present in the client file. |

| # | STANDARD | MEASURE |
|------|--|---|
| 9.7 | <u>Increase Health Literacy</u> Staff assesses client ability to navigate medical care systems and provides education to increase client ability to advocate for themselves in medical care systems. | <ul style="list-style-type: none"> • Documentation of health literacy evaluation and education is present in the client file. |
| 9.8 | <u>Coordination of Care</u> Staff assists in the coordination of client medical care while incarcerated including, but not limited to, medical appointments and medications. | <ul style="list-style-type: none"> • Documentation of coordination of care is present in the client file. |
| 9.9 | <u>Medication Regimen Establishment/Transition</u> Staff assists clients to become eligible for TXMP/ADAP medication program prior to release. Staff assists client with transition of medication from correctional facility to outside pharmacy. | <ul style="list-style-type: none"> • Documentation of THMP/ADAP application and its submission is present in client file. • Documentation of connection/referral to outside pharmacy. |
| 9.10 | <u>Transitional Team Multidisciplinary (TTMD) Review</u> Staff creates opportunities for MDT review with all involved agencies to discuss client's case. | <ul style="list-style-type: none"> • Schedule of available times for TTMD reviews with involved agencies available for review. • Documentation of TTMD reviews present in client file. |
| 9.11 | <u>Discharge Planning</u> Staff conducts discharge planning into Houston HIV Care Continuum. Discharge planning should include but is not limited to: <ul style="list-style-type: none"> • Review of core medical and other supportive services available upon release, and • Creation of a discharge plan. | <ul style="list-style-type: none"> • Documentation of review of services present in client file. • Documentation of client discharge plan is present in client file. |
| 9.12 | <u>Referral Process</u> Staff makes referrals to agencies for all clients to be released from Harris County Jail. The referral will include a packet with <ol style="list-style-type: none"> a. A copy of the Harris County Jail Intake/Assessment Form, b. Proof of HIV diagnosis, c. A list of current medications, and d. Provide client ID card or "known to me as" letter on HCSO letterhead to facilitate access of HIV/AIDS services in the community. | <ul style="list-style-type: none"> • Documentation of referral present in client file • Documentation of referral feedback present in client file. • Copy of "known to me as" letter present in client file. |

| # | STANDARD | MEASURE |
|------|--|---|
| 9.13 | <p><u>MOUs with Core Medical Services</u> The Agency must maintain MOUs with a continuum of core medical service providers. MOUs should be targeted at increasing communication, simplifying referrals, and decreasing other barriers to successfully connecting clients into ongoing care.</p> | <ul style="list-style-type: none"> • Review of MOUs at annual quality compliance reviews. • Documentation of communication and referrals with agencies covered by MOUs is present in client file. |

DSHS STATE SERVICES 12-13 HOUSTON HSDA OUTCOME MEASURES

EARLY INTERVENTION SERVICES FOR THE INCARCERATED

Purpose: The purpose of the DSHS State Services Outcome Measures is to provide a measurement of the effectiveness of services in terms of health, quality of life, cost-effectiveness, and knowledge, attitudes, and practices (KAP), where applicable.

| Outcome Measure | Indicator | Data Collection Method |
|---|--|---|
| 1.0 Knowledge, Attitudes, and Practices | | |
| 1.1 The scores from pre and post test administered to clients regarding risk reduction, HIV modes of transmission, etc. will increase. | 70% of clients will experience a 70% increase on scores of pre and post tests administered. | Pre and Post Tests |
| 2.0 Health | | |
| 2.1 The percentage of newly-diagnosed clients (incarcerated 30 days or longer) that initiate care will be increased/ maintained. | <ul style="list-style-type: none"> 80% of newly diagnosed clients (incarcerated 30 days or longer) that initiate care within the HCJ. | <ul style="list-style-type: none"> CPCDMS System |
| 2.2 The percentage of clients accessing care within 60 days of release from HCJ will be increased. | <ul style="list-style-type: none"> 80% of clients served by the HCJ EIS program will access care within 60 days of release from HCJ. | <ul style="list-style-type: none"> CPCDMS System |
| 3.0 Quality of Life | | |
| 4.0 Cost-Effectiveness | | |

ENHANCING LINKAGES TO HIV PRIMARY CARE AND SERVICES IN JAIL SETTINGS INITIATIVE: LINKAGE TO SOCIAL SUPPORT SERVICES

Spring 2010
Issue 1, Vol.2

Special points of interest:

- Barriers to appropriate linkages include the conflicting missions of the correctional system and public health initiatives.
- System-wide barriers include: disease stigma, lack of knowledgeable personnel, lack of coordination between medical and social service providers

“Social services effectively become a durable link for released inmates to gain entrance into and remain committed to coordinated HIV clinical care, supportive services, and risk reduction.”

DISCHARGE TO THE STREETS:
RE-INTEGRATING THE HIV+ INMATE FROM
COUNTY JAILS

Ten sites in a Special Projects of National Significance (SPNS) Health Resources and Services Administration (HRSA) Initiative (funded September 1, 2007 to August 31, 2011) have initiated *Innovative Demonstration Models of HIV Testing and Linkage to Care* and are utilizing a variety of social service interventions to implement re-integration into community life for HIV+ individuals.

Barriers to appropriate linkages include the conflicting missions of the correctional system and public health initiatives. Disease stigma, lack of knowledgeable personnel within jail environments, and a lack of coordinated efforts by medical and so-

cial service providers to work around a system designed for failure prevail. In addressing these barriers, an emphasis on the utilization of staff with considerable experience in jail systems will help expedite medical care, case management, psychiatry, substance abuse treatment, HIV education, and supportive services.

Social services effectively become a durable link for released inmates to gain entrance into and remain committed to coordinated HIV clinical care, supportive services, and risk reduction. The SPNS multi-site evaluation study seeks to examine linkages to HIV-clinical care as one measure of successful outreach.



To ensure timely linkages into clinical care, social services are utilized and further enriched with enhancements that may include, but are not limited to, case management and outreach, substance abuse treatment, transportation, food, shelter, phone cards, and clothing.

NEEDS ASSESSMENT: CURRENT PROBLEMS

Targeted county jails cannot meet all identified needs

Jails often lack the incentive or resources to deal with the multi-faceted needs of HIV+ inmates requiring appropriate discharge planning. Inmates are stigmatized; left with no supportive counseling

for housing, mental health, substance abuse, HIV care and services or employment. HIV education, testing for HIV disease and linkages into medical care are either not available, sporadic in availability, linked to an accident or trauma, or openly avoided due to the resulting costs that HIV disease manage-

ment may introduce into already strained budgets.

Barriers to care that predominate within the jail environments also exist upon discharge. Basic needs such as establishing identity; finding shelter, clothing, food, and

Continued at top of p. 2

“...structured discharge and reintegration planning is often lacking...This brief suggests the need for flexibility and resourcefulness among all professionals involved in an inmate’s discharge.”

transportation; dealing with mental illness or the stress of domestic chaos and ostracism overshadow the need for medical care. Pursuing a seamless continuum of adherence to HIV care with these unresolved stressors would be a miracle without designed and concerted efforts that are rooted in social networking through a variety of social management systems.

Critique of policy options

In an ideal world, HIV education, appropriate counseling, discharge planning, and reintegration programs for inmates from county jails would be structured and comprehensive. Corrections treatment team members, parole staff, discharge planners, case managers, clinicians, and other linked social support personnel would convene to develop discharge and reintegration

work plans specific for the HIV+ inmate’s medical and social acuity. However, **structured discharge and reintegration planning is often lacking.** In an attempt to deal with the unexpected, this brief suggests the need for flexibility and resourcefulness among all professionals involved in an inmate’s discharge. It also encourages immediate responses to find alternative solutions when customary linkages are unavailable.

The support provided by linkage to social support services helps to deploy case management and other outreach worker models, which are community level interventions used to provide supportive services to the targeted county jails in order to address the needs of people with HIV disease who are currently incarcerated and reintegration efforts from

the moment of discharge (“Connecting to Care: Addressing Unmet Need in HIV” AIDS Action Council, 2003). Key characteristics of this demonstration model are the outplacement, or deployment, of case managers and outreach workers to assess and refer HIV+ inmates to medical and community-based services in both urban and rural settings to insure successful reintegration back into independent living and community life. Funding may not always be available for ideal staffing, but working through a conceptual framework of the options may help to link the inmate into all of the needed services.

POLICY RECOMMENDATIONS

Strategies employed in the demonstration models

Be creative with your case managers. This can be within the jail setting or initiated in the transitioning process that exists between the jails and other AIDS service organizations at the point of discharge. Case managers within jail systems, or working with jail administrators during the inmate’s stay within the jails, help to monitor and link clients into appropriate medical care, sub-

stance abuse and mental health treatment, legal and parole requirements, and supportive services in their local communities. The goal of initiating social services at the point of discharge is to appropriately link multiple service providers to a client to achieve successful reintegration into the community; maintain healthy behaviors including adherence to HIV care; reduce risky behaviors; and reduce recidivism.

Strategies built upon prior experiences with the target population

Exposure to high-risk places, persons, and situations occurs over-night as inmates move from controlled environments to almost complete freedom, with few having developed relapse prevention skills during their incarceration to deal with these risks. Assessment and planning can be structured to address identified risks and provide coping solutions to reduce recidivism. This

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requires clients to have access to clean, safe, and affordable housing, knowledge of community resources, access to telephones, and support from on-call staff who can provide linkages to transportation and services.

Challenges accompany parole release. With parole there are conditions that the inmate knows must be fulfilled including addressing substance abuse, maintaining employment, observing curfews, and staying away from certain high-risk places and persons. Enforcement of these requirements may help in behaviors, but can also result in increased surveillance of infractions and increase the likelihood of detecting technical violations resulting in a renewed incarceration (Travis: From Prison to Home, The Dimensions and Consequences of Prisoner Reentry. Urban Institute Justice Policy Center, June 2001). Identifying parole requirements and implementing compliance solutions are required to reduce recidivism.

Mental illnesses provide a host of challenges, and mental health issues may be made more complex by years of addiction. Suc-

cessful reintegration depends heavily on the availability of treatment options and the ability to access those options within the community. Inmates with mental illnesses are more likely to have been homeless before incarceration and to be homeless upon discharge. The evolving triad of HIV disease, mental illness, and addictions is often complicated by other co-morbid health, social, and economic issues. Comprehensive reintegration planning can incorporate mental health assessment and treatment planning. Mental Health assessment and treatment planning ideally should take place prior to discharge and should be done by collaborations between jail primary care providers and the psychiatrist/consultant.

Employment opportunities are limited. Many communities will not hire ex-offenders, and felony convictions often preclude the newly released inmate to find employment. Illiteracy and lack of job skills can also put the ex-offender on the defensive when looking for employment. Efforts to link the discharged inmate with durable wage earning positions should deal with the medical acu-

ity, substance abuse and mental health status, job readiness training and educational skills of the client, along with discrimination found among employers.

Family can be welcoming or the first barrier to reintegration. The psychosocial assessment for family reintegration should start during the period prior to discharge. Upon discharge the family can be the first link to durable housing and stability. Domestic chaos or the lack of compassionate family can set the stage for relapse into drug addictions or crime. Family issues need to be identified and addressed prior to discharge and/or throughout the reintegration process.

Housing may be the number one stumbling block if the released inmate lacks family contacts or economic capacity for rental units. Associations between lack of housing and lack of adherence with HIV medical care speak of the dire need to have clean, safe, and affordable housing for all clients living with HIV/AIDS. Homeless shelters may be the only resort for many former inmates in need of housing, but they too, are not always available.

“Housing may be the number one stumbling block [to reintegration] if the released inmate lacks family contacts or economic capacity for rental units.”



Authors

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About the Initiative:

Enhancing Linkages is a multisite demonstration and evaluation of HIV service delivery interventions for HIV+ individuals in jail settings who are returning to their communities.

The Enhancing Linkages Initiative is sponsored by:

- US Department of Health and Human Services
- Health Resources and Services Administration
- HIV/AIDS Bureau
- Special Projects of National Significance Program

RECOMMENDATIONS TO ADDRESS THE RE-INTEGRATION OF HIV + COUNTY JAIL INMATES INTO THE COMMUNITY

Summary of options

1. All released detainees are assessed for individualized treatment plans and linked to providers that offer a continuum of services under the observed and coordinating leadership of a deployed case manager.
2. The program model would be designed so that foreseeable barriers are minimized or eliminated to the point that is fiscally feasible and possible when merging systems with conflicting missions. E.g. corrections systems and public health initiatives.
 - Transportation is provided from the jail on day of release to transitional housing within the community that provides substance abuse treatment.
 - Utilize a non judgmental staff who are trained in cultural sensitivity to minimize and/eliminate discrimination.
3. Primary medical care is combined with dentistry and ophthalmology, two essential unmet needs of the targeted population. Coordination of care is used to promote easy access for consultation on complicated medical histories helping to expedite treatment planning. Programs should be efficient with minimal waiting time for all appointments.
4. Case managers collaborate with service providers to help keep all client records up to date and to ensure continuing access into care. The care settings are carefully chosen based on their level of service and commitment and sensitivity to the community.
5. There is coordination of care by the case managers to insure that their services are available during the reintegration process.
6. Treatment plans are designed to improve the patient's HIV medical status and address social service needs.
7. Intense relapse prevention efforts should be utilized through the use of consult/liaison psychiatry and substance abuse counseling.
8. The case managers and outreach workers meet clients on their turf to "sell the service".
9. The project administrators and educators market their program to other providers including known collaborating agencies. Medical and dental society meetings, informational gatherings; AIDS Education and Training Centers lectures; local AIDS consortia; social service agencies; and religious groups should all be targeted to disseminate information about the available services.

SUMMARY OF POINTS

In brief, reentry back into society for HIV+ inmates is a complex undertaking that requires collaboration between county jail systems, AIDS service organizations, substance abuse treatment centers, the medical community and the community at large in order to successfully reintegrate the inmate. Reintegration also requires creative, knowledgeable, flexible and resourceful staff to navigate

the myriad of systems in out of county jails. Reintegration is only as strong as the weakest link provided to the client. Missing and/or deficient supportive services have direct consequences resulting in poor outcomes: loss of social stability and incapacity to remain free in a world with complex health and social systems.

From Medscape Education HIV/AIDS

Crossing Bridges: Transitioning HIV Care From Corrections Into the Community

Faculty and Disclosures

Related Downloads: [MP3 Audio file](#) (Right-click and select "Save Target As..." to download)

OVERVIEW

Patients infected with HIV who are leaving jail or prison face extraordinary challenges. Most individuals infected with HIV struggle not only with HIV, but also with substance use, mental illness, and possibly hepatitis as a result of infection with hepatitis B virus (HBV) and/or hepatitis C virus (HCV). Although HIV may be the primary concern of the medical provider, the primary concern of the person being released may be reconnecting with a spouse or family, having a safe place to live, finding employment, addressing continued legal problems, or just dealing with the overwhelming demands of life "on the outside." Given the challenges faced during this turbulent time, reincarceration is unfortunately common.

Successful transition of HIV care from the correctional setting to the community requires a collaborative relationship between correctional and community healthcare providers and a willingness of the individual infected with HIV to engage with care. This process requires communication between care sites and requires that the patient be able to attend appointments and obtain medications, and community providers must understand and acknowledge that community reentry is often a difficult time for the patient.

1. There is communication between correctional healthcare providers and community providers. This is essential to ensure that ongoing care plans are continued, the community providers are aware that the patient is being released and that care is being transitioned, and that community-based support services such as mental health care and substance abuse treatment and counseling can be arranged. This process may entail multilevel communication among a variety of providers, including HIV clinicians, discharge planners, social workers, case managers, and medical records keepers.
2. The community providers accepting care of the patient infected with HIV need to be flexible in terms of the provision of care. Given the obstacles the patient may face, such as the lack of financial means, health insurance, and transportation, and given other competing priorities in his or her life, appointments may be missed. Rather than refusing to care for the "noncompliant" patient, the provider should assess barriers to care and help alleviate them whenever possible.

A primary care model of healthcare is often needed to address the myriad needs of the patient. In addition to assessing the patient's HIV disease, including need for antiretroviral treatment and prophylactic medication to prevent opportunistic infections, the HIV provider should be proactive in addressing other comorbidities. Common concurrent illnesses should be treated, including hypertension, chronic obstructive pulmonary disease/asthma, diabetes mellitus, viral hepatitis, and other sexually transmitted infections. Access to community-based mental health and substance abuse treatment may be limited; therefore, it helps if the HIV provider and/or support staff can assess and provide treatment for these common problems, reserving referral for those with the greatest needs. A comprehensive model of care will help keep the patient engaged with longitudinal care.

MEDICAL NEEDS

Disease Burden Among Incarcerated Populations: Not Just HIV

Incarcerated populations have a disproportionately higher burden of HIV/AIDS,^[1-3] HBV and HCV infections,^[4-6] tuberculosis,^[7] sexually transmitted diseases,^[8] and mental illness.^[9] Incarceration is an opportunity to address multiple medical problems and follow-up medical care in the community after release must be comprehensive and integrated. An estimated 70% of AIDS among inmates was contracted through preincarceration injection-drug use, compared with only 32% in the general population.^[1] Sexual transmission is also the method of infection for a substantial number of those with HIV in this population.^[10-13] Many inmates engage in numerous behaviors that put them at high risk for HIV prior to incarceration, and if these behaviors are not addressed during the incarceration, many will resume familiar patterns of risk-taking behavior after they are released. Additionally, an estimated 43% of all individuals in the country with HCV pass through a correctional facility each year.^[7] This means that many inmates who are infected with HIV will also be infected with HCV. HCV education, secondary prevention, and treatment need to be addressed after the person is released, and HIV treatment should be transitioned to the community setting.

HIV Care

Patients being released from the correctional setting may only have a short supply of medications provided (7-30 days). One of the primary goals during community reentry is for patients to have uninterrupted access to antiretroviral medications. This can be a substantial challenge. A recent report in Texas found that only 30% of individuals with HIV who were released from prison filled their antiretroviral prescriptions within 60 days of release.^[14] To avoid similar interruptions in medication adherence, access to medications can be facilitated through the community-based clinic by enrolling patients in AIDS Drug Assistance Programs upon release. Counseling on the need for adherence to medications should also be provided and barriers to adherence should be addressed. In addition, transfer of medical records from correctional providers to community providers is also essential so that established care plans can be continued and so that community providers have access to the patient's most recent laboratory work (CD4 count and HIV plasma viral load). This transfer of records will also inform the community provider about other comorbidities that were diagnosed prior to or during the incarceration. These may include tuberculosis, HBV, HCV, sexually transmitted infections, and noninfectious diagnoses such as hypertension, chronic obstructive pulmonary disease/asthma, diabetes mellitus, and mental health disorders. With this information, the community provider can initiate a care plan that includes maintenance of HIV viral suppression (if treatment is indicated) and treatment or monitoring of comorbidities. A comprehensive primary care approach to medical care will enable the patient to receive his or her care within one medical setting, thus facilitating access and feasibility. In this model, the providers can also address ongoing substance use, addiction, and other social stressors that affect the patient's ability to stay healthy.

Substance Use

Many incarcerated individuals face ongoing struggles with addiction, and relapse to addiction following incarceration is common. Dealers and drug-using "friends" are available "24/7" and often meet inmates at release. Incarceration is usually a period of forced sobriety; thus, many people leaving correctional institutions have been abstinent from drugs for the duration of their incarceration. Within 1 month of release from incarceration, however, 55% of former prisoners return to their habit.^[15] Studies have shown that as many as 75% of untreated parolees with histories of heroin and/or cocaine use are reported to return to drug use within 3 months of their release^[16,17] and that nearly 95% of released state inmates with a history of drug use have a relapse within 3 years.^[18] These high rates of relapse suggest that although physical dependence on drugs may wane during a period of forced sobriety, the compulsive behavioral manifestations of addiction (ie, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*-defined substance dependence) are still present and warrant aggressive treatment. One study found that a minimum of 5 years of heroin abstinence was necessary to considerably reduce the likelihood of future relapse, but a quarter of participants had a relapse even after 15 years of abstaining.^[19] Return to drug use is typically

accompanied by increased criminal activity,^[20,21] disproportionately high risk for HIV infection,^[22] overdose death,^[23] and ultimately, recidivism.^[21]

TURNOVER RATES AND THE "REVOLVING DOOR" OF INCARCERATION

Although correctional facilities may seem to be separated from the rest of the community, the incarcerated population moves frequently between imprisonment and their home communities,^[21] a situation often referred to as a "revolving door."^[24-26] Once an individual becomes involved with the criminal justice system, his or her chance of becoming arrested or incarcerated again increases.^[26] In fact, 41% of prisoners with one prior arrest are rearrested within 3 years, 55% of those with 3 prior arrests are rearrested, and 82% of those with 15 or more prior arrests are rearrested within 3 years.^[26] Approximately two thirds of individuals released on parole are rearrested within 3 years, most commonly in the first 6 months after their release.^[27] Inmates with a history of drug use often resume drug-use patterns after release,^[18] and the recidivism rate among drug users is particularly high.^[28,29] Although individuals with untreated addiction are more likely to reoffend, those in addiction treatment are vulnerable to arrest resulting from the restrictions of probation and parole, old warrants, and fines.

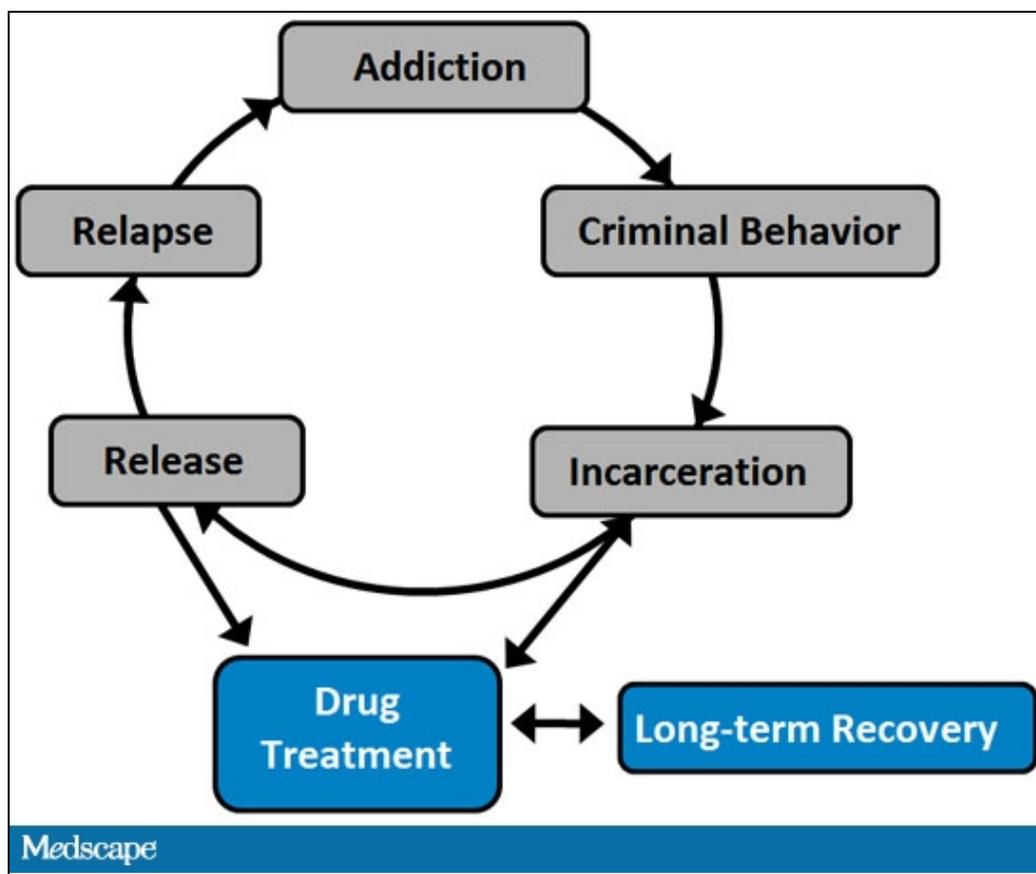


Figure. Cycle of drug addiction and incarceration.

Postrelease: Differing Priorities

When individuals walk out of the jail or prison, their lives are almost always chaotic. Re-entry into society poses extraordinary challenges. From a clinician's point of view, HIV care may be the most important priority for the patient. However, the priority for many newly released prisoners is satisfying basic survival needs, such as housing, income, and food, and these often supersede their need for HIV/AIDS care.^[30]

Most inmates return to neighborhoods that have high rates of drug use, unsafe housing, violence, and unemployment, with few opportunities for work or education. Recently released persons may engage in survival sex (ie, sex for food or sex for shelter)^[31] or commercial sex work. In addition, prolonged periods of single-sex living conditions (ie, periods of incarceration)^[32] can lead to high-risk sexual behaviors that place the sexual partners of offenders who are HIV positive at risk of becoming infected. Increased sexual and drug-related risk behaviors may result even if former inmates are educated about the risks of such behaviors.^[33] Additionally, former inmates who are addicted to opiates face a significantly elevated risk of overdose in the weeks immediately following their release from incarceration.^[34-36] The period of incarceration and the time immediately following release is a critical time for public health interventions to reduce risks. All of this speaks to the importance of developing a holistic approach to addressing the myriad needs, both social and medical, that inmates have when they are released back into their communities. Although continuity of HIV care is often perceived as being essential by the medical community, without addressing the associated complications of reintegration into society, continuity of care is much less likely to succeed.

Developing Trust: An Essential Component of Care

Individuals who are incarcerated often have difficulty developing trusting relationships and may have received little help or support from the medical community in the past. Incarceration provides a key opportunity for the development of a trusting relationship with an outreach worker or case manager who can help address the full range of needs upon release. The importance of that initial contact prior to release cannot be underestimated. An outreach worker or case manager visit with an inmate who is HIV positive can make all the difference in terms of helping the inmate understand that he or she has access to resources and support on the outside and is not alone in dealing with the obstacles of reintegration into society. This visit is crucial to arrange for the person's first community medical visit and ensure that the individual has transportation to the clinic where HIV care will be provided. It is helpful for an inmate who is HIV positive to see the medical community as more than a clinician in a white coat. An outreach worker or case manager can serve as a "face" of the HIV clinic. This person needs to share common cultural characteristics with the person infected with HIV, must communicate clearly, in the same language, and must have empathy. Incarcerated individuals have been in a relatively hostile environment that frequently lacks both empathy and directed support services. The provision of case management is an opportunity to provide both a caring approach and an organized linkage to services.

A Successful Model for Linkage to Care: Project Bridge

Since October 1996, The Miriam Hospital in Providence, Rhode Island, has been funded by the Health Resources and Services Administration. The program was developed to address the needs of HIV-positive inmates who are released from state and federal prisons. The program is a partnership between the Miriam Hospital, the Rhode Island Department of Corrections, and the Rhode Island Department of Health. The program provides a comprehensive approach to linkage to care, including case management, transportation, and medical services. The program has been successful in increasing the number of HIV-positive inmates who are linked to care upon release. The program is a model for other jurisdictions that are looking for ways to improve linkage to care for HIV-positive inmates.

following release, and are encouraged to have daily contact for the first month, weekly encounters for the next 2 months, and bimonthly encounters for the remaining 15 months of enrollment.

Throughout his or her participation in Project Bridge, each participant is accompanied by the social worker to medical appointments. Given that the levels of literacy, especially health literacy, in the population are quite low, having the social worker present is helpful to ensure that participants fully understand their healthcare visit. In addition, the outreach worker maintains regular contact with the client in the community, which provides additional opportunities to follow up on any concerns that participants may have with their care. Collectively, the social worker and outreach worker also work to assist in housing placement, accessing addiction and/or mental health treatment, and other supportive services.

Project Bridge has been successful in keeping patients engaged with their HIV provider. Services are provided for a period of 18 months following release from the correctional setting and retention in the program is quite high, with 89% completing 15 months of enrollment and 75% completing the entire 18-month program. Not surprisingly, reincarceration is the leading cause of early program termination. More than 83% of clients visited a medical provider at least once every 6 months while enrolled, and 98% of clients receive medical care within a month of leaving prison. Of those who completed the program, 93% remained in medical care 6 months later.

CONCLUSION

A substantial number of persons infected with HIV pass through jail or prison. Linking them back to services in the community upon release is complex and challenging. This transition can be successful if there is communication between correctional and community providers, if transition planning starts prior to release with the aid of a case manager or social worker, and if concurrent needs, such as addiction, are addressed. Successful linkage to care ultimately leads to less HIV-related morbidity and mortality for the recently released patients and decreased HIV transmission within the community to which they return.

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References

Addressing HIV/AIDS in US Correctional Facilities

1. [Understanding Transmission Patterns and Strategies to Reduce Harm Within Correctional Facilities](#)
2. [Designing Effective Antiretroviral Therapy Regimens for Incarcerated Patients](#)
3. **Crossing Bridges: Transitioning HIV Care From Corrections Into the Community**

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