

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

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

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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

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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.

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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.