Transitional Care Programs Needed in U.S. Jails and Prisons

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Substantially more needs to be done to transition incarcerated people living with HIV into supportive health care services upon release from jails and prisons in the United States, according to a comprehensive review and analysis of available data published in the September 1 issue of *Clinical Infectious Diseases*.

According to Sandra Springer, MD, of the AIDS Program at Yale University School of Medicine and her colleagues, five distinct factors need to be addressed to improve outcomes among prisoners reentering the community: pre- and post-release case management, continuation of antiretroviral (ARV) therapy, treatment of substance use disorders, continuation of mental illness treatment and reduction of behaviors associated with the ongoing transmission of HIV.

Nearly 10 million people are released from incarceration every year in the United States—8.6 million people are transiently held in jails during criminal justice proceedings, and 597,000 are paroled from prisons after completing sentences. “The sheer magnitude of the incarcerated population and the disproportionate prevalence of HIV infection and acquired immune deficiency syndrome (AIDS) within the criminal justice system (CJS),” Springer and her colleagues write, “result in 16.9 percent of all HIV-infected individuals in the U.S. being within the CJS annually.”

An upswing in initiatives focusing on testing incarcerated individuals for HIV and linking those found to be positive for HIV to care and treatment has helped reduce AIDS-related death rates in the United States. However, Springer explains, “released prisoners infected with HIV not only continue to experience increased HIV-related mortality but have worsened HIV treatment outcomes, represented by increases in [viral loads] and decreases in CD4+ [counts].”

Not only would transitional programs that fully support continuity of care and ARV treatment benefit the people living with HIV being released from jails and prisons, but the programs would also have the potential to decrease the possibility of ongoing transmission of the virus. And while transitional programs do exist, Springer and her colleagues demonstrate, a great number of missed opportunities remain.

Take case management services, for example. These are currently the mainstay of prisoner-release programs for inmates living with HIV—but much less so for individuals held temporarily in jails while awaiting court appearances. The services aim to provide a seamless system of care,

reduce recidivism, maintain overall health and avert drug use. Yet, according to the authors, it's still not clear how much case management is required to maximize results—studies are needed to address this unanswered question. What's more, many prisoners lose medical and social entitlements upon incarceration and are ineligible to reapply until released, often leaving a considerable gap in the provision of care until entitlements are restored.

Even under the best of circumstances, however, case management services alone appear to be insufficient, because they are often unable to effectively address the multiple complex needs that are often required to ensure successful transition after release from prison.

According to the report by Springer's group, prisoners also face obstacles maintaining adherence to ARV therapy after release, particularly after having received compulsory medical care and adherence guidance (for example, directly observed therapy) during incarceration. After prisoners reenter the community, factors such as insufficiently treated substance use and/or psychiatric disorders, homelessness, unemployment, complicated ARV regimens and multiple health problems can lead to poor adherence of a prescribed regimen or discontinuation of therapy altogether.

Though adherence counseling strategies have been shown to change patients' knowledge, attitudes and beliefs about medical treatment and to improve their adherence to ARV regimens, studies have not determined the best possible programs for individuals released from prisons. While continuation of directly observed therapy (DOT) has been shown to be effective among released prisoners—it's the only adherence intervention to be explored thus far in well-designed trials—the costs of bringing DOT programs to scale may be prohibitive.

Community re-entry programs are also needed for formerly incarcerated individuals with substance abuse and mental illness disorders, as both have been independently linked to decreased ARV treatment adherence. More than 80 percent of prisoners living with HIV had substance use disorders before incarceration, Springer's group explains. In addition, an estimated 56 percent of state prisoners, 45 percent of federal prisoners and 64 percent of local jail inmates self-report having mental illness. After release, only 46 percent to 69 percent were eventually treated.

Multiple interventions aimed at addressing these issues have been identified and may work best when used together. According to Springer's group, multi-pronged approaches to substance use and mental illness need to be introduced during incarceration and as part of comprehensive release programs to help foster HIV treatment adherence while transitioning back into the community.

Finally, more needs to be done to identify prisoners living with HIV and to test and treat incarcerated individuals with other sexually transmitted infections (STIs). Despite the availability of rapid assays, many HIV-positive individuals continue to pass through jails without learning their HIV and other STI infection statuses because of logistical, financial and legal constraints.

In conclusion, Springer's group notes, the many challenges facing prisoners living with HIV as they

reenter the community have been identified. What's needed now, particularly with so many public health programs beginning to focus intently on retention in care to ensure health outcomes, are efforts to overcome these obstacles in jails and prisons. "Although uniform structural approaches may overcome some barriers, effective programs will require integrated approaches and individualized treatment plans," the authors write. "Existing community resources are insufficient to address these complex needs. Innovative solutions are urgently needed that involve partnerships between all existing stakeholders, including individual inmates, the CJS and communities, to overcome existing impediments."

To read more about the need for transitional care for people living with HIV released from prison, see POZ*'s "Hard Return," featured in the January/February 2010 issue of the magazine.*

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