HIV Care: Bridging the Gap from the Correctional to the Community Setting

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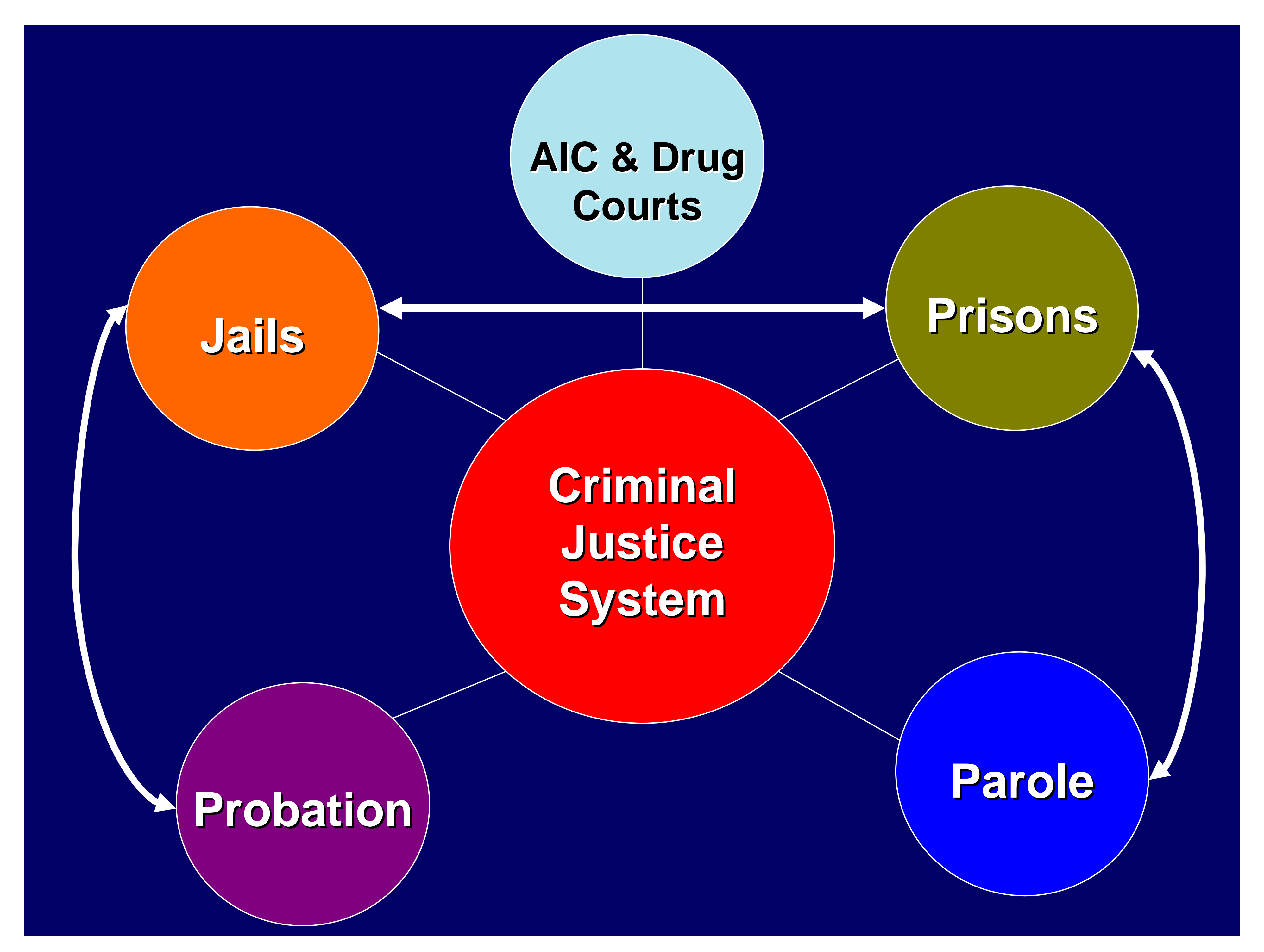
Why Should We Get This Right?

- 10 million individuals at high risk for HIV are released from the U.S. correctional system each year
  - 26% of all HIV+s in US go through correctional system
- Transition from prison is extremely hard irrespective of HIV disease
- Most prisoners do extremely well with HIV treatment in correctional facilities
- HIV disease is different, particularly if improperly managed after release:
  - Decreased access to and adherence with HIV care and HAART after release
  - High medical, psychiatric and substance use co-morbidities
  - Increased HIV risk-taking behavior
  - Increased costs to the individual, health care system and society if not adequately addressed

Barriers to Effective Transitional Care

- Societal factors
  - Attitudes
  - Costs
- System factors
  - Correctional health care system
  - Community health care system
- Individual factors


AIC & Drug Courts
Jails
Prisons
Criminal Justice System
Probation
Parole

Creating a Continuum of Care

Probation

Prisons

Parole

Communication

AIC/Drug Courts

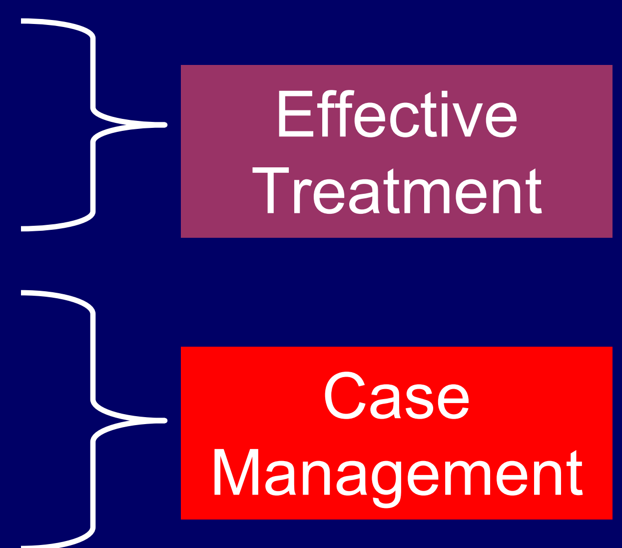
Intake Centers

Pre-Release Centers

Transition Programs

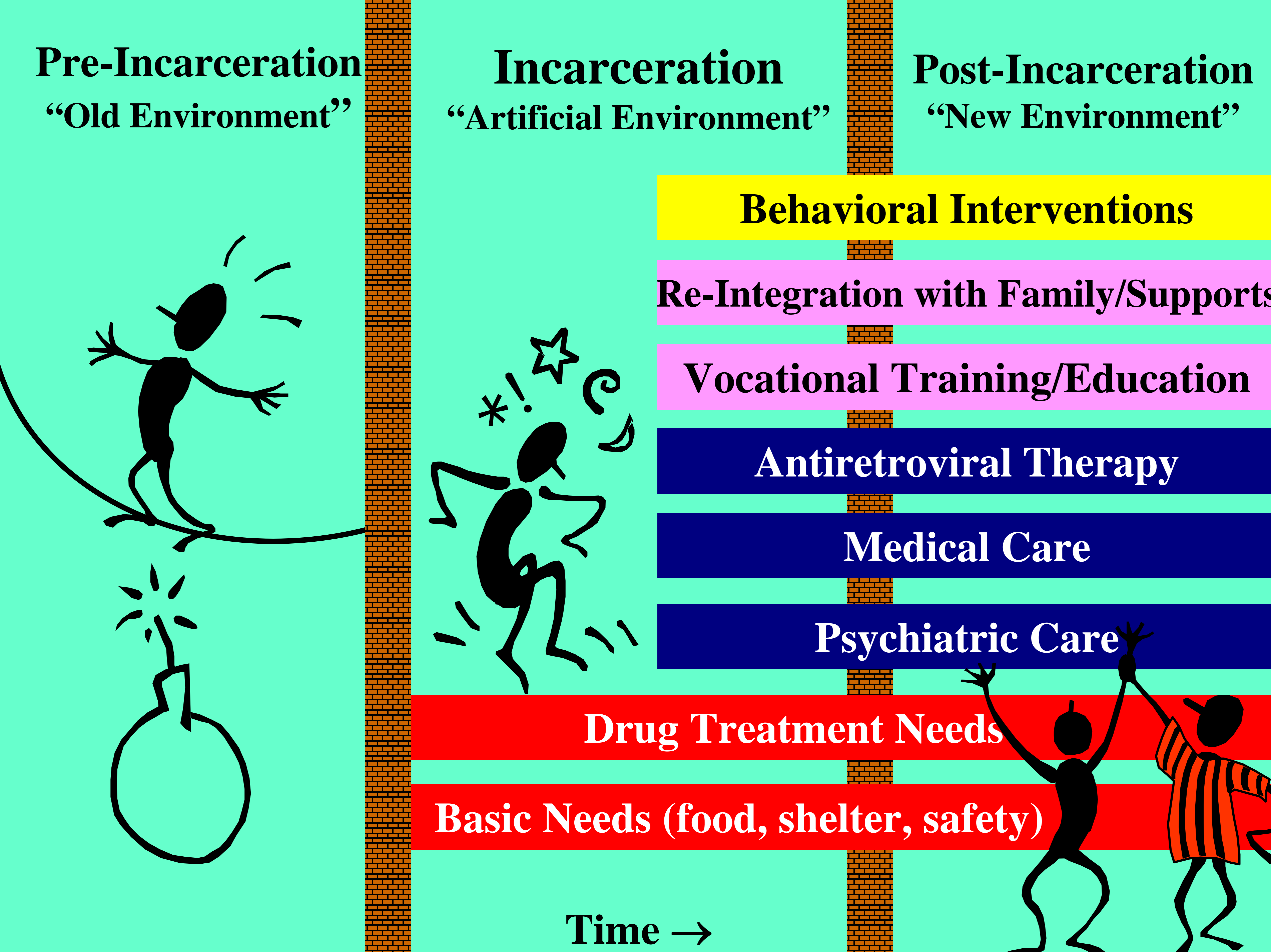
What do HIV+ Prisoners Face?

- High medical co-morbidity
  - Substance use disorder
  - Mental illness
- Social destabilization
  - Homelessness
  - Lack of social/medical entitlements
  - Unemployment
- Ineffective drug treatment
  - Within prison
  - Decreased access after release
- Unhealthy relationships
  - Interpersonal
  - Fragmented health care system (access and utilization)
  - Criminal justice system (probation, parole)



Hierarchy of Needs

Basic Needs


Pre-Incarceration
"Old Environment"
Incarceration
"Artificial Environment"
Post-Incarceration
"New Environment"
Behavioral Interventions
Re-Integration with Family/Supports
Vocational Training/Education
Antiretroviral Therapy
Medical Care
Psychiatric Care
Drug Treatment Needs
Basic Needs (food, shelter, safety)
Time →

Special Issues in Prisons vs. Jails

- **Jails**
  - Short-term facilities (peak at 3 days and 42 days)
  - Located close to community from where prisoner lives
  - Poses obstacles to screening, prevention and treatment
  - Often chaotic with large numbers of admissions and court dates
- **Prisons**
  - Houses inmates with sentences >1-2 years
  - Located remotely from urban centers
  - More amenable for screening, prevention and treatment
  - Multiple inter-institutional transfers (continuity)

Probation and Parole

- Large proportion of individuals within criminal justice system
- Case load often too great to develop effective interventions
- Interventions tend to be coercive in nature, but often are successful during the period of supervision
- Professional staff often not equipped to handle complex issues faced by clientele
- Lack of emphasis on integration with other services

Can we be more effective at diagnosing HIV?

HIV Testing in Correctional Institutions: Evaluating Existing Strategies, Setting New Standards

Sanjay Basu, Duncan Smith-Rohrberg, Sarah Hanck, and Frederick L. Altice

- Logistics (jails vs. prisons)
- Mandatory, routine & voluntary testing
- Rapid vs. standard testing
- Ability to link to care
- Timing of testing (intake, pre-release)
- Ethical considerations
  - Beneficence (do good, avoid evil)
  - Non-maleficence (do no harm)
  - Respect for autonomy (self-determination)
  - Distributive justice (societal needs align with the individual)

AIDS Public Policy Journal, 2005

Comparison of point-of-care rapid HIV testing in three clinical venues

Sabrina R. Kendrick[a,b,c], Karen A. Kroc[a], Eileen Couture[b] and Robert A. Weinstein[a,b,c]

- Only 70% deemed eligible (SUD or MI)
- Acceptance of testing 43%
- Follow-up HIV care (22%)

Feasibility and Acceptability of Rapid HIV Testing in Jail

CURT G. BECKWITH, M.D.,[1] SARAH ATUNAH-JAY, B.A.,[2] JONATHAN COHEN, M.D.,[3] GRACE MACALINO, Ph.D.,[4] MICHAEL POSHKUS, M.D.,[5] JOSIAH D. RICH, M.D., M.P.H.,[1] TIMOTHY P. FLANIGAN, M.D.,[1] and MICHELLE A. LALLY, M.D., M.Sc.[1]

- Unclear who was eligible for testing
- Acceptance of testing 88%
- Conducted in a system with longstanding routine HIV testing

Does HAART Work in Correctional Settings?

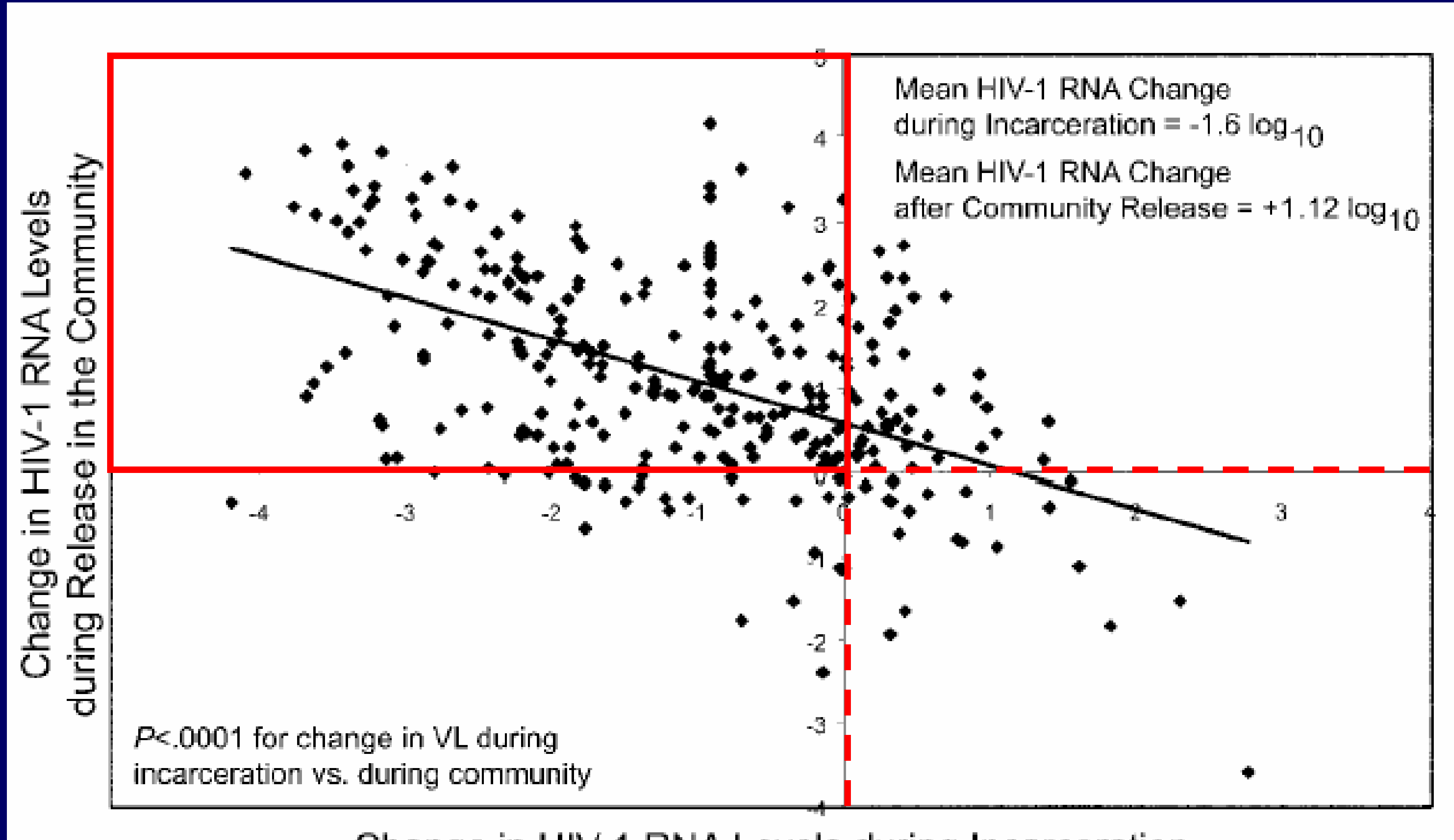
Trust and the Acceptance of and Adherence to Antiretroviral Therapy

Frederick L. Altice, Farzad Mostashari, and Gerald H. Friedland

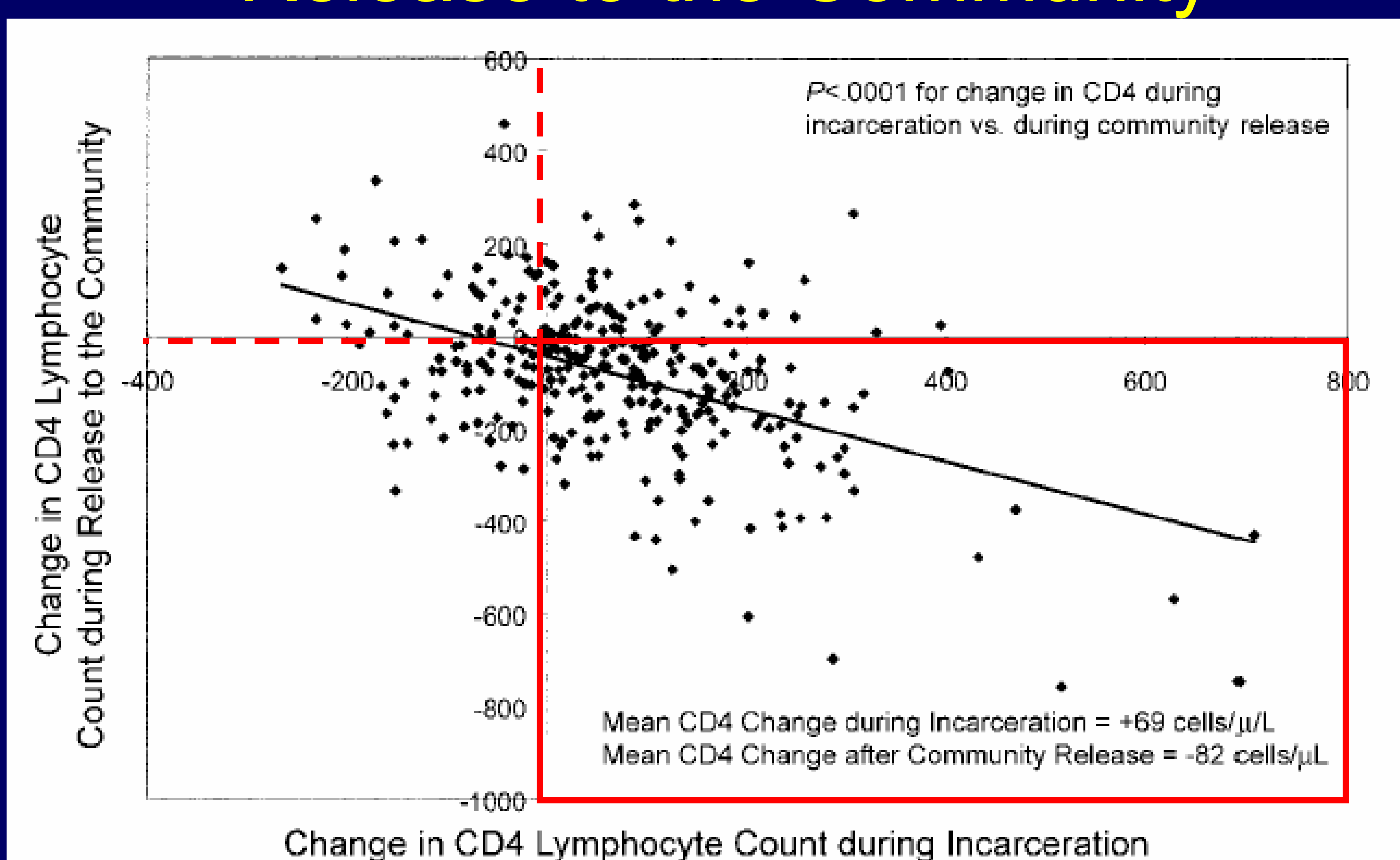
- Acceptance of ART = 80%
- Adherence with ART = 84%
- Determinants of acceptance and adherence are distinct
- Trust (physician and medication) remains key mediating factor in acceptance
- Side effects, complexity of regimen and social support key mediating factors in adherence

JAIDS 2001

Loss of Viral Suppression After Release to the Community



Loss of CD4 Count After Release to the Community



Why doesn't transitional case management alone work?

- Relapse to drug use (ineffective treatment)
- Discontinuation of treatment for mental illness
  - Inmates often stop treatment to be transferred to lower security facilities
  - Lack of integration of mental health treatment into release program
- Poor relationship with community health care system

What does work in the community setting?

Community-Based Examples of Evidence-Based Interventions

- Case Management
- Medication adherence
- Medical care
  - Pharmacotherapy for HIV and other conditions
  - Pharmacotherapy for mental illness
- Effective drug treatment
  - Opiate substitution therapy
  - Counseling (CBT, MET, 12 steps)
  - Therapeutic communities
- Contingency management

Adaptation for the Correctional Setting

- Formative research (individual, system)
- Change in intervention (content, dose, logistics)
- Manual development and refinement
- Feasibility and fidelity
- Efficacy $\rightarrow$ Effectivness
- Generalizability
- Replication

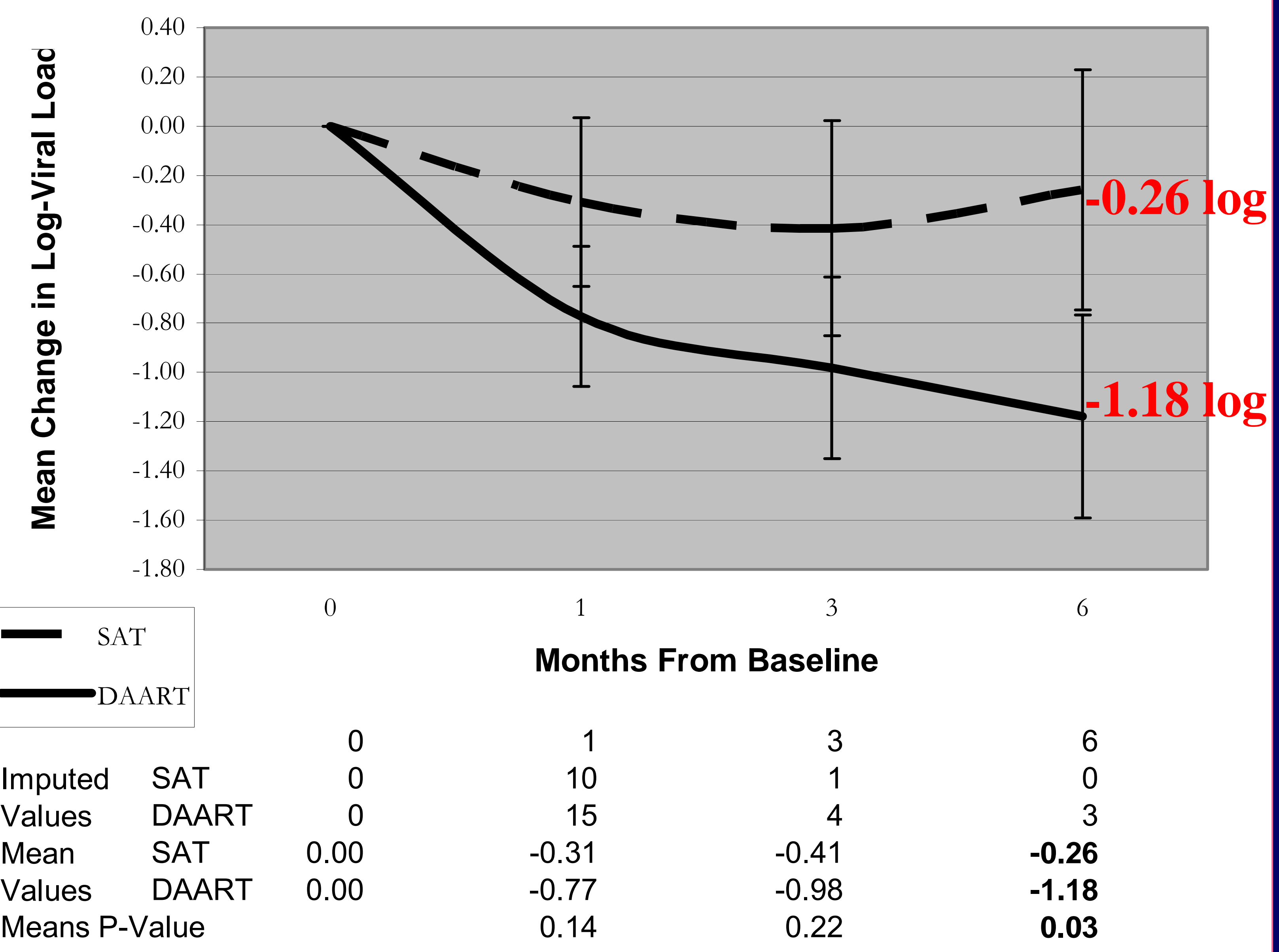
Community Collaborations

A Public Health Model to Connect Correctional Health Care With Communities

Thomas J. Conklin, MD, CCHP
Thomas Lincoln, MD
Timothy P. Flanigan, MD

- Hamden County jail
- Comprehensive health care approach
- Community health centers participate with provision of services
- Replication and evaluation underway through COCHS

Figure 3. Log-Viral Load by Treatment Arm

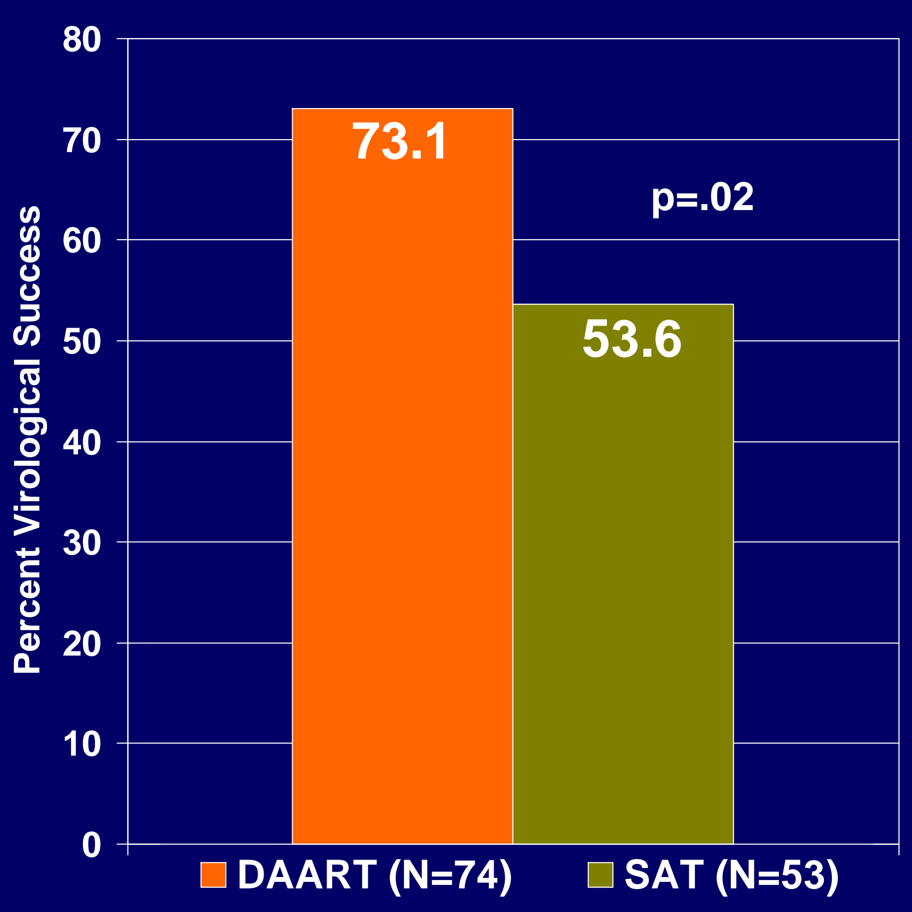


		0	1	3	6
Imputed	SAT	0	10	1	0
Values	DAART	0	15	4	3
Mean	SAT	0.00	-0.31	-0.41	**-0.26**
Values	DAART	0.00	-0.77	-0.98	**-1.18**
Means P-Value			0.14	0.22	**0.03**

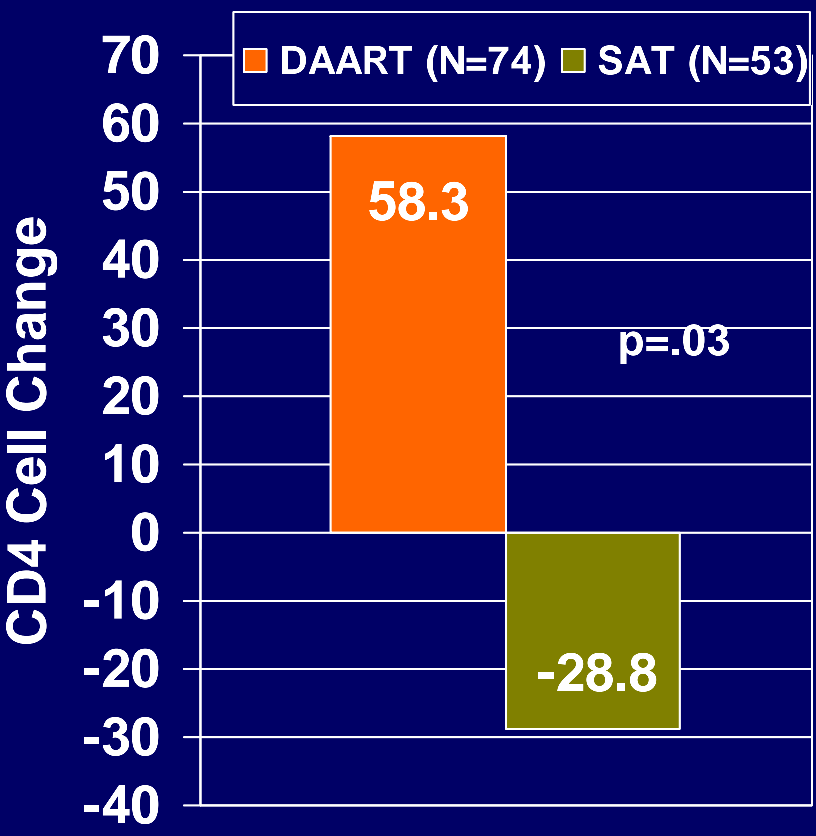
Note: Treatment means are adjusted for censoring; p-values are additionally adjusted for viral load at baseline

Primary Outcomes: Six Months

VL<400 or >1.0 log decrease



Change in CD4 Count



Evidence-Based Pharmacological Treatment

- Opioid Dependence
  - Methadone (pure opioid agonist)
  - Buprenorphine (partial opioid agonist)
  - Naltrexone (pure opioid antagonist)
- Alcohol Dependence
  - Naltrexone (oral, monthly IM injection)
  - Acamprosate (thrice daily)
  - Disulfuram (aversion therapy)

Drug Treatment and Correctional Linkages

- Jails
  - MMTP in NYC and Philadelphia
  - Pilot BPN in San Francisco and Connecticut
- Prisons
  - Pilot relapse prevention with MMTP in Rhode Island
  - Pilot relapse prevention with MMTP and BMTP in Connecticut with HIV+ inmates
- Probation
  - BMTP in Long Island

Problems With Opiate Substitution Therapy as Relapse Prevention

- Correctional obstacles
  - Believe forced abstinence is effective drug treatment
  - Lack of medicalization of drug treatment
  - Costs
- Inmate obstacles
  - “Drug-free” mantra
  - Prior “detox” experiences upon incarceration
- Community obstacles
  - Willingness to accept patients who are not “active”
  - Lack of treating providers (BMT, MMT)

Smith-Rohrberg, J Drug Issues, 2004

Trust and the Acceptance of and Adherence to Antiretroviral Therapy

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TABLE 4. *Health beliefs about antiretroviral therapy and illicit drug use*

Category	Number agreeing to comment (%)
Believes ART to be harmful when taken with heroin or cocaine	155/201 (77)
Believes ART to be harmful when taken with methadone	122/200 (61)
Will not take ART if planning to get "high" on "street" drugs	126/188 (67)
Has seen people get sick and die after starting ART	124/205 (60)
Has seen people get sick and die after stopping street drugs	120/205 (59)

[a] $p > .05$ for all comparisons of acceptance and adherence.

JAIDS, 2001

Project CONNECT

NIDA R01 DA 017059

Project BRIDGE

NIDA R21 DA 019843

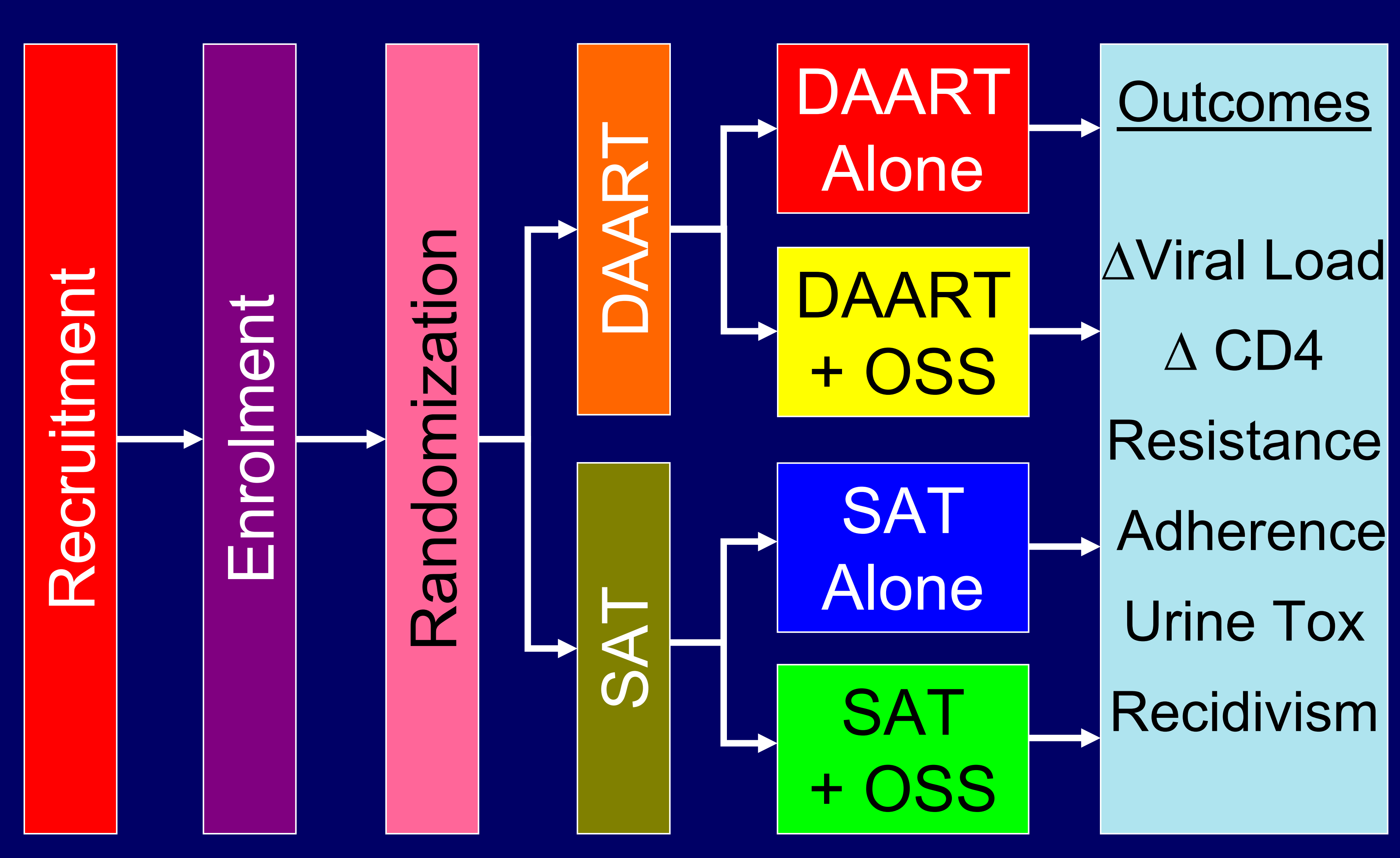
Project CONNECT

- Randomized controlled trial of DAART vs. SAT
- Eligibility criteria
  - HIV+
  - Eligible for and/or receiving HAART
  - Returning to New Haven or Hartford areas
  - Having served a sentence of ≥ 3 months
  - No pending court cases

Project CONNECT

- DAART is provided once-daily, seven days per week
- All prescriptions, including for other chronic conditions, are provided as DAART (co-morbidity is frequent)
- If meets DSM-IV criteria for opioid-dependence, will be offered MMT or BMT (patient preference) for relapse prevention
- All subjects receive standard case management services

Study Design: Project CONNECT



Considerations for Jails

- Rapid diagnosis and treatment
  - HIV
  - Substance use disorder
  - Mental illness
- Uniform database (??????)
- More intensive interventions for frequent flyers
  - Community-based involvement
  - Intensive case management (ACT, ACCESS adaptations
  - Opiate substitution therapy
  - Contingency management (e.g., Rep Payee)

HIV Prevention

Sexual behaviours of HIV-seropositive men and women following release from prison

Becky L Stephenson MD[1], David A Wohl MD[1], Rosemary McKaig MPH PhD[2], Carol E Golin MD[1], Lara Shain BSN MPH[1], Monica Adamian MPH[3], Cathy Emrick MPH[1], Ronald P Strauss DMD PhD[1], Cathie Fogel FNP PhD[1] and Andrew H Kaplan MD[1]

- Significant HIV risk behaviors before and after release
- High risk sex associated with use of alcohol and drugs
- HIV status disclosure associated only with a "primary" partner
- Post-release follow up relatively short

Project PLUS

NIDA (R21DA021093)

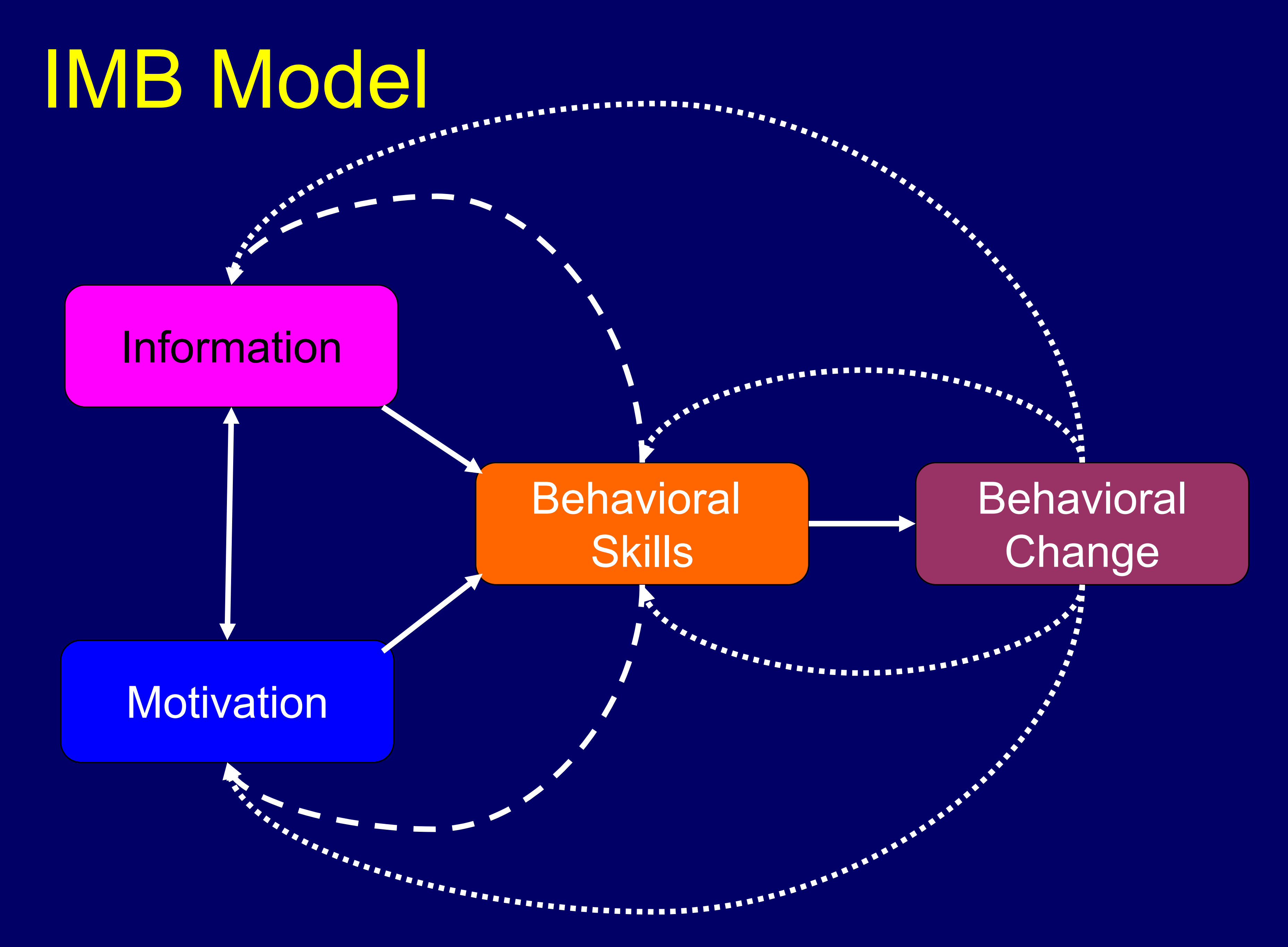
CDC (UR6PS000391)

Project PLUS

- Randomized controlled feasibility study of an evidence-based risk reduction intervention (HHRP) for HIV+ prisoners who are transitioning from the correctional to the community
- Subset of subjects linked to adherence intervention (CONNECT)
- “Healthy Transitions” intervention will be comprised of four manual-guided intervention modules with one booster session

Healthy Transitions Intervention

- Objective: enhance knowledge, motivation, and behavioral skills to prevent secondary HIV transmission risk
- 4 groups of 45-minutes each while incarcerated
- One 90-minute comprehensive “booster” group after release
- Targets: sex-risk, drug-risk and medication adherence behaviors

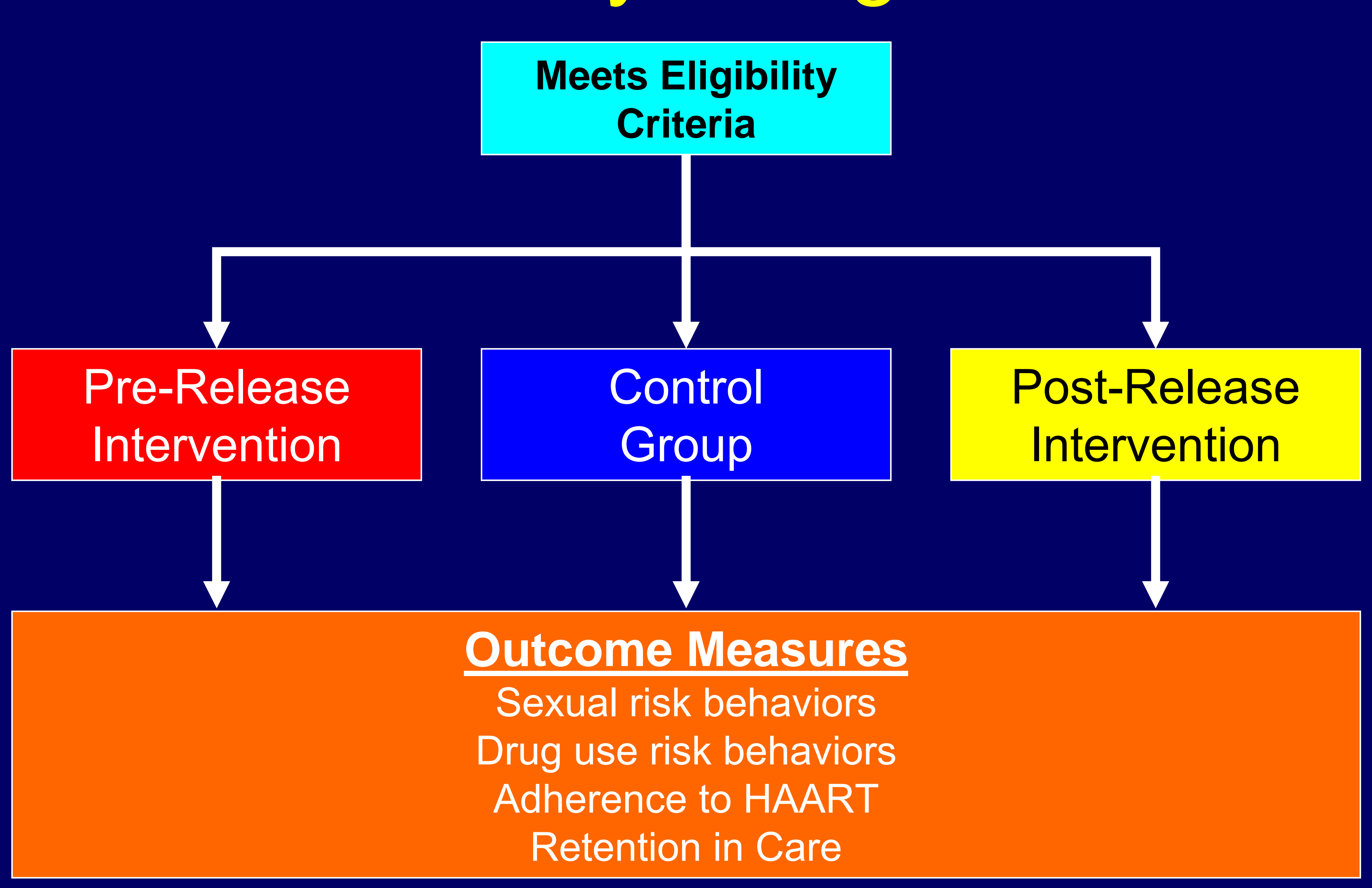

IMB Model
Information
Motivation
Behavioral
Skills
Behavioral
Change

Content of Intervention Groups

Group Topic	Information, Motivation, & Skills Taught
Active Health Care Participation	Understanding HIV And Your Immune System, Strategies for Improving Health, Developing a Partnership With Health Care Providers
Reducing Drug-related Risk	Identifying Drug-Related HIV-Risks, Learning About Proper Needle Cleaning, Managing Drug Cravings
Risk Reduction With Latex	Identifying Sex-Related HIV-Risks, Learning About Latex Products and Their Correct Use
Negotiating Risk Reduction With Partners	Negotiating Use of Latex, Communicating About Sex- and Drug-related HIV-Risk

Adapting Healthy Transitions to the Correctional Setting

- Timely referrals from correctional setting
- Demonstrations using:
  - Condoms (male and female)
  - Lubricants
  - Syringes and needles (? video or slides)
- Securing space for interviews and meetings (group vs. individuals sessions)
- Expediting process through DOC Research Committee
- Interviewing correctional and medical staff


Study Design
Meets Eligibility Criteria
Pre-Release Intervention
Control Group
Post-Release Intervention
Outcome Measures
Sexual risk behaviors
Drug use risk behaviors
Adherence to HAART
Retention in Care

Summary

- Correctional systems are an integral part of our public health system
- They are an important place to detect and initiate treatment (albeit with multiple challenges)
- Many evidence-based interventions are available, yet have not been adapted for and tested in correctional settings
- Effective and “fully integrated” community transitional programs are urgently needed to positively impact both treatment and prevention efforts

McPrison
A Million Sentenced!
A Million Sentences Served!
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Sentenced
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