RESIDENTIAL SUBSTANCE ABUSE TREATMENT (RSAT)

Training and Technical Assistance

RSAT Training Tool

Preventing, Detecting and Treating HIV/AIDS and Viral Hepatitis: Health Promotion and Risk/Harm Reduction in Substance Abuse Treatment

This project was supported by grant No. 2016-MU-BX-K021 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Point of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

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Table of Contents

Introduction 3

Why Learn About HIV/AIDS? 3

HIV/AIDS by the Numbers 4

Why HIV Testing Is Essential 5

Challenges and Threats on the Horizon 5

Relevance and Role of RSAT Programs 6

Resources and Additional References 7

Module I: HIV/AIDS in Correctional Treatment Settings 8

A. HIV/AIDS Basics: What Is It, How Is It Transmitted, and Who Is at Risk? 9

B. Context and Background: HIV Issues in Custody 12

C. Priorities for RSAT Staff 15

D. Resources and Review 19

Module II: HIV and Related Issues in Addiction Treatment 21

A. HIV/AIDS and Substance Use 22

B. Best Practices in Substance Abuse Treatment 25

C. Preparing RSAT Clients for Testing and Results 26

D. Viral Hepatitis and HCV Treatment 30

E. Resources and Review 32

Module III: Meeting the Needs of RSAT Clients Living with HIV/AIDS 35

A. HIV-Positive Individuals in Correctional Facilities 36

B. Supporting RSAT Clients with AIDS 40

C. Re-Entry and Continuity of Care 43

D. Resources and Review 47

References 49

Appendices 58

Introduction

RSAT staffs are hardly expected to be responsible for attending to all clients' medical issues in substance abuse treatment programs. However, they do play a significant role in promoting behavioral change, and that includes addressing health risk behaviors associated with substance use disorders. Correctional treatment programs provide a unique opportunity to educate participants about HIV and how they can modify high-risk drug use and sexual behaviors to remain HIV-free and/or reduce the risk of transmitting the infection to others. Addiction professionals have an important role in reducing the spread of HIV/AIDS and of viral hepatitis among clients in substance abuse treatment. Further, custody settings can provide a unique opportunity to detect and treat these infectious diseases. RSAT staff is in an ideal position to educate clients in long-term treatment programs about prevention, the benefits of testing and early identification, and the availability of treatment, if appropriate. RSAT staff can also offer support to clients diagnosed with serious health conditions so they can learn to cope, make informed choices about medical care, and take responsibility for protecting others from exposure.

RSAT programs serve a population at extremely high risk of HIV infection and at high risk of two forms of viral hepatitis B and C, which means RSAT programs can improve both public health and public safety through comprehensive treatment of substance use disorders. Ensuring RSAT clients are screened and tested for HIV and other infectious diseases and that they understand how to protect themselves, their partners and companions are all recommended components of addiction treatment.

Why Learn About HIV/AIDS?

The rate of HIV among sentenced individuals in custody is 5 to 7 times that of the general population and comprises about a quarter of all HIV-positive individuals in the United States (BJS, 2017). Although intravenous (IV) drug users are particularly vulnerable to HIV infection, other subgroups of incarcerated individuals that enter RSAT programs are also vulnerable, including men who have sex with men, African Americans, women, juveniles, and individuals who use cocaine and methamphetamine. RSAT clients living with HIV/AIDS need specialized care coordination while in custody and upon re-entry. RSAT programs can structure mechanisms for collaboration with medical care team members and expand their contacts with specialized community resources available to people who are at risk of contracting HIV/AIDS or who are living with HIV/AIDS.

Testing and risk reduction counseling in correctional settings has the potential to reach a high-risk population that might not otherwise learn of their HIV status, giving them an opportunity to access treatment. It also helps reduce the likelihood of infection by reaching at-risk individuals before they are infected and teaching them to modify high-risk behaviors. Identifying and reducing the spread of HIV among the incarcerated population helps reduce the spread of the infection among the general population.

The potential to reduce the spread of HIV/AIDS by intervening with individuals with substance use disorders when they become involved with the criminal justice system is so great that the National Institute on Drug Abuse (NIDA) launched a widescale research initiative to identify and treat this population (NIDA, 2010b). Its goals were to identify HIV-positive individuals in custody and ensure they received follow-up treatment upon release.

HIV/AIDS by the Numbers

At the end of 2015, an estimated 1.1 million people age 13 and older were living with HIV infection in the United States, including an estimated 162,500 (15%) of people whose infections had not been diagnosed. The 10 states with the highest number of infections are listed below. Most incarcerated individuals with HIV/AIDS are also in the states listed.

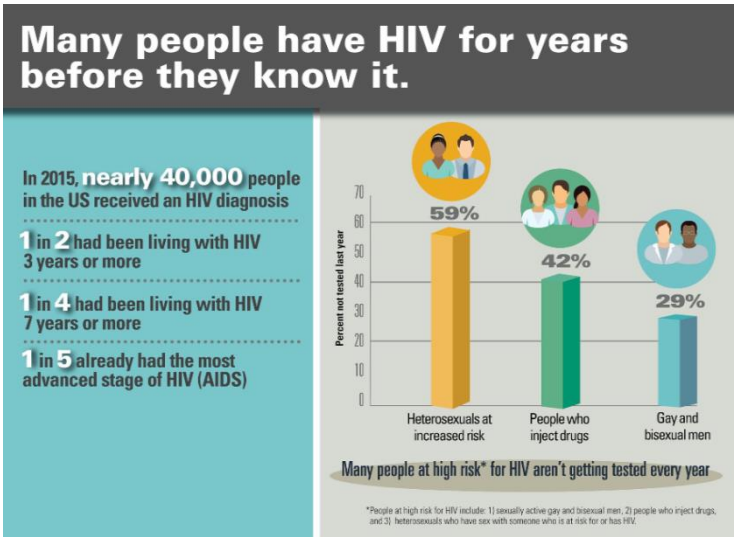
State/Dependent Area	Number of Diagnoses of HIV Infection, 2016
California	4,972
Florida	4,957
Texas	4,472
New York	2,877
Georgia	2,716
North Carolina	1,414
Illinois	1,391
Louisiana	1,153
Pennsylvania	1,152
New Jersey	1,146

In 2016, the number of new HIV diagnoses in the United States was 39,782. There were 32,131 diagnoses among adult and adolescent males (13 years or older), 7,529 among adult and adolescent females, and 122 among children younger than 13 years.[1]

[1] Centers for Disease Control and Prevention (CDC). (2017, November). *HIV surveillance report: Diagnoses of HIV infection in the United States and dependent areas,* 2016, vol. 28. Retrieved from http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html

Why HIV Testing Is Essential

As indicated above, it is crucial to identify infected individuals so they can receive treatment and to prevent the spread of infection to others. It is important to identify HIV infections as soon as possible. Unfortunately, about half of patients with HIV who go on to develop AIDS and serious medical complications do so within one year of learning of their HIV status (CDC, 2011). It is estimated that of the one million plus people in the U.S. infected with HIV, about a quarter of them are not aware of it (National HIV/AIDS Strategy, 2010). For the last decade, the number of new infections each year in the U.S. has remained fairly stable, but the more unidentified cases of HIV there are, the greater the chances of transmission.



As the graphic from the Centers for Disease Control and Prevention (CDC) illustrates, many of these individuals are not tested for HIV until they are at an advanced stage of the disease. Their grave condition is almost completely preventable. Advances in the treatment of HIV/AIDS have made early detection critically important. New antiretroviral therapies can reduce the likelihood of transmission, extend life, and delay the onset of AIDS-related health problems, perhaps indefinitely for many. If individuals who detect their infection early adhere to a course of antiretroviral treatment and receive the specialized services they need, such as drug and alcohol treatment, they can remain healthy for decades.

The CDC recommends HIV testing for individuals entering correctional facilities, during incarceration, and just prior to release. CDC guidelines, *HIV Testing Guidance for Correctional Facilities*, also recommend medical treatment and education about HIV risk behaviors. As will be discussed, HIV prevention education should address male-to-male sex, tattooing, injection drug use, and other high-risk behaviors that can occur during and after incarceration.

Challenges and Threats on the Horizon

The opioid epidemic, including the resurgence of heroin as people who become addicted to pain medication find it easier and cheaper to switch to heroin, is threatening to increase infectious diseases, including HIV and hepatitis. In May of 2017, the director of the U.S. Department of Health and Human Services (HHS) Office of HIV/AIDS and Infectious Disease Policy commented on new CDC data that showed new HCV infections nearly tripled in the past 5 years, largely as a result of opioid-related injection drug use. He cautioned that the "current situation threatens to become a perfect storm, with the opioid, HIV, and viral hepatitis epidemics intersecting in dangerous ways."[2]

[2] Wolitski, R. (2017, May 17). *Interconnected, intertwined, and colliding: Co-occurring epidemics of HIV, viral hepatitis, and opioids* [blog post]. Washington, DC: U.S. Department of Health and Human Services. Retrieved from https://www.hiv.gov/blog/co-occurring-epidemics-of-hiv-viral-hepatitis-and-opioids

The rate of hepatitis C infection (HCV) among people with substance use disorders and among the custody population is staggering. This manual includes an expanded section that discusses recent advances in HCV treatment, preventing and reducing HCV transmission in custody, and how correctional systems are dealing with the challenge of meeting the healthcare needs of individuals in custody with HCV given the fiscal constraints they operate under.

The Drug Enforcement Administration's (DEA) 2016 *Threat Report* states: "Over the past 10 years, the drug landscape in the United States has shifted, with the tripartite opioid threat (controlled prescription drugs, fentanyl, and heroin) having risen to epidemic levels, impacting significant portions of the United States." It goes on to indicate that the size of the heroin-using population is increasing aggressively, and overdose deaths continue to rise. Pharmaceutically manufactured fentanyl, once diverted from the market for illicit use on a small scale, is now manufactured in labs in Mexico or China and then smuggled into the United States, where it is often mixed with heroin and other drugs with deadly consequences.

In addition to numbers in need of testing, the rapid turnover in jails makes testing challenging since many people are released in fewer than 72 hours. In 2010, a study conducted in New York City jails found that 28% of HIV-positive individuals had not been diagnosed at the time of intake. Also, studies have shown that even though there has been a fourfold increase in HIV testing in jails, the rate of acceptance when testing is offered is still low (Begier et al., 2010).

Relevance and Role of RSAT Programs

Substance abuse multiplies a person's risk of HIV infection nearly 12 times and negatively impacts HIV/AIDS outcomes and (CSAT, 2000). Best practices in community-based substance abuse treatment include HIV testing, prevention education, and risk reduction counseling. The adverse impact of untreated substance use disorders on the criminal justice system and the prevalence of HIV among incarcerated populations make it even more critical to integrate HIV testing and prevention education into RSAT programs. Because RSAT programs are long-term, they afford opportunities to work with participants and to offer prevention education and risk reduction counseling, as well as support for those learning of their status and those in need of HIV treatment.

This manual provides RSAT staff with the information they will need to participate in a team approach to prevention education aimed at reducing the risk of HIV transmission and supporting individuals with HIV. RSAT staff can help familiarize people with testing procedures, explain the benefits of knowing their HIV status, and support care coordination for HIV-positive individuals re-entering communities.

This manual emphasizes the role community-based HIV programs can play in supporting the re-entry population. HIV prevention programs are also key partners in reducing the combined threats of opioid overdose, injection drug use, and HCV. Many offer testing to justice populations as well as in-reach programs for HIV-positive individuals in custody. They are experienced providers of harm reduction services. Strengthening relationships with these programs can offer resources to RSAT staff and services to RSAT participants. The updated edition contains the most current information on the prevalence of HIV/AIDS and related epidemiological data pertaining to the general population and correctional populations, which are footnoted for convenience. New information on best practices and an expanded section pertaining to viral hepatitis among correctional populations have been added. The reference pages list all sources used to develop the original manual as well as the updated edition.

Resources and Additional References

The Centers for Disease Control and Prevention. (2017). *HIV Surveillance Report: Diagnoses of Infections in the US and Dependent Territories*, 2016 vol. 28.

The Centers for Disease Control and Prevention. (2009). *HIV Testing Guidance for Correctional Facilities*.

The Centers for Disease Control and Prevention. (2017, May 11). *CDC Hepatitis Surveillance Report: New Hepatitis C Infections Nearly Tripled Over Five Years*.

U.S. Department of Justice Drug Enforcement Administration. (2016, November). 2016 National Drug Threat Assessment: Summary.

Module I: HIV/AIDS in Correctional Treatment Settings

A. HIV/AIDS Basics

B. Context and Background: HIV Issues in Custody

C. Priorities for RSAT Staff

D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

- Define HIV and two symptoms that indicate progression into AIDS,
- Explain three ways HIV can be transmitted and give one example of casual contact that does not result in transmission,
- Discuss the prevalence of HIV/AIDS among incarcerated populations and name two factors that place them at increased risk of HIV infection, and
- List three advantages of HIV testing and prevention education for RSAT clients.

Knowledge Assessment Pre-Test

True/False Questions

1. The overall prevalence of HIV infection among individuals in U.S. correctional facilities is more than five times higher than in the general population.
2. At least one out of every four HIV-positive people in the United States has been in a correctional facility at some point in their life.
3. There are clear guidelines and uniform standards for HIV testing in jails and prisons.
4. HIV is the known cause of one type of AIDS, but the cause of other types of AIDS is unknown.
5. If someone who is HIV positive spits on a staff member and the saliva comes into contact with skin, it is not considered an exposure because there is no risk of HIV infection.
6. The above staff member should take a protective course of antiretroviral medication to be completely safe and prevent HIV transmission.

(answers at the end of this module)

A. HIV/AIDS Basics: What Is It, How Is It Transmitted, and Who Is at Risk?

Before we learn more about HIV prevention and testing in substance abuse treatment and correctional settings, it is important to understand the basics of HIV/AIDS, the ways it is transmitted, and the latest recommendations and guidelines for intervening. First, some definitions and basics.

Human Immunodeficiency Virus Type 1 (HIV-1)*:* HIV is the retrovirus isolated and recognized as the cause of AIDS. HIV-1 is by far the most common cause of AIDS worldwide and the major virus type. Generally, when people refer to HIV without specifying the type of virus, they are referring to HIV-1. Infection results in the virus inserting its own RNA into the host cell's DNA, preventing the host cell from carrying out its natural functions and turning it into an HIV factory.

Human Immunodeficiency Virus Type 2 (HIV-2): This is a relatively uncommon virus concentrated in West Africa and is rarely found elsewhere. HIV-2 is closely related to HIV-1 and is transmitted the same way, resulting in similar opportunistic infections.

Acquired Immunodeficiency Syndrome (AIDS)*:* Usually, a person is diagnosed with AIDS once the virus has attached to the immune system and weakened it, resulting in one or more serious illness such an AIDS-related cancer or an opportunistic infection like pneumocystis pneumonia. The CDC lists numerous infections and health conditions that constitute an AIDS diagnosis when they occur in the presence of HIV infection. AIDS is also defined by the degree of immunodeficiency in an HIV-infected individual. This occurs when the number of immune system cells (CD4 cells) in the blood of an HIV-positive person drops below a certain level (under 200 per cubic millimeter of blood or less than 14% of all lymphocytes).

Types of HIV Tests: Screening (Conventional and Rapid) and Confirmatory Tests

Two types of tests are required when diagnosing HIV: a *screening test* and a *confirmatory test*.

1. Conventional screening tests

ELISA antibody test: Looks for HIV antibodies in the patient's blood. A patient's serum is placed in contact with particles of HIV in the presence of an indicating substance. If there are any HIV antibodies in the serum, they will bind to the HIV particles and cause the serum to change color. **If the ELISA test is positive, the laboratory will automatically perform a second confirmatory test.**

2. Rapid screening tests

Rapid tests are similar to the standard ELISA test in that they look for antibodies to HIV in the patient's blood. They are called rapid because the results are available within an hour or less. Results of the rapid test are very accurate—as accurate as conventional tests—but a confirmatory test is required when results are positive. **If a rapid test is positive, it MUST be followed up with a confirmatory test.**

1. Western blot (WB) confirmatory tests

This is the most widely used confirmatory test. It uses an electrophoretic technique that separates out specific HIV particles, or antigens. On rare occasion, the WB will yield an indeterminate result if the exposure was very recent (i.e., within the last 3 months).

2. *Immunofluorescence antibody (IFA) confirmatory tests*

Infected HIV cells are fixed to a microscope slide. Serum with HIV antibodies is added and allowed to react with the HIV. A fluorescent label will light up the slide if the sample is HIV positive.

Conventional Versus Rapid Testing

Conventional HIV tests use the ELISA test and then labs automatically follow it with the WB or IFA to confirm the diagnosis of HIV infection. These tests can take up to a week to complete. Rapid testing is well-suited to jail settings because patients can receive their results right away (CDC, 2010b). This is particularly important among jail populations held before trial when they may be released in a matter of days.

How should rapid HIV test results be interpreted?

Any positive rapid test result MUST be followed with a confirmatory test. A positive HIV rapid test ***usually*** means the patient most likely is HIV positive. Part of the likelihood that a patient testing positive on a rapid test is truly infected with HIV is calculated based on how common HIV is in the community. In a population with a high HIV prevalence, a positive rapid test result is likely to be a true positive, but in a population with a low HIV prevalence, a false positive is possible.

A *patient who receives a negative rapid HIV test result is almost assuredly not infected, barring a very recent exposure (risky sexual contact or needle-sharing with an infected person within 3 months prior to the test date).* A patient with a history of recent HIV risk behaviors or possible exposures should have a repeat test within 3 to 6 months.

HIV Transmission

There are five common ways that people become infected with HIV:

1. Having sexual intercourse with an infected partner;
2. Using a syringe or sharing other drug injecting equipment with someone who is infected with HIV;
3. Mother-to-child transmission can occur during pregnancy, labor/delivery, or through breastfeeding; and
4. Receiving a transfusion, blood product, or organ transplant from an infected individual.
5. Healthcare professionals can also become infected through needle sticks or other exposures to HIV-contaminated products they handle under certain circumstances.

Exercise 1: Modes of Transmission

Please place the number (1–5) mode of transmission listed above next to the corresponding prevention measure below that it pertains to.

_____ *United States has seen a 95% decrease in this mode of transmission since 1992, when doctors began giving antiretroviral drugs to pregnant women.*

_____ *Using a new syringe and never sharing drug injecting equipment are precautionary measures, although procedures for disinfecting syringes may be a "last resort."*

_____ *Proper and consistent use of a latex condom is effective.*

_____ *In 1985, most sources declared the blood supply was safe due the new testing procedures that had been put into place.*

_____ *All victims of sexual assault should be evaluated for post-exposure prophylaxis (PEP) when they disclose a recent attack to a medical provider or any other professional.*

_____ *Once a suspected exposure is evaluated for risk, medical staff can begin PEP right away, which consists of a course of antiretroviral drugs to reduce the likelihood of HIV infection.*

_____ *Uninfected persons who have HIV-positive sexual partners and/or know they will be in situations where exposure to HIV infection is likely can take antiretroviral drugs in advance to reduce the likelihood of transmission (pre-exposure prophylaxis or PrEP).*

(answers at the end of this module)

Exposure and Infection

It is important to understand that for HIV to spread, it must be passed directly from one infected person to another person. Fortunately, HIV, unlike some other viruses, cannot survive outside the host. It is completely dependent on human tissue to survive and can only be transmitted through specific types of person-to-person contact. This is important to keep in mind when working in an institutional setting. HIV exposure from casual contact is extremely unlikely. Exposure fears of both staff and incarcerated individuals cannot be discounted completely, but they can be reduced by providing accurate information and distinguishing high-risk from no-risk situations.

In general, HIV transmission requires a combination of conditions:

- A specific body fluid must serve as the vehicle transporting the virus;
- The fluid must contain a sufficient quantity of the virus;
- The virus must have a means of entering the bloodstream and/or lymph system; and
- The infected body fluid must enter the bloodstream and/or lymph system within a very brief period after it leaves an infected person's body.

Most people in the U.S. who were infected through the blood-to-blood transmission route used a syringe or other drug delivery equipment that was used by someone infected with HIV. It is theoretically possible to transmit HIV with equipment used to tattoo or pierce if it were to have residual blood from an HIV-infected individual and was used on another person immediately. Although there are no documented cases of this type of transmission in the community, in a prison setting, makeshift tattooing equipment presents a significant health risk because it is far more likely to contribute to the spread of hepatitis C (HCV). RSAT clients should be advised of the risk. More information about viral hepatitis and other infections that sometimes occur in combination with HIV is included in Module II.

HIV has been isolated in virtually every body fluid that contains white blood cells. However, the quantity of virus in some of these fluids is not sufficient to pose a risk of HIV transmission. Epidemiological studies have repeatedly demonstrated that person-to-person transmission occurs through blood, semen, vaginal and cervical secretions, and breast milk.

The data has consistently failed to implicate other body fluids as a risk, including cerebrospinal fluid, amniotic fluid, bronchial secretions, urine, tears, or saliva.

Sexual Transmission

The most efficient means of HIV transmission is through blood-to-blood contact. Certain types of sexual intercourse (defined as the penetration of the penis of one partner into the rectum or vagina of the other partner) are also high-risk. They create the conditions necessary for HIV transmission in both male-to-male and heterosexual anal and vaginal intercourse.

The highest risk sexual behavior is being on the receiving end of anal sex, whether the receiving partner is male or female. Since anal intercourse involves excessive stress to the rectum and anus, there is sometimes tearing of these tissues. Women who engage in anal sex with a male partner infected with HIV/AIDS may be at particularly high risk of transmission. This is because women rarely use condoms during receptive anal sex. One study showed that less than a quarter of women use condoms during anal sex as opposed to nearly two-thirds of men who have sex with men (NYC Health, 2010).

Vaginal intercourse also carries a high risk of HIV transmission, especially for the female on the receiving end. A great deal of male and female sexual fluid is produced during vaginal intercourse. The large areas of mucous membrane that are exposed in the vaginal area place women at twice the risk of HIV exposure/transmission during heterosexual vaginal intercourse versus men. Although there are documented cases of HIV transmission through oral sex, it is not considered a high-risk behavior. However, the presence of sores or lesions in the mouth or on the gums can increase the risk.

If it is a nonconsensual situation, forced sex, or sexual assault, especially involving more than one perpetrator, the risk of exposure is heightened due to the tearing and bleeding that can occur. This is often true in cases of prison sexual assault. Testing for HIV is part of the follow-up forensic medical examination for victims of a sexual assault (and for any identified assailants). If the assault is recent, victims should be evaluated for and offered post-exposure prophylaxis by the medical staff responsible for their forensic examination, as appropriate (National Prison Rape Elimination Commission, 2009).

HIV testing should be offered to all victims of sexual assault, no matter when the assault is reported or where it took place.

Post-exposure prophylaxis (PEP) is a short course of antiretroviral medication given right after a suspected exposure to HIV. This minimizes the chances of infection. Health workers and staff exposed to contaminated body fluids are usually evaluated to see if they should be given a course of PEP. Current Bureau of Prisons (BOP) guidelines for staff exposures are included in the resources listed at the end of this module.

When discussing ways to reduce the risk of sexual transmission (safer sex) as part of risk reduction counseling, especially with HIV-positive individuals, it is important to repeatedly emphasize the hierarchy of risk behaviors. HIV prevention programs use a harm reduction model. If individuals are aware of the behaviors that carry the highest risk of HIV transmission, they may be willing to avoid them. This can significantly reduce their level of risk, even if they do not abstain from every behavior that carries risk of HIV transmission.

B. Context and Background: HIV Issues in Custody

The rate of HIV among sentenced individuals in custody is 5 to 7 times that of the general population and comprises about a quarter of all HIV-positive individuals in the United States (BJS, 2017). A recent report, *HIV in Prisons, 2015*,[3] suggests that prevention and detection efforts within correctional systems are succeeding. The Bureau of Justice Statistics (BJS) report estimated that 17,150 state and federal prisoners were known to have HIV at the end of 2015. This is the lowest number of reported HIV-positive individuals in custody since they began tracking the HIV prevalence among the incarcerated population in 1991 (when there were 17,680 known cases).

[3] Maruschak, L. M., & Bronson, J. (2017, August 24). *HIV in Prisons, 2015*. Washington, DC: Bureau of Justice Statistics. Retrieved from https://www.bjs.gov/index.cfm?ty=pbdetail&iid=6026

Here are some additional facts the report revealed about individuals with HIV in prisons:

- Almost 93% of known cases of HIV in state prisons were among men.
- Most people were infected with the virus before entering a correctional facility.

Infection rates have declined among both men and women in prisons but have dropped faster among women (a 31% decrease as opposed to a 14% decrease among men). However, 5 years earlier, HIV prevalence was twice as high among women in state prisons compared to men.

AIDS-related deaths in state and federal prisons declined 16% for each of the years between 2010 and 2015 due to efforts to test and treat and due the advances in HIV/AIDS treatment.

Among jail populations:

- African American men were five times as likely as white men, and twice as likely as Hispanic/Latino men, to be diagnosed with HIV.
- African American women were more than twice as likely to be diagnosed with HIV as white or Hispanic/Latino women.[4]

These racial disparities in HIV infection rates mirror the disparities found among the general population, but they are more pronounced among the prison population and even greater among the jail population.

Current CDC guidelines for testing in community healthcare settings, which are also appropriate for testing in custody, are as follows:

1. HIV screening should be available for all patients ages 13–65 in all healthcare settings, after the patient is notified that testing will be performed, unless the patient declines (opt-out screening).
2. Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
3. Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in healthcare settings.
4. Persons at high risk of HIV infection should be screened for HIV at least annually.

In 2015, approximately 34% of those entering prison did so in states that conducted mandatory HIV testing upon intake. Another 31% entered in states that offered routine HIV testing during intake but gave people the option to decline (BJS, 2017). Some facilities only offer HIV testing to individuals who request it or test only those who have known HIV infection risk factors. These methods are not as likely to increase the proportion of individuals getting tested. In high-risk settings such as correctional facilities, routine, voluntary HIV testing has been shown to be cost-effective and clinically advantageous (Paltiel et al., 2005).

[4] Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. (2017, March 14). *HIV among incarcerated populations* [web page]. Retrieved from https://www.cdc.gov/hiv/group/correctional.html

The CDC's *HIV Testing Implementation Guidance for Correctional Settings* supports universal opt-out testing. (See the resources listed at the end of this module.) These guidelines are intended to help correctional institutions establish the most appropriate testing strategy for their settings. They present the components of effective testing programs and discuss common obstacles one may encounter during the implementation process. The National Commission on Correctional Health Care (NCCHC) also recommends routine universal HIV screening at intake.

Testing for HIV prior to re-entry is also a critical aspect of release planning and an important strategy for preventing HIV transmission. Studies have shown that when people find out they are HIV positive, they tend to take measures to reduce the risk of transmitting HIV to others. When re-entering individuals know their HIV status and how to prevent transmission, the result is increased public safety and public health (Pacific AIDS Education Center, 2008).

If individuals are not tested in prison or jail, research has also shown that re-entering men may avoid getting tested for HIV in the community (Kacanek et al., 2007). Some of the reasons they avoided HIV testing outside prison included lack of time, lack of resources, fear of knowing the results, or perceiving they were not at risk (MacGowan et al., 2006).

NCCHC Recommendations

The National Commission on Correctional Health Care (NCCHC) endorses the concept that medical management of HIV in correctional settings should parallel that offered in the community. "HIV screening is recommended for patients in all healthcare settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening). Consistent with CDC guidelines, NCCHC recommends that all pregnant women be tested for HIV and, if infected, given antiretroviral treatment to prevent transmission to the infant. Correctional administrators should make HIV education to women a priority and encourage them to be tested for HIV, especially if they are pregnant."

—NCCHC Administrative Management of HIV in Correctional Institutions

Transmission rates among those who do not know they are infected are 3.5 times higher than for people who know about their HIV infection.

Federal Bureau of Prisons (BOP) guidelines offer voluntary opt-out testing upon intake but mandate HIV testing for certain high-risk or symptomatic individuals. In 2016, BOP released *Management of HIV Infection*, *Federal Bureau of Prisons Clinical Guidance*. It should be noted that BOP policy includes the admonition that "All inmates tested for HIV infection should receive pre-test counseling from qualified healthcare personnel, in accordance with current BOP policy. Counseling should provide information on HIV transmission, methods for preventing the spread of the virus while in prison and upon release to the community, and the meaning of the test results."

The type of testing that people in custody are most likely to take advantage of is voluntary HIV testing routinely provided to everyone during the intake medical evaluation (Kavasery, Maru, & Sylla, 2009). This universal approach normalizes HIV testing, eliminates the onus on individuals to specifically request it, and reduces the potential stigma in custody environments that afford limited confidentiality (CDC, 2009).

RSAT staff members need to be armed with the facts, prepared to educate clients about prevention of HIV transmission, extol the benefits of testing, increase motivation to change high-risk behaviors, and provide support to those who may be living with HIV/AIDS.

However, HIV detection and AIDS treatment in correctional settings can be complex. Individuals in custody have a right to healthcare, but there are no enforceable standards, and healthcare policies and capacities in state prisons and in jails may vary. Confidentiality, costs, and continuity of care make HIV-related correctional health policy decisions challenging.

For example, some jails offer HIV testing to everyone as part of their routine medical intake procedure, but many are released before they receive the test results. Some prisons have had individuals who were diagnosed with AIDS begin treatment with antiretroviral medication (ATR) while incarcerated only to find that compliance was not possible upon release. This is a serious problem because receiving intermittent dosages of antiretroviral drugs, as well as discontinuing or habitually missing doses, poses many serious risks. It can cause HIV to mutate and create new strains of the virus that are medication-resistant. The benefits of initiating treatment while incarcerated must be weighed along with the risks, since these types of medication compliance issues are associated with increased risk of serious progression, severe complications, or death (Siegel & El-Sadr, 2006).

BOP HIV Testing Guidelines

Opt-out voluntary testing is offered to all designated inmates after arrival to the designated institution.

Voluntary testing is also done when the inmate requests testing via an *Inmate Request to Staff Member*. This voluntary testing is available to all inmates regardless of their sentencing or duration of stay.

Mandatory testing is performed when there are indications/risk factors and the test is clinically indicated and/or surveillance testing is required. Inmates must participate in mandatory HIV testing programs.

Involuntary testing is performed following an exposure incident. Written consent of the inmate *is not* required. If an inmate refuses testing, testing will be conducted in accordance with the *Program Statement on Use of Force*.

C. Priorities for RSAT Staff

Stigma, Confidentiality, and Discriminatory Practices

HIV and AIDS are associated with a high degree of stigma in both the general population and an even higher degree in prisons and jails. Individuals in custody may fear stigmatization from staff or others in custody, as well as institutional discrimination. Information is a valuable commodity in a custody setting, and people learn to guard personal information and hide anything that could increase their vulnerability. Men are motivated to hide their status because it may put them at increased risk of sexual or physical assault from other inmates because it may rightly or wrongly be assumed they are homosexual. This can put them at increased risk of physical assault, gang rape, sexual slavery, and HIV infection from forced or coerced unprotected sex (National Prison Rape Elimination Commission, 2009).

Past (or current) institutional discrimination against individuals with HIV and AIDS has included segregated housing units; exclusion from work sites, vocational programs, and prison jobs; and

exclusion from rehabilitation programming and recreation. These practices have been found to violate constitutional mandates. In 2004, Mississippi and Alabama's practices of discriminatory segregation of HIV-positive individuals in prisons were challenged and disallowed (Sylla, 2008).

It is important to note that segregation for purposes of exclusion is distinct from the practice of clustering people with AIDS for the purposes of providing intensive medical care to high-need patients. There are prison housing units in California, for example, where people living with AIDS are assigned so they can take advantage of medical resources and doctors who specialize in HIV/AIDS.

Confidentiality for HIV-positive individuals and people living with AIDS is extremely important but may be nearly impossible in some facilities even when staff is well-versed in confidentiality requirements and careful about disclosing medical information. In small jails and high-security prisons, maintaining medical confidentiality may be logistically impossible. "Med call" is a visible activity and, in some cases, everyone can tell who is getting pills at different points during the day, who goes down for sick call, when someone sees a specialist, and even when others have lab tests and obtain results.

RSAT staff should familiarize themselves with the specific policies of the facility, federal confidentiality requirements, and the laws of their state so they can provide information to clients about what level of confidentiality they can expect and offer support to help them maintain their privacy throughout the testing, notification, and treatment process.

RSAT staff can help address HIV/AIDS issues within the scope of their roles. The following checklist of priorities outlines the basics for RSAT staff.

- ☐ Knowledgeable about HIV/AIDS prevention transmission risks
- ☐ Comfortable talking about details in plain language with clients in groups and individually
- ☐ Have handouts and client information resources
- ☐ Know testing procedures well enough to explain them
- ☐ Can explain the benefits of testing
- ☐ Comfortable supporting HIV-positive clients through the notification process
- ☐ Knowledgeable about care coordination for individuals with HIV/AIDS inside and outside of facility
- ☐ Can use motivational counseling skills to encourage changing high-risk behaviors
- ☐ Can provide emotional support to RSAT clients living with HIV/AIDS

Armed with this knowledge and skill set, RSAT staff will be able to do the following:

Educate RSAT clients about the risk of transmission and precautions that can reduce the risk of HIV infection during sex and if they return to drug use. Help modify high-risk behaviors and educate HIV-positive clients about precautions that help reduce the chances of transmitting the virus to others. Education can also dispel irrational fears and contribute to personal and institutional safety.

Explain the benefits of knowing their status and the effective treatments available. Once a person is aware that they are HIV positive, they can take steps that will improve the quality and length of their life and protect the health of those they are close to. If people in substance abuse treatment programs learn they do not have HIV, they may also be more motivated to adopt preventive behaviors.

Provide emotional support to individuals before and after testing. If an individual in substance use disorder treatment must face a difficult health diagnosis, it is better they deal with it while they are in a treatment program where they have resources and support. The information can strengthen their motivation to recover. Conversely, finding out about their diagnosis after leaving treatment can contribute to relapse unless an adequate support system is in place.

Motivate behavioral change and harm reduction among people who are at risk. In a perfect world, every RSAT client would leave treatment and never use drugs again. No one would have unprotected sex and nonconsensual acts would not occur. Unfortunately, this is not the case. Understanding harm reduction measures and motivating incremental behavioral change that reduces the risk of HIV infection can make a difference.

Safeguard confidentiality rights and inform clients. Counselor responsibilities include understanding and explaining public health requirements for reporting cases of HIV and for partner notification, linking clients with resources for medical treatment, and release planning and coordinating care. RSAT staff also need to understand their responsibilities under federal Prison Rape Elimination Act (PREA) laws that mandate all sexual assault reporting in correctional facilities.

Exercise 2: Meet Joe. What do you know?

Joseph has just been transferred to your facility and is entering the RSAT program. He is an IV drug user from a Puerto Rican community in a large New England city. He has opted out of HIV testing but has asked to talk with you because he has a lot of questions. Think about how you would answer each of his questions. Before you formulate an answer, consider the information provided.

Joe: *I am not gay or nothing, and I don't like that they wanted to see if I had AIDS. That pissed me off. Why did they do that?*

Information: Universal testing means you have an answer for Joseph. When HIV testing is routine upon intake, RSAT counselors can normalize the procedure. If your facility tests only high-risk inmates, you can still explain that testing is routine in substance abuse treatment, pre-natal care, and most healthcare settings for anyone age 13–65. RSAT staff can emphasize that the decision to test is strictly the client's choice (unless facility guidelines mandate testing).

YOUR ANSWER:

Joe: *If I take the test, how long do I have to wait to find out the answer?*

Information: RSAT staff can know what the facility HIV testing method and notification procedure is by consulting with health services or reviewing the written policy. If the facility offers rapid testing, Joseph can get preliminary results on the spot. Going over the pros and cons of testing and leaving the decision to the client is likely to minimize resistance. Clients should be assured they will have your support and access to substance abuse treatment no matter what choice they make.

YOUR ANSWER:

Joe: *I'm not taking the test because they send you to some crappy place up north with a bunch of skinners and tell everyone you got the worm. Are they going to tell my wife?*

Information: Joseph can be told that court decisions against discrimination and segregation have been handed down in favor of individuals in custody. Become familiar with resources and practices so you can

go over them with clients. Know the laws in your state that govern partner notification. If positive test results are reported to the health department and partner notification follows, RSAT staff should be able to explain this process to clients.

YOUR ANSWER:

Joe: *Even if I had it, I wouldn't want to know. I can't stay clean anyway, so why should I find out something that will make me want to get high more?*

Information: Many people feel this way when they begin addiction treatment. RSAT clients generally have severe substance use disorders and most have never had an opportunity to get the long-term treatment they need. Increasing self-efficacy and motivation are fundamental substance abuse treatment tasks. In Joseph's case, he may be motivated to stay clean once he knows he is not HIV positive, which is the more likely result. If he is HIV positive, he will have recovery support and limited access to the drugs he abuses.

YOUR ANSWER:

Joe: *What can you do for me in here if I was sick?*

Information: Joseph should know he can get medical care if he needs it, but one day at a time. RSAT staff can encourage clients to stay in today and deal with the issues at hand, rather than worrying about something that may never happen. The most important information is the advantages of testing and the advances in treatment mean that those who know they are HIV positive can get medical care and live long and healthy lives. RSAT clients may also need to understand that there are specific programs that pay for the medical needs of people with HIV/AIDS.

YOUR ANSWER:

For Discussion and Reflection

How do you think Joseph suspects he may have been exposed?

What do you think all his questions indicate about his desire to get tested?

How would you go about increasing Joseph's motivation, self-efficacy, and hope?

How do you think Joseph's fears about HIV could impact his drug use?

Did you have all the information about facility policies and procedures, state laws, public health requirements, and available resources to respond to Joseph's questions? The resources list included at the end of each module can help RSAT staff locate some of the information they need, such as the following:

- Lists of state laws regarding HIV and notification requirements and procedures;
- Testing recommendations and clinical care guidelines for correctional settings;
- Information and guidelines on HIV/AIDS and pregnancy;
- Federal Bureau of Prisons guidelines on possible staff exposures to HIV/AIDS;
- Handouts and fact sheets for clients and families;
- Training and consultation resources;

- Hotline numbers for questions;
- Best practices for substance abuse treatment programs regarding HIV testing, prevention education, and working with clients with HIV/AIDS;
- Evidence-based HIV prevention interventions and practices;
- Resources for re-entering individuals with HIV/AIDS; and
- Advocacy and legal information.

Staff will also need to become familiar with some specific information about their facilities, including the following:

- Facility HIV testing policies and procedures,
- Information on the type of testing and treatment available, and
- State laws governing notification and public health reporting requirements.

D. Resources and Review

Review

Individuals in custody are at increased risk of HIV/AIDS, especially if they have a substance use disorder. Routine universal voluntary testing at intake and upon release is a best practice for correctional systems. Ideally, correctional institutions and RSAT programs should assess clients' risk of HIV infection, as well as offer prevention education, access to testing, and pre- and post-test counseling and risk reduction counseling.

HIV is the virus that causes AIDS. It is mainly transmitted sexually and through blood products. It is not transmitted through casual contact.

Testing guidelines have changed over the years. Current guidelines recommend routine opt-out HIV screening as a part of all routine healthcare.

Opt-out testing means that everyone in a healthcare setting is tested unless they decline. Consent for HIV testing is part of the consent for general medical treatment. People in custody have the right to know they are being tested. Unless the facility policy is mandatory testing, they have a right to refuse (opt out).

RSAT staff can benefit their clients greatly through education about HIV/AIDS prevention, reducing the risks of HIV transmission, and the advantages of knowing their status and getting treatment with newer effective medications that can keep them from becoming ill. Staff can help familiarize them with testing procedures and support them through notification and care coordination.

Stigma is an enormous issue for people with HIV, especially inside correctional facilities where it is often more difficult to ensure medical confidentiality. RSAT staff should become familiar with all facility policies, state and local laws, and public health reporting requirements and resources available to HIV-positive clients.

Many social service and health organizations in the community offer resources that can be useful to staff and services for at-risk populations in custody and for people living with HIV/AIDS.

Resources

HIV/AIDS Clinical Care Guidelines and Recommendations

The Centers for Disease Control and Prevention Guidelines for HIV testing in Correctional Settings (2009): https://www.cdc.gov/hiv/pdf/group/cdc-hiv-correctional-settings-guidelines.pdf

Management of HIV: The Federal Bureau of Prisons Clinical Practice Guidelines (2016): https://www.bop.gov/resources/pdfs/mgmt_hiv.pdf

National Commission on Correctional Healthcare Position Statement on HIV (2014): https://www.ncchc.org/filebin/Positions/Administrative_Management_of_HIV.pdf

Medical Management of Exposures: HIV, HBV, HCV, Human Bites, and Sexual Assaults—Federal Bureau of Prisons Clinical Practice Guidelines (2014): https://www.bop.gov/resources/pdfs/exposures.pdf

Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission (2017): https://aidsinfo.nih.gov/contentfiles/lvguidelines/perinatalgl.pdf

U.S. Department of Health and Human Services Clinical Care Guidelines (2014): https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/2014guide.pdf

Testing Laws, Training, and Technical Assistance

The national state HIV testing compendium of testing laws and policies for each state: http://www.ucsf.edu/hivcntr/StateLaws/Index.html

A. The National HIV/AIDS Clinicians' Consultation Center

Warmline (800-933-3413) for individual clinician case consultations

PEP Line (888-448-4911) for consultations on post-exposure prophylaxis

Perinatal Hotline (888-448-8765) for questions about HIV-infected pregnant women

B. AIDS Education and Training Centers (AETC): https://aidsetc.org/

The Ryan White CARE Act funds 11 regional centers that provide training, professional tools, fact sheets, and patient education materials, including the following:

The AETC National Resource Center

The AETC National Multicultural Center

The AETC National Center for HIV Care in Minority Communities by HIV/AIDS

The AETC National Evaluation Center

Re-Entry and Client Care Resources

Center for HIV Law and Policy resources on HIV/AIDS in prisons and jails: http://www.hivlawandpolicy.org/issues/prisons-and-jails

HIV/AIDS services locator (find testing and care by zip code): https://www.hiv.gov/

Pre-test answers
1. True
2. True
3. False
4. False
5. True
6. False

Exercise One
3
2
1
4
1
5
1

Module II: HIV and Related Issues in Addiction Treatment

A. HIV/AIDS and Substance Use

B. Substance Abuse Treatment Best Practices

C. Preparing RSAT Clients for Testing and Test Results

D. Viral Hepatitis and HCV Treatment

E. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

Discuss at least two reasons IV drug use, crack/cocaine, methamphetamine, and other drugs heighten the risk of HIV infection.

Give two examples of why drug and alcohol use and unsafe sexual behaviors frequently occur in combination.

Identify at least two services pertaining to HIV that substance abuse treatment providers should make sure clients can access.

List two types of HIV tests and describe the basic elements of pre-test and post-test counseling.

Identify two ways hepatitis C is commonly transmitted in custody.

Knowledge Assessment Test

True/False Questions

1. Most people in prisons and jails who have HIV were infected while incarcerated.
2. Only HIV rapid tests require a follow-up confirmation test.
3. Most RSAT clients who do not use IV drugs are at minimal risk of HIV infection.
4. If RSAT clients test negative for HIV upon intake into a facility but tell staff they have been recently exposed to HIV, then they should be re-tested.
5. Even if some RSAT clients return to drug use when they are released, there are still ways they can reduce their risk of HIV infection.
6. Needle exchanges and opioid replacement therapy are all examples of universal precautions.
7. Hepatitis C is rarely transmitted through sexual contact.

(answers at the end of this module)

A. HIV/AIDS and Substance Use

Substance abuse treatment providers have a critical role in helping people reduce their risk of HIV infection. The Center for Substance Abuse Treatment promotes rapid testing, counseling, and referral to care as a best practice in substance abuse treatment (SAMHSA, 2007). A 2009 survey of community-based substance abuse treatment providers showed that about half of facilities offered counseling and education on HIV and AIDS, but only about a quarter offered testing (SAMHSA, 2010).

Drug and alcohol use places people at a higher risk of HIV infection. Research shows that health risk behaviors tend to occur in combination with one another. This is true of substance use and unprotected sex, which can result in any number of sexually transmitted infections (STIs). Alcohol use has been linked with unprotected sexual activity, especially among youth and has also been associated with sexual violence, date rape, and sexual assault. IV drug users are also at risk of blood-to-blood transmission and tend to also place their partners at risk (NIAAA, 2008; NIDA, 2010b). An increasing number of new HIV infections among women who are married or in exclusive committed relationships can be the result of becoming infected by a partner who is an IV drug user or who engages in other high-risk behaviors.

People in the advanced stages of alcohol and drug addiction have a higher likelihood of experiencing multiple health problems, which makes them more vulnerable to HIV infection and to progression of AIDS and related diseases, including hepatitis and other STIs. About 4 of every 10 AIDS deaths are related to drug abuse (NIDA, 2010b). For those living with AIDS, use of street drugs can interact with medications, causing medication levels to be ineffective. Use of cocaine, opiates, methamphetamines, and other substances may directly affect HIV disease progression.

Note: Although medication-assisted treatment (MAT) has become recognized as part of the standard of care for opioid use disorders,[5] not all the FDA-approved medications used to treat addiction are compatible with all the medications used to treat HIV/AIDS. According to SAMHSA (2016),[6] there are fewer potential interactions between buprenorphine and antiretroviral medications (ARVs) than potential interactions with methadone. Medical providers that specialize in treating HIV/AIDS can select, adjust, and monitor antiretroviral medications for individuals receiving medication-assisted treatment for an opioid or alcohol use disorder. There appear to be few significant interactions between drugs used for MAT and most medications used to treat HCV.

Drug Use and Unsafe Sex

The relationship between substance use, unsafe sex, and HIV transmission is complex. Substance users are more likely to have multiple sexual partners. For a lot of people, drugs and sex go together. When people are under the influence of alcohol or drugs, their judgment is often impaired. Drug use, including alcohol use, increases the chance that people will not protect themselves during sexual activity. People with drug addiction might be in situations where they trade sex for drugs and find it difficult to set limits on what they are willing to do.

Impairment from substance use also can make people more vulnerable to sexual assault because they are less able to fight off or escape an assailant. Sexual predators target people who use substances

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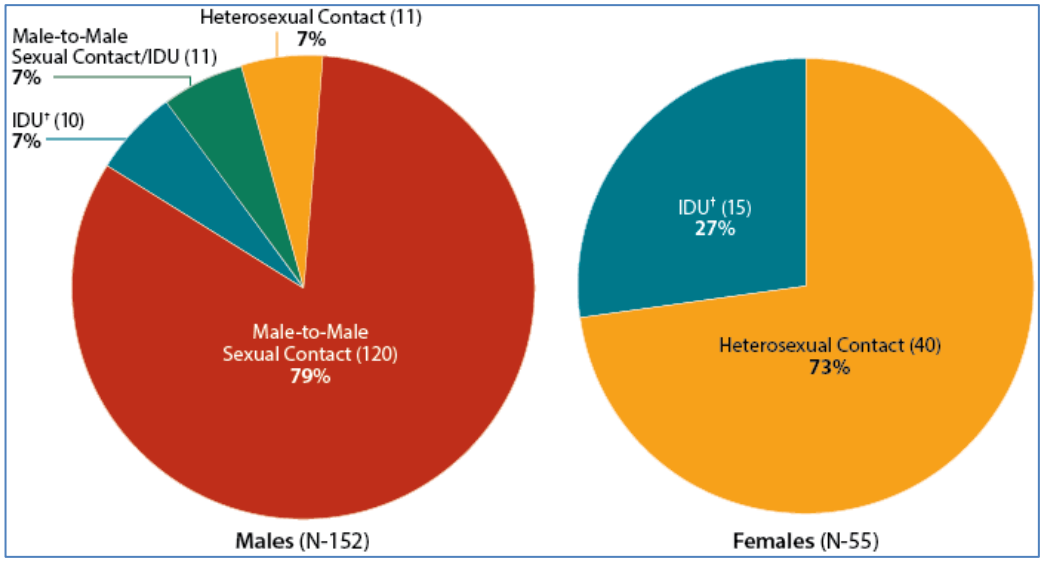
[5] See, e.g., American Society of Addiction Medicine. (2015). National practice guideline for the use of medication in the treatment of addiction involving opioid use. Retrieved from www.asam.org

[6] Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). *Sublingual and transmucosal buprenorphine for opioid use disorder: Review and update*. Rockville, MD: Author.

(Dawgert, 2009). Substances are also strategically used by sexual predators to carry out assault on men, women, and children. Women in advanced stages of addictive illness may not access gynecological care and may have other untreated sexually transmitted infections, which *greatly increases the chances of HIV infection*.

The charts below show transmission modes for men and women newly infected with HIV in 2015. The chart highlights the role of sexual transmission in new cases of HIV infection. It differs greatly from the distribution of modes of HIV transmission that were reported just a decade ago and will probably continue to change.



Source: CDC HIV Surveillance—Epidemiology of HIV Infection (through 2015)

Exercise 3: Pie Chart

For the following questions, refer to the pie charts above that show trends in the mode of HIV transmission for newly infected cases among men and women in the U.S. population.

1. Are men or women more likely to be infected via IV drug use?
2. Are men or women at greatest risk of infection from heterosexual contact?
3. Are men or women at greatest risk of infection from any type of sexual contact?
4. How are most men infected?
5. If these charts were only for people in prisons and jails, name one thing that might be different?

(answers at the end of this module)

Relapse Risks upon Release

The majority of HIV-positive individuals in custody are infected with HIV before they enter facilities. A much smaller number contract HIV while in custody (CDC, 2006). Incarceration and re-entry can add to existing risk factors for justice-involved individuals with substance use disorders.

Relapse upon release presents an enormous risk of HIV infection, as well as overdose, especially among individuals with opioid use disorders. Studies on post-release drug use and sexual behavior among young men released from jails and prisons have shown that some adopt a *make up for lost time* attitude and engage in unprotected sex and IV drug use within hours of release. For men, using substances soon

after release is a predictor of also engaging in high-risk sexual behaviors (Khan et al., 2011). This is especially true for men who are not in a primary intimate relationship and for those who have not completed a drug and alcohol treatment program.

Risks are still high among RSAT clients, even when they seem motivated to remain drug-free. This is especially true when they do not have access to medication-assisted treatments and in areas of the country where fentanyl is often mixed with heroin or pressed into "bootleg" pain pills.

Connecting with immediate re-entry support for ongoing recovery from addiction is a crucial need for RSAT clients to prevent both a return to drugs and unsafe sex. HIV prevention in RSAT programs should target both post-release drug use and high-risk sexual behaviors, link people with medication-assisted treatment providers, and link people with harm reduction/overdose prevention programs (Okie, 2007). HIV prevention programs are often part of harm reduction networks that also offer overdose prevention services.

Studies have found that 75% of incarcerated HIV-positive individuals received their first antiretroviral treatment while in custody, underscoring the importance of supporting RSAT clients who are undergoing HIV/AIDS treatment (Baillargeon et al., 2009).

Exercise 4: Risk Factors

Using the substances numbered below, place the number next to the description that matches the HIV risk factors associated with it.

1. Any injected drug use
2. Crack, any cocaine use, especially smoked and IV use
3. Opioid use, especially IV use
4. Methamphetamine use, IV smoked and nasal use
5. Alcohol

_____ Use may be associated with exchanging sex for money or drugs, having multiple partners, inconsistent condom use, or a continuation of high-risk sexual contact even after learning of HIV status (Campsmith, Nakashima, & Jones, 2000).

_____ Associated with impaired judgment, intimate partner violence, unprotected sex, and unintended pregnancy (especially among adolescent girls). It has also been shown to reduce condom use and safer sex practices, even among sex workers (Bryant, 2006). Adversely affects HIV/AIDS treatment adherence and disease progression.

_____ Used to enhance sexual endurance, which can contribute to friction, dryness, irritation, and tearing of the skin, which increases the likelihood of transmission (Drumright et al., 2006). Strongly associated with unprotected sex and HIV infection, especially among men who have sex with men. It is sometimes combined with erectile dysfunction drugs and club drugs.

_____ High risk of blood-borne HIV transmission. Users or their partners may also become infected through sexual transmission, even if they do not share equipment. Increases risk of hepatitis B and C infection. Consistently responsible for about a third of HIV infections over the years. Some harm reduction measures can reduce the risk of HIV transmission.

_____ Risk of overdose for HIV-positive clients on antiretroviral drugs. May be a high risk of blood-borne infections depending on drug delivery method and an

increased risk of sexual transmission of HIV. Overdose risk is extremely high during the first 48 hours after release. Replacement therapy can be effective and is recommended for pregnant women.

(answers at the end of this module)

B. Best Practices in Substance Abuse Treatment

According to the Center for Substance Abuse Treatment, Substance Abuse Treatment for Persons with HIV/AIDS, Treatment Improvement Protocol 37 (2000), **treating substance abuse disorders without addressing risk behaviors leaves patients at a high risk of HIV infection.** Best practices specific to HIV/AIDS in substance abuse treatment include pre-test counseling and information on the advantages of testing, rapid testing and referral to treatment, HIV prevention education, risk assessment, risk reduction counseling, and information for those who are HIV positive on preventing transmission.

Motivating behavioral change, cultural responsiveness, and skill rehearsal are key components of group or individual sessions. Individual risk reduction counseling is sometimes the most effective approach for high-risk clients. Many behaviors that place people at high risk of HIV are highly stigmatized and cannot be disclosed in a group setting, especially in a correctional environment. RSAT programs that incorporate HIV prevention groups should select an evidence-based curriculum suited to the population they serve. Resources and options will be discussed later in this module. RSAT programs may not need to rely exclusively on existing staff to deliver these programs. Many correctional facilities have found they can call upon community providers, health departments, universities, or cooperative extensions or local AIDS service organizations to come into facilities and assist with prevention education, risk reduction counseling, and pre-release care coordination.

Treating HIV-positive clients is a collaborative endeavor. RSAT programs will need to establish linkages with a variety of services and systems both inside their facilities and outside. When collaborating with other systems, it is helpful to make use of recognized best practices and to ensure that all team members have access to guidelines and information that support the selected approaches.

HIV/AIDS Effective Behavioral Best Interventions

Centers for Disease Control and Prevention (CDC) maintains a compendium of effective behavioral interventions for HIV. They are the equivalent of what substance abuse treatment professionals know as evidence-based practices. In the early days of HIV/AIDS, efforts to contain the spread of the virus were based on limited research. By 2003, the CDC began the *Diffusion of Effective Behavioral Interventions*. Evaluated approaches were catalogued, and training and technical assistance became available. Some federal HIV funding became conditional upon the use of an effective behavioral intervention as part of service delivery.

Today, the CDC supports the replication of effective behavioral interventions. The interventions are now divided into risk reduction topics and treatment adherence topics and listed as group interventions, individual interventions, or community-level interventions. Interventions are also grouped according to target population characteristics. Some are geared toward drug users, correctional populations, pregnant women, African Americans, Native Americans, etc. Some of them are a single session, and others are more comprehensive. Three examples of effective behavioral interventions appear in the appendices at the end of this manual. The compendium of effective behavioral interventions and best practices is available at https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html.

The National AIDS Education Training Centers are composed of 11 regional training centers funded by the CDC. Some of the training centers and their specializations are listed in the resource section at the end of this module. They offer a variety of courses, including online courses, an HIV core curriculum, and courses geared specifically toward substance use and HIV. Some training centers collaborate closely with state correctional systems in their regions and offer training in implementation of effective interventions. The link to information on national training centers is https://aidsetc.org/.

Interventions for Women in Custody

Women in the criminal justice system are an extremely high-risk population and have been historically at least three times more likely to be infected with HIV than men (De Groot & Uvin, 2005), although recent efforts to prevent, test, and treat incarcerated women have reduced these rates. All pregnant women and women of childbearing age should receive HIV counseling, testing, and prevention education. This is a critical need because certain antiretroviral treatments during pregnancy can almost eliminate the possibility of transmitting the infection to the infant during labor and delivery.

Women in prisons and jails are at still 3 to 4 times more likely to be infected with HIV than women in the general population (Council of State Governments, 2005). Women who report intimate partner violence or early and chronic sexual abuse have a high incidence of HIV-related risk behaviors and markers compared to women without abuse histories (Wyatt et al., 2002). Risk of substance use disorders and criminal justice involvement are also higher in women with a history of traumatic experiences. Past victimization among incarcerated women is estimated as high as 92% and co-occurring mental health and substance use problems are more the rule than the exception (Women's Prison Association, 2006).

Simply educating women about the risk of HIV infection can only be effective if they have the power to make a choice regarding safe sex. Many women live in high-risk sexual conditions. The term "survival sex" is sometimes a more accurate description than "engaging in high-risk sexual behavior." Studies suggest that a victim of a violent spouse or partner seldom, if ever, is in a position to negotiate condom use and may perceive partner violence as a greater threat than HIV infection (El-Bassel, 2010; Raiford, DiClemente, & Wingood, 2009). High-risk survival sex is also common among both male and female juveniles experiencing homelessness (Aetna, 2011). **Research on at-risk women and youth shows safety as a bigger predictor of change in HIV high-risk behaviors than education** (NIDA, 2011; Raiford, DiClemente, & Wingood, 2009).

RSAT programming for women should include education on intimate partner violence, especially how women can safeguard themselves and their children from abusive former or current partners. Women should be educated on the availability of court orders of protection, domestic violence shelters, safety planning, and other specialized services and advocacy available to them in the community.[7]

C. Preparing RSAT Clients for Testing and Results

HIV Testing Procedures and Confirmation of Results

HIV testing detects the presence of antibodies. Generally, it takes most people about 3 months or more from the time they are infected to produce a sufficient amount of HIV antibodies to be detectable. Once this takes place and HIV antibodies reach detectable levels, it is called seroconversion. The incubation period required for this to happen is known as the "window." This window is one of the reasons HIV

[7] Azar, S. V., Berringer, K. R., & Epperson, M. W. (2014). A Systematic Review of HIV Prevention Interventions Targeting Women with Criminal Justice Involvement. Washington, DC: National Institute of Corrections.

tests should be repeated if a very recent exposure is suspected, even if the initial test is negative. Annual testing is also recommended for individuals at who are high risk of HIV infection.

Various guidelines suggest correctional healthcare providers offer repeat testing to:

- Injection drug users and their sex partners,
- Persons who exchange sex for money or drugs,
- Sex partners of HIV-infected persons,
- Men who have sex with men (MSM),
- Heterosexual persons with multiple partners or sexual contact with someone who has had multiple partners,
- Any persons known or suspected to have engaged in drug use or sexual activity while incarcerated, and
- Any victim or suspected victim of a sexual assault (and any identified assailants).

In addition, it is also recommended that pregnant women at high risk of HIV infection be re-tested in their third trimester. (See the resources listed at the end of this module for the *CDC Fact Sheet on Preventing Mother to Child Transmission*.)

Consent and Pretest Information

What Patients Should Be Told: Qualified healthcare professionals are generally available in correctional healthcare settings to explain the following points to patients. It is unlikely that RSAT counselors will be the ones that convey this information on intake prior to testing, but it is very likely clients may feel comfortable with RSAT staff members and may bring questions to them about the process.

What RSAT staff can tell participants about HIV testing:

- Knowing you have HIV infection can improve your prognosis with treatment.
- Knowing you have HIV infection can help you take precautions so you don't pass it to others.
- Refusing an HIV test will not affect the care you receive.
- Test results are kept confidential. (However, in certain states, including California, the law requires the results of a confirmatory positive test to be reported to the health department.)
- A negative test means you do not have HIV infection. However, the test may not show a recent infection from an exposure within the past 3 months.
- A negative test in patients recently exposed to HIV requires a repeat test to be sure. Usually, the test is repeated in 3–6 months to confirm the negative results.
- A positive test does not mean your health is poor or even that you need to begin treatment immediately, but now that you know your status, you can find out what the best course of action is. Starting medications when recommended can help people live long, healthy lives.

Legal Issues

Laws regarding HIV testing vary from state to state. Some state laws are specific to their state prison and county jail population. Federal prisons are governed by laws regarding mandatory testing for high-risk individuals. State laws may differ in the type of consent they require (verbal versus written), their implementation of opt-out testing, pre-test and post-test counseling requirements, and reporting requirements for newly diagnosed HIV infections. Federal laws govern confidentiality regarding clients

in substance abuse treatment. Each RSAT program should become familiar with facility and state guidelines and align practices accordingly. The National HIV/AIDS Clinicians' Consultation Center, listed in the resource pages at the end of Module I, provides information on state laws and a hotline for clinicians with questions.

Pre- and Post-Test Counseling

Healthcare professionals are trained to provide information to individuals before and after HIV testing. In a correctional environment pre- and post-test counseling may be limited and may not offer comprehensive information. With the battery of tests involved in prison or jail intake, questions may not come up until individuals settle in or find someone they feel they can trust. Individuals in substance abuse treatment who find out they are HIV positive are likely to need support from counselors and require more information. Links to handouts for clients are on the resources list at the end of this module, along with some general CDC infographics. There is no shortage of high-quality patient information materials that RSAT staff can access using some of the resources listed in this manual.

Risk reduction information specifically pertaining to drug use can be presented in a hierarchy that emphasizes changing the highest risk behaviors first and prioritizes safety measures that have the greatest effect. For example, the number one risk reduction measure for drug users is not using drugs. However, if there is a return to drug use, the next risk reduction measure is not injecting drugs, then not sharing needles, and so forth (NIDA, 2001). The general components that pre- and post-test education and risk reduction counseling include the following:

- Repeating drug and sex-related risk reduction messages at each contact,
- Offering testing and emphasizing the advantages of getting tested, and
- Providing information on risk reduction and preventing transmission.

Post-Test Counseling for an HIV-Positive Client

If an RSAT client receives notification that they are HIV positive, it is important to provide support, provide information, and preserve medical confidentiality. Remember, a confirmatory test is required before a preliminary HIV-positive screening test is considered definitive, *although false positives are uncommon*.

An RSAT client just learning that they are HIV positive may need the following:

- Short-term mental health support and/or a mental health evaluation;
- Assessment of suicide risk and monitoring, as indicated;
- Information on exactly how to interpret a positive test result;
- Steps that can be taken to get more detailed information regarding their condition;
- Information about follow-up medical care and treatment options for people with HIV;
- Encouraging HIV-positive people to inform their drug and sex partners about the risk of infection and the importance of testing;
- Counseling on partner/contact notification; and/or
- Positive support, empathy, hope, and responses to concerns and questions.

In these cases, RSAT staff should be working with others, including primary care and mental health personnel, although RSAT clients may wish to turn to their alcohol and drug counselors for support and information.

Harm Reduction and Correctional Environments

Because there is no cure for HIV/AIDS, harm reduction strategies have been at the forefront of the global response to the epidemic. Harm reduction, health promotion, and wellness are now an important part of mental health and substance abuse treatment and recovery. The National Commission on Correctional Health Care recommends that correctional administrators implement harm reduction strategies. Some harm reduction methods that are more common across Europe and Australia include making condoms and clean syringes widely available to prisoners, providing opioid replacement medications during incarceration, and providing naloxone kits prior to release.

Providing information on disinfecting a used syringe with bleach before using it to inject drugs is also a harm reduction strategy. When used correctly, bleach can kill HIV but not HCV. Some studies suggest the approach is minimally effective because once users are under the influence, they abandon efforts to disinfect their equipment or do not do it properly (CDC, 2004). However, in a prison environment where makeshift equipment is at a premium and likely to be shared, disinfecting equipment with bleach could be a lifesaving measure. In the United Kingdom and other European countries, bleach pills have been distributed in some prisons with promising results (UNAIDS, 2004).

Crack cocaine users have been one of the highest risk categories of drug users for HIV infection. They have not responded well to past risk reduction efforts. However, more recent research on crack use and high-risk sexual behavior has yielded the following key principles that have relevance to RSAT programs (NIDA, 2004).

Counseling sessions are more effective on an individual basis than a group basis. Subjects have made it very clear that HIV risk behaviors involve many private, personal issues they had never before discussed. They found it easier to discuss these experiences with one person rather than a group.

Counselors need to focus on the individual's multiple social roles during intervention counseling. Individuals don't want to be labeled simply as "drug users." Instead, they want the social context of their daily lives to be addressed, including their family roles.

Co-Occurring Disorders and Mental Health Support

The first National HIV/AIDS Strategy report was released by the White House in 2010. It estimates that up to 50% of people living with HIV have a mental illness. Some data suggest these estimates may be low. At least one in three people with HIV experience depression. Mood disorders are 7–10 times more common, and anxiety disorders are 5–10 times more common than among the general population (Bing et al., 2001). If left untreated, depression in HIV-positive individuals in custody can increase the risk of suicide.

Correctional administrators need to ensure sufficient support and mental health services are available to patients who are HIV positive, especially for those learning of their status for the first time. RSAT programs should collaborate with mental health services, keeping in mind that mental health assessment may be ongoing as needs and health status change or AIDS-related conditions progress. The mental health assessment process for clients with HIV/AIDS can be complex. Psychiatric symptoms may be caused by HIV/AIDS-related illness, by medications used to treat patients, or by preexisting psychiatric disorders. Cognitive impairment can be present and must be evaluated because it may be attributable to a number of causes. It is important for RSAT staff to make sure HIV-positive clients displaying symptoms of cognitive impairment are not perceived as deceitful, defiant, or manipulative by security staff or others (CSAT, 2000).

Mental health services improve prevention efforts. RSAT clients with co-occurring disorders can benefit from education on HIV prevention, risk reduction, and skill rehearsal. Many high-risk conditions and behaviors that contribute to the spread of HIV are associated with untreated mental health disorders, depression, sexual abuse, trauma histories, and marginalization. For this reason, RSAT and mental health staffs should collaborate in developing HIV prevention programming.

Mental health treatment improves health outcomes. If an RSAT client is HIV positive, receiving mental health treatment generally improves their chances of HIV treatment adherence. For this reason, it is important to provide integrated mental health and substance abuse services to HIV-positive clients before they begin ART treatment, whenever possible. Several studies show that receiving psychiatric treatment can lead to slower disease progression, better treatment adherence, and lower mortality among HIV-positive patients (Belanoff et al., 2005; Himelhoch, Moore, Treisman, & Gebo, 2004).

D. Viral Hepatitis and HCV Treatment

Hepatitis B virus (HBV) and hepatitis C virus (HCV) cause serious illness among millions of people. Of the estimated 3.5 million HCV-infected people in the country, 800,000 are incarcerated, institutionalized, or homeless (Edlin, 2015). About half of all infected people are unaware they are infected (Denniston, 2012; Holmberg, 2013). The CDC recommends HCV testing for anyone born between 1965 and 1985 and anyone who has ever spent time in a correctional facility, even if there are no other risk factors. Viral hepatitis is also closely connected with HIV, injection drug use, and high-risk sexual behaviors. HBV and HCV are both more easily transmitted than HIV because the amount of virus in the blood is much higher for both forms of hepatitis (CDC, 2004).

Hepatitis B (HBV) is spread by body fluids, most often through unprotected sexual contact or unsafe injection drug use and sometimes from mother to baby at birth. It can be contagious when an outbreak occurs in a community or in an institutional setting. HBV is usually an acute condition that can be treated and cleared by the immune system, but symptoms are often mild or unnoticeable, so many people do not realize they are infected and continue to pass the infection to others. A small number of people infected with HBV develop chronic (long-term) HBV infection, which can lead to serious liver damage (including liver failure or cancer). Among drug users and people with HIV, past hepatitis B infection is extremely common. Once a person has had HBV, they develop the antibody and are resistant to reinfection. A vaccine is available for HBV, but because of the expense, people are tested for the antibody to see if they require the vaccine. If the antibody is not present, RSAT and other staff working in correctional facilities and people in custody who have or are at risk of HIV or HVC exposure should be vaccinated.

HCV among people entering correctional facilities is at least 10 times higher than the rate among the general public. Prevalence among women in custody is about 33% higher than for their male counterparts. There is no vaccination for HCV. Although it affects about 1% of the U.S. population as a whole, it affects more than 17% of the overall prison population. Several issues regarding HCV have made it a health policy challenge for state correctional institutions.

Unlike HIV, HCV is found only in blood products and is not usually transmitted through sexual contact, but the virus is very hearty and can live outside the host. Even in a microscopic bit of contaminated blood, invisible to the naked eye, the virus can live for days on a syringe, tattooing equipment, or shaving equipment. Education about HCS transmission is critical for RSAT clients and individuals entering custody. Healthcare workers, security staff, and others should be aware of precautions, and any

suspected blood-to-blood exposure should be evaluated. Vaccines for hepatitis A and B should be administered to anyone with HCV or anyone at high risk of exposure to HCV.

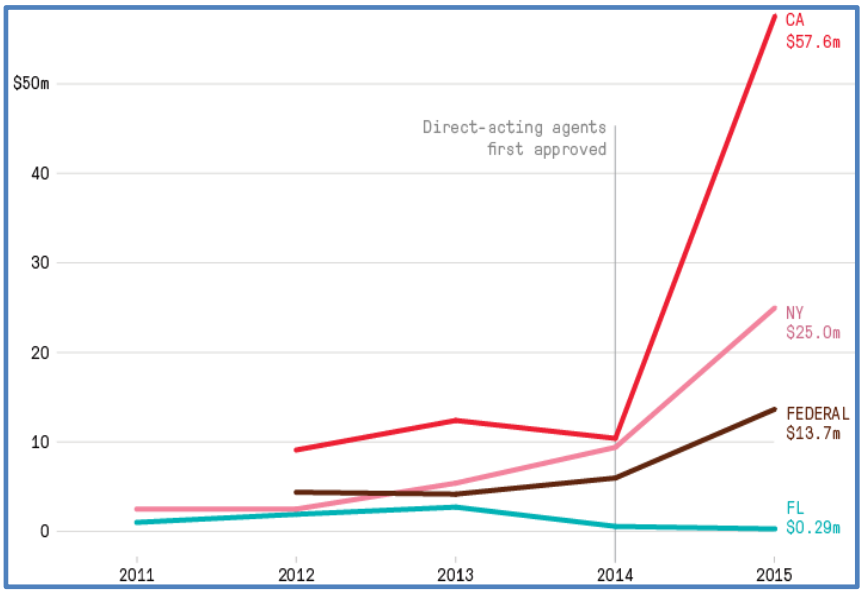
Co-infection refers to HIV-positive individuals who also have another infectious disease. Hepatitis C co-infection is fairly common among HIV-positive injection drug users, occurring in about a third of HIV-positive individuals (SAMHSA, 2016). Liver disease due to HCV infection is a leading cause of non-AIDS-related sickness and death in HIV-positive patients (CDC, 2010a). Therefore, hepatitis testing and treatment are important needs for RSAT clients and HIV-positive individuals.

Hepatitis C Prevention and Treatment in Prisons

It is important that RSAT staff stay up to date with changing institutional policies on this issue. RSAT clients need prevention to reduce the risk of HCV transmission. They should be tested, assessed for liver damage, and treated as appropriate. However, testing procedures differ among facilities. Some correctional facilities offer HCV testing to all individuals, some only test people with known risk factors or symptoms, and some only test upon request. Although correctional systems have a constitutional mandate to provide healthcare to inmates, the high cost of treating large numbers of individuals with HCV provides a disincentive for implementing universal testing protocols in correctional settings.

There have been recent monumental breakthroughs in the treatment of HCV. Over the last 2 years, the FDA has approved a new class of drugs that are more than 90% effective at curing patients with HCV—far more effective than prior treatments. But these direct-acting antiviral drugs (DAA's) are costly and can make prison systems reluctant to identify every infected individual. Prison healthcare budgets are limited, and the HCV treatment price tag can overwhelm them. For this reason, many prisons and jails face an increasing number of lawsuits over access to HCV treatment. (See list of links to related articles in the resources section at the end of this module.)

Marshall Project, 2016, Federal BOP, NY State DOCCS, California Correctional HealthCare Services, Florida DOC Rates of Spending and Number of Cases of HCV Treated



Examples of how various prison systems have dealt with this critical healthcare issue include California, where 17,000 prison inmates have tested positive for hepatitis C, although experts speculate the actual number infected is much higher. The prison system began treating people with DAAs at a cost of $70,000 to $80,000 per treatment and a total projected expenditure of more than $57 million to treat

more than 900 HCV-positive individuals in custody. The chart compares spending in four prison systems.

New York State has treated more than 600 inmates, sustaining a 350% spending increase on HCV medications. In contrast, Florida is reported to have only treated five inmates in 2015; Texas reportedly treated 43, although there are plans to ramp up treatment.

There are two issues that contribute to the correctional cost burden: prison systems generally do not have the negotiating power of insurers when it comes to dealing with pharmaceutical companies and are usually forced to pay full price for the new drugs. Second, new research on the cost effectiveness of routine testing and treatment of HCV in prisons shows that long-term savings and other benefits are largely realized by communities, not correctional systems. A recent study analyzed the costs of implementing universal HCV testing in prisons and estimated it would require a 12% increase in correctional healthcare spending (He et al., 2015). Although treatment outcomes appear to be quite positive, the high costs of the drugs are a significant barrier, especially when many infected individuals are asymptomatic. The newest DAA medication approved for treating HCV is less expensive (estimated cost of treatment is $54,000). The hope is that more competitive options will become available, but the patents on the new class of drugs will not begin to expire until after 2025 for their replacement by much cheaper generic versions of the medication.

Massachusetts, Minnesota, Pennsylvania, and Oregon are among the growing list of state correctional departments that have been sued by inmates over access to treatment. In several states, suits have also been filed outside of the correctional system in response to attempts to restrict Medicaid coverage of HCV treatment for all infected individuals living in the community.

Some resources that may help justice professionals deal with the dilemma at hand are included in the resource section. The Federal Bureau of Prisons (BOP) updated its clinical HCV guidelines in 2016 to include universal voluntary screening of all inmates and a level system that prioritizes candidates for treatment according to medical necessity. Oregon DOCs comprehensive policy is similar; it evolved out of a mediated settlement in response to a lawsuit regarding HCV treatment and has been updated regularly. Washington State has worked with a community-based Hepatitis Education Project to implement an inmate education program. *Obviously, prevention is not only the best but is also the least costly response to dealing with HCV.*

HCV Information

BOP 2016 Clinical Guidelines for the Evaluation and Management of Chronic HCV Infection: https://www.bop.gov/resources/pdfs/hepatitis_c.pdf

National Hepatitis Correction Network, An Initiative of the Hepatitis Education Project: http://www.hcvinprison.org/

Note: For a complete list of HCV resources, including model policies for state correctional systems, see the appendices.

E. Resources and Review

Review

Best practices in substance abuse treatment include HIV testing, risk reduction and prevention education, and referral and care coordination for those living with HIV/AIDS or with AIDS. RSAT staff

may need to answer questions prior to testing or when clients receive results and should be familiar with the processes and all applicable policies.

The relationship between the use of various substances, blood-borne HIV infection, injection drug use, and sexual transmission is complex. Individual risk reduction interventions and education groups can be offered to RSAT clients through community providers or by staff members trained in effective HIV/AIDS behavioral interventions.

Co-infection means an HIV-positive individual has another infectious disease such as HCV. All HIV-positive individuals should be tested for other infectious diseases. People in custody are at very high risk of HCV infection and testing is recommended, although testing policies may differ by jurisdiction. New treatment medications can cure more than 90% of HCV infected individuals, but they are expensive. RSAT staff should be familiar with testing and treatment policies that apply to their clients.

Most people with HIV have mental health needs; if an RSAT client first learns of their HIV+ status while in treatment, mental health support and ongoing assessment should be available. Risk of suicide may increase. All people with HIV infection need to be treated for mental health and substance use disorders prior to beginning antiretroviral treatment.

The demographics of newly infected people with HIV have changed considerably. African Americans and young women are increasingly affected. Prevention and treatment is effective when approaches are culturally responsive, and when they consider safety, exposure to violence, discrimination, access to care, and other issues unique to the background of each individual. HIV testing is a two-part process that involves a screening test and a confirmatory test.

Testing for pregnant women and women of childbearing age is critical, as is HIV risk reduction education, domestic violence services, and mental health services. Women who are pregnant should begin a course of antiretroviral medication while they are pregnant to prevent mother-to-child transmission.

Confidentiality is essential. Individual counseling is often warranted for clients at high risk of HIV infection and for those who are HIV positive. Harm reduction measures can be lifesaving. Information and fact sheets from reliable source are available. Long-term evidence-based treatment for substance use and co-occurring mental health needs is beneficial for at-risk individuals and for people living with HIV/AIDS. Medication used in addiction treatment can interact with some HIV medications and should be monitored by doctors. RSAT programs should establish linkages with HIV prevention resources in the community. They sometimes offer in-reach services, prevention programs, testing in correctional facilities, and harm reduction and care coordination during re-entry.

Resources

Practice Guidelines

SAMHSA Substance Abuse Treatment for Persons with HIV/AIDS, 2000. Treatment Improvement Protocol 37: http://www.ncbi.nlm.nih.gov/books/NBK64923/

SAMHSA Addressing Viral Hepatitis in People with Substance Use Disorders, 2011. Treatment Improvement Protocol 53: https://www.ncbi.nlm.nih.gov/books/NBK92036/

SAMSHA Behavioral Health and HIV/AIDS Information: http://www.samhsa.gov/hiv/

CDC Compendium of Effective Behavioral Interventions: https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html

HIV Infection: Detection, Counseling, and Referral in *CDC 2015 Sexually Transmitted Diseases Treatment Guidelines*: https://www.cdc.gov/std/tg2015/hiv.htm

Training and Workforce Development

Listing of regional CDC-funded AIDS Education Training Centers: https://aidsetc.org/

NIDA Community-Based Outreach Model: *A Manual to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users* (Appendix with 24 cue cards): http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf

CDC HIV Risk Reduction Tool (helpful for risk assessment): https://wwwn.cdc.gov/hivrisk/

HIV Prevention Information and Patient Education Materials

CDC Patient Education Series on Preventing Mother to Child Transmission: https://www.cdc.gov/globalaids/Resources/pmtct-care/docs/WallCharts.pdf

CDC Fact Sheet on Hepatitis B: https://www.cdc.gov/hepatitis/HBV/PDFs/HepBGeneralFactSheet.pdf

Current Fact Sheets and Harm Reduction Information for Clients from AIDSinfo—full listing: http://www.aidsinfonet.org/fact_sheets/view/1000

Opioid Replacement Therapy, 2017: http://aidsinfonet.org/uploaded/factsheets/238_eng_301.pdf

Stopping the Spread of HIV, 2017: http://www.aidsinfonet.org/fact_sheets/view/150

Harm Reduction and HIV, 2016: http://www.aidsinfonet.org/fact_sheets/view/155

Safer Sex Guidelines, 2014: http://www.aidsinfonet.org/fact_sheets/view/151

Hepatitis C Prevention, 2014: http://www.aidsinfonet.org/fact_sheets/view/673

Pre-test answers

1. False
2. False
3. False
4. True
5. True
6. False
7. True

Exercise 3

a. women
b. women
c. men
d. male to male sexual contact
e. injection drug use higher

Exercise 4

A. 2
B. 5
C. 4
D. 1
E. 3

Module III: Meeting the Needs of RSAT Clients Living with HIV/AIDS

A. HIV-Positive Individuals in Correctional Facilities

B. Supporting RSAT Clients with AIDS

C. Re-Entry and Continuity of Care

D. Resources and Review

Learning Objectives

After completing this module, participants will be able to:

Explain at least two supports RSAT staff can provide to clients who have been living with HIV/AIDS when they enter substance use disorder treatment.

List two types of supports RSAT staff can provide to clients learning of their HIV status and/or clients receiving medical treatment while in custody.

Describe key elements of re-entry planning and transitional care for RSAT clients living with HIV/AIDS and name two resources.

Knowledge Assessment Pre-Test

True/False Questions

1. ART is the federally funded program that provides healthcare coverage to people living with HIV/AIDS.
2. Re-entering individuals are not eligible for housing resources for people living with AIDS or for Ryan White Care Act-funded services.
3. Whenever possible, it is best to address mental health disorders among HIV-positive RSAT clients prior to the initiation of antiretroviral therapy.
4. Prisons do not provide antiretroviral medications to individuals in custody who are living with HIV/AIDS.
5. The success rate of antiretroviral therapy for people with HIV/AIDS who are treated in prison is significantly lower than for those receiving treatment in the community.
6. Successful medication treatments can reduce the amount of HIV in the blood to the point where it is undetectable.

(answers at the end of this module)

A. HIV-Positive Individuals in Correctional Facilities

Challenges of Diverse Care Needs

As we learned in Module II, most incarcerated people who have HIV are infected before they enter correctional institutions (CDC, 2006), but many of them may be unaware of it. They may learn of their HIV status while in custody, and some may begin treatment for HIV/AIDS prior to release. Others may enter prison or jail knowing their HIV status. Some may be undergoing treatment with antiretroviral medications in the community prior to intake. Continuity of care for these persons is of critical importance upon entry into facilities, during transfers between facilities, and upon their re-entry into the community. Interrupting treatment with these medications can lead to medication resistance and the spread of resistant strains of HIV. Complex medical issues, behavioral health disorders, and access to re-entry resources all present compounded challenges for an HIV-positive individual in custody and for those responsible for their care.

The purpose of this module is to acquaint RSAT staff with the issues facing RSAT clients living with HIV/AIDS. RSAT staff is a primary source of addiction recovery treatment and support. However, medical care, case management, mental health treatment and other supports are also common needs among these clients. Ideally, RSAT staff and substance abuse treatment professionals should be part of a team approach for care coordination and release planning that includes medical and mental health staff. Although RSAT staff members cannot and should not function outside the scope of their knowledge, training, and expertise, they are better equipped to support recovery among HIV-positive individuals in substance abuse treatment when they understand the emotional and logistical demands of coping with HIV/AIDS in early recovery. They also need to understand the client care needs that emerge at each stage of the progression of the disease, including medical treatment options and decisions they face.

HIV-positive clients in RSAT programs have many of the same treatment needs as any other RSAT participant. They need effective interventions and support to change their substance use behaviors, as well as other high-risk behavior. Behavioral change is possible, but there is nearly always ambivalence. Motivational counseling approaches that help resolve ambivalence are useful whether an RSAT participant is grappling with the decision to get tested, a commitment to reducing risk behaviors, abstinence from substances, or adherence to complex medication regimes. Empathy, authenticity, and peer support are also helpful for HIV-positive clients in substance abuse treatment. HIV peer educators have been evaluated systematically and have demonstrated a high degree of influence of over behavior (Spector, 2007).

Sadly, studies show that without encouragement and support upon re-entry, the vast majority of persons who receive antiretroviral therapy while incarcerated do not obtain prescriptions for continued treatment within 30 days of release. Many of these individuals have had excellent responses to these treatments while in custody, but critical treatments are often disrupted upon release. Although this situation is unfortunate, the research offers very helpful information about how RSAT staff can prioritize aspects of pre-release planning for HIV-positive program graduates to help them maintain the gains they have made. One study of HIV-positive individuals released from Texas prisons found three factors were associated with not obtaining antiretroviral drugs in time to continue their treatment:

1. **Race**: Hispanic and African American patients were significantly less likely to have prescriptions filled than white patients.
2. **Viral load**: Patients with a detectable viral load were less likely to obtain anti-HIV drugs than those whose treatment had resulted in an undetectable viral load prior to release.

3. **Help from a drug assistance program:** Patients who had help prior to release applying for the AIDS Drug Assistance Program (ADAP, http://adap.directory) tended to continue vital medication regimens. Those who did not were less likely to obtain HIV treatment after release (Baillargeon et al., 2009).

Approaches for HIV-Positive Individuals Entering Custody

Individuals who know they are HIV positive before they enter a correctional facility may fall into one or several categories, each with different care needs. The categories and guidance on the corresponding approach RSAT staff can take are outlined below. In all cases, it is important for RSAT staff to provide information, provide motivation, and relate all these issues to addiction recovery.

a) Clients who do not disclose their HIV status, even to medical staff

These individuals are motivated to conceal their HIV status. They may refuse or opt out of testing if given the choice. They may avoid accessing health services even when they need them. Some may have been in jail or prison before. Medical records may or may not identify these individuals or contain records of treatment for HIV/AIDS. These behaviors can be motivated by one or more of the following:

- Fear of ostracism/stigma;
- Distrust of medical providers and/or correctional medical care, in particular;
- Having a co-occurring mental health disorder(s);
- Concerns that they may be labeled as gay and/or victimized (whether or not they are gay);
- Gay, bisexual, or transgender individuals may fear violence, harassment, or sexual assault; and/or
- They may have experienced harassment or victimization during prior periods of incarceration.

***Approaches for RSAT staff*:** Those reluctant to disclose their status may benefit from individual counseling that includes a realistic discussion of confidentiality safeguards and limits. Sessions can include modifying high-risk drug use and sexual behavior to prevent HIV transmission and a discussion of choices about disclosure of their status. In addition to trust and rapport building, RSAT staff can assure clients that testing and medical treatment is voluntary (unless facility policy mandates testing) and can offer hope and empathy, as well as information about how to access medical treatment. In late-stage addiction, many clients feel hopeless. Research indicates that many HIV-positive individuals in custody do not seek treatment because they think they are going to die anyway (Okie, 2007). It is important to educate clients about treatment advances and improved prognoses for people with HIV.

b) Clients may disclose their status but have had limited access to care

Research indicates that many HIV-positive people enter custody without health coverage and from communities that are underserved. They may be aware of their HIV status and may disclose it but may have never received the medical care they need. Factors that may contribute to this situation include the following:

- Distrust of medical providers and/or correctional medical care, in particular;
- Belonging to a minority that experiences disparities in access to quality care (NCCHC, 2002a);
- A history of experiencing economic barriers to care and limited access; and/or
- Untreated substance use and mental health issues compounding avoidance/neglect of heath.

***b) Approaches for RSAT staff**:* All clients with HIV benefit from a medical evaluation to determine how far the disease has progressed and if treatment should begin. This includes immunological monitoring, which provides information about T-cell counts and viral levels, blood tests that measure CD4+ cell counts, and plasma HIV RNA levels (the amount of HIV present). Other medical services may include diagnostic tests for tuberculosis and other potential co-infections or conditions, testing and vaccinations for hepatitis, and routine gynecological care for women. RSAT staff can outline the advantages of getting medical care and support clients as they work with medical staff. It is helpful to go over resources that will continue to pay for HIV treatments after release, offer help with applications for prescription assistance, and link clients with providers and other services in their community.

c) Clients may not have advanced to the point of seeking antiretroviral treatment

Staff will encounter RSAT clients that know and disclose their HIV status, have had at least some medical care and evaluation for HIV prior to intake, and are aware of their T-cell count and viral level. Some of these asymptomatic clients may have been told in the past that they could wait to begin treatment.

- They may be healthy and asymptomatic.
- They may have been actively using prior to intake and have recently neglected medical care.
- In the past, they may have been told they did not need to begin treatment yet.
- They may have been urged to consider treatment but have chosen to wait.
- They may have advanced to the point that they need to begin treatment.

c) Approaches for RSAT staff: Routine ongoing immunological monitoring and medical care are necessary while they are in custody. As of 2018, HIV clinical care guidelines recommend beginning antiretroviral treatment as soon as possible. RSAT staff can explain these changes and link clients with medical staff to make a decision about beginning treatment based on current medical indicators, length of sentence, and other considerations that ensure treatment will not be interrupted once it has begun. In some cases, a decision to wait until release may be the best choice. These clients benefit from risk reduction counseling and from focusing on strengthening recovery from substance abuse and co-occurring mental health disorders. Re-entry planning and access to community care/resources for both recovery and HIV care are essential. Documentation of HIV status and medical records are critical for connecting with community providers and for those transferring to work release or re-entry facilities.

The three categories of RSAT clients described above are considered *treatment naïve* HIV patients, meaning they have never had a course of antiretroviral drugs. The next category is comprised of patients that have had treatment for HIV/AIDS prior to intake.

d) Clients may have been undergoing antiretroviral treatment in the community

These clients with HIV have some of the most critical care needs because it is so important for their treatment to continue without interruption. In these cases, patients are likely to have been evaluated and continued care coordination at intake, before RSAT staff come into contact with them. However, it is possible, especially in jail-based RSAT programs, that health records might not be available for a client in this category. They might delay disclosing their treatment history.

- They may need to obtain documentation and medical records pertaining to pre-intake care.
- RSAT staff can advise them to contact their doctor to ask for records and a letter outlining their treatment regimen and prescribed drugs (Lambda Legal, 2010).

- Facilities may not have the required drugs on hand and are not required to continue the exact same course of treatment.
- Staff can collaborate with health services to assist with care coordination.

d) Approaches for RSAT staff: Staff can help clients obtain medical records and treatment history, as appropriate, and coordinate with medical staff to re-establish or continue care. Any RSAT client undergoing antiretroviral treatment may require flexibility and support to both adhere to their medical care plan and continue substance abuse treatment. Preserving confidentiality may be a challenge. Clients in RSAT programs, especially in women's facilities, have been known to disclose their HIV status to the group; however, there should be no pressure to do so. If the client initiates a conversation about such a decision, RSAT staff can help them think through all the ramifications in individual sessions.

Clinical Care Guidelines for Starting Antiretroviral Treatment

Below is a summary of the U.S. Department of Health and Human Services (DHHS) guidelines for beginning antiretroviral treatment (as of January 2018). Even though RSAT staff is not responsible for clinical care of HIV-positive clients, it is helpful for them to understand the medical decisions and the factors that influence the decision to begin medications to prevent or slow the progression of HIV/AIDS.

Summary of 2018 DHHS Recommendations for Initiating Antiretroviral Treatment (ART)

- Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. ART is recommended for everyone who has HIV to help them live longer, healthier lives. It also helps reduce the likelihood of transmitting HIV.
- People with HIV should start ART as soon as possible. In people with HIV who have the following conditions, it is especially important to start ART right away:

  →Pregnancy (see guidelines for more detailed discussion),
  →Recent HIV infection (up to 6 months after infection with HIV),
  →History or diagnosis of an AIDS-defining illnesses,
  →HIV-associated nephropathy, or
  →Presence of hepatitis B virus or other co-infection(s).
- Before starting ART, people with HIV discuss the benefits and risks of ART with their healthcare providers and the importance of medication adherence (taking HIV medicines every day and exactly as prescribed).

Adherence considerations are critical for any individual who begins ART. Mental health, addictive illness, cognitive impairment, poverty, side effects, and stigma may influence a client's ability to stick to demanding medication regimens. RSAT staff can work with medical care providers to support adherence as they prepare for treatment and offer encouragement. The Bureau of Prisons recommends care teams consider the preparations below for clients who will begin ART in custody. Some of these preparations will be coordinated by medical staff, but RSAT staff can support clients as they prepare for ART and while they are undergoing treatment by doing the following:

- Establish level of readiness to start therapy;
- Provide education on medication dosing;
- Review potential side effects;

- Anticipate and treat side effects;
- Use educational aids, including pictures and calendars;
- Engage family and friends;
- Simplify regimens, dosing, and food requirements;
- Use a team approach among nurses, pharmacists, and peer counselors; and
- Provide an accessible, trusted healthcare team.

B. Supporting RSAT Clients with AIDS

Some clients may have advanced from HIV infection to AIDS and may have numerous health issues and complex treatment needs. These clients can sometimes be very ill and symptomatic and may require medical care that interferes with RSAT program participation. They also need mental health treatment and addiction recovery supports. Some of the symptoms and conditions they may be dealing with include the following:

Co-infections: Clients may have co-morbid hepatitis C, tuberculosis, or other infectious diseases along with HIV/AIDS. Once their immune system is compromised and they have progressed into AIDS, they become susceptible to many other opportunistic infections such as pneumonia, cryptococcal meningitis, herpes, toxoplasmosis, candidiasis (thrush), and other fungal infections.

Complicating conditions: Complications that may occur include anemia, Kaposi's sarcoma and other cancers, skin conditions, seizures, diarrhea, blindness, wasting syndrome, and HIV-associated dementia (Bureau of Prisons, 2006).

Clients should not be excluded from programming solely on the basis of their health status. Each individual's wishes should be respected along with the medical recommendations of the clinical care team. If participation in RSAT program activities interferes with meeting medical care needs, places a burden on the client, or presents a risk to the client, then alternate arrangements for recovery support are in order. End-stage AIDS patients often require analgesic medications for pain management. Substance abuse treatment professionals can support the care team by providing information on minimizing the potential for abuse; encouraging clients to adhere to the doctor's orders; and helping them work through typical reactions like guilt, craving, and temptation to abuse medications. (For more information, see the resources listed at the end of this module.)

Early detection of HIV means people can live much longer. However, some RSAT clients may progress to AIDS within a year or less, especially if their HIV infection went undetected for a long time prior to incarceration. Their needs may vary over time. Effective drug therapies may bring down their viral level and they can improve significantly. Others may become very ill with opportunistic infections and complicating conditions listed in the previous sections, including HIV-related dementia, delirium, and cognitive impairment.

For additional information on meeting the needs of clients in substance abuse treatment with HIV or AIDS, see Substance Abuse Treatment for Persons with HIV/AIDS. Treatment Improvement Protocol Series, No. 37*, listed on the resource pages in Module I.*

People Diagnosed with HIV/AIDS While in Custody

For many with substance use disorders, entry into a correctional facility may be their first contact with treatment, their first chance at medical care in a long time, and the first time they have been offered HIV

testing. As testing in jails, prisons, and substance abuse treatment settings becomes more available, many people with HIV will learn about their status in these settings.

RSAT programs present an opportunity for them to access long-term substance abuse treatment and to ensure co-occurring disorders are identified and addressed. This can improve their chances of successful medical treatment for HIV/AIDS. Research also shows that incarceration can be a prime opportunity to detect and treat HIV and related conditions, as well as an opportunity for prevention education and risk reduction counseling (CSAT, 2000).

FDA-Approved HIV Medications

In 1992, azidothymidine (AZT) was first prescribed to help block the replication of HIV. By 1997, AZT was conclusively shown to reduce mother-to-child HIV transmission. A new class of drugs called protease inhibitors was also being prescribed in combination therapies. Today, at least 35 medications have been approved by the FDA for treatment of HIV-related disease. People on ART take a combination of HIV medicines (called an HIV regimen) every day. A person's initial HIV regimen generally includes three HIV medicines from at least two different drug classes. (See more by following the link to the HIV glossary at AIDSinfo, the DHHS website for information on HIV/AIDS.)

Although ART cannot cure HIV, antiretroviral therapy is recommended for everyone with HIV to help them live longer, healthier lives. HIV medicines also reduce the risk of HIV transmission. The AIDSinfo website includes a list of all approved FDA HIV medications through 2018 (https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/58/fda-approved-hiv-medicines).

The quality of correctional healthcare for a person living with HIV varies widely among facilities and states. Many correctional systems with large numbers of incarcerated persons who are HIV positive have improved the quality of treatment available. Research shows that when HIV/AIDS is treated during incarceration, results can be positive.

A study of more than 1,000 inmates who received 6 months of treatment while in custody found that 59% of them had undetectable viral loads by the time they left prison (Hubbard, Jones, & O'Leary, 2010).

Although treatment can be successful for people who are incarcerated, transitions in and out of prisons and jails often result in interrupted treatment (Clements-Nolle et al., 2008). Treatment adherence is critical and medication regimens are complex. Drugs must be replaced as patients experience side effects and develop drug resistance. Skipping doses, interrupting treatment, and other adherence problems allow the virus to replicate and mutate and can render some medications ineffective. This can lead to drug-resistant strains of HIV that can be transmitted to others and may limit the types of drugs left for patients to use in the future.

Low adherence to ART is associated with poor outcomes, including earlier death for people living with HIV/AIDS. Adherence has been found to be a particular problem among women, African Americans, Native Americans, and other diverse cultural subgroups that experience economic and health disparities (Siegel & El-Sadr, 2006). Depression and other mental health problems can make clients up to seven times more likely not to adhere to ART regimens. In addition, less than optimal adherence has also been among reported HIV-infected intravenous drug users (Battaglio-DeNero, 2007).

Adherence levels of 95% are required for best results. Fortunately, other studies have found that opioid use disorder treatment, including methadone- and buprenorphine-assisted treatment, can improve treatment adherence significantly (plus or minus 20%), especially among recently incarcerated persons

re-entering the community (Springer, Chen, & Altice, 2010; Ullman et al., 2010). However, as previously noted, patients receiving MAT for opioids must be monitored for medication interactions. Methadone doses may need to be adjusted for some clients taking certain HIV/AIDS medications.

Candidates for treatment: Clients must remain in custody for a sufficient length of time, must be committed to treatment adherence, and should fully understand the ramifications of missing doses. They should be treated for substance use and mental health problems prior to receiving ART whenever possible (Bae, Guyer, Grimm, & Altice, 2011). They should be prepared to experience side effects. **Because the best chance of successful ART is usually the first attempt, it is important to consider all readiness factors with treatment naïve-clients.**

Clients receiving ART: The correctional environment presents many challenges for an RSAT client on a medication regimen. Flexible meal times and medication dispensing times are often out of the question; confidentiality is frequently compromised. Most facilities use one of two methods to dispense antiretroviral medications.

Directly observed therapy (DOT) involves nursing staff watching the patient take their medication. It has the advantage of better adherence and preventing misuse of medications. Disadvantages include risks to confidentiality and additional demands on the time of nursing staff. DOT also does not prepare people with HIV to manage their own care when they leave the correctional facility.

Keep on person (KOP) is a more flexible option. With this option, HIV patients can carry some of their medication with them so they can take it when they need to. There are still some risks to confidentiality (a cell mate can find the meds), but it affords more privacy, may make program participation easier, and promotes self-management skills. This is only available in facilities that support the approach.

Exercise 5: HIV-Related Counseling Needs (answers at the end of the module)

Match the counseling needs for RSAT clients with HIV/AIDS by inserting the letter in the space provided to the HIV-related counseling topic or approach that best matches the need.

a) Risk reduction counseling and HIV education
b) Motivational sessions, balancing pros and cons
c) Mapping, schedules, calendars, and visual aids
d) Permanency planning for children
e) Preparation and readiness for beginning ART treatment
f) Expedited case management and advocacy
g) Counseling on partner notification

_____ Tests positive for HIV upon entry
_____ Has progressed from HIV to AIDS
_____ Tests negative for HIV upon entry
_____ Receiving ART in facility
_____ Refuses testing
_____ Pregnant and tests positive for HIV
_____ Enters custody while currently receiving ART in the community

C. Re-Entry and Continuity of Care

Re-entry planning, connections to community care, resources, and a support system are critical needs for every RSAT client who is HIV positive. Just as research has found RSAT programs are more effective if followed by continuing care and treatment after release, the same holds true for HIV/AIDS treatment, only more so. This module assists RSAT staff with re-entry planning and with locating potential resources for individuals living with HIV/AIDS.

Linking individuals who have HIV/AIDS with care prior to re-entry should be a priority. At least a quarter of the HIV-infected population and almost 40% of those infected with HCV (hepatitis) pass through correctional facilities each year, policymakers have realized that failure to provide incarcerated populations with effective prevention and treatment services will eventually increase infection rates among the general population (NYC Commission on AIDS, 2005). There are programs that can provide resources for persons with HIV/AIDS reentering the community:

The Ryan White CARE Act is a major funding stream for services to people living with AIDS. Reauthorized in 2006, it increased resources directed toward outreach to incarcerated and re-entering HIV-positive individuals. Ryan White pays for medical care for people on work release or re-entering from correctional facilities, provided those facilities are no longer responsible for their care.

Housing Opportunities for People living With AIDS (HOPWA) provides housing support to re-entering individuals as long as they meet the income eligibility guidelines. It is the only federal program dedicated to the housing needs of people living with HIV/AIDS. Under it, the U.S. Department of Housing and Urban Development (HUD) makes grants to local communities that have a high prevalence of HIV infection, as well as to states and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.

AIDS Drug Assistance Programs (ADAP) provides HIV-related services and approved medications to more than half a million people in need annually working in cooperation with state, city, and local organizations to 1) help people with HIV/AIDS without sufficient healthcare coverage or financial resources, 2) provide grants to emerging communities in all 50 states and U.S. territories, and 3) improve the quality and availability of HIV/AIDS healthcare and support services. There is a directory for ADAP that can be found at http://adap.directory/. The directory can link people living with HIV to information, resources, medical care, and treatment options by state and U.S. territories. It is sponsored by major pharmaceutical companies. **Helping eligible individuals apply for prescription assistance before release is critical.**

The problem remains, however, that researchers have found that most those who begin ART in correctional facilities cannot or do not continue with HIV drug therapies once they are released to the community (Baillargeon et al., 2009). One study, for example, found that less than 6% had their medication prescriptions filled within 10 days and only about 30% had them after 60 days after release. Those that had help filing an ADAP application were more likely to have their medications (Clements-Nolle et al., 2008).

According to the Council of State Governments (2012), coordinated and integrated treatments for HIV/AIDS, substance abuse, and mental illness are critical to managing those ongoing health conditions. Unfortunately, few facilities actively plan transitional services for incarcerated individuals with this constellation of interrelated risk factors and needs.

Exercise 6: Steps to Ensure Clients Can Qualify for Care

Make notes in the space provided about how you or the client might go about locating the needed documentation, who to contact, and how long will it take. If they are to be successful, HIV-positive RSAT clients preparing to leave the facility will need to make a seamless transition, especially if they are taking medications. The first thing they need to qualify for medical care through Ryan White-funded programs is documentation.

1. *Verification of HIV status*: The original test that detected the HIV, or a copy of current lab work, or a letter from the treating physician documenting HIV status and outlining the current course of medical care.

_____
_____

2. *Verification of release*: A parole certificate or other verification of release date is helpful. Clients have up to 30 days to provide any missing documentation. If released from prison within the last 30 days, they fall into an eligible category.

_____
_____

3. *Verification of residence in service area*: If the client will be released to the area, or to another catchment area, they will need to verify residence.

_____
_____

4. *Insurance cards, Medicaid, Medicare, or U.S. Department of Veterans Affairs (VA) enrollment cards*: Ryan White is the payer of last resort and needs to verify that no other coverage exists.

_____
_____

5. *Driver's license, photo ID, and Social Security card*: Proof of a Social Security number is acceptable. A state-issued photo ID is important for re-entry.

_____
_____

6. *Income verification*: Two paystubs, disability award letters, tax returns (unless they have no income—limits are 300% of poverty level or below).

_____
_____

7. *Medical records*: Recent viral load and T-cell counts are especially helpful.

_____
_____

8. Name and contact for primary care provider: The facility doctor should be listed along with any primary care provider that may be lined up in the community.

_____
_____

9. *Denials of benefits*: HIV+ inmates should apply for all benefits they may qualify for; denial letters are important for Ryan White, as the payer of last resort.

_____

_____

How confident are you that clients can leave the facility with the needed documents? If there are administrative barriers to overcome, who might you go to? Are there AIDS service organizations in your area that can help?

Services, Resources, and Needs

AIDS Action is a nonprofit AIDS advocacy organization that develops education materials, assist persons with AIDS and organizations that serve them, and advocates for funding as well as social policy and legislative reforms (2007). A link to their workbook, *Connection to Care: Addressing the Unmet Need—Rural and Formerly/Currently Incarcerated,* is listed at the end of this module. It contains examples of collaborative practices that correctional systems and community-based agencies have evaluated. The authors have also identified some of the barriers they are working to help correctional agencies overcome, such as the following:

- Lack of HIV knowledge/expertise among staff in correctional settings,
- Lack of privacy and confidentiality in the correctional setting,
- Interruption in care upon release,
- Lack of awareness of care resources when released,
- Substance use, and
- Mistrust of providers.

Care transitions for HIV-positive clients, especially those undergoing ART, have mostly been inadequate, are in need of improvement, and have often resulted in treatment discontinuation and poor health outcomes for re-entering patients (Hammett, Roberts, & Kennedy, 2002). The corrections system has made progress, but capacities vary and may be limited, and treatment needs are complex. Re-entering patients are best served by leaving facilities with a 30-day supply of their medications, although that is not always possible. RSAT program staff can help achieve better outcomes through collaboration with community-based HIV organizations. The resources and links on the last page of this module offer fact sheets with infection rates by state and county and gender and ethnicity, the funding levels for HIV related-programs, and the HIV/AIDS grant-funded programs in your state. There is also a link to a list of all local AIDS service organizations by state.

Ryan White Care Act Services (through DHHS)

Since 2000, Ryan White funds have increasingly supported work with incarcerated and re-entering people. Not all services are funded in every state, but you can use the link to the state fact sheets at the end of the module to view the programs available in your state.

Part A: Funds services in cities that are disproportionately affected by HIV/AIDS.

Part B: Helps state health departments with services and funding for ADAP, which helps with medications for low-income families, minority AIDS initiatives for underserved and disproportionately affected groups, and the supplemental emerging communities' grants for towns with where increasing numbers of AIDS cases are reported.

Part C: Early intervention services support competitive state-level grants for HIV testing and medical care, such as oral health services, risk reduction, outreach, medical case management, nutrition, medical transport, and planning.

Part D: Capacity building and Women, Infants, Children, Youth, and Their Families focuses on the growing vulnerabilities to HIV infection for women and women of color.

Part E: Ryan White also funds ATEC-AIDS regional educational and training centers.

Part F: The Ryan White Care Act Dental Program pays for access to oral health services and education on HIV/AIDS for dentists.

Part G: The Ryan White SPNS (Special Projects of National Significance) projects pilot and evaluate new care models and innovations based on research. Recently, 11 jail SPNS aimed at improving links for HIV+ people in jails and returning to communities.

Housing Opportunities for People with AIDS (HOPWA)

HOPWA is funded (through HUD) in states and cities with higher numbers of people living with HIV/AIDS. They are not available everywhere, but recent projects in several urban areas have been specifically developed to serve re-entering people with HIV. Most require applicants to have income at or below a multiple of the poverty level, usually between 300% and 500%. Generally, homelessness definitions are pretty lenient because the purpose of the program is to ensure people with HIV/AIDS get into housing before they become homeless and their health is affected.

Several key government and non-government AIDS agencies have turned to justice issues and developed guidelines and webinars encouraging AIDS service organizations to work with correctional facilities. Some community-based organizations offer AIDS education workshops to inmates at orientation, work inside facilities on pre-release planning with HIV-positive clients, and assist with Medicaid and Social Security applications and help people get stabilized in the community. RSAT program administrators are likely to be grateful for the help, and RSAT staff may have a re-entry resource for HIV-positive clients they have not tapped, including Ryan White-funded medical case managers.

Supporting HIV-positive RSAT clients and people living with AIDS is challenging, but RSAT programs do not have to go it alone. Both internal and external care teams and partners can be used. Persons in recovery who are actively engaged in managing their needs are likely to achieve success. The same is true for HIV-positive clients. In the healthcare field, patient-centered self-management is the hallmark of success for individuals with chronic medical conditions as well. For people with substance use disorders who are at risk of or living with HIV, there is nothing more empowering than recovery and the ability to stay clean and sober.

Exercise 7: Collaboration with Other Agencies

List the agencies you work with. Rate how well they work with reentering individuals with HIV/AIDS. If you have a contact you can note that assists with re-entry planning, list them. If not, make a note to touch base with someone at the agency.

Substance abuse treatment _____

Temporary Assistance for Needy Families (TANF) _____

Job readiness and training _____

Child welfare _____

Housing assistance _____

Mental health services _____

Recovery/AA/peer support _____

Ministries, churches, synagogues, mosques _____

Domestic violence/rape crisis _____

Food pantry, clothing exchanges, etc. _____

Gyms, YMCA, recreational programs _____

Prescription assistance resources _____

Minority community organizations_____

AIDS service organizations (ASOs) _____

Health departments _____

Harm reduction/overdose prevention _____

Recovery community centers _____

Other:

_____

_____

_____

D. Resources and Review

Review

HIV-positive RSAT clients may fall into different categories that have varying care needs. This includes clients just learning of their HIV status, clients transitioning from community care to custody, asymptomatic clients, those receiving treatment with antiretroviral drugs, and those with AIDS.

HIV-positive RSAT clients also have special counseling needs. Staff can support them through health decisions, offer encouragement, and assist them with adhering to their treatment regimes. RSAT staff is not expected to practice beyond the scope of their training. A team approach that includes medical and mental health staff is effective**.**

Care transitions and documentation are two important issues for HIV-positive clients within correctional systems. Those taking medications for their condition must carefully adhere to treatment. This makes both confidentiality and program participation challenging. Transitional planning has generally been inadequate for most re-entering HIV-positive individuals and results in risks to treatment continuation and health.

Re-entry planning for HIV-positive clients includes all aspects of transition planning required by any RSAT client, including attention to risk factors that predict recidivism, the need for follow-up community-based substance abuse treatment, or aftercare and recovery community support. Counselors can also make sure clients are connected with Ryan White-funded services and other programs for people living with HIV/AIDS and medical services in the community.

There are many resources that RSAT staff can tap to increase the correctional system's capacity to serve inmates who are at risk of or living with HIV/AIDS. AIDS service organizations can help with risk reduction education and also with re-entry planning and connections with medical case management services, housing, and healthcare coverage.

Resources

The AIDSinfo website includes a list of all approved FDA HIV medications through 2018 (https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/58/fda-approved-hiv-medicines) and current clinical care guidelines (https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/52/when-to-start-antiretroviral-therapy)

State fact sheets on Ryan White and other related program funding in each state: https://hab.hrsa.gov/sites/default/files/hab/Publications/factsheets/partbfacts2016.pdf

Ryan White program information and locator: https://hab.hrsa.gov/about-ryan-white-hivaids-program

United States AIDS service organization (ASOs) by state: http://www.thebody.com/index/hotlines/other.html

Housing Opportunities for People Living with HIV/AIDS (HOPWA) portal https://www.hudexchange.info/programs/hopwa/

AIDS Drug Assistance Program (ADAP) site and directory: http://adap.directory/

ADAP and other prescription assistance information: http://pozitiveattitudes.com/adap-patient-assistance-programs/

Connecting to Care: *Addressing the Unmet Need in HIV, Rural, and Current/Formerly Incarcerated, Workbook II*. AIDS Action Foundation: https://careacttarget.org/library/connecting-care-addressing-unmet-need-hiv-ii

Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative Transitional Care Coordination: From Incarceration to the Community: https://careacttarget.org/sites/default/files/file-upload/resources/EnhanceLinkPolicyBriefs.pdf

Opening Doors: The HRSA-CDC Corrections Demonstration Project for People Living with HIV/AIDS: https://careacttarget.org/sites/default/files/file-upload/resources/openingdoors.pdf

Pre-test answers

1. False
2. False
3. True
4. False
5. False
6. True

Exercice 5

G
D
A
C
B
E
F

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Appendices

1. Sample programs: The following examples are from the Centers for Disease Control and Prevention *Compendium of Effective Behavioral Interventions* of HIV prevention education and risk reduction programs that have been implemented in correctional settings. Information on a variety of other effective interventions can be accessed online at https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html.

a) Example of effective HIV prevention education and risk reduction intervention for women in RSAT programs

SAFER SEX SKILLS BUILDING

TARGET POPULATION: Heterosexually active women in drug treatment

GOALS OF INTERVENTION:

- Increase condom use
- Decrease unsafe sexual behaviors
- Increase safer sex negotiation skills
- Increase HIV/STD risk awareness

BRIEF DESCRIPTION: Safer Sex Skills Building (SSSB) is a group intervention consisting of 5 sessions, approximately 90 minutes each, designed to increase HIV/STD risk awareness, condom use, and partner negotiation skills of women attending community outpatient drug treatment programs. Two female counselors deliver the intervention to groups of 3-8 women over 3 weeks, using active problem solving, behavioral modeling, role-play rehearsal, interval practice, troubleshooting, and peer feedback and support. Topics include HIV transmission, testing and counseling, prevention and treatment; personal risk assessment and awareness, triggers, and support; skills for condom use, safer sex negotiation, and safety planning; partner abuse risk assessment; and slip II behaviors. Special emphasis is placed on women's safer sex negotiation skills and safeguards against the risk of partner abuse that may result from safer sex assertiveness.

b) Example of effective HIV prevention education and risk reduction intervention for RSAT programs in juvenile facilities

SAFE ON THE OUTS

TARGET POPULATION: Adolescents in juvenile detention facilities

GOALS OF INTERVENTION:

- Reduce risky sex behavior
- Reduce sex while drinking

BRIEF DESCRIPTION: Safe on the Outs is a group-level intervention delivered in a single session to typically 3-5 adolescents of the same sex. It combines a group psychosocial intervention (GPI) for sexual risk reduction with group motivational enhancement therapy (GMET). The GPI portion uses group activities, videos, condom demonstrations, a video game, general HIV transmission information, and local information and health services resources to increase HIV knowledge, and develop self-efficacy, normative perceptions, and positive attitudes toward condoms. A movie depicting ethnically representative young people emphasizes and explicitly models being prepared for safer sex and the importance of good communication skills with current and potential sex partners. In a video game participants make a series of choices related to sexual activity to consider how negative consequences of unprotected sex would impact life goals. Participants then pick a safer sex goal they want to accomplish in the next 3 months to increase positive intentions. The GMET portion focuses on alcohol use, including feedback on drinking behaviors, and uses the FRAMES (Feedback, Responsibility, Advice, Menu, Empathy, and Self-Efficacy) to organize its structure. It uses motivational interviewing (MI) and empathetic, open, and non-confrontational motivational-enhancement-therapy style group discussion….

c) Example of effective HIV prevention education and risk reduction intervention for RSAT programs in men's facilities

PROJECT START

TARGET POPULATION: Young men soon to be released from prison.

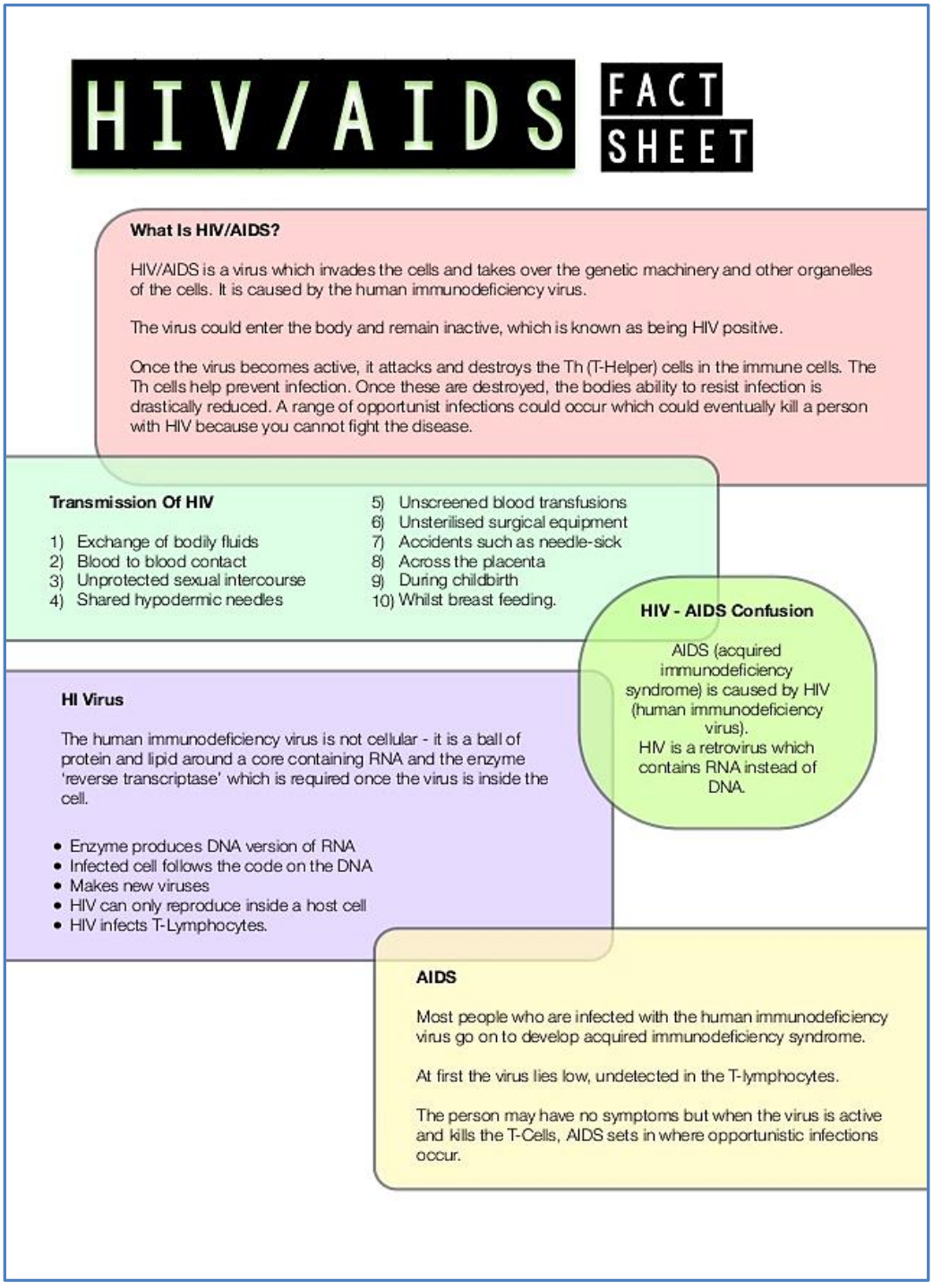
GOALS OF INTERVENTION:

- Eliminate or reduce risk behaviors for HIV, STD and hepatitis after release.

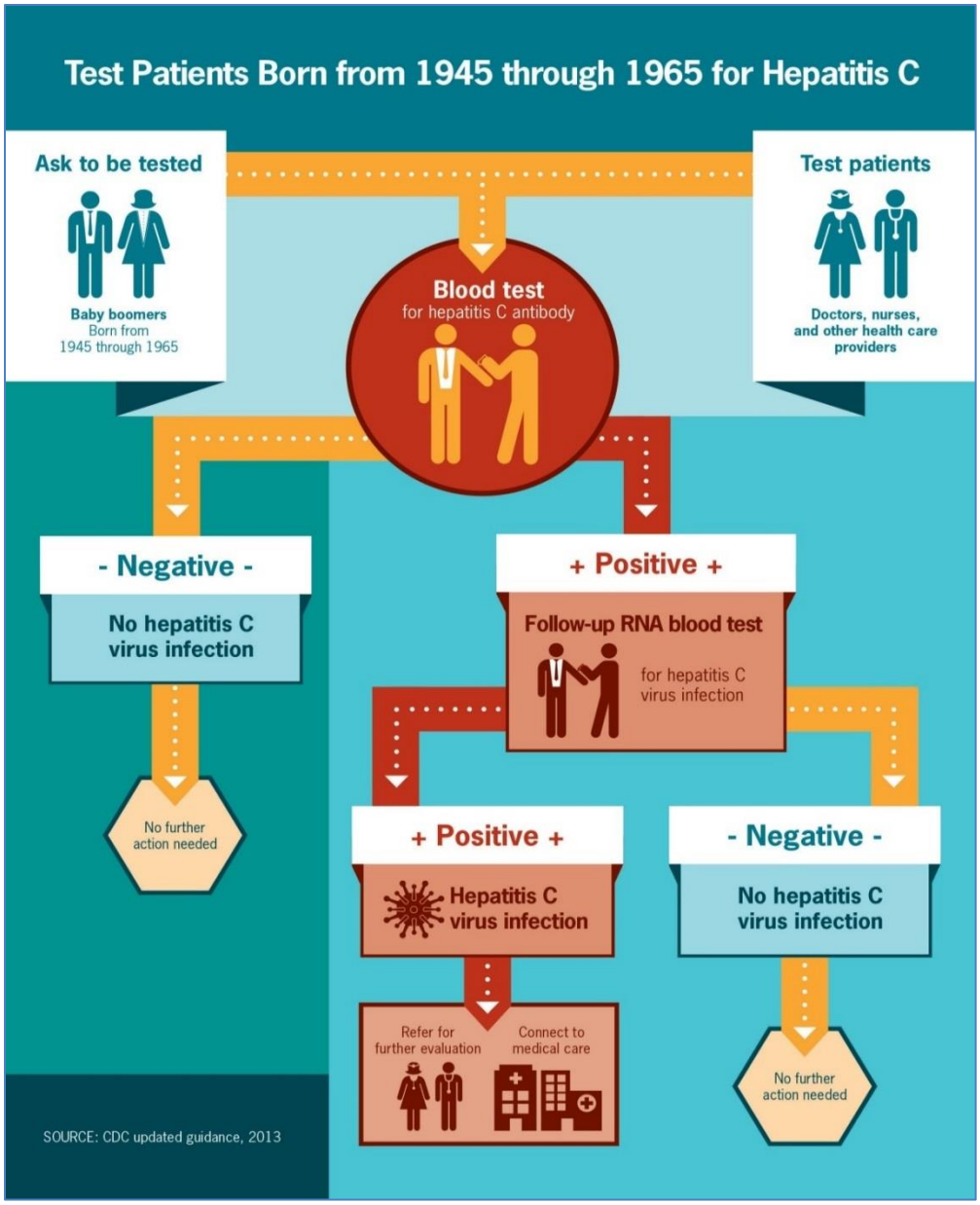
BRIEF DESCRIPTION: Project START is a 6-session individual-level HIV, STD, and hepatitis risk reduction intervention for men soon to be released from prison. It incorporates features of prevention case management, motivational interviewing, and incremental risk reduction. This intervention consists of 2 individual sessions conducted within 60 days before release and 4 individual sessions at 1, 3, 6, and 12 weeks after release. In the first in-prison session, the interventionist assesses the participant's knowledge of HIV/AIDS, STD, and hepatitis, conducts a brief HIV-risk assessment, and helps the participant develop a personal risk-reduction plan. The interventionist also provides information, skills training, and referrals and helps to identify incremental steps towards risk reduction. The second in-prison session focuses on community reentry needs and referrals for housing, employment, finances, substance abuse, mental treatment, legal issues, and avoiding re-incarceration. The post-release sessions involve a review of the previous sessions and discussion of the facilitators and barriers to implementing the risk reduction plan. Additional sessions are available for participants in the enhanced session as needed during the intervention period.

Source: CDC Compendium of Evidence-Based HIV Prevention Interventions

2. Infographics: Infographics can be downloaded at the links provided at the bottom of each page or printed and copied.



Link: [CDC Basic HIV Fact Sheet]



Link: [CDC HCV Testing Infographic]

3. Information on Hepatitis C Testing and Treatment Policies in Correctional Systems

BOP 2016 Clinical Guidelines for the Evaluation and Management of Chronic HCV Infection: https://www.bop.gov/resources/pdfs/hepatitis_c.pdf

National Hepatitis Correction Network, An Initiative of the Hepatitis Education Project: http://www.hcvinprison.org/

New Mexico DOC Policy: Management of Acute and Chronic Infection Viral Hepatitis, 2015: http://cd.nm.gov/policies/docs/CD-176200.pdf

Oregon DOC Comprehensive Hepatitis C Policy, 2016: http://www.oregon.gov/doc/OPS/HESVC/docs/2016%20ODOC%20HCV%20RX%20Guidelines.v1.0.pdf

Hepatitis Education at the Washington State Prison System, *Knowledge is Power: Inmate Hepatitis Education:* http://correctionalnurse.net/knowledge-power-inmate-hepatitis-education/

4. Information on Litigation and Cost Effectiveness of Treating HCV in Custody

New 2015 research study on cost-effectiveness of treating inmates with Hepatitis C, *Prevention of Hepatitis C by Screening and Treatment in U.S. Prisons*: http://www.natap.org/2015/HCV/AIME201601190-M150617.pdf

The Marshal Project Article on Prison System Spending on Hepatitis C Treatment, 2016: https://www.themarshallproject.org/2016/02/22/why-some-prisons-are-spending-millions-on-a-pricey-new-drug?ref=hp-1-122#.1urO8cOTG

Minnesota Lawsuit—Hepatitis C Treatment for Inmates: https://www.prisonlegalnews.org/news/2015/jul/31/minnesota-doc-sued-over-failure-provide-new-hepatitis-c-treatment-protocol/

Mississippi DOC—State Prisoners with Hepatitis C and Cost of Treatment: http://www.clarionledger.com/story/news/2016/05/25/mississippi-has-about--300-inmates-hepatitis-c/84905756/

Tennessee Hepatitis C Rates in prisons: http://www.wcyb.com/news/inmates-with-hepatitis-c-high-in-tn/39475172

Benefits of Treating Inmates with Hepatitis C: http://www.tennessean.com/story/news/crime/2016/05/08/study-treating-hepatitis-c-prison-benefits-broader-public/83979268/

2008 Federal Ruling on Denial of HCV Treatment Illinois Department of Corrections: http://herald-review.com/news/local/four-men-win-lawsuit-for-being-denied-hepatitis-c-treatment/article_e3ae8e24-c6c9-5f6a-8f0c-19d1324a43d0.html

2005 Mediated settlement of Oregon DOC suit over access to treatment for Hepatitis C: http://www.hcvinprison.org/images/stories/hcvinprison/docs/or_settlement.pdf

Pew Article on Medicaid and Correctional Obligations to Pay for Hepatitis C Treatment, 2016: http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/02/09/are-states-obligated-to-provide-expensive-hepatitis-c-drugs

5. Resources: Cultural Competence, Health Literacy, and Other Issues

Minority HIV/AIDS Initiative: https://www.hiv.gov/federal-response/smaif/overview

National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards): https://www.thinkculturalhealth.hhs.gov/clas

National Latino AIDS Action Network: http://www.latinoaidsagenda.org/

Henry J. Kaiser Family Foundation fact sheet: Black Americans and HIV/AIDS: https://www.kff.org/hivaids/fact-sheet/black-americans-and-hivaids-the-basics/

Office of Minority Health—HIV and African Americans: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=21

Bureau of Justice Statistics: Sexual victimization reported by adult correctional authorities, 2009–2011: https://www.bjs.gov/content/pub/pdf/svraca0911.pdf

RSAT Health Literacy Manual (2017): http://www.rsat-tta.com/Files/health-lit-without-appendix-copies