MENTAL HEALTH AND SUBSTANCE ABUSE AMONG PRISONERS LIVING WITH HIV/AIDS

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INTRODUCTION

With approximately 80% of the United States' 2 million prisoners seriously involved in drugs and alcohol (CASA 1998, Beck *et al* 2002), it is almost impossible to talk about incarceration without also talking about substance abuse. More than one quarter of all prisoners are incarcerated because of arrests for using, possessing or dealing drugs. The tripling of the U.S. prison population between 1980 and the mid-1990s is considered to be in large part due to drug-related convictions (CDC 2001).

Mental health is also a critical issue in prisons. Nearly one-third of all prisoners report that they have a mental condition or have received mental health services at some time (Ditton 1999). It's thought that the prevalence of mental disorders among prisoners is at least five times that of the general population (Kupers 1999).

A very high proportion of incarcerated women — more than 60% — report histories of sexual and physical abuse, which are associated with both mental illness and substance abuse (Herfkens 2001).

Issues of substance abuse and mental health are a central concern for many prisoners living with HIV/AIDS. Experts believe that 40–60% of prisoners with HIV/AIDS have a mental illness and that 50% of that mental illness is undiagnosed and untreated (Altice 2001). Intravenous drug use is thought to be the most common source of infection for prisoners living with HIV/AIDS (Braithwaite *et al* 1996).

Service providers and correctional staff working with prisoners living with HIV/AIDS are likely to be aware of the high rates of mental health and substance abuse issues affecting this

population. Providing effective services and treatment requires an appreciation of how substance abuse, mental health, HIV/AIDS and incarceration are interrelated, and how services addressing these problems can be linked.

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This booklet aims to provide basic background information and resources about mental health and substance abuse for anyone who works with HIV-positive prisoners. It covers the basic statistics and facts about mental health, substance abuse and HIV/AIDS; describes proven interventions to help prisoners dealing with these issues; and offers practical advice about providing services for people living with HIV/AIDS both before and after release from prison.

Case Study 1: *Regina M. is living with HIV/AIDS in a maximum-security prison in the Northeast. After several years of cocaine use, Regina has been "clean" from drugs since the beginning of her 4-year sentence. "I'm definitely going to stay clean," she says, "because I need to keep a job and get my kids back. I will not come back to prison, ever." As she approaches her end-of-sentence date, discharge planners who work for a local AIDS service organization have arranged a placement in a group home for ex-offenders in recovery. As a condition of parole, she'll stay there for six months and will have to pass regular drug tests. The discharge planners have also arranged for her to get an ADAP card. ADAP is the AIDS Drug Assistance Program, a government program that helps people with HIV/AIDS pay for their medications. Regina says, "I didn't know I was HIV-positive until I got to prison. So I never had to take medications on the outside. I didn't have an AIDS doctor or any regular doctor. Now I have a doctor's appointment in the neighborhood I'm paroling to. The ADAP card means I can get meds for free."*

Some Important Terms

CBO: Community-based organization. Usually refers to a nonprofit agency that serves a specific geographic or social community. For this booklet, CBO refers to any AIDS service organization, non-profit agency, health clinic, hospital or other organization providing assistance to people living with HIV/AIDS.

HIV/AIDS: HIV = Human Immunodeficiency Virus; AIDS = Acquired Immune Deficiency Syndrome

HCV: Hepatitis C Virus

Jail: Local detention facility for those awaiting trial, on trial, awaiting sentencing or for those serving shorter sentences — usually misdemeanors. Every county, many larger cities, the District of Columbia, U.S. Territories, Native American tribes and the federal government all operate jails.

Parole: An agency that oversees post-release supervision for many ex-prisoners. Parole agencies may establish conditions of release for individual parolees, and violation of these conditions may result in reincarceration or other penalties. Parole is generally considered a branch of law enforcement.

Prison: Facility for the custody of sentenced felony offenders, usually those serving sentences longer than one year. Prisons are maintained by every state, U.S. Territory and the federal government.

Prisoners (vs. Inmates): In this booklet, the term "prisoners" is used to describe anyone in the custody of a jail or prison.

HIV/AIDS IN PRISON

Prisons have a high proportion of people living with HIV/AIDS and those who are at high risk of becoming infected. Prisons therefore offer a crucial opportunity to reach the people most affected by HIV/AIDS.

The overall rate of AIDS among U.S. prisoners is, on average, about five times that of the U.S. population as a whole (Maruschak 2001). As in the world outside prisons, the impact of HIV/AIDS among prisoners varies according to race and gender (see Table 1).

In 1999, about 26,000 prisoners, or 2.1% of the total state and federal prison population, were living with HIV/AIDS (Maruschak 2001).

There has not been enough research to say conclusively whether most HIV-positive prisoners are already HIV-positive when they enter jail or prison or if most acquire their infections while behind bars. Expert opinion generally holds that the vast majority of HIV-positive prisoners are infected before they come to prison (Spaulding *et al* 2002), but it is also known that high-risk behavior (unsafe sex, sharing needles and tattoo equipment) does occur behind bars.

Table 1. Percentage of State Prisoners Ever Testing HIV-Positive, 1996–1997

African-American Women	3.9	African-American Men	2.7
Latinas	4.2	Latinos	2.4
White Women	2.3	White Men	1.4

(Source: Hammett *et al* 1999, adapted from Table 8)

HIV/AIDS AND MENTAL HEALTH

People living with HIV/AIDS have high rates of mood and affective disorders, including major depression, anxiety, panic disorder, post-traumatic stress disorder, impulsivity or personality disorder (Friedland 2002). According to the National Institute of Mental Health, as many as one in three people living with HIV/AIDS may suffer from depression, and depression itself can accelerate the progression of HIV to AIDS (NIMH 2000).

Living with HIV/AIDS and being incarcerated are both major sources of stress, which can contribute to depression and other psychological impairments. But that does not mean that major depression should be seen as a natural or inevitable condition. It is important to screen for and treat depression in prisoners living with HIV/AIDS for a number of reasons:

- ✓ Depression itself is a serious illness that can have a devastating effect on a person's quality of life.
- ✓ Untreated depression is associated with an increased risk of suicide.
- ✓ Depression and other psychiatric illnesses may impair a person's ability to adhere to antiretroviral treatment regimens, and thus may complicate efforts to treat HIV/AIDS.
- ✓ Depression shares many symptoms with other serious neurocognitive disorders and complications. Persons with symptoms of depression should be evaluated by a skilled health care provider who is able to screen for other impairments, including bipolar disorder, schizophrenia, AIDS dementia complex, medication interactions, HIV encephalopathy or other diseases of the central nervous system.

Mental Health and HIV/AIDS: The Facts

- ✓ Adults with severe mental illness have had increasing rates of HIV infection in recent years (Otto-Salaj and Stevenson 2001; Cournos and McKinnon 1997).
- ✓ Certain types of mental illness, including bipolar disorder — sometimes called manic-depression — and possibly schizophrenia, are associated with increased HIV risk behaviors (Otto-Salaj and Stevenson 2001).
- ✓ A study of male prisoners in Connecticut showed that a history of mental illness tripled the likelihood that a patient would become infected with HIV (Altice *et al* 1998).
- ✓ An estimated 43–65% of incarcerated women have experienced physical, sexual or psychological abuse before their admission to prison or jail. High levels of abuse may also contribute to the high prevalence of post-traumatic stress disorders and other psychological impairments among women prisoners (CDC 2001a).
- ✓ Among mentally ill prisoners, 78% of women and 30% of men report prior physical or sexual abuse (Ditton 1999).
- ✓ Substance abuse is correlated with all major mental illnesses, including schizophrenia, depression, bipolar disorder and severe personality disorders (Cournos 2001).

Symptoms of major depression include:

- ✓ Feelings of sadness, hopelessness.
- ✓ Loss of interest in formerly enjoyable activities, including sex.
- ✓ A sense that life is not worth living or that there is nothing to look forward to.
- ✓ Feelings of excessive guilt, or a feeling that one is a worthless person.
- ✓ Slowed or agitated movements (not in response to discomfort).
- ✓ Recurrent thoughts of dying or of ending one's own life, with or without a specific plan.

- ✓ Significant, unintentional weight loss and decrease in appetite; or, less commonly, weight gain and increase in appetite.
- ✓ Insomnia or excessive sleeping.
- ✓ Fatigue and loss of energy.
- ✓ A diminished ability to think, concentrate or make decisions.
- ✓ Physical symptoms of anxiety, including dry mouth, cramps, diarrhea and sweating (NIMH 2000).

Any or all of these symptoms may occur from time to time as part of life's ups and downs and do not necessarily indicate that a person is seriously, clinically depressed. The National Institute of Mental Health suggests these criteria for determining if depression may be approaching clinical levels:

- ✓ The symptoms last all day, every day, for at least two weeks.
- ✓ The symptoms occur together during the same time period.
- ✓ The symptoms cause daily events such as work, self-care and child care or social activities to be extremely difficult or impossible.

Prisoners' symptoms of mental illness are sometimes seen as simple behavioral problems and are therefore dealt with as security/punishment issues, rather than as health care issues. It is important for service providers and correctional staff who

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For prisoners, as with anyone living with HIV/AIDS, psychological impairments may have existed prior to a person's HIV infection, they may be related to substance abuse (either current or previous), or they may be complications of HIV-infection itself, of opportunistic illnesses, of medication side effects, or of metabolic abnormalities (NIMH 2000). Appropriate treatment requires an accurate identification of the source of the impairment (Karasic and Dilley 1998).

In addition to the high levels of pre-existing mental illness among prisoners in general, it is important for service providers and correctional staff working with prisoners with HIV/AIDS to be aware that HIV/AIDS itself can also cause some mental impairments. Prisoners with HIV/AIDS should be screened and monitored by mental health professionals capable of diagnosing and treating such complications. Cognitive and motor impairments directly related to HIV-infection are rare among asymptomatic HIV-positive people, but their prevalence increases in people with more advanced HIV-disease. These can include delirium, depression, mania, anxiety disorders, cognitive impairment and dementia (Karasic and Dilley 1998).

Case Study 2: *Javier is a life-sentence prisoner who first tested HIV-positive in the late 1980s. Javier has exhausted most treatment options for his HIV-infection, and now his virus is resistant to all known HIV medications. In the past eight months, his T-cell count has declined and his viral load has skyrocketed. Although he has no history of mental illness or disciplinary problems in prison, Javier's behavior has recently started to change. The HIV specialist doctor in the prison heard from correctional officers that Javier had been issued write-ups for insubordination (not following orders), and was facing a transfer to the segregation unit. At a regularly scheduled infirmary visit, Javier told the physician that he had fallen from his bunk, and that in general his balance seemed to be "off." The physician also noted that Javier seemed slow to react to instructions and other verbal cues. With Javier's consent, he ran a battery of tests for AIDS dementia complex and other HIV-associated illnesses.*

AIDS Dementia Complex (ADC) can be one of the most serious complications of late-stage AIDS. ADC impairs cognition (i.e. thinking, the intellect), motor skills and sometimes behavior. There are several different stages of ADC, and the more severe stages are most often found in persons with advanced HIV disease. The earliest stages of ADC are characterized by difficulty in dealing with the more complex tasks of daily living, forgetfulness and difficulty with complex thinking. Later stages can entail an inability to manage even the basic tasks of daily living (including taking medications), disorientation, slowed thought and speech, unstable and slowed walking and other movement (Price 1998).

ADC symptoms are similar to those of several other serious AIDS-related illnesses, including central nervous system lymphoma and hydrocephalus. As in the case of prisoners with symptoms of depression, prisoners with symptoms of ADC

should be evaluated by a skilled health care provider who is able to diagnose and distinguish between these serious illnesses. To aid in the screening process for ADC, Johns Hopkins University publishes an HIV dementia scale. It is available online for free at the following address: http://www.iapac.org/clinmgt/mh/demscale.html

SUBSTANCE ABUSE ISSUES AMONG PRISONERS LIVING WITH HIV/AIDS

Since the beginning of the HIV/AIDS epidemic, injection drug use has accounted directly and indirectly for more than one-third of AIDS cases in the United States (CDC 2002). It is estimated that more than 1 million U.S. residents are active injection drug users, including users from all racial and socio-economic groups — but it is communities of color who are most heavily affected by injection-drug-associated AIDS (see Table 2).

TABLE 2. Injection Drug Use-Associated AIDS Cases in Adults and Adolescents, as a Percentage of All AIDS Cases, Year 2000

African Americans	26%
Latinos/as	31%
Whites	19%

Source: CDC 2002

Substance abuse is the key to understanding the prevalence of HIV/AIDS in prisons and jails. State prisoners incarcerated for drug-related offenses were more likely to be HIV-positive than those in prison for violent, property-related or public order offenses (Hammett *et al* 1999). In 1996, the proportion of all state prisoners who were HIV-positive was 2.3%, but the proportion of prisoners with a history of injection drug use who were HIV-positive was 4.6% (Hammett *et al* 1999).

Correctional staff and service workers working with HIV-positive prisoners are on the front lines of a critical battle in the fight against HIV/AIDS. Prisons provide a point of access to many people with substance abuse problems who are among the most at-risk, underserved populations affected by the epidemic. The Centers for Disease Control have named prisons and jails

Substance Abuse and HIV/AIDS: The Facts

- ✓ Substance abuse among prisoners is implicated in recidivism: the proportion of first-time offenders reporting a history of regular drug use is 41%, but this rises to 81% among prisoners with five or more prior convictions. (Varghese 1999).
- ✓ Illicit drug use within prisons is, of course, illegal — but it unquestionably goes on. A focus group study with former New York state prisoners in 1996 found that prisoners had used a number of unsafe means of injecting drugs while in prison, including used syringes and pieces of pens and light bulbs (Mahon 1996).

as a key strategic site for HIV prevention among injection drug users and have identified three main goals for such work:

- ✓ help the uninfected stay that way
- ✓ help infected people stay healthy
- ✓ help infected individuals initiate and sustain behaviors that will keep themselves safe and prevent transmission to others (CDC 2002)

Because so many prisoners have histories of substance abuse, prisons and jails are key sites for promoting health, substance abuse treatment and HIV prevention. HIV-positive prisoners with substance abuse histories also have an increased likelihood of being coinfected with hepatitis B and C as well as other blood-borne illnesses or serious health concerns, including bacterial skin and respiratory infections, endocarditis and renal (kidney) disease (Friedland 2002).

There is little statistical evidence to describe those who are "triple diagnosed" — that is, people with HIV/AIDS, mental illness and substance abuse problems — in prisons. But even among non-prisoners, the statistics are striking. People receiving treatment for serious mental illnesses are three to

25 times more likely than the general population to have a substance abuse problem, and 10 to 50 times more likely to be HIV-positive (Friedland 2002). Because of the high prevalence of mental illness, substance abuse and HIV/AIDS in prisons, it is expected that the number of incarcerated people facing these interlocking challenges is significant.

Experts in the treatment of triple diagnosed persons note that integrated treatment of all three conditions (mental illness, drug use and HIV/AIDS) is likely to be more successful and efficient than separate or consecutive services (Friedland 2002, Lurigio and Swartz 2000).

MENTAL HEALTH TREATMENT AND ACCOMMODATION IN PRISONS

In 1998, 16% of U.S. prisoners were considered to be mentally ill, and 60% of those who were considered to be mentally ill received mental health treatment of some kind in prison or jail (Ditton 1999). As with substance abuse treatment, there is evidence of racial disparity in mental health treatment in U.S. correctional facilities. In state prisons in 1998, 64% of white prisoners considered to be mentally ill were receiving treatment, as compared with 60% of Latina/os and 56% of African Americans (Ditton 1999).

Many people with mental illnesses end up in prison or jail because the criminal justice system has become "the system that can't say no" to arrestees, even when all parties involved would prefer to access mental health facilities instead (Lurigio and Swartz 2000). The deliberate deinstitutionalization of people with mental illnesses in the United States reduced the population of people living in state mental hospitals from 560,000 in 1955 to 77,000 in 1994 (DHHS 1994) — many people who were displaced by deinstitutionalization, or who in earlier years would have been addressed through mental health institutions, have instead ended up consigned to prisons and jails. Although not designed as treatment facilities, a great burden of the responsibility for acute and chronic mental health treatment for those most desperately in need of such services has fallen on correctional institutions and the service agencies with whom they have formed partnerships.

Case Study 3: *David is a 15 year old who has lived in a series of foster homes and group homes. He was caught stealing at his most recent group home and is now awaiting trial at a juvenile facility. David says he has a history of suicide attempts and that he regularly uses alcohol and a number of different drugs. After being caught having sex with another young male prisoner in the facility, David is placed in segregation and is counseled to take an HIV test. The test is negative. When the counselor informs David of his test result, he is nonchalant: "Whatever — I assumed I was positive. What difference does it make?" The counselor talks to him about the risk of HIV infection, but feels that depression may be playing a role in David's behavior. The counselor refers David to the psychologist as well as the facility's infirmary for a mental health and medical assessment. Because David is awaiting trial and his release date is uncertain, the counselor and the facility's discharge planning team try to immediately begin making arrangements for follow-up medical and mental health services after David's release. Because David is a minor, all such arrangements have to be coordinated with the state Department of Youth and Family Services.*

Acutely mentally ill prisoners are at high risk for suicide and self-harm, as well as other destructive behaviors. Prison and jail protocols for dealing with inappropriate behavior should take account of the high prevalence of mental illness among inmates and should seek to channel mentally ill prisoners into opportunities for treatment whenever possible, rather than further punishment. Acutely mentally ill prisoners can undoubtedly be a source of stress, worry and disruption to other prisoners and staff that live and work in their vicinity. But punishment and isolation will often make such behaviors worse and cause real harm or danger to the prisoner acting out. Service organization staff and correctional staff working with such prisoners need adequate support from medical and mental health professionals trained in HIV/AIDS and mental health issues.

All mental health services depend in the first instance on appropriate screening and triage. The American Medical Association,

the American Psychiatric Association, the American Correctional Association and the American Association of Correctional Psychologists all publish standards for screening new prisoners for mental illnesses and potentially violent and/or suicidal behavior (Lurigio and Swartz 2000).

People living with HIV/AIDS who also have mental illnesses are subject to stress in the prison environment which can exacerbate their illnesses. Staff working with prisoners with HIV/AIDS should be trained in intake/screening procedures for mental illness and should also be trained in recognizing the HIV-associated impairments discussed earlier in this booklet.

A person's HIV infection is not a reason to avoid or delay providing mental health treatment, including pharmaceutical treatment. Indeed, mental health treatment may play a key role in stabilizing a person enough to facilitate development of an HIV/AIDS treatment strategy. That said, there are a number of important drug interactions between psychoactive medications and antiretrovirals. Because this is a complicated and fast-moving area of medicine, there is no substitute for the supervision of an experienced, qualified physician. Medical and mental health practitioners must be able to coordinate their prescribing in order to monitor drug interactions.

The Bureau of Justice Statistics has identified several different types of mental health support and treatment services offered to prisoners: screening, psychiatric assessments, 24-hour mental health facilities, therapy and counseling, psychotropic medications and assisting releasees in obtaining mental health services after release. More comprehensive services are more likely to succeed, especially those that link several different kinds of services (housing or shelter assistance, substance abuse, mental health, HIV/AIDS care) and are linked with community-based programs.

Case Study 4: Maryland Community Criminal Justice Treatment Program

The Maryland Community Criminal Justice Treatment Program is a multiagency state and local collaborative effort that provides housing and treatment services to Maryland prisoners and ex-prisoners with major mental illnesses. The program screens individuals in local jails, prepares treatment and aftercare plans for them and provides community follow-up after release. MCCJTP case management services include crisis intervention, screening, counseling, discharge planning and community follow-up. MCCJTP also offers long-term housing and provides a range of substance abuse treatment services. In some locations, MCCJTP also provides pre- and post-booking diversion programs to keep mentally ill offenders out of jail. MCCJTP is considered a model for interagency collaboration, and continuity of care. The National Institute of Justice profile on this program can be found online at www.ojp.usdoj.gov/nij

Source: Conly 1999.

SUBSTANCE ABUSE TREATMENT IN PRISONS

Prison-based substance abuse treatment can be an important element of HIV/AIDS prevention and treatment. Substance abuse treatment for prisoners not only can prevent primary new infections among at-risk populations, it also can reduce secondary new infections among sex partners and drug-injection partners of currently incarcerated HIV-positive persons, it can reduce a type of unhealthy behavior among HIV-positive drug users and it can reduce recidivism (CASA 1998).

Prison provides an opportunity to reach populations at high risk for HIV infection who might otherwise not receive HIV/AIDS prevention services. Prison also represents an opportunity to provide substance abuse treatment to heavily drug-involved populations who might otherwise not receive such services in the community (Varghese 1999).

There is a significant gap between the estimated need for substance abuse treatment and the actual availability of such services for U.S. prisoners. According to the Office of National Drug Control Policy, corrections officials estimate that 70% to 85% of prisoners need some form of substance abuse treatment, but a 1997 survey found that only 11% of the prisoner population were receiving such services (ONDCP 2001).

There are racial disparities among prisoners who do receive substance abuse treatment in prisons. Table 3 shows the percentage of alcohol- or drug-involved state and federal prisoners who report receiving treatment for substance abuse while in prison (see Table 3).

Table 3. Prisoners Who Report Receiving Substance Abuse Treatment in Prison, 1997

	State Prisoners	Federal Prisoners
African Americans	13.5%	11.9%
Latina/os	12.5%	8.2%
Whites	17.0%	16.0%

Source: Mumola CJ (1999) *ibid.* Adapted from Tables 14 and 15.

Closing the gap between the need for substance abuse services and their provision requires an expansion in the number of substance abuse treatment programs for prisoners, as well as a commitment among "gatekeepers" to such services to make them available to all prisoners who could benefit from them.

As in the case of mental health treatment, HIV infection is not a reason to avoid or delay providing substance abuse treatment. Many people with substance abuse problems, particularly those receiving substance abuse treatment who have ongoing access to clinical care, have been able to adhere to medication schedules and have benefited from recent advances in HIV/AIDS treatment (Friedland 2002). Methadone has significant, though manageable, interactions with many drugs used in the treatment of HIV/AIDS and opportunistic illnesses, and concurrent administration of HIV/AIDS medications and methadone should be carefully supervised by experienced, qualified physicians.

Substance abuse treatment based in prisons can include psychotherapy, peer discussion groups, individual counseling, group counseling, vocational therapy, cognitive therapy, 12 step meetings (such as Narcotics Anonymous and Alcoholics Anonymous), drug education, residential treatment such as therapeutic communities and methadone maintenance. Many jurisdictions have instituted mandatory drug testing for prisoners. As in the case of HIV testing, drug testing only provides

information about the fact that drug use is taking place; it should not be conflated with substance abuse treatment.

The office of National Drug Control Policy estimates that substance abuse treatment for prisoners and parolees can reduce recidivism by about 50 percent (NIJ 2000). A Federal Bureau of Prisons study on the effectiveness of prison-based residential substance abuse treatment found that the program significantly reduced both the likelihood of re-arrest and using drugs in the first six months after release (ONDCP 2001). Another study of state substance abuse programs found that the greatest effects on re-arrest and drug use rates among recent ex-prisoners were achieved when prisoners participated in a combination of several different kinds of drug treatment programs.

Correctional staff and those who work with corrections-associated agencies should be familiar with substance abuse treatment services available for prisoners and should be skilled in matching prisoners' individual needs and problems to appropriate services — particularly in the case of triple diagnosed prisoners (those with mental health issues, substance abuse issues and HIV/AIDS), matching services to the needs of individual prisoners may improve the success rates of such programs.

It is also important to remember that individual staffers' commitments can make a difference in prisoners' lives and in the success of substance abuse programs for prisoners. A National Institute of Corrections study on effective substance abuse programs for incarcerated women and youthful violent offenders found that staffing was the most critical factor affecting program success: "Staffing emerges as the most critical variable. Although staff numbers and training are considered important, the more vital variables are commitment to individual offender progress as well as to program goals. Insight into human behavior and belief that behavior can change tend to outweigh training as variables in effective staffing" (NIC 1994).

RECENTLY RELEASED FORMER PRISONERS: HIV/AIDS, MENTAL HEALTH AND SUBSTANCE ABUSE ISSUES

Working with recently released prisoners can be a high-pressure, stressful task. But it can also be very rewarding when releasees are able to meet their goals, stay out of harm's way and avoid reincarceration. The issues of HIV/AIDS, substance abuse and mental health all add urgency to the task of providing services to recently released prisoners:

- ✓ For ex-prisoners receiving HIV/AIDS antiretroviral treatment, there is no "breathing period" of time to arrange post-release medical care; HIV/AIDS treatment must be absolutely continuous to avoid the development of resistance to antiretroviral medications.
- ✓ Prisoners with substance abuse problems are at risk of relapsing into active drug use upon release from prison or jail. Relapse entails a risk of re-arrest for new drug-related charges or reincarceration due to parole violations.
- ✓ Prisoners with mental health issues can require intensive case management services before and after release to ensure continuity of mental health treatment and adequate consideration of mental health issues in other post-release decisions, including substance abuse treatment, medical treatment, housing, parole conditions and employment.

In general, the key to providing adequate post-release services for recently released HIV-positive prisoners is for the contact between service providers and prisoners to begin as early as possible. Some discharge/transitional planning programs now

link agencies with current prisoners, so that post-release services can begin to be put in place up to six months before release. Others provide less access to current prisoners, but maintain close working relationships with correctional and service agency staff to facilitate post-release referrals and paperwork.

Long-term contracts or memoranda of understanding among agencies (including state mental health departments, public health departments and AIDS service organizations) can help determine which prisoners will be able to receive services from various agencies and the lines of accountability and funding that support these alliances (Lurigio and Swartz 2000).

One important factor in working with recently released HIV-positive ex-prisoners is documentation. Ex-prisoners should be released with medical documentation, usually a medical summary, after-care letter or service referral with a description of the ex-prisoner's health needs. Although it is often the responsibility of the prison or jail administration from which the prisoner was released to provide this type of documentation, it is not always provided and can sometimes be incomplete or inaccurate. Staff working in agencies serving former prisoners may find it helpful to be able to work with appropriate authorities to generate this type of paperwork when necessary. Having good working relationships with medical providers skilled in working with former prisoners, with parole authorities, and with sheriff's and correctional agencies will often help in this task.

In some jurisdictions, it may be possible to obtain ADAP (AIDS Drug Assistance Program) cards for HIV-positive prisoners upon their release. Ideally, the process of applying for Medicaid and other federal benefits will begin well before release dates, so these can be in place when it is time for the prisoner to transition back into the community.

In some areas, a referral can be made to appropriate medical providers without an ADAP or Medicaid card. In other areas, a means of payment must to be in hand before the visit. Some providers will submit applications themselves and defer receiving payment for their services until funds are available; some providers can apply for payment to a state's charity pool or emergency Medicaid fund. In some areas, however, the only option for non-emergency care is to wait until the means of payment is in place.

For substance abuse and mental health treatment, service providers should be familiar with locally available treatment services and their requirements for both eligibility and payment. Substance abuse treatment options may include group and individual counseling, short-term residential programs (also known as 28-day programs), long-term therapeutic communities (often 18 months) and a wide range of intermediate-term residential treatments. Twelve step groups are free-of-charge, while other options usually require payment. Medicaid usually covers 28-day programs, as well as longer programs if relapse consistently occurs after shorter treatments. Available mental health programs will vary widely depending upon locale.

ADDITIONAL RESOURCES AND READING

National Criminal Justice Reference Service Virtual Library, Section on Corrections: (subsections on mentally ill offenders and inmate drug treatment)

virlib.ncjrs.org/Corrections.asp

The Body's HIV/AIDS and Mental Health Page:

www.thebody.com/mental.html

The Body's HIV/AIDS and Substance Abuse Page:

www.thebody.com/whatis/druguse.html

AIDS.About.com's Substance Abuse page:

aids.about.com/cs/substanceabuse/

The American Psychiatric Association's HIV/AIDS Resource Center:

www.psych.org/aids

The National Institute of Mental Health, Center for Mental Health Research on AIDS:

www.nimh.nih.gov/oa

Mental Health Infosource:

www.mhsource.com

Substance Abuse and Mental Health Service Administration:

www.samhsa.gov

Mental Health in Corrections Consortium:

www.mhcca.org

The National GAINS Center for People with Co-Occurring Disorders in the Justice System (funded by the Substance Abuse and Mental Health Services Administration):

www.prainc.com/gains

For referrals to substance abuse treatment programs, call the National Institute of Drug Abuse:

Phone 1-800-662-HELP

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"Punishing prisoners for the symptoms of mental illness or impairment will generally not deter the behavior in the future and can often make the situation worse, both for the prisoners involved and for the staff and other prisoners who work and live with them."

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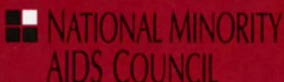

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