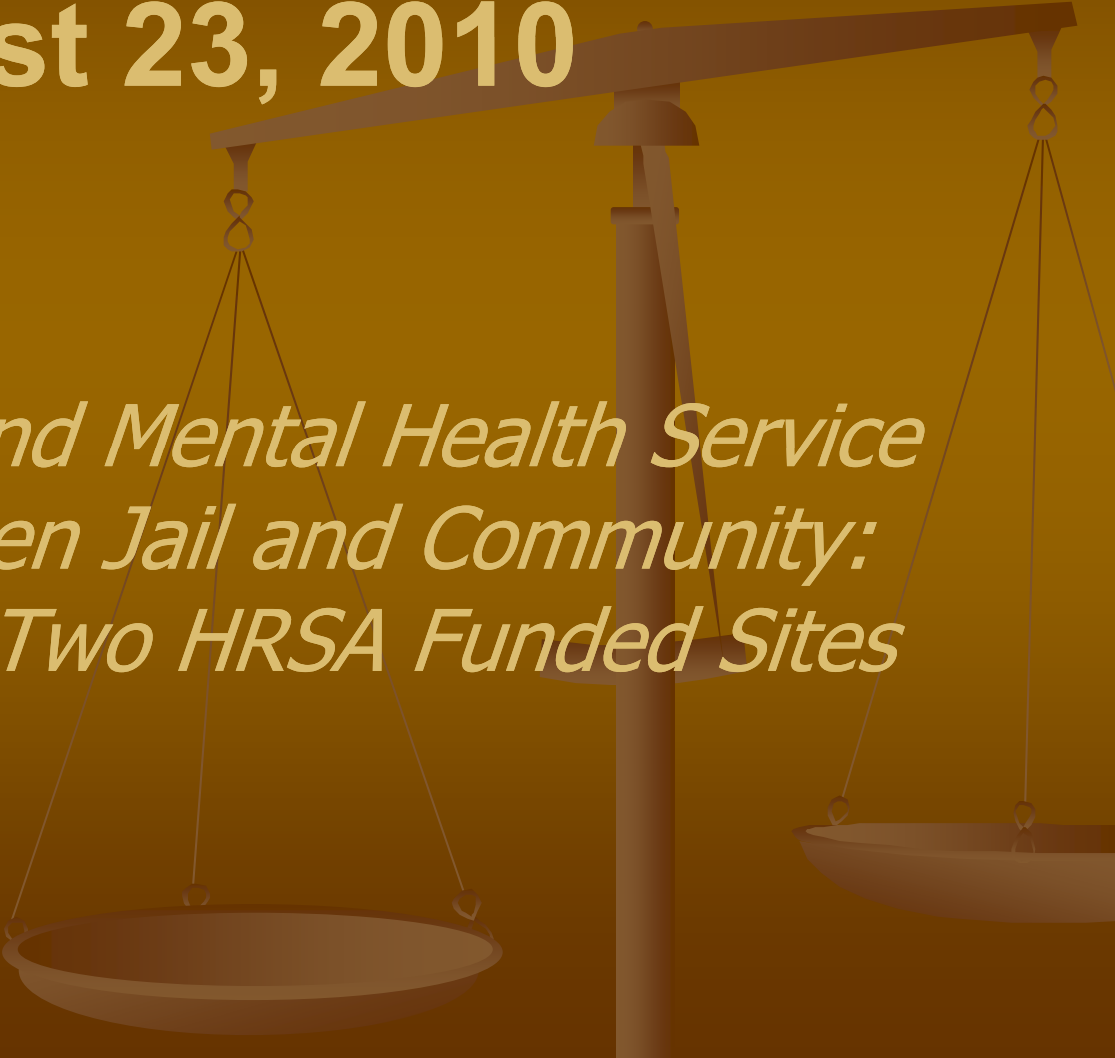


All Ryan White Grantee Meeting August 23, 2010

*Enhancing HIV and Mental Health Service
Linkages Between Jail and Community:
The Example of Two HRSA Funded Sites*



Disclosures



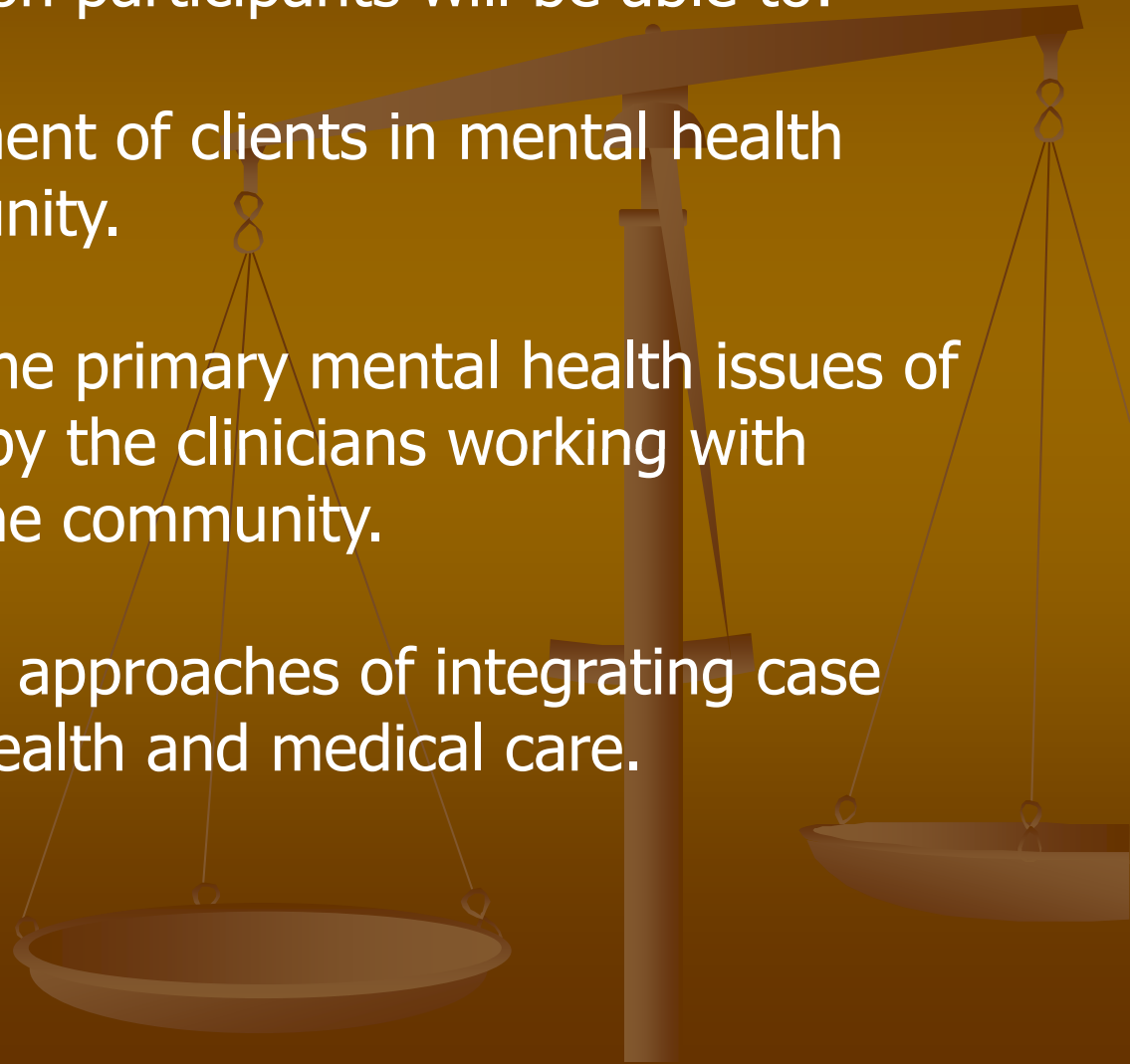
Maureen Desabrais, M.Ed, LSW, LADC 1, CCDP-D and Rachel Ciomcia, MSSA, LISW-S have no financial interest or relationships to disclose.

- HRSA Education Committee Disclosures
HRSA Education Committee staff have no financial interest or relationships to disclose.
- CME Staff Disclosures
Professional Education Services Group staff have no financial interest or relationships to disclose.

Learning Objectives:

By the end of this session participants will be able to:

1. Discuss the engagement of clients in mental health care from jail to community.
2. Have knowledge of the primary mental health issues of HIV patients identified by the clinicians working with clients in jail and into the community.
3. Describe the various approaches of integrating case management, mental health and medical care.



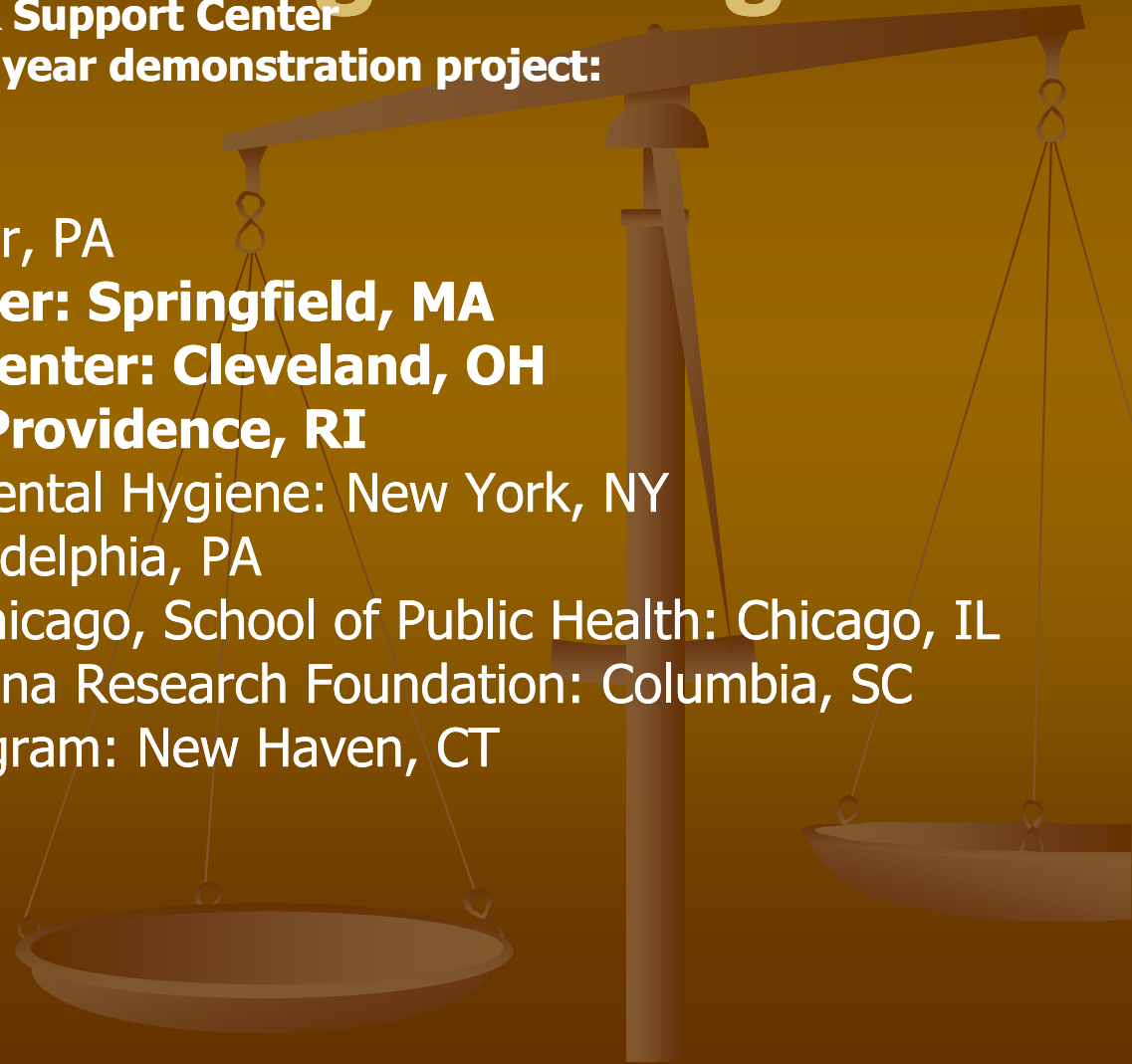
Special Project of National Significance

SPNS Enhancing Linkages

Emory University: Evaluation & Support Center

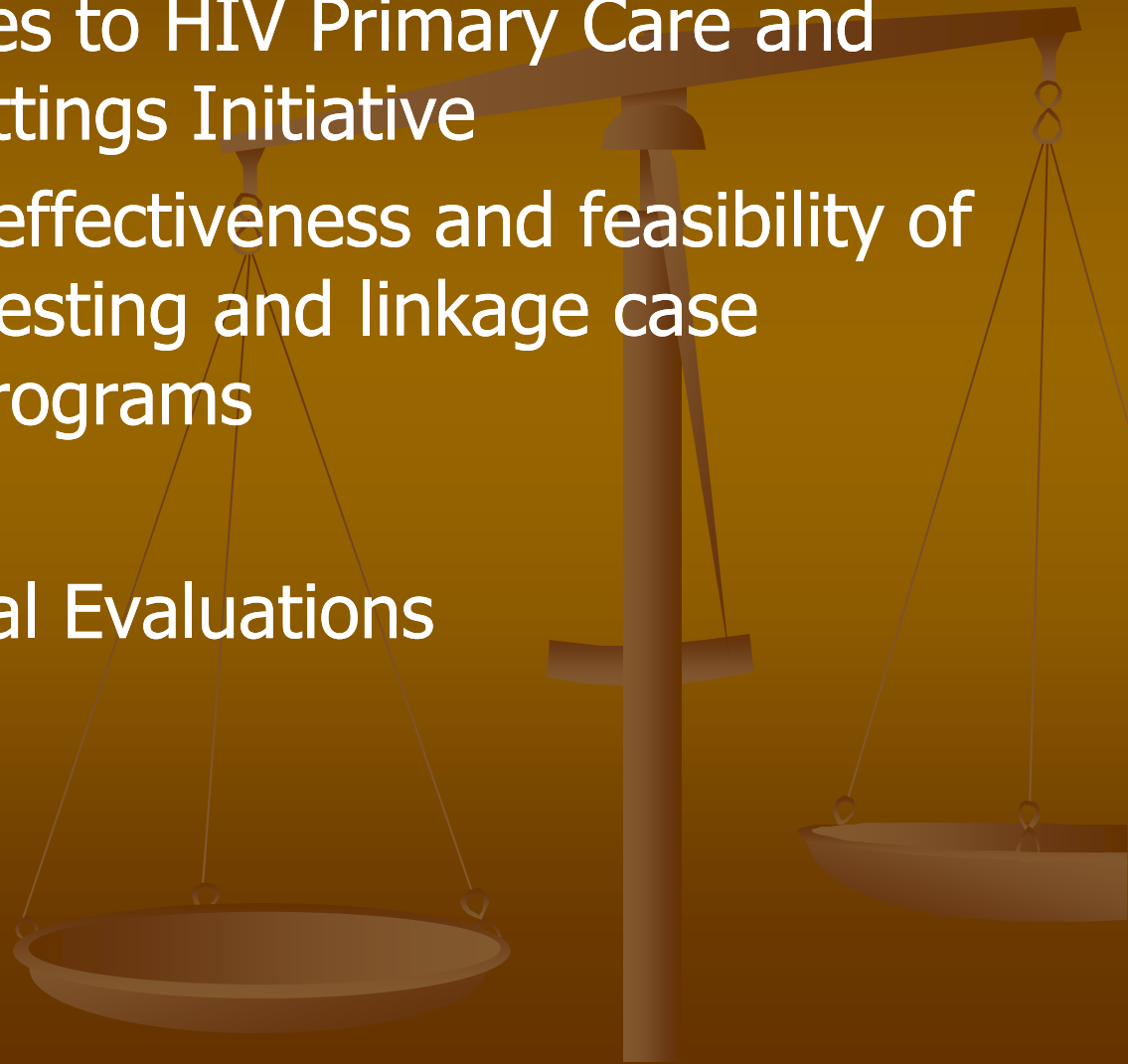
Ten sites nationally awarded 4 year demonstration project:

- AID Atlanta: Atlanta, GA
- AIDS Care Group: Chester, PA
- **Baystate Medical Center: Springfield, MA**
- **Care Alliance Health Center: Cleveland, OH**
- **The Miriam Hospital: Providence, RI**
- NYC Dept. of Health & Mental Hygiene: New York, NY
- Philadelphia FIGHT: Philadelphia, PA
- University of Illinois at Chicago, School of Public Health: Chicago, IL
- University of South Carolina Research Foundation: Columbia, SC
- Yale University AIDS Program: New Haven, CT



The SPNS Grant

- Enhancing Linkages to HIV Primary Care and Services in Jail Settings Initiative
 - Goal: Evaluate effectiveness and feasibility of jail based HIV testing and linkage case management programs
- Multi-site and Local Evaluations



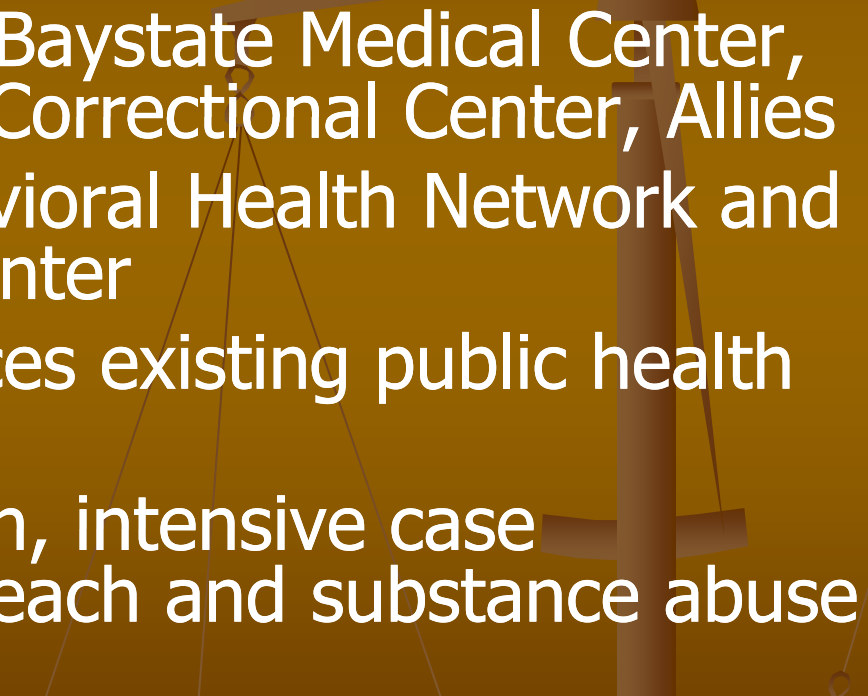
Baystate Medical Center



Hampden County Correctional Center



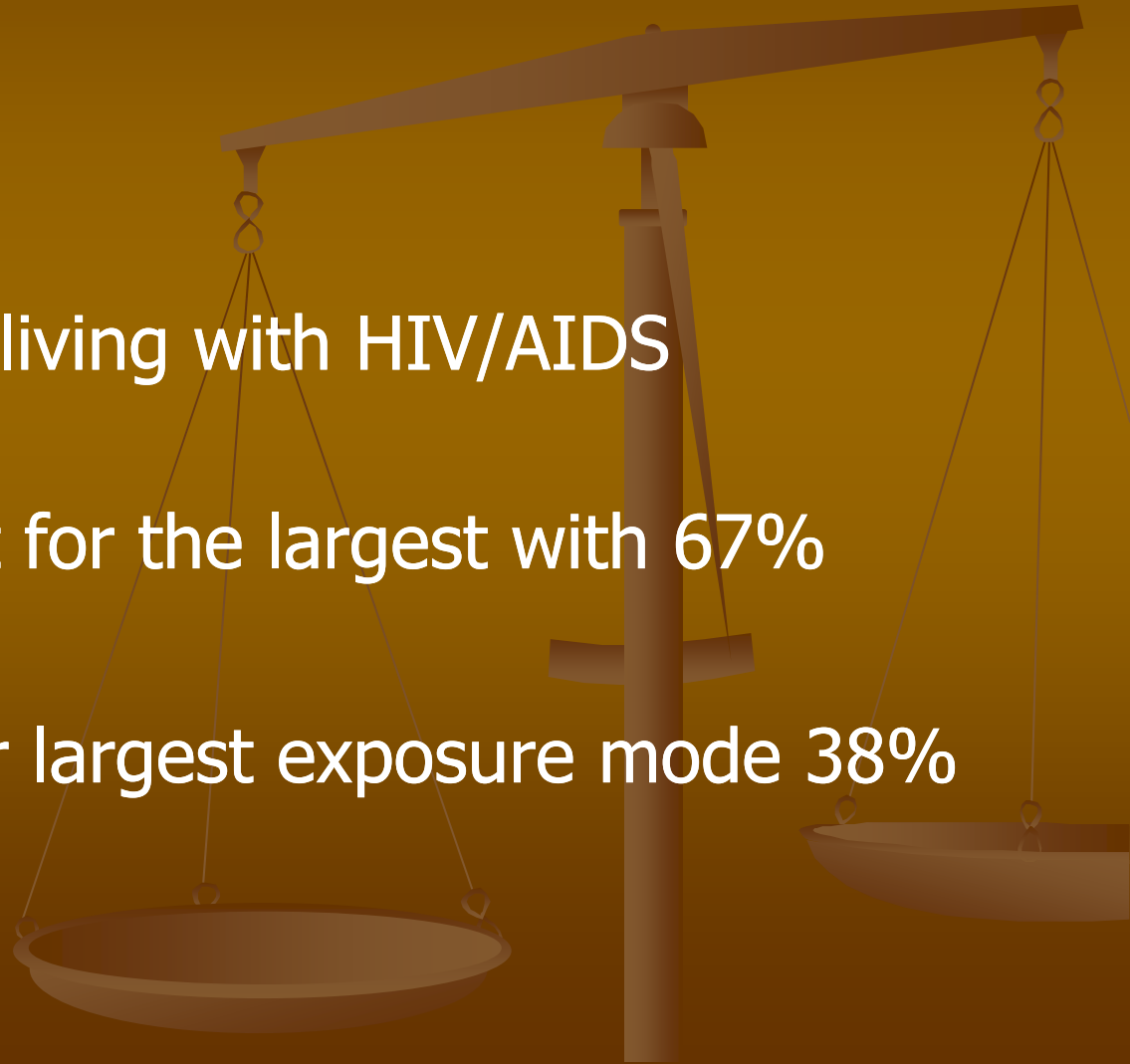
Mental Health as New Continuity Enhancement MHANCE

- A collaboration of Baystate Medical Center, Hampden County Correctional Center, Allies in Recovery, Behavioral Health Network and Holyoke Health Center
 - Expands & enhances existing public health model
 - Adds mental health, intensive case management/outreach and substance abuse services
- 

HIV Profile in Springfield/Holyoke

As of March 2010:

- 1,686 reported living with HIV/AIDS
- Latinos account for the largest with 67%
- IDU account for largest exposure mode 38%



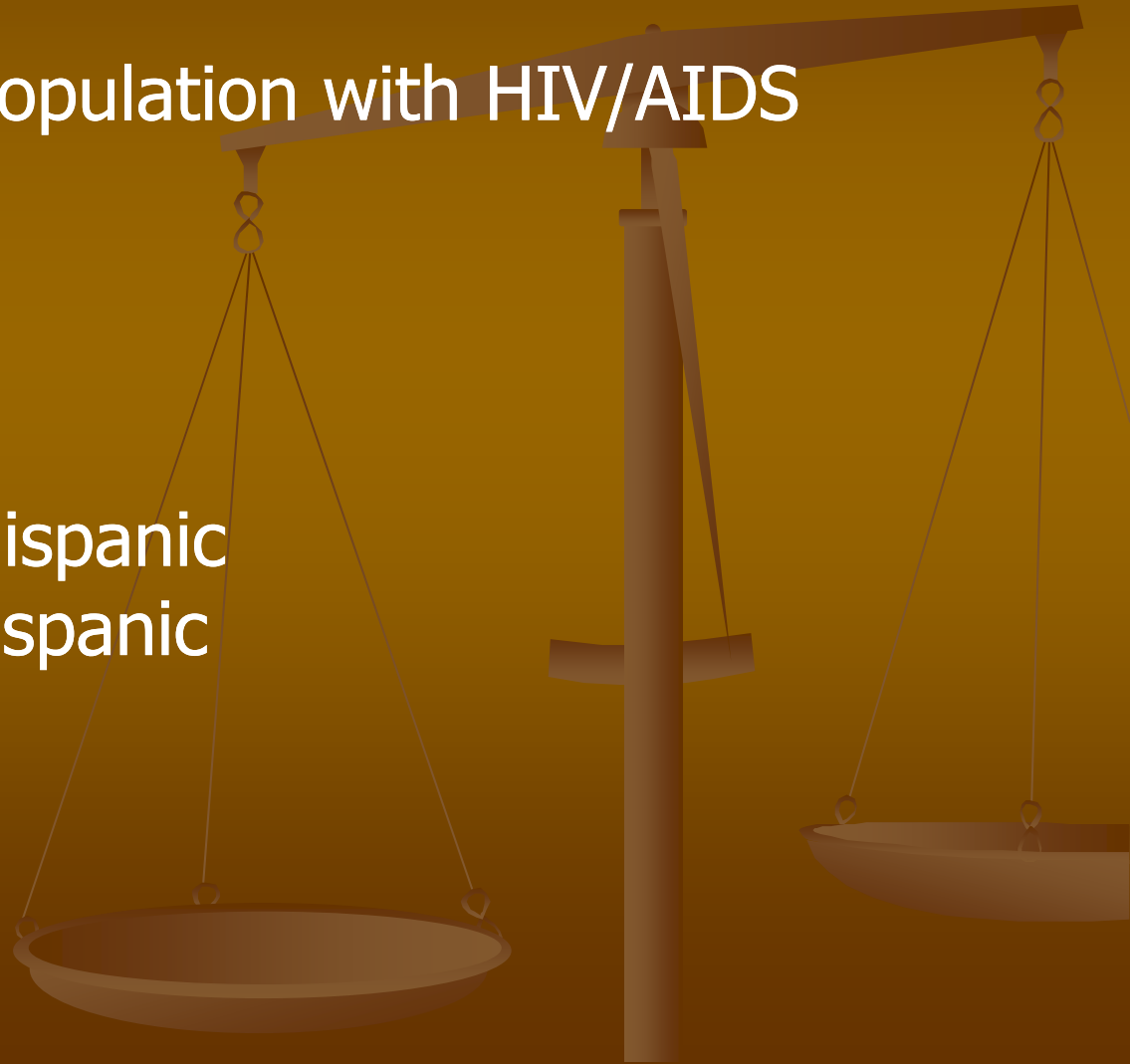
Profile MA Prisons/Jails

As of 12/2009

- 953 (5%) of MA population with HIV/AIDS
- 87% males
- 13% females

Race/Ethnicity

- 29% White Non-Hispanic
- 30% Black Non-Hispanic
- 40% Hispanic
- < 1% API
- 1% Other



HIV/AIDS Exposure in MA Prisons/Jails

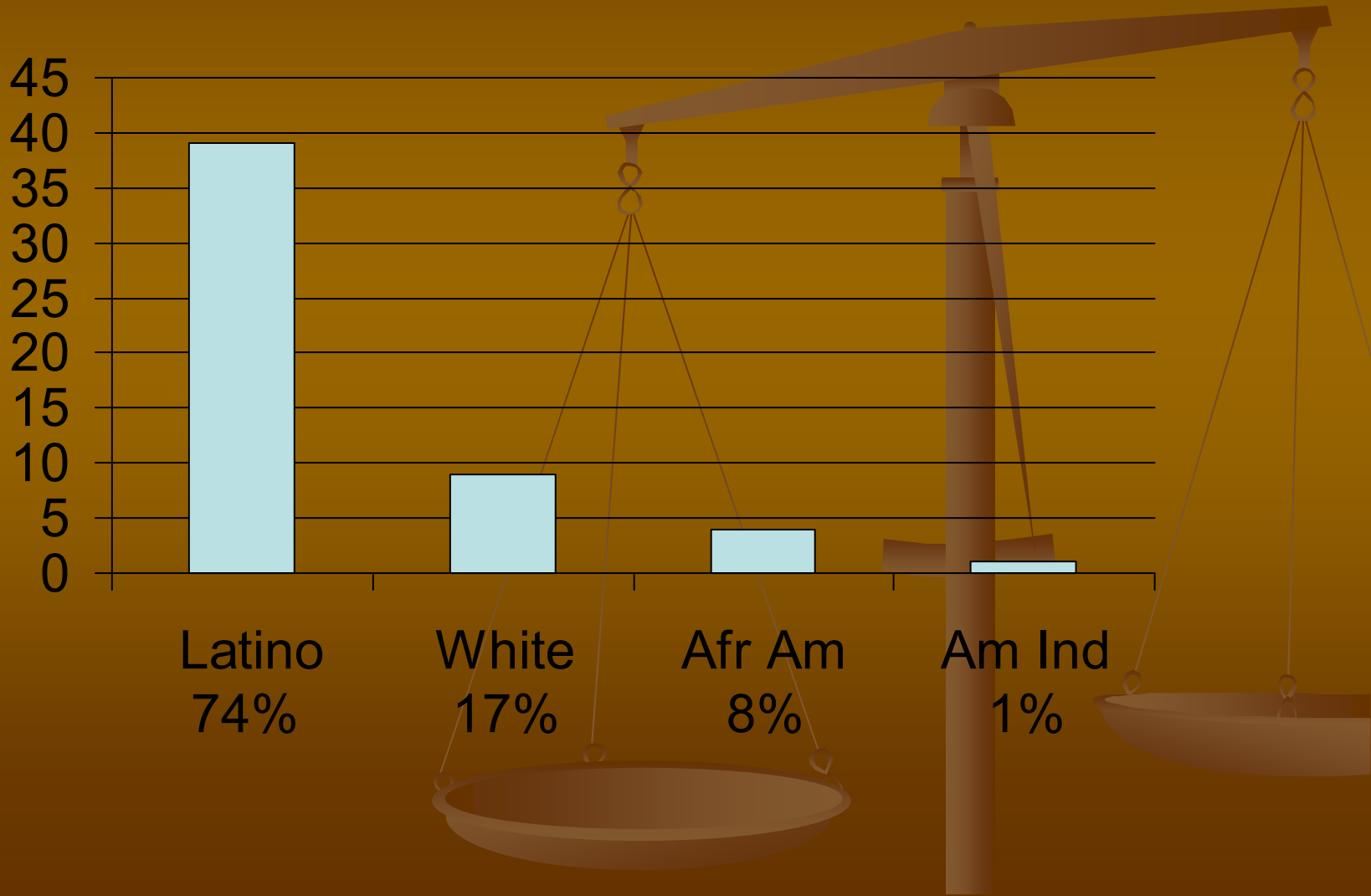
- 6% MSM
- 70% IDU
- 6% MSM/IDU
- 5% HTSX
- <1% Other
- 8% Presumed HTSX
- 5% Undetermined



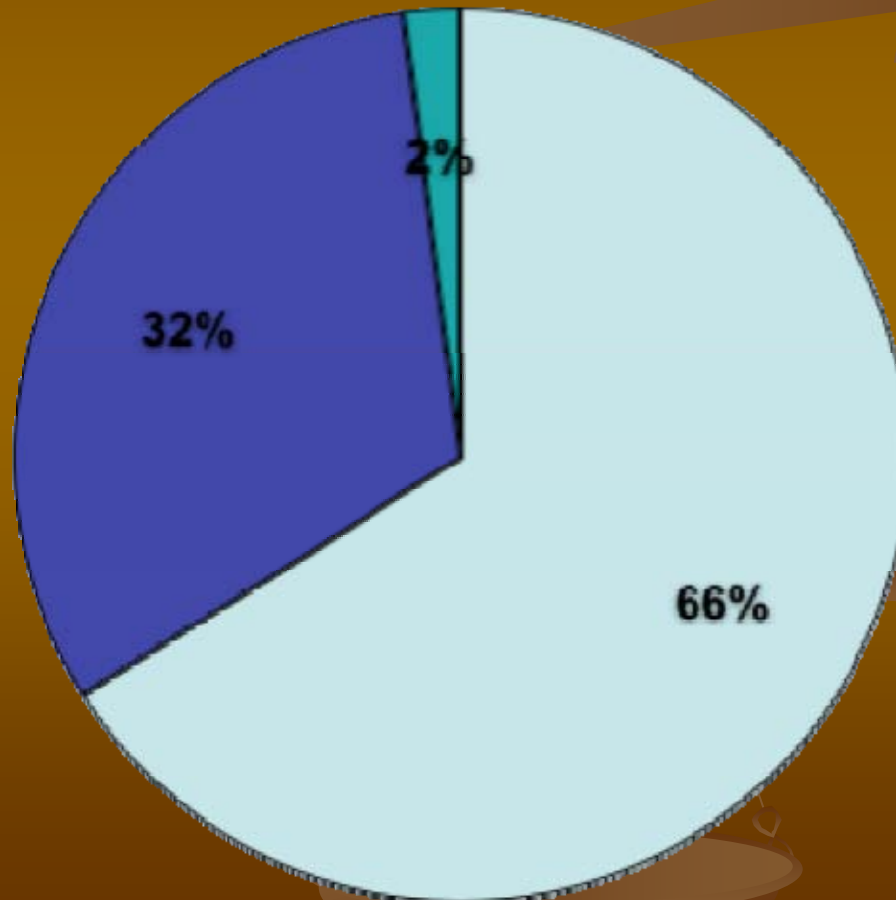
Profile of 50 Inmates at 30 Days Post-Release



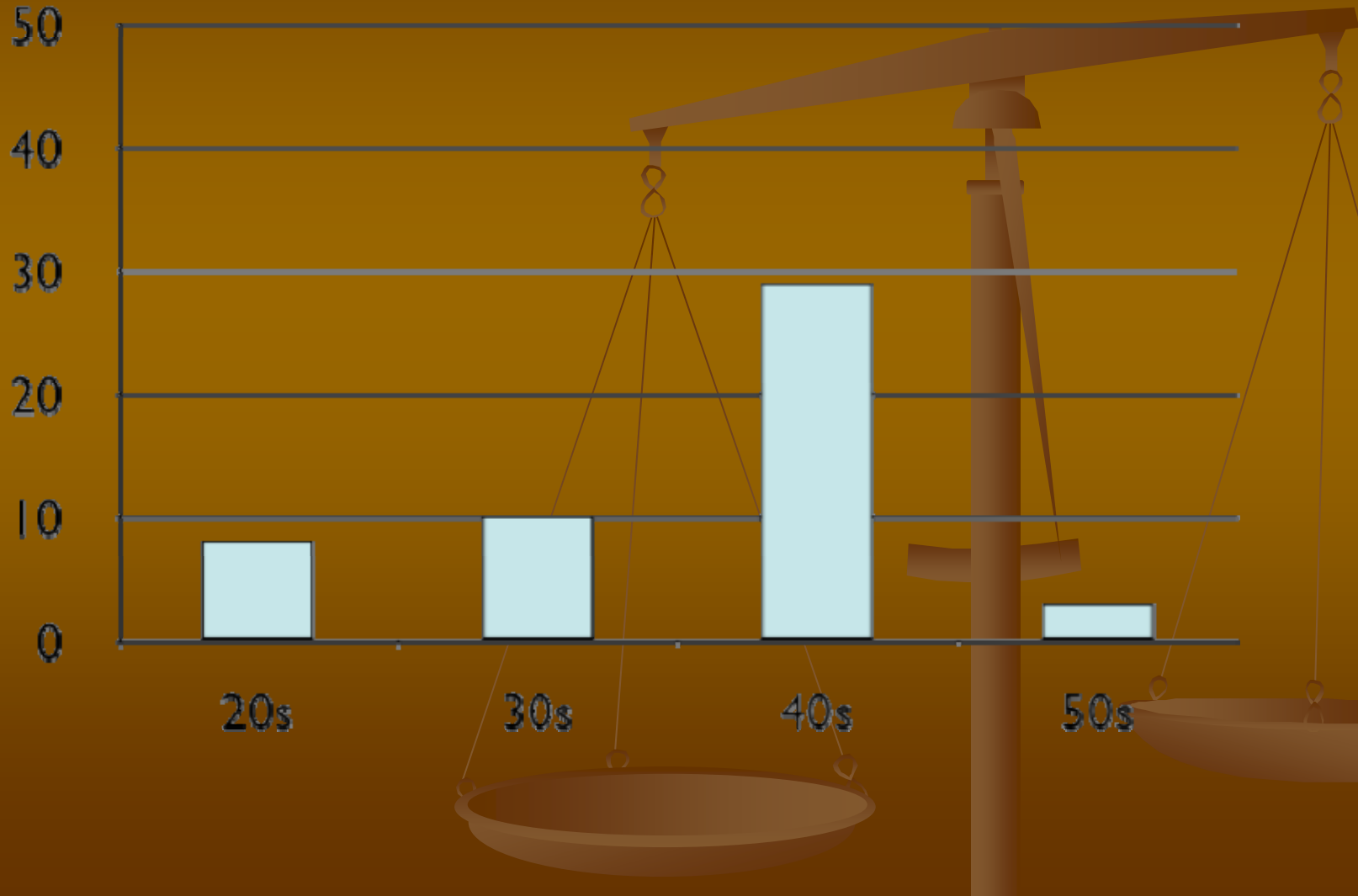
Ethnicity/Race N=50



Gender



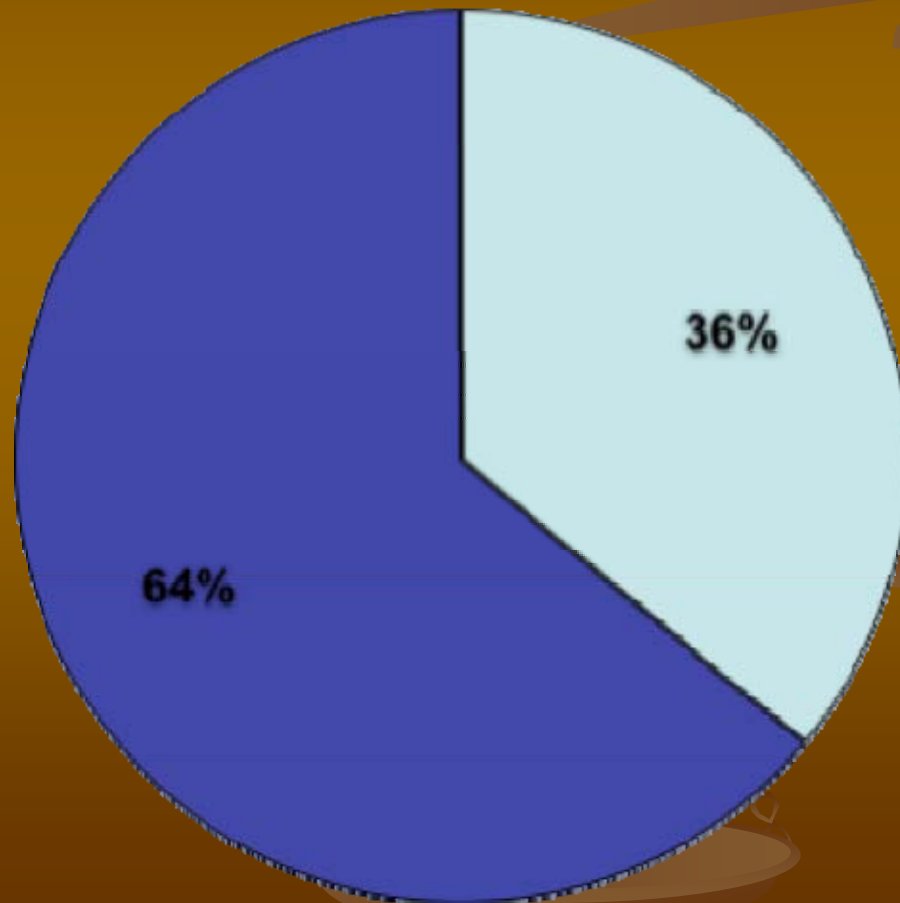
Age



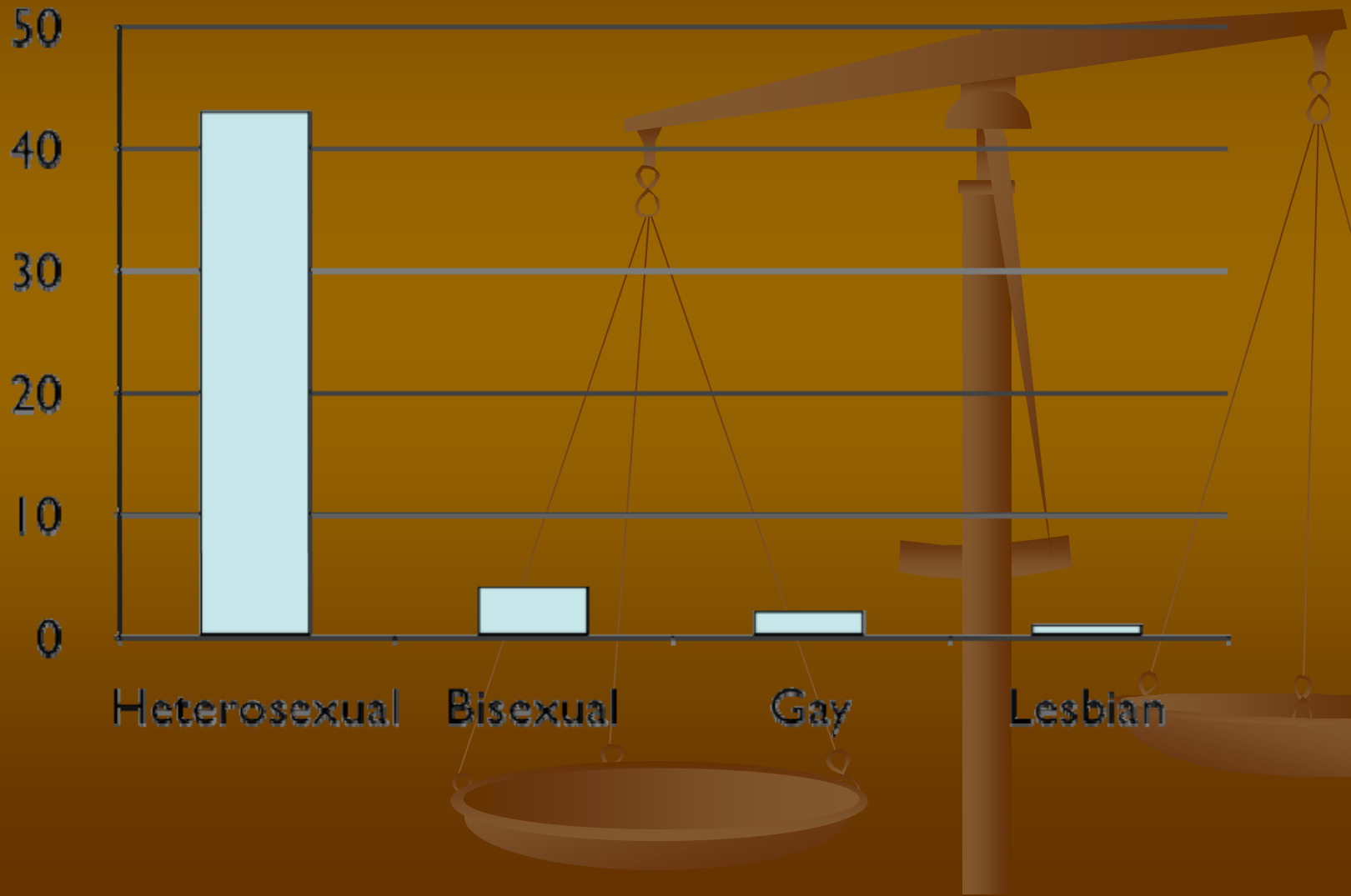
Primary Language Spoken

English

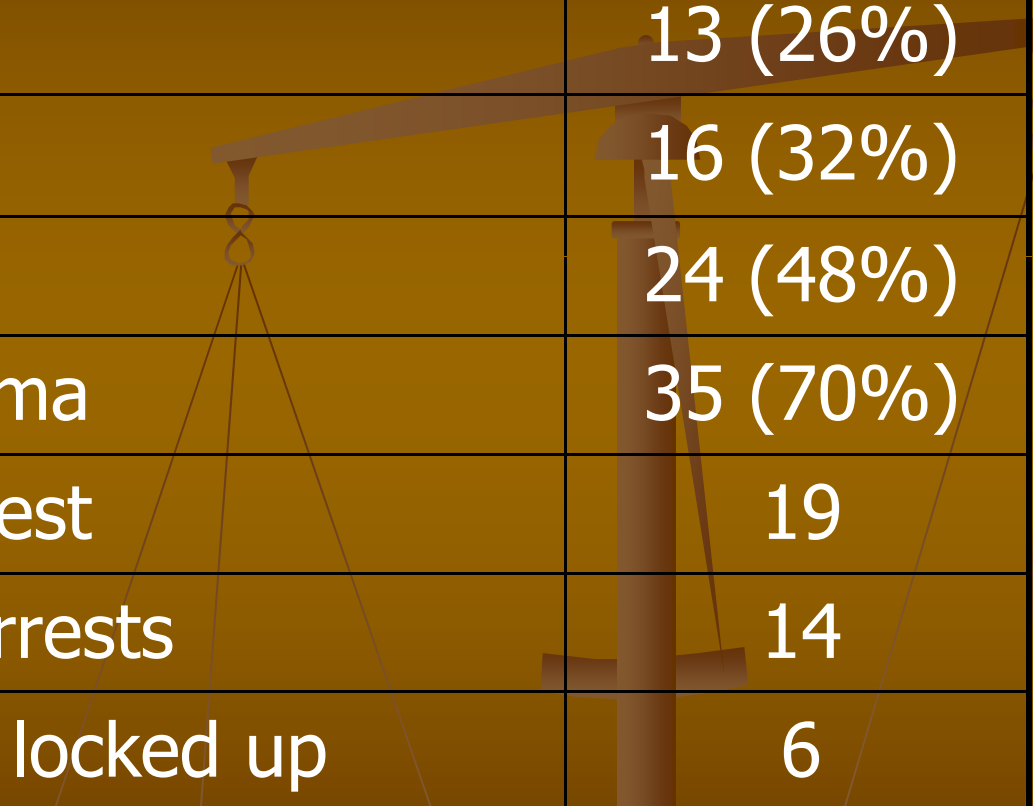
Spanish



Sexual Orientation

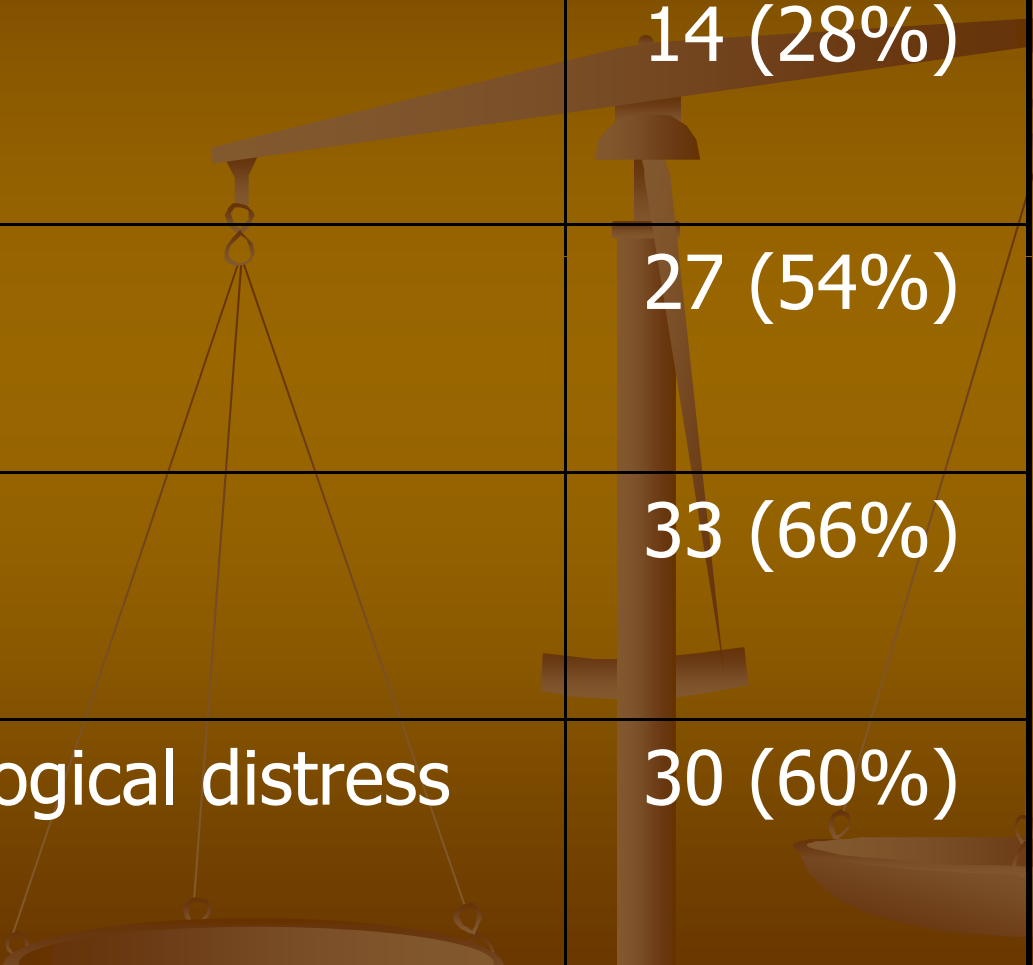


Prior to Incarceration (N=50)



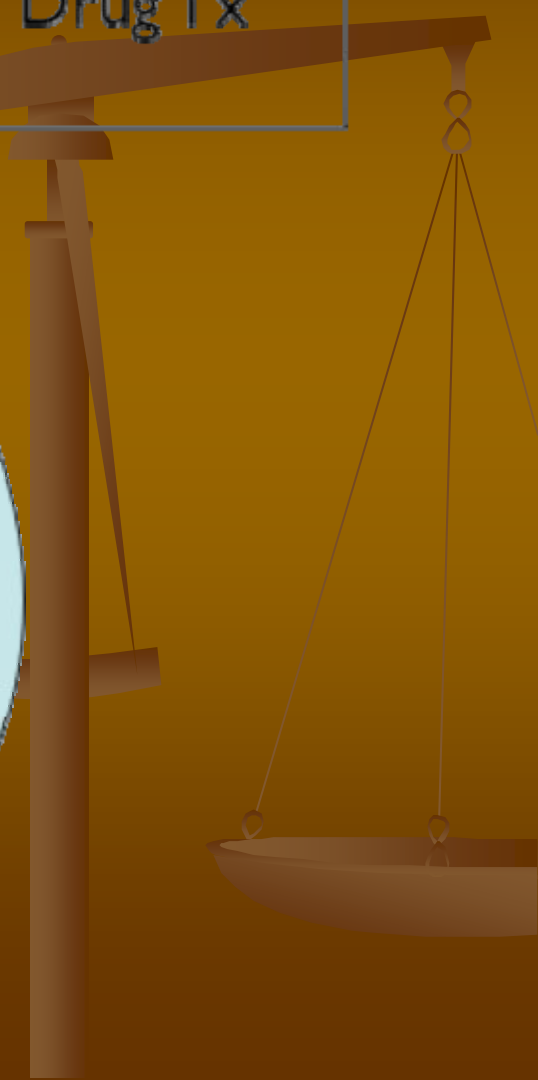
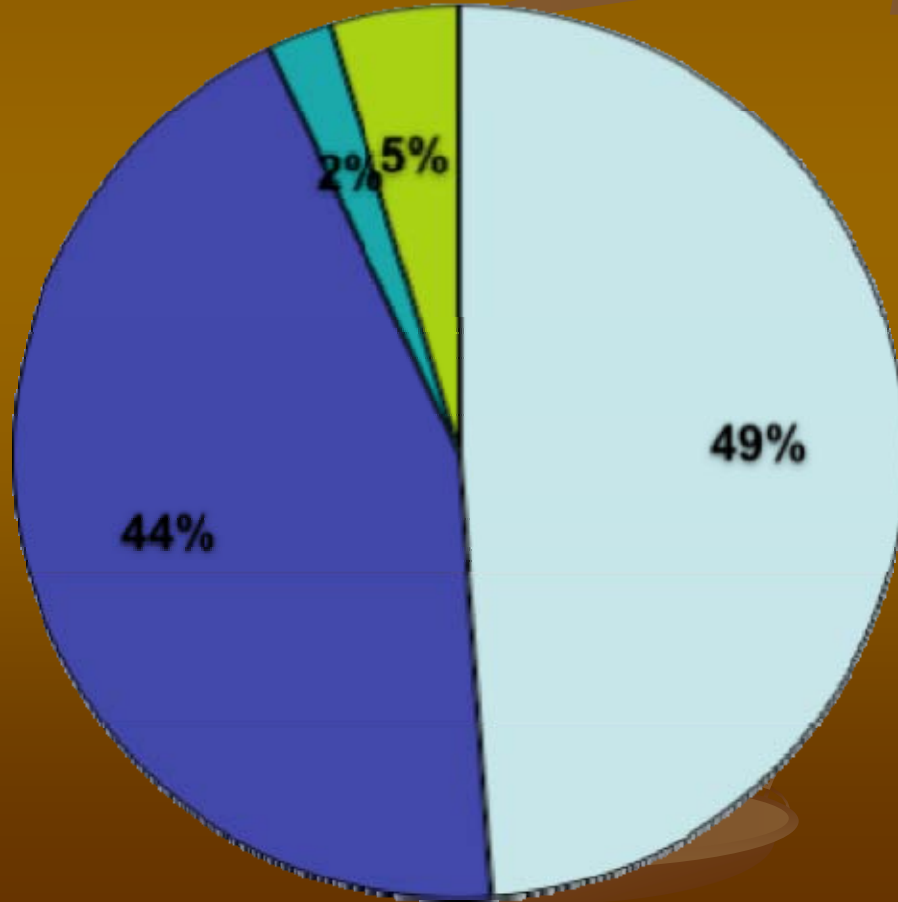
Dependent children	13 (26%)
Homeless	16 (32%)
Food Insufficiency	24 (48%)
No high school diploma	35 (70%)
Average age first arrest	19
Average # lifetime arrests	14
Average years spent locked up	6

Just Prior to Incarceration (N=50)

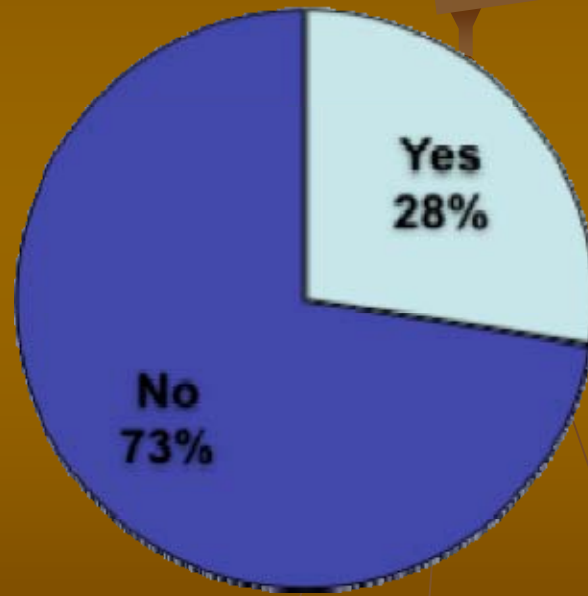


Drank to intoxication	14 (28%)
Used heroin	27 (54%)
Used cocaine	33 (66%)
Experienced psychological distress	30 (60%)

First Diagnosed with HIV in...

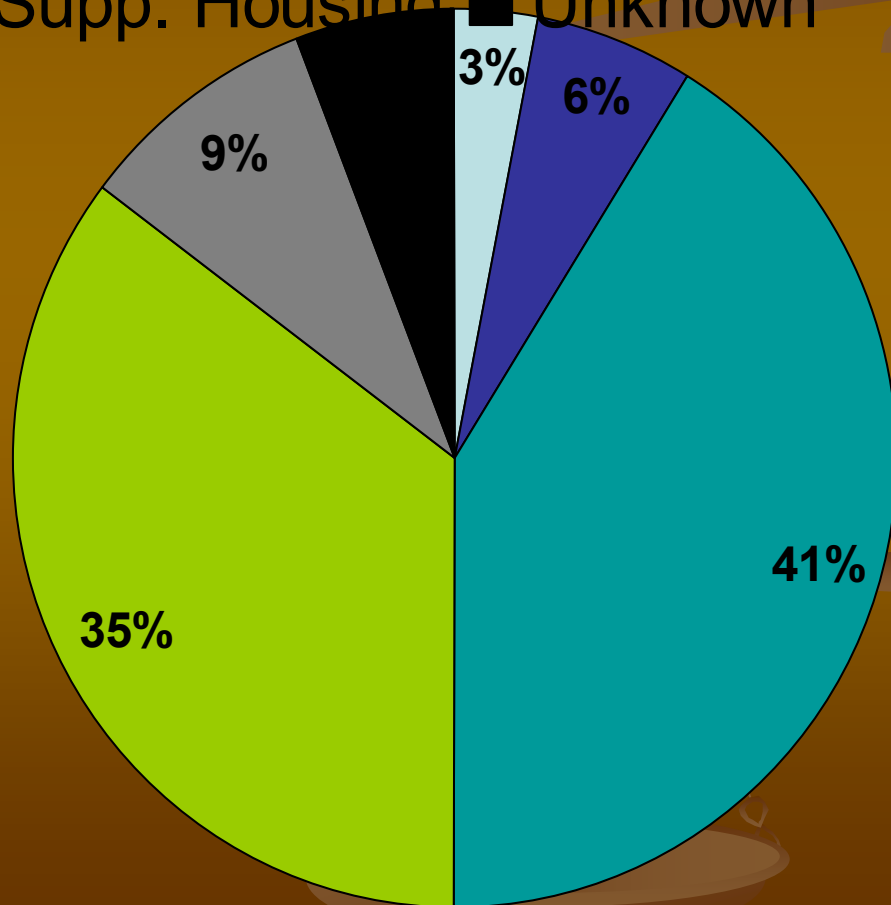


Taking HIV Meds Prior to Incarceration?

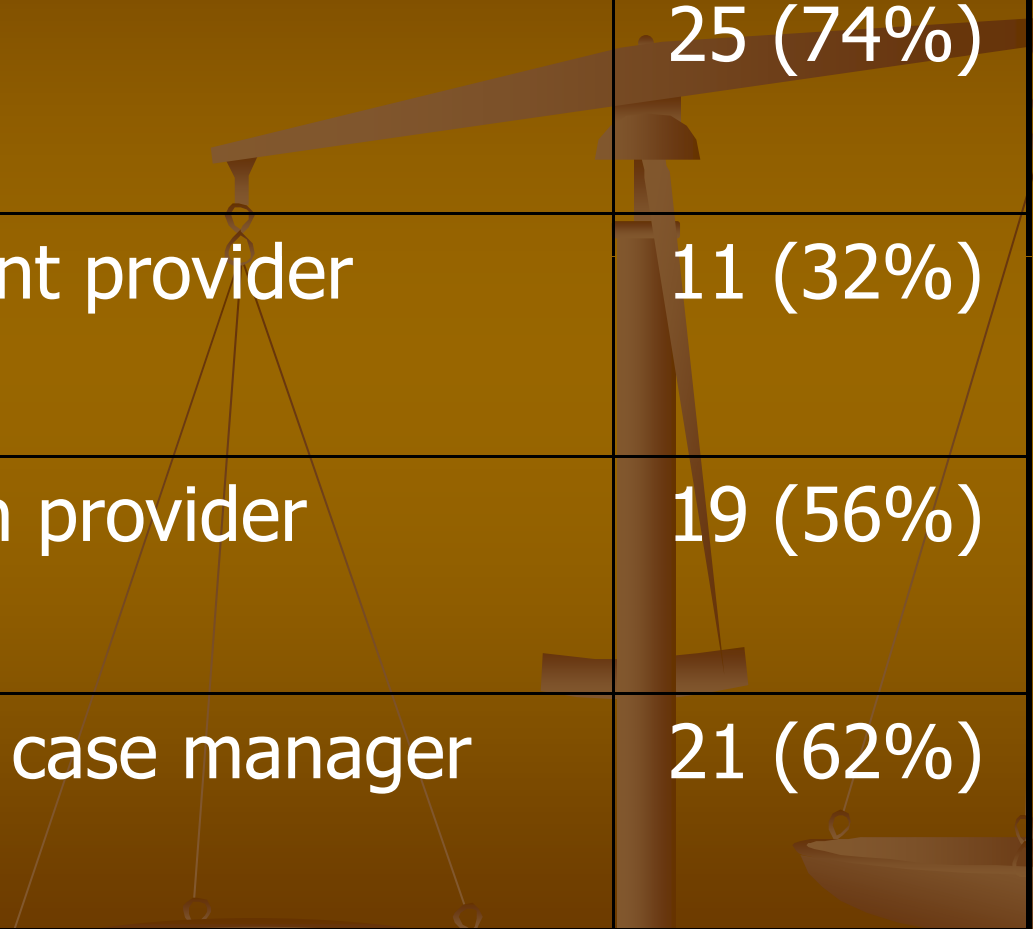


Housing 30-days Post Release

- Jail
- Inpatient
- Housed
- Homeless
- Supp. Housing
- Unknown

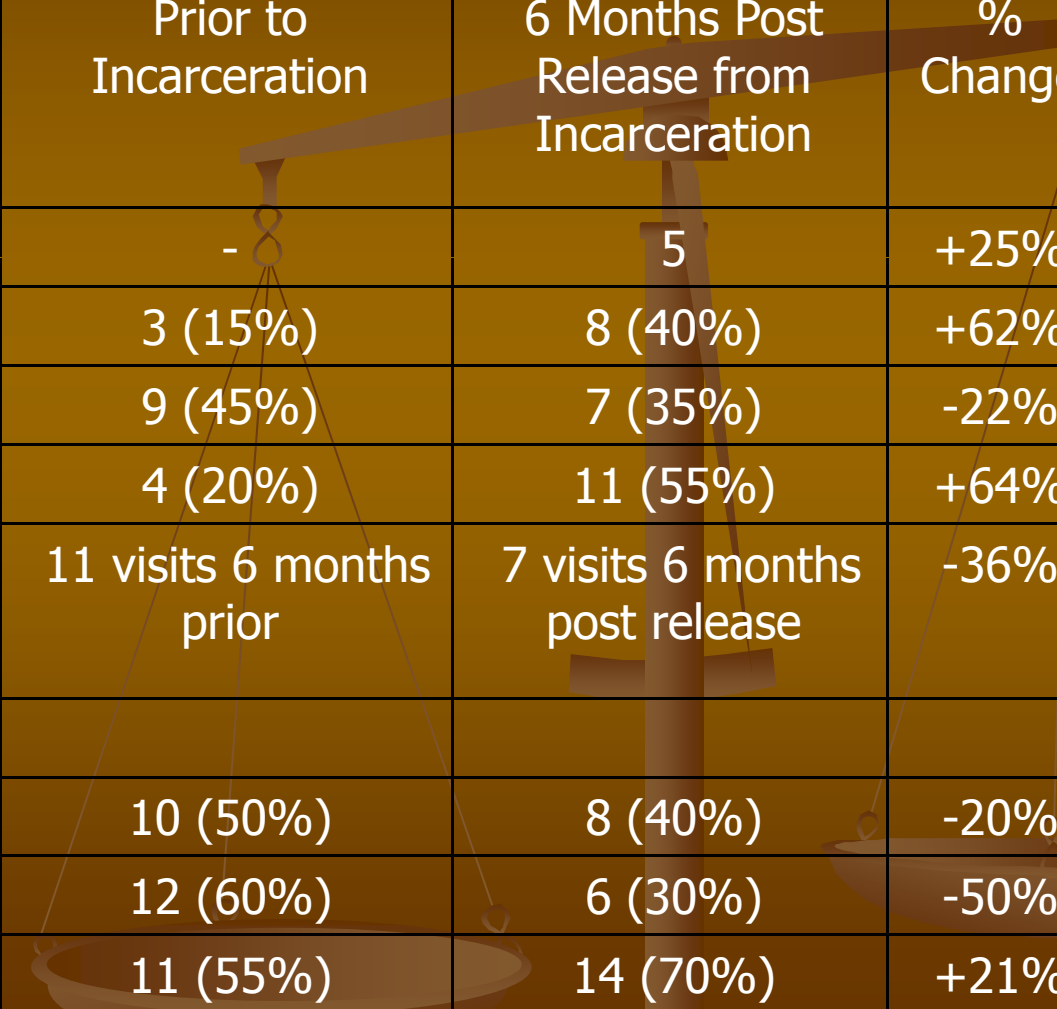


30 Day Post-Release (N=34)



Visited HIV provider	25 (74%)
Visited drug treatment provider	11 (32%)
Visited mental health provider	19 (56%)
Visited grant-funded case manager	21 (62%)

Prior to Incarceration Compared w/ 6 Month Post Release



N=20	Prior to Incarceration	6 Months Post Release from Incarceration	% Change
Reincarcerated	-	5	+25%
Homelessness	3 (15%)	8 (40%)	+62%
Food insufficiency	9 (45%)	7 (35%)	-22%
On HIV meds	4 (20%)	11 (55%)	+64%
ER visits	11 visits 6 months prior	7 visits 6 months post release	-36%
Used heroin	10 (50%)	8 (40%)	-20%
Used cocaine	12 (60%)	6 (30%)	-50%
Experienced psychological distress	11 (55%)	14 (70%)	+21%

Case Study

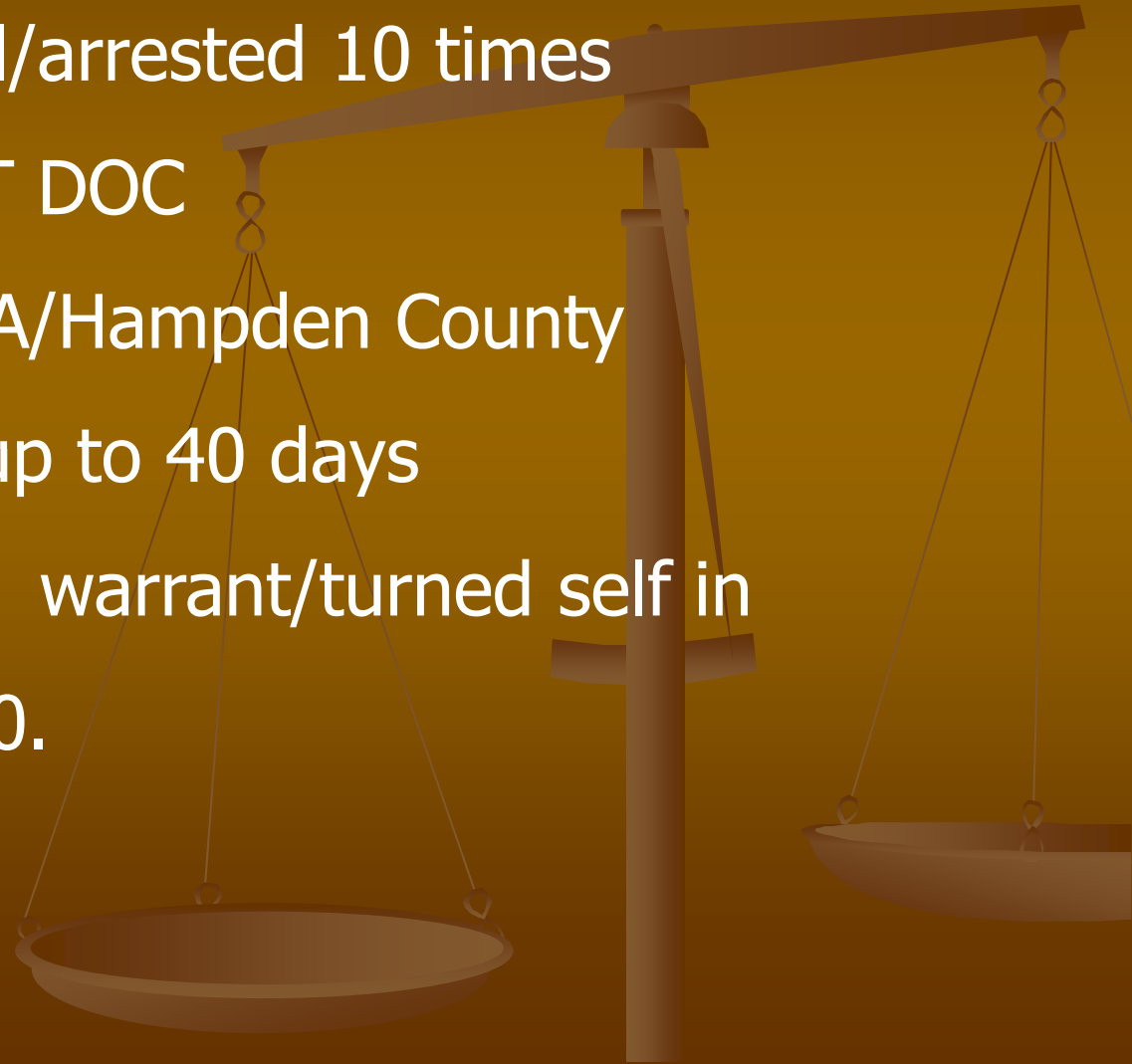


History

- 25 yo Latino/PR: Heterosexual Male
- No children
- GF over 10 years
- No income: works pt when available
- Lives with family members

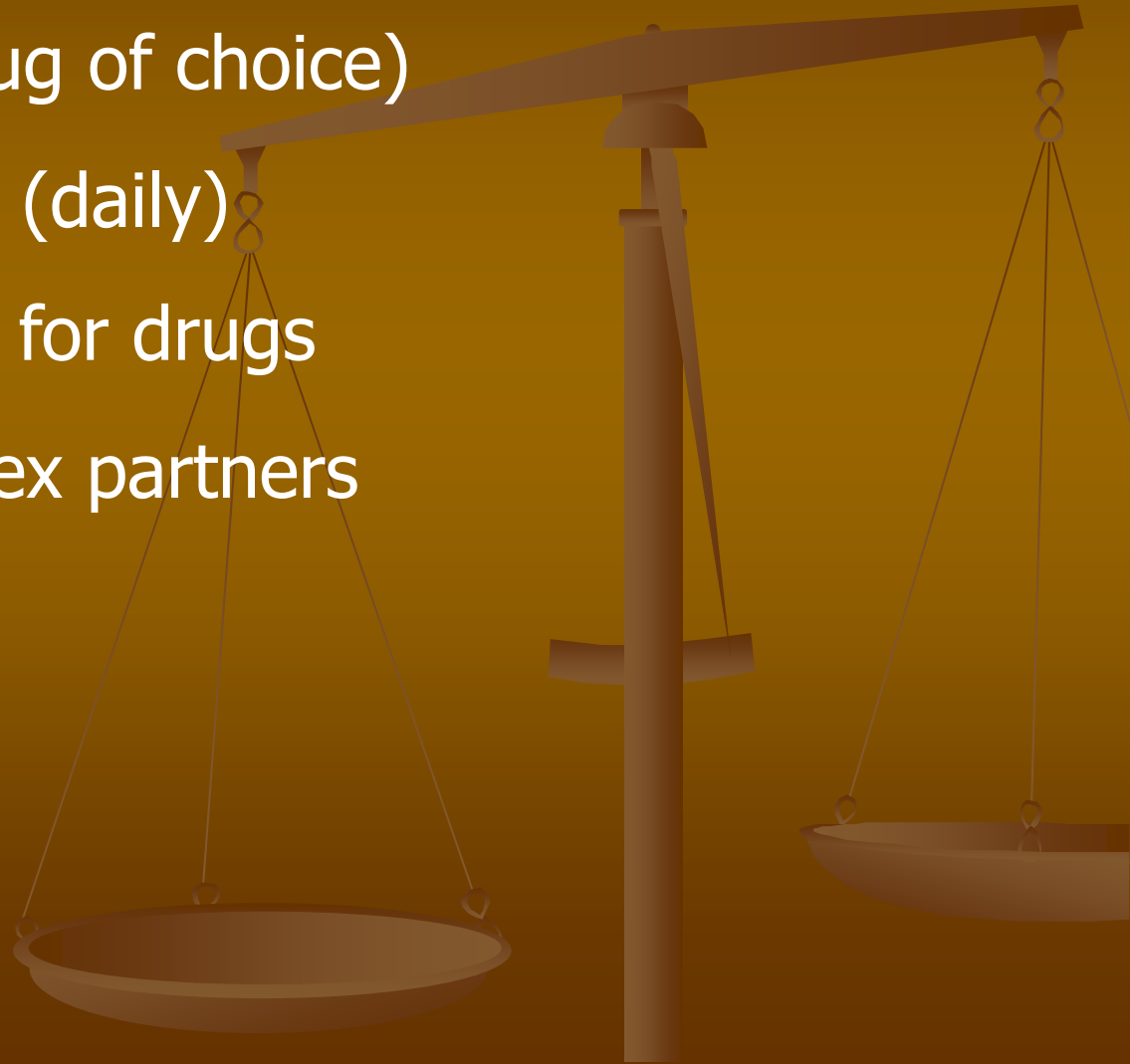
Incarceration History

- 5 years in jail/arrested 10 times
- 2 years in CT DOC
- 3 times in MA/Hampden County
- Short stays up to 40 days
- Most recent: warrant/turned self in
- B & E > \$250.



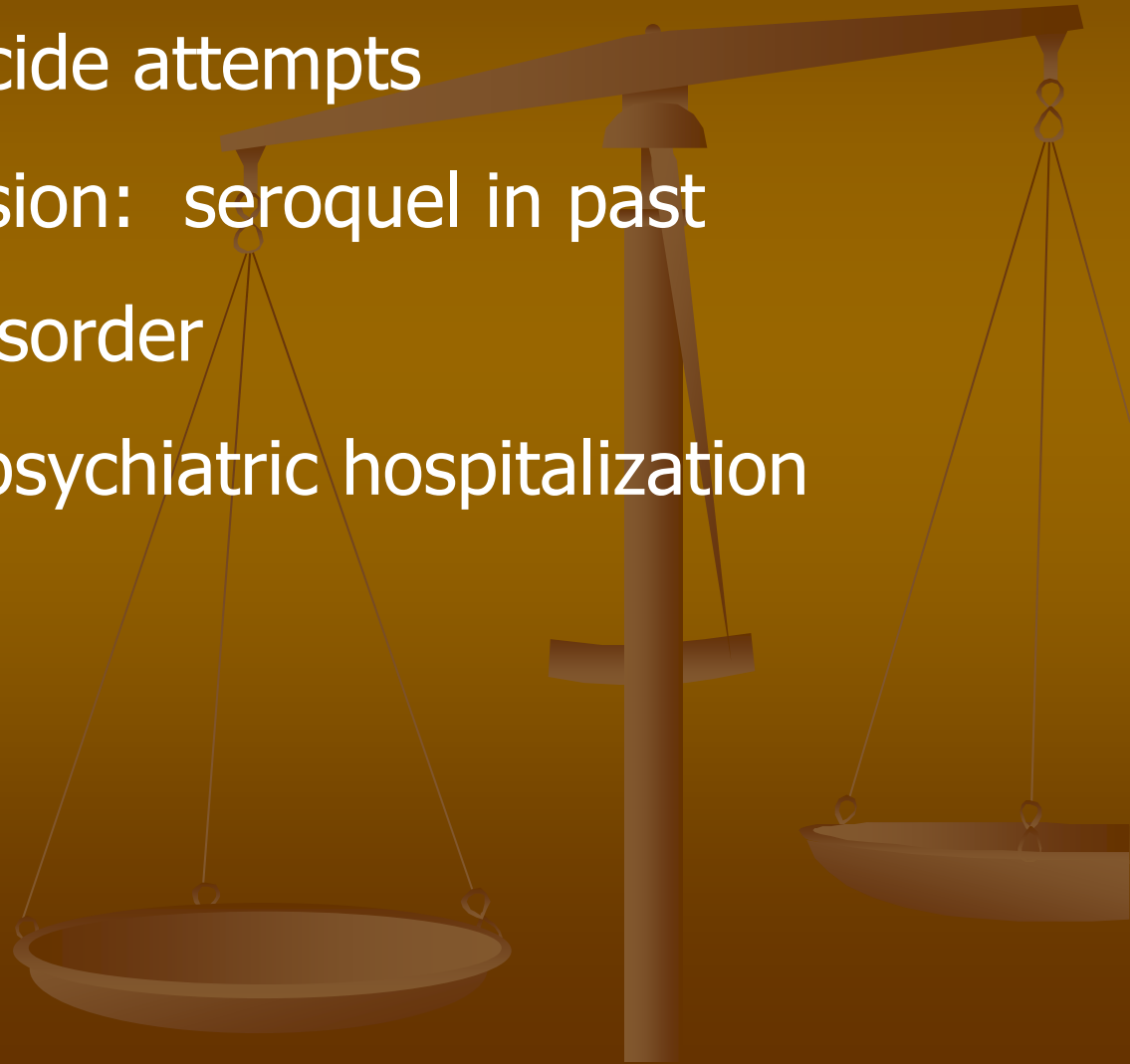
Substance Abuse/Risk Factors

- Crack (drug of choice)
- Marijuana (daily)
- Trade sex for drugs
- Multiple sex partners



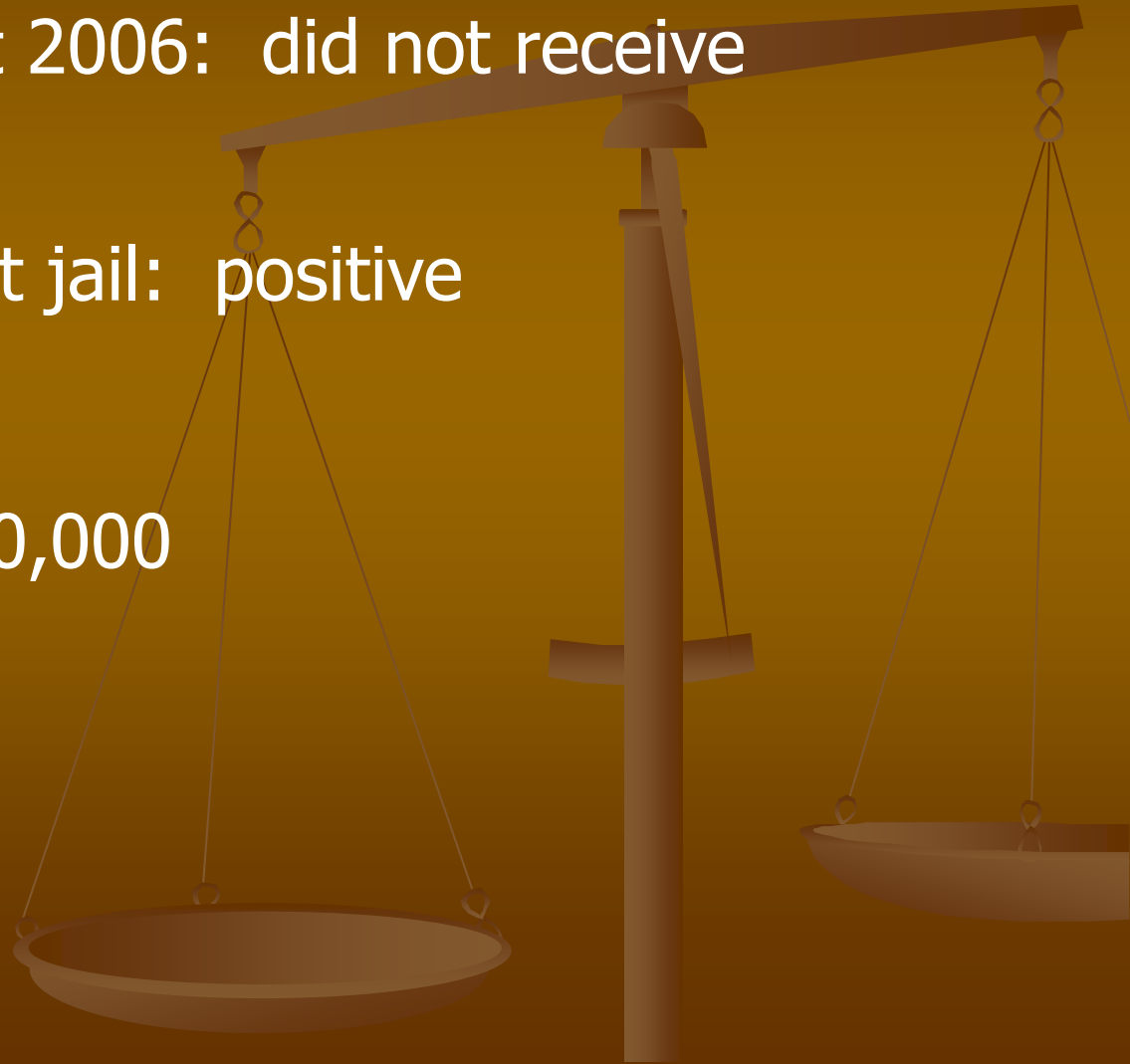
Mental Health

- History of suicide attempts
- Major Depression: seroquel in past
- Adjustment disorder
- History of IP psychiatric hospitalization



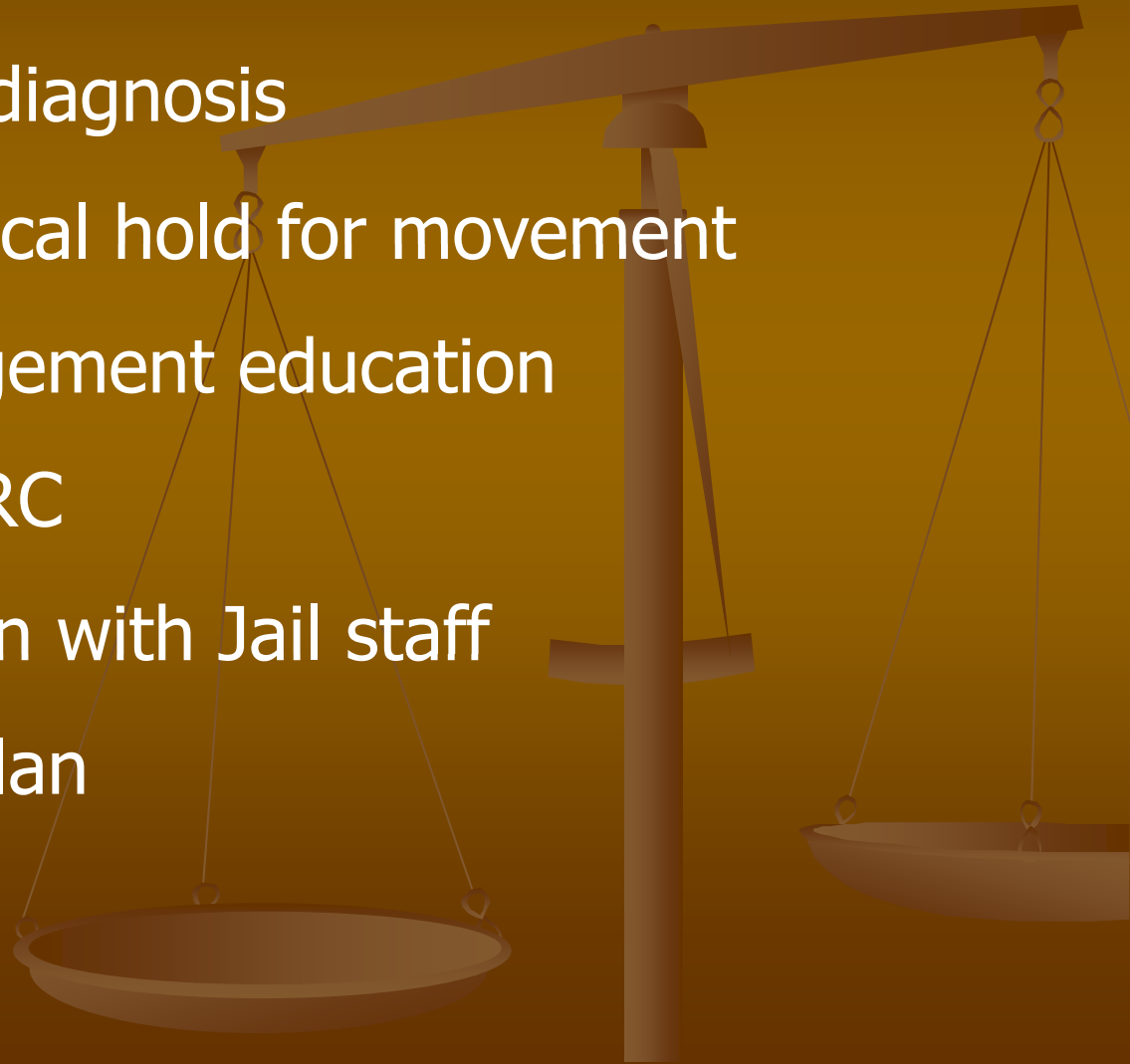
Medical History

- Last HIV test 2006: did not receive results
- Tested 2/10 at jail: positive
- CD 4: 410
- Viral Load: 50,000



MHANCE Jail/Team

- Seen upon diagnosis
- Put on medical hold for movement
- Case management education
- Moved to PRC
- Collaboration with Jail staff
- Discharge plan



MHANCE Community

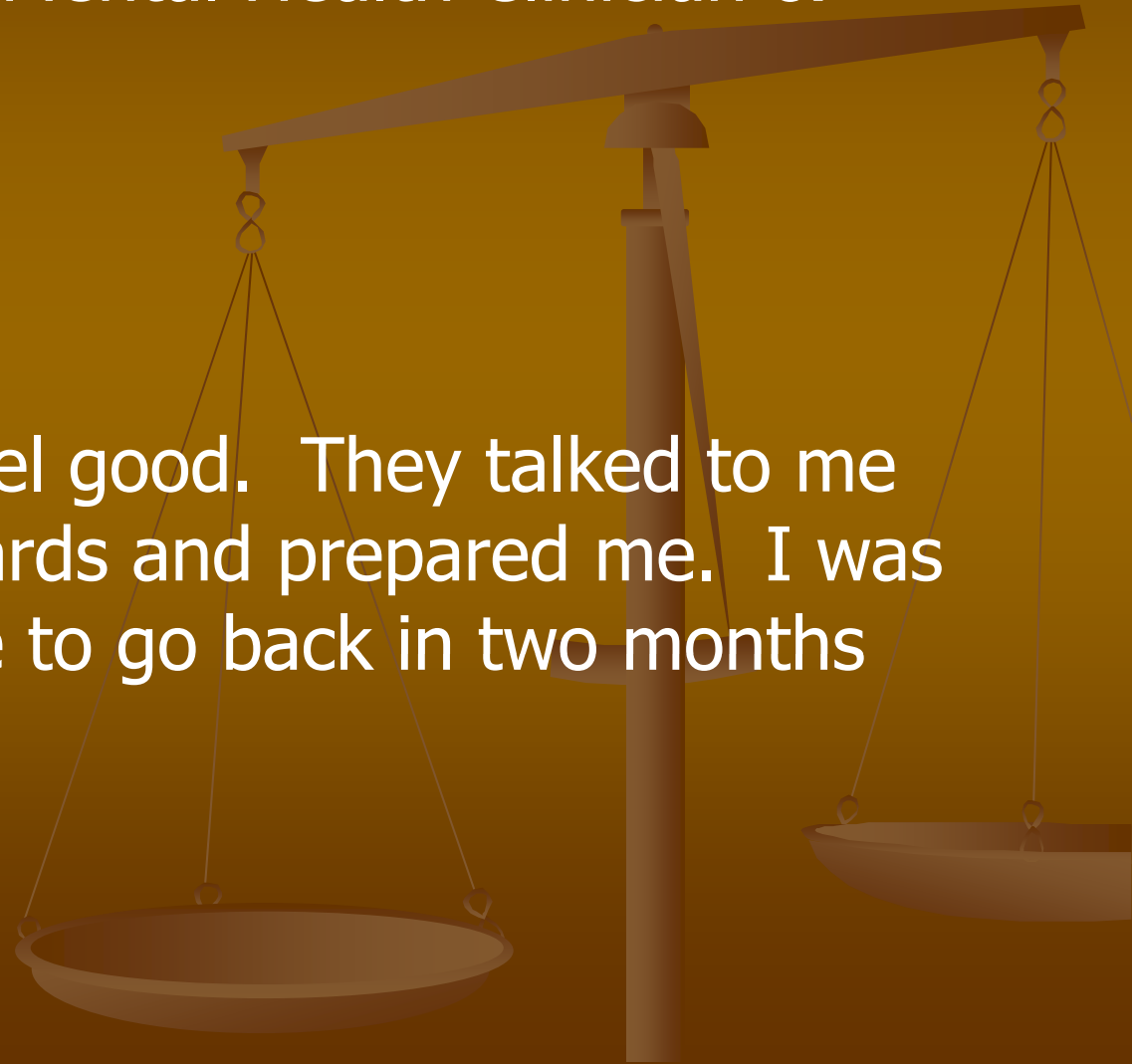
- F/U at 1st appointment
- Clinician and Case Manager
- Clinic staff support
- Disclosure
- Testing of GF



Disclosure & Testing

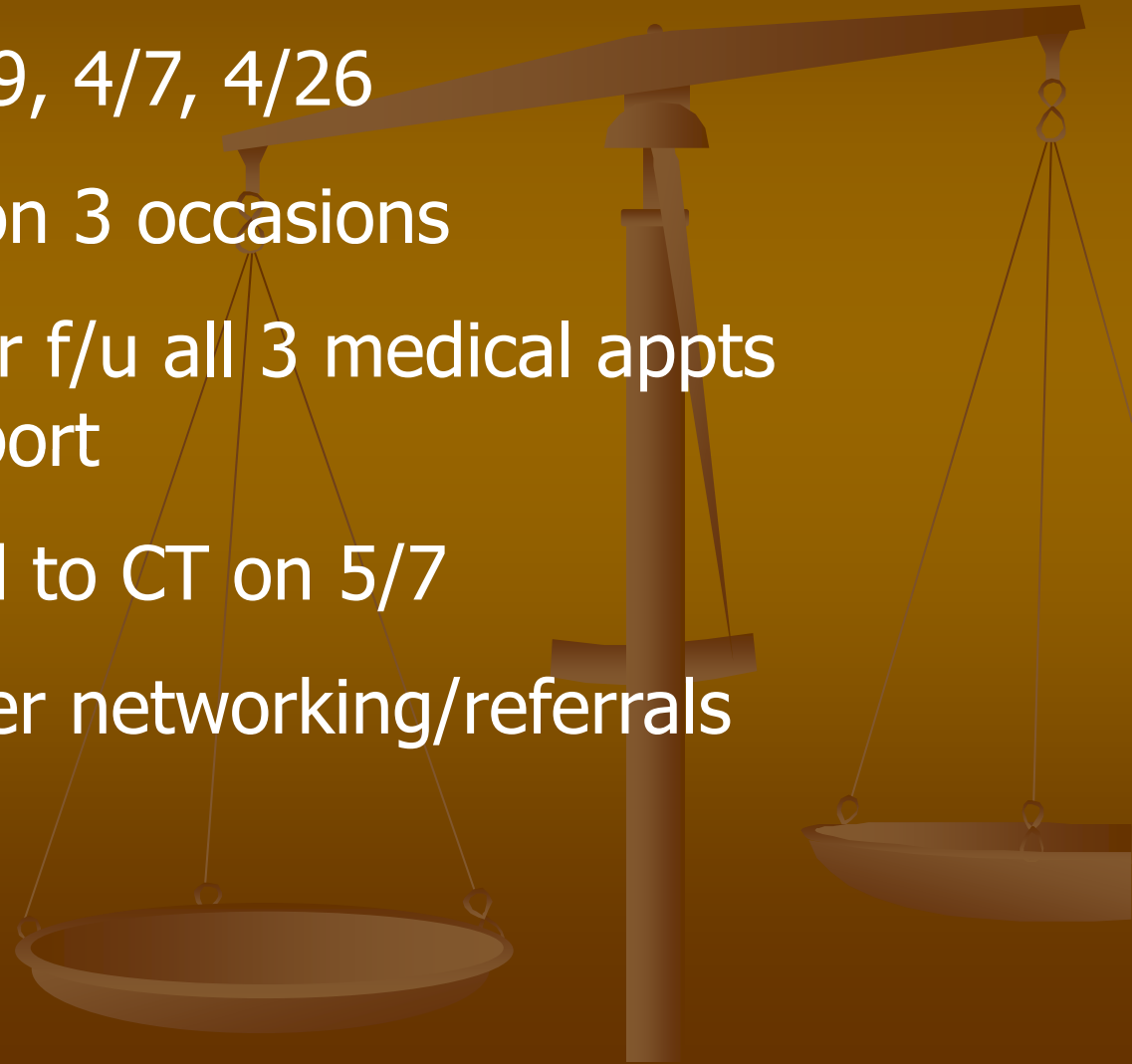
- Client assisted: Mental Health Clinician & Case Manager
- Testing on-site
- GF about team:

“They made me feel good. They talked to me before and afterwards and prepared me. I was scared. I still have to go back in two months and be retested.”



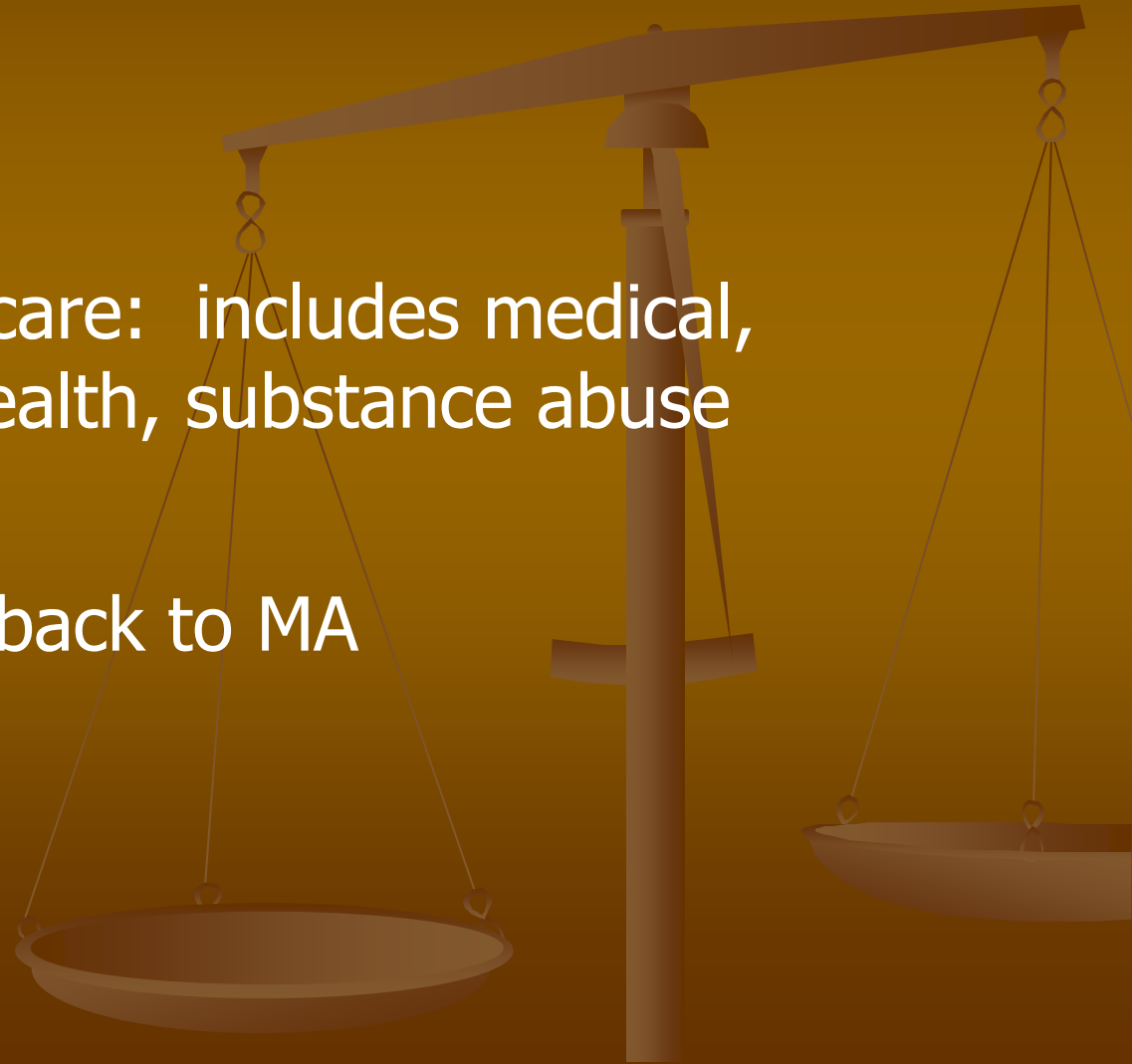
F/U in Community

- Appts on 3/29, 4/7, 4/26
- Clinician f/u on 3 occasions
- Case Manager f/u all 3 medical appts and phone support
- Client moved to CT on 5/7
- Case Manager networking/referrals



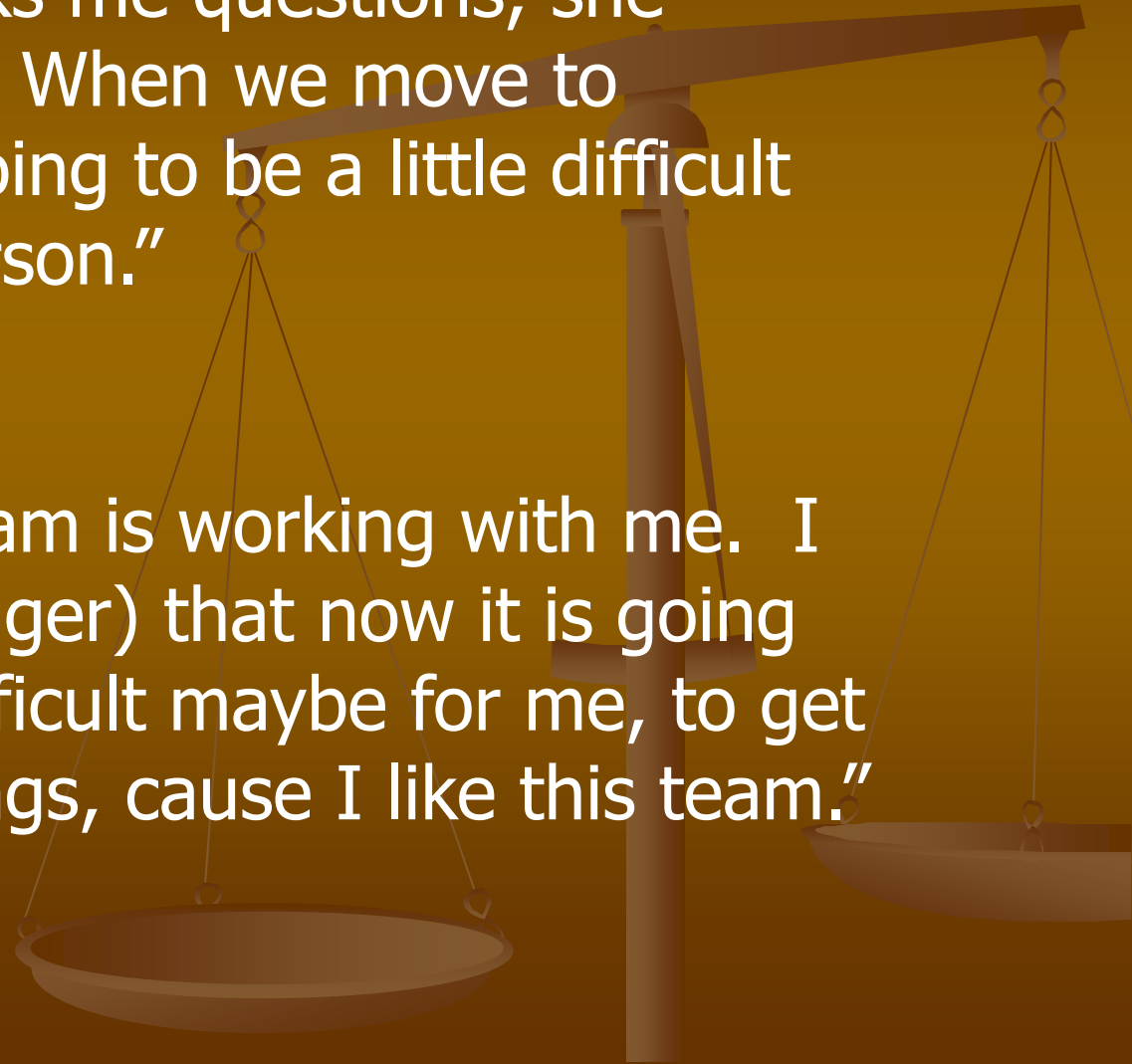
Case Study Outcomes & Updates

- GF testing
- Continuity of care: includes medical, social, mental health, substance abuse treatment
- Client moved back to MA



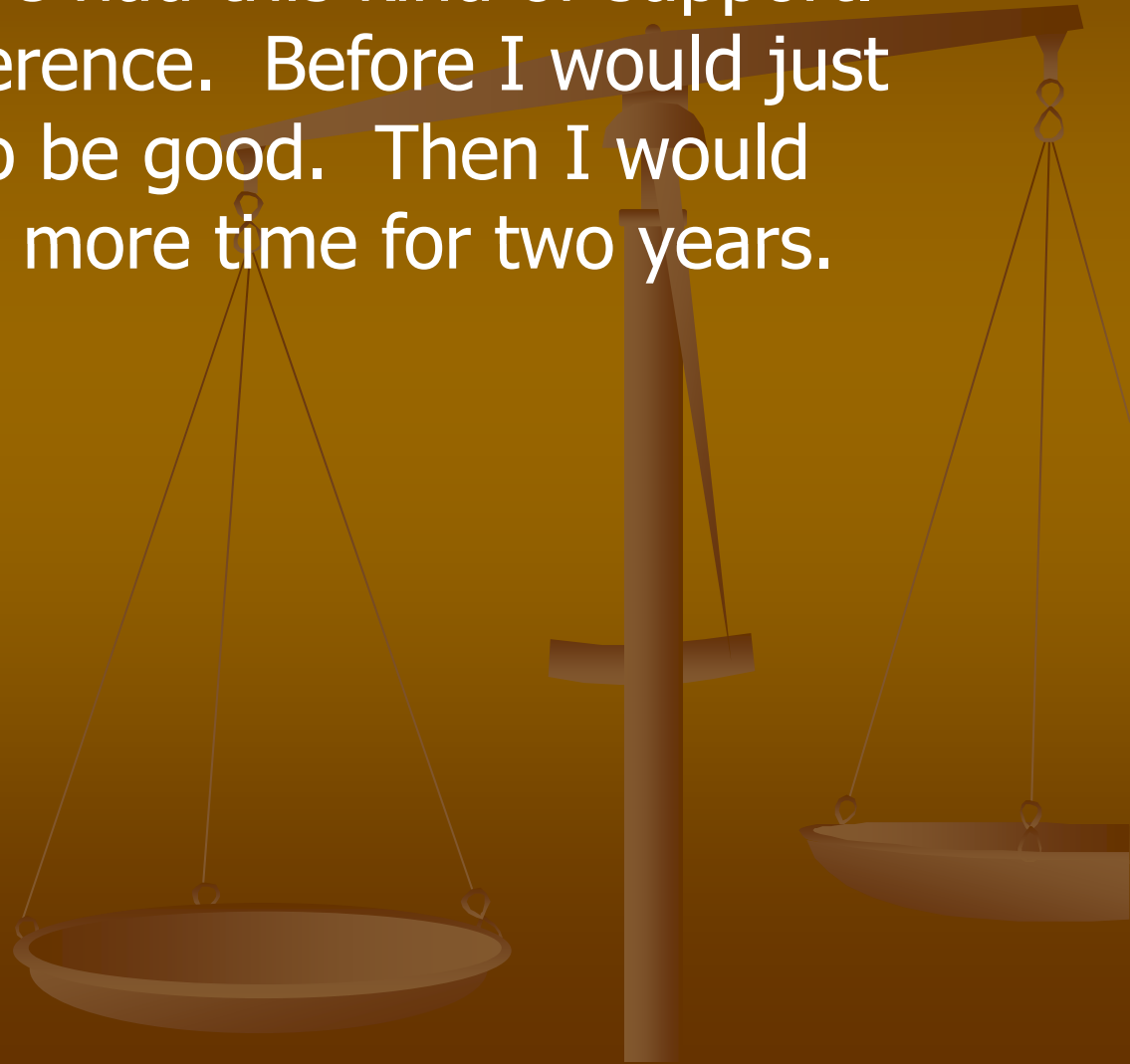
Client Interview

- “My therapist asks me questions, she doesn’t judge me. When we move to Connecticut it is going to be a little difficult to find another person.”
- “It feels like a team is working with me. I said to (case manager) that now it is going to be a little bit difficult maybe for me, to get some different things, cause I like this team.”



Interview Continued

- “ First time I have had this kind of support. It is making a difference. Before I would just leave jail, I’d try to be good. Then I would say F**** it....one more time for two years. It was tough.”



ATLAS Counseling Program

- NAF Grant
- Referral
- Diagnostics Assessments
 - CES-D, MAST, DAST
- Individual Service Plan
- Weekly Individual Counseling
- Community Linkage
- Community Follow Up



ATLAS Counseling Program

- Common Diagnoses
 - Cocaine Dependency
 - Alcohol Dependency
 - Opioid Abuse
 - Depressive Disorder
 - Bipolar Disorder
 - Schizophrenic Disorder
 - Anxiety State

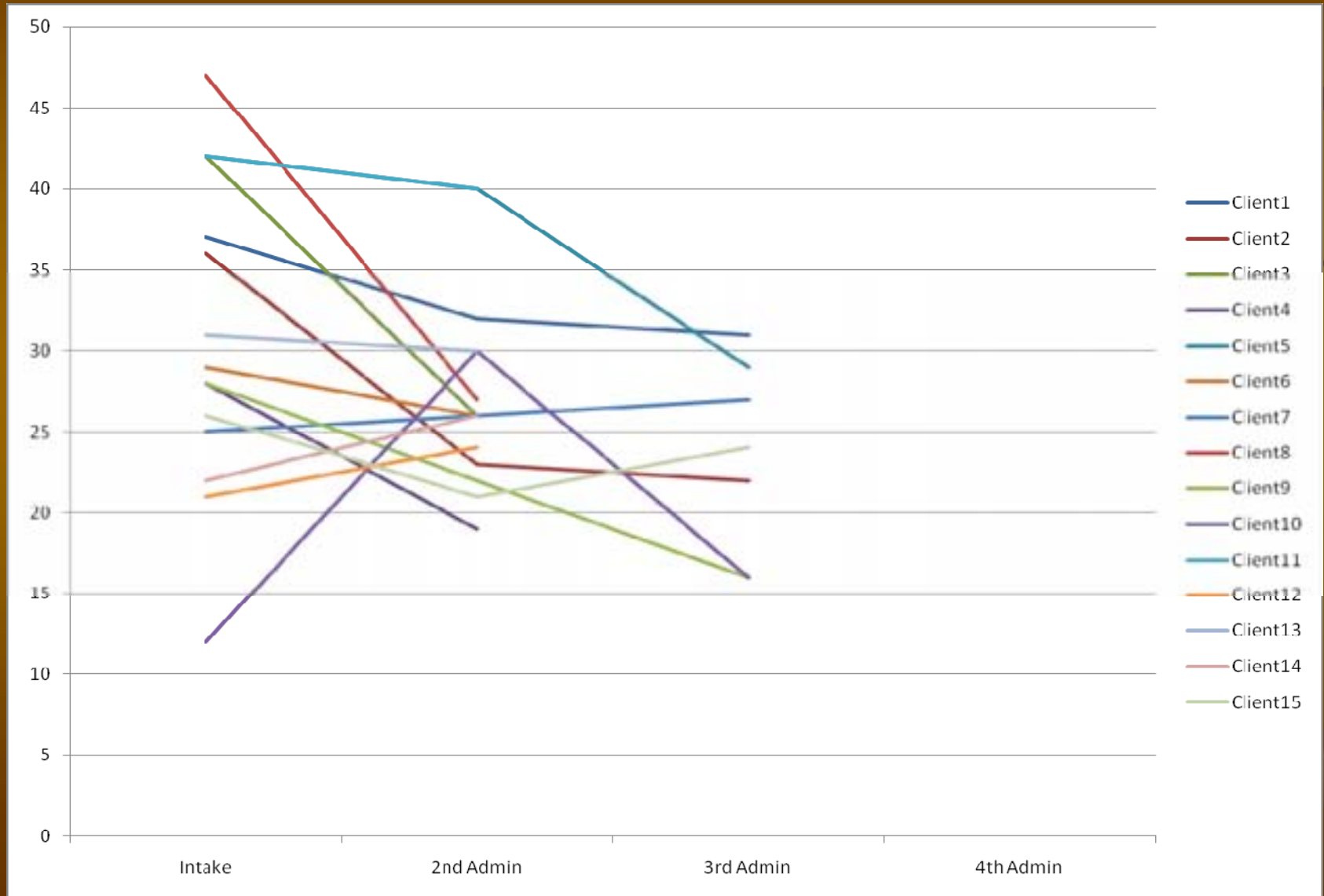


ATLAS Counseling Program

- Average CES-D Depression Score at Intake:
 - 33 (scale 0-60)
- Average CES-D Depression Score at 3 Months Post-Release:
 - 23 (scale 0-60)

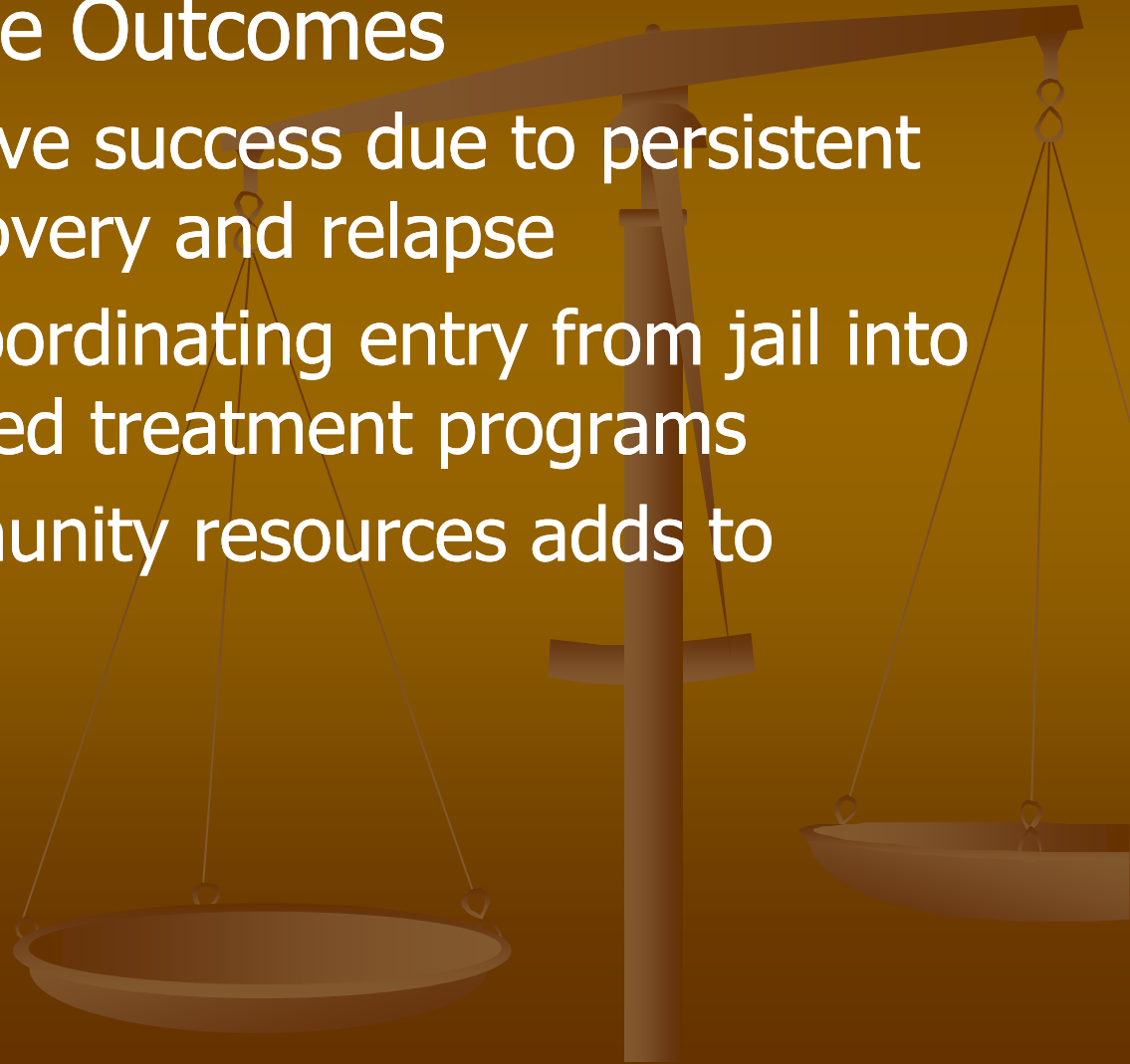


ATLAS Counseling Program

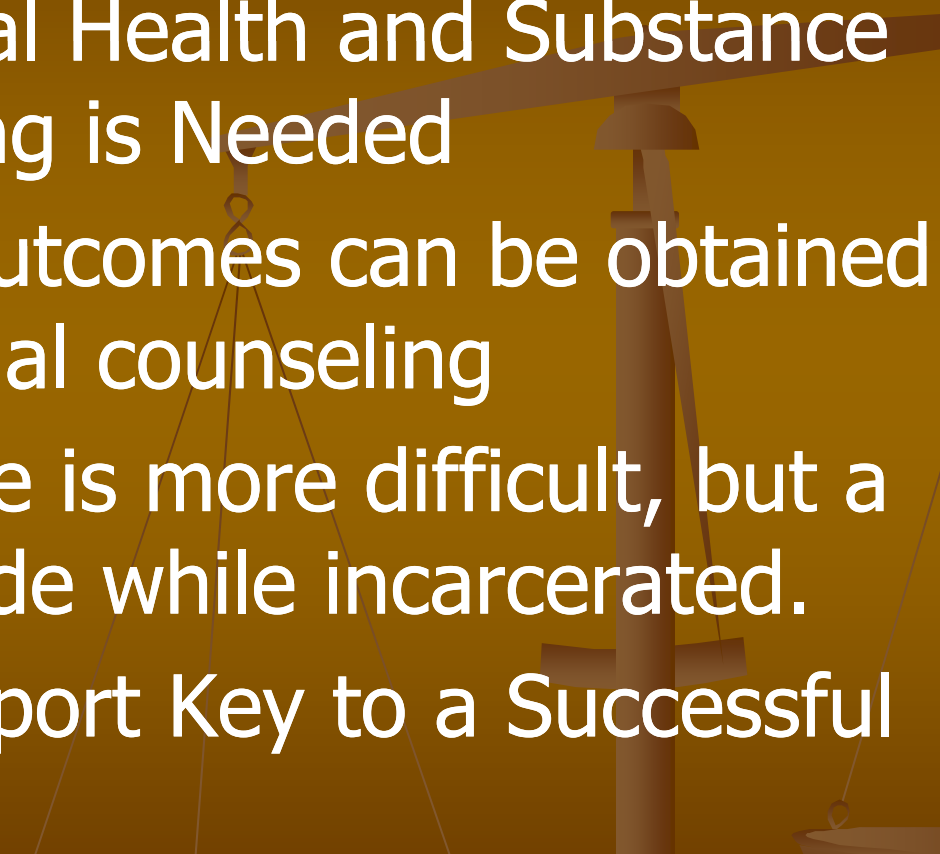


ATLAS Counseling Program

- Substance Abuse Outcomes
 - Harder to achieve success due to persistent issues with recovery and relapse
 - Success with coordinating entry from jail into community based treatment programs
 - Strain on community resources adds to difficulties



ATLAS Counseling Program

- Jail Based Mental Health and Substance Abuse Counseling is Needed
 - Mental Health outcomes can be obtained through individual counseling
 - Substance Abuse is more difficult, but a start can be made while incarcerated.
 - Community Support Key to a Successful Re-Entry
- 

Contact Us

Maureen Desabrais, M.Ed, LSW, LADC 1, CCDP-D

- Maureen.desabrais@bhs.org
- 413-794-6661

Helen Loewenthal, MSW

- HLoewenthal@lifespan.org
- 401-793-4824

Rachel Ciomcia, MSSA, LISW-S

- rciomcia@carealliance.rog
- 216-781-6228, ext 425

