Reintegrating Ex-Offenders with HIV into the Community: the Massachusetts Transitional Intervention Project

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Abstract

Objectives. This research evaluated the operations of the Transitional Intervention Project (TIP), which provides intensive case management services to support reintegration of incarcerated individuals living with HIV into the community. The objectives were to determine how TIP operates, identify factors that influence utilization of TIP and successful reintegration, and assess the feasibility of replicating the program.

Methods. This was a multi-method observational study that used TIP programmatic data on 884 clients with 1,265 cases, substance abuse treatment data on services to TIP clients, and focus groups and interviews with 28 TIP clients, 12 TIP case managers in the community, seven HIV coordinators in jails, and five infectious disease coordinators in prisons.

Results. TIP helped clients keep 93% of post-release medical and support services appointments, and appears to have reduced recidivism. Ongoing program challenges include the lack of adequate housing options and mental health services

Conclusions. Transitional case management is effective in helping inmates living with HIV meet multiple needs to ensure successful transition to the community.

Background

Massachusetts currently holds more than 20,000 inmates. Almost all (97%) of these people will eventually be released to the community.[3] The estimated prevalence of HIV in 2001, at 3.0% (2.8% of male prisoners and 5.7% of female prisoners), was 50% higher than the national average, and the prevalence of confirmed AIDS, at 1.2%, was more than twice the national average. Moreover, 59% of men and 68% of women entering the Massachusetts prison system reported past injection or inhalation of drugs.[7] Twenty-seven percent of male inmates and 44% of female inmates are infected with hepatitis C.[8]

The population of inmates returning to the community, then, brings significant medical, mental health and substance abuse needs that, if unmet, undermine the quality of life for both the individual and the community. At the same time, this population has few resources on which to draw and faces additional obstacles to its success. These obstacles range from social norms and prejudices against ex-offenders to institutional policies and practices. For example, inmates with "dual diagnoses", having both mental illness and a substance abuse disorder, often cannot obtain the comprehensive treatment they need because many organizations do not allow individuals to participate in substance abuse treatment programs if they are taking psychotropic medications.[10]

Transitional assistance is especially important in light of a "hard time" philosophy instituted in Massachusetts in the early 1990s. This policy mandates that inmates convicted of serious crimes complete almost all of their sentences in a correctional setting. They are then released without supervision, going abruptly from a place with a rigid social structure to one with little or none. Of 4,000 violent offenders discharged without parole from Massachusetts facilities between 1995 and 1997, 21% returned to jail within three years for a violent crime or sex offense, whereas the comparable rate among parolees is 16%.[15] Of all states in the United States, Massachusetts has the ninth lowest rate of post-release supervision.[16]

The high rates of substance abuse, infectious disease, and other complex needs are some of the reasons for the evolution of case management that specializes in the transition from incarceration to the community for persons living with HIV. By helping inmates access needed

services, transitional case management holds promise for both reducing recidivism and improving the health of the individual and of the community.

The TIP Project

This article reports an observational evaluation of the Transitional Intervention Project (TIP), a statewide public-private partnership that provides intensive case management services to support the successful reintegration of incarcerated individuals living with HIV back into the community. TIP is administered by the HIV/AIDS Bureau (HAB) of the Massachusetts Department of Public Health (MDPH). During the time period reported here, it was funded as part of the national Corrections Demonstration Project by the HAB, the U.S. Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). The HAB hired *Capacities*, a private research firm, to conduct an evaluation of TIP.

The project builds on HIV-related services that were already supported by the HAB in correctional facilities such as prevention & education, counseling & testing, and case management. HAB-funded HIV coordinators in jails, infectious disease nurses and case managers in prisons, and other correctional facility staff refer clients to TIP during incarceration – preferably at least six months prior to release, if possible. (Clients also can self-refer to TIP or be referred by other TIP clients or service providers post-release.) TIP case managers from the clients' "home" region work with them while they are still incarcerated to assess their post-release needs. Upon the clients' release, TIP staff implement the client-specific service plan, providing help in areas such as:

- Acquiring health insurance and other benefits
- Finding a primary care physician skilled in HIV care
- Adhering to HIV medical treatment regimens
- Accessing mental health treatment, substance abuse treatment, and other community services
- Travelling to medical care and other appointments
- Obtaining safe housing

The expectation is that clients will no longer require TIP intensive case management after about six months in the community. More details about the program have been published elsewhere. [19, 20]

The premise is that successful client reintegration into the community will decrease substance abuse relapse, recidivism, AIDS morbidity and mortality, and further HIV transmission. These will, in turn, create a safer and healthier community. Given the over-representation of persons of color in jail and prison, the program, if successful, should help to ameliorate some of the persistent racial and ethnic disparities in health and access to care.

Evaluation Questions

The evaluation sought to answer the following questions:

1. What services does TIP provide, and how have these evolved over time?
2. What factors influence (facilitate or deter) utilization of TIP services?
3. How successful is TIP at improving post-release outcomes, such as keeping appointments, adhering to medication, and reducing recidivism – and why?
4. What systems issues – e.g., training, staffing, linkages – need to be addressed in order to improve and replicate TIP?

Method

This was a multi-method observational study, using both quantitative data – i.e., programmatic data collected by TIP case managers – and qualitative data – i.e., focus groups and interviews with TIP clients, TIP case managers and correctional staff. The protocol was reviewed and approved by the MDPH Institutional Review Board, and informed consent was obtained from all participants in the interviews and focus groups.

Sample and Data Collection Procedures

Programmatic data

Programmatic data from MDPH included three levels of data: client level, case level, and event level. Clients who were re-incarcerated would begin a new case. For each case, at intake,

TIP case managers recorded standard demographic information about the client, such as age, ethnicity, gender, race and marital status.

For each case, at intake, TIP case managers also recorded case information, which included the date the case was opened, case status, release date, date case was closed and the TIP service provider. A summary of short-term and long-term needs was also recorded, and detailed needs assessments were conducted at intake for a sub-sample of cases. A case was considered closed if a closing date was entered or the status was listed as completed, transferred, or "on hold," (meaning the case was inactive, but the case manager anticipated possible future services). For closed cases, if no closing date was entered, it was deemed to be the date of the last service event. Case duration was computed by subtracting the intake date from the closing date.

Generally, a subsequent case indicates a subsequent incarceration; however, some cases were closed and a new one opened because a client changed where they intended to live (and so switched TIP agency and case manager), or received a longer sentence than anticipated (and needed a new case closer to release). Also, although most clients were no longer incarcerated, few release dates were recorded. To estimate recidivism, we examined only cases with a known release date and used a subsequent case as a proxy for re-incarceration. Cases with a release date before 3/31/03 were examined for a subsequent case within one year to calculate a 1-year recidivism rate. Because of limited data, it was not possible to calculate a 3-year recidivism rate.

As the case progressed, case managers also recorded utilization ("event") data by case for each service and monitoring activity. The broadest category of service event was case management, which included activities involving advocacy, building trust, counseling, escorting/ transporting, follow-up, service planning, and generic case management. Other service events were setting up appointments and procurement of services (e.g., medical treatment, mental health treatment, substance abuse treatment, medications, and non-medical assistance). Monitoring events involved observing case status variables at critical junctures, such as release from jail or prison or a change in housing, as well as routine monitoring. We counted the total number of events for each case. Some service events requested the amount of time spent on the event, which allowed us to calculate the total number of hours spent on those events for each case. When possible, an indication of whether or not the service was successful (i.e., completed, continuing, postponed, or unsuccessful) was recorded.

We constructed dichotomous need variables in five areas – medical, mental health, substance abuse, housing and transportation – by counting affirmative responses to the relevant items from the case intake, the detailed needs assessment, and subsequent needs assessment events (details published elsewhere [ref]).

Client and staff focus groups and interviews

Qualitative data were used to supplement the quantitative programmatic data. TIP staff invited current or former TIP clients living in the community to take part in either an interview or a focus group at the community-based organization that hosts TIP. In the urbanized catchments, three focus groups were conducted in English, lasting about 2¼ hours; participants were paid $60. In the two more dispersed catchments, face-to-face interviews were conducted in English or Spanish, lasting about one hour; participants were paid $25. Three separate focus groups of staff, lasting one to two hours, included (a) TIP case managers who work in correctional facilities and in the community, (b) HIV coordinators who work in jails, and (c) infectious disease nurses and case managers in prisons. The evaluator recruited staff by email. To clarify evaluation findings and their interpretation, the evaluator conducted one-hour interviews by telephone with a senior case manager from each site, an HIV coordinator, and an infectious disease nurse – all of whom had taken part in a focus group – and in person with a specialist from the Massachusetts Department of Youth Services were used. Staff participants did not receive a stipend. All focus groups and interviews were tape-recorded.

Analysis

1. Services provided by TIP were analyzed by computing descriptive statistics (frequencies and means) for data from Case Event records (Table 3). In addition, we summarized client and staff description of TIP services in the interviews and focus groups.

2. To identify factors that influence utilization of TIP services and client retention, we used multivariate regression analysis to examine the simultaneous impact of client sociodemographic characteristics and needs on the number of cases, case duration, number of selected service events, and time expended on those events (Table 4). Other factors affecting service utilization, including obstacles, and retention, including mainstreaming

model, were identified by analyzing qualitative interviews and focus groups with clients and staff.

3. We assessed the impact of TIP case management services, and various components, on post-release outcomes by comparing programmatic data on keeping appointments, adhering to medication, and recidivism to reports in the literature, and by analyzing qualitative data from client and staff interviews and focus groups.

4. The evaluation questions concerning systems issues were explored exclusively by analyzing qualitative data from client and staff interviews and focus groups.

Results

Participants

Programmatic data were collected for 884 TIP clients whose characteristics are summarized in Table 1. Characteristics of the qualitative study participants are also in Table 1. Seventeen clients took part in a focus group; face-to-face interviews were conducted with eleven others. Although we draw no statistical inferences from the focus group or interview data, for a small number, they were a fair representation of TIP clients. Over 60% were persons of color. Twenty-five staff members took part in a focus group: twelve TIP case managers, seven HIV coordinators (from jails) and five infectious disease nurses (from prisons). Eight staff interviews were conducted: five with TIP case managers, and one each with an HIV coordinator (jail), an infectious disease nurse (prison), and a specialist for the Massachusetts Department of Youth Services. The participation of only one African American staff member reflects a discrepancy in ethnic makeup between the staff and the client pool.

There were 1,265 cases involving these 884 clients (a case closed when a client who had been released was re-incarcerated; if the client wanted services again, a new case was opened). Case characteristics are set forth in Table 2. The number of new cases increased from 1998-9 to 2002 as the demonstration project got underway, and then tapered off a bit in 2003. Results of the needs assessments are described in detail elsewhere [ref].

1. TIP Services

Nearly all cases (95%) involved a first contact before the client was released (Table 3). Clients described learning of TIP in a variety of ways – usually through HIV coordinators or HIV nurses, but also through the HIV physician, corrections case workers, and friends in and out of prison. Services while incarcerated included helping clients to focus on what they wanted to do after release, assistance to fill out forms/ applications, finding and arranging appropriate housing for clients upon release, discussing and setting up post-release medical treatment and non-medical appointments, and building a trusting relationship. "He [the TIP Case Manager] was telling me how I could change my life, I didn't have to live the way I'd been living. And it got to the point where I let down my guard and I trusted, I trusted someone, which I never did before."

A total of 22,863 service-related "events" were documented (Table 3). More than half (12,431) were in the general category of case management. Another 3,375 events were appointment setups; 2,670 case reviews were recorded, and 1,729 were intake assessments. Many clients described vividly how important it was that the TIP case manager had picked them up at jail or prison when they were released. "No sooner I'd get out the first thing I'd do was go get high. That was my life, you know, that's all I was to do, until I came involved with TIP. When I got out of jail I had nothing but the clothes I had on, and about $60 that I had in my canteen, and that was it. But [the TIP case manager] was there. He took me to the house. He gave me clothes, and it was okay."

TIP post-release services were portrayed as "one-stop shopping" for clients; given that clients have multiple needs, most service events addressed multiple needs. For example, in the course of accompanying a client to a medical appointment, a TIP case manager might provide transportation and, en route, discuss with the client how to address difficulties in adhering to medication or counsel the client about other life issues, such as prevention the transmission of HIV to one's partners. Clients described with appreciation how, on release, their TIP counselor had a whole program laid out that included a series of appointments addressing needs in various domains. "If you have somebody to pick you up, this is what helped me. I'd say, 'Oh my god I've got this stupid appointment. It's 20 below out (because it was winter). Oh, I can go next

month. I've got enough meds.' But [the TIP case manager] kept me moving forward, she wouldn't let me slide. 'I'll be there in 10 minutes.' It makes it so much easier to get the ball rolling." And clients were particularly grateful that TIP counselors not only took them to appointments, such as to apply for SSI or housing or college, but that they would also stay with the client throughout the appointment and help them answer questions and fill out forms, and explain things.

Quite a few clients noted a reduction in other services accessed by TIP, particularly housing, due to budget cuts. They described longer waits for first doctor appointments, Social Security appointments, and transitional assistance. Staff workers were also aware of longer waits after release for initial appointments with case managers for social services in the community (from one day to 2-3 weeks), and for Massachusetts Health (Medicaid), with no provision for early approval. "The pathway to good medical care…has gotten much worse," especially if the client is too well for SSI (SSI facilitates Massachusetts Health), yet still needs Massachusetts Health for medications. Most clients have multiple diagnoses – mental health, hepatitis C, HIV, diabetes – exacerbating this decline. "What do you do when you get out of jail and you don't have needles and insulin?"

Some also noted backlogs in HIV units in correctional facilities, affecting the timeliness of referrals to TIP. Although clients can be referred six months before release, lead time is down to one week, or even one day, in some cases. This reduces the support services that can be procured before the client's release.

Some returning clients noted that TIP now offers a broader array of services as it tries to fill in gaps left from budget cuts in other programs. Doing so, in turn, takes more of their time away from direct work with clients. TIP case managers concurred.

2. Utilization

One-third (32%) of the clients had more than one case during the five-year period; two-thirds did not return to TIP during that time (Table 2). In the 421 cases where the release date was recorded, the case duration was only slightly longer after release than before (although there

was wide variation), while the amount of time staff spent providing services was greater after release than before.

Next, we examined factors that influenced service utilization (Table 4). None of the models explained more than 11% of the variance. Age at intake was a significant negative factor in the number of cases; this was considered to be a proxy for the passage of time, since clients with later admissions had less opportunity to return. Clients with multiple cases had fewer medical and housing needs. Among closed cases, those of Hispanic clients and returning clients were open for a longer duration, had more events, and required more case manager time than other cases. Cases of male clients remained open longer, whereas those of female clients accounted for more of case managers' time. Cases with high substance abuse needs had more case events. Finally, case managers spent more time on cases where the client needed mental health services or housing and less time on cases with African American clients.

When asked about obstacles to utilizing TIP services while incarcerated, nearly all clients and most staff cited privacy concerns. Inmates who have not revealed their HIV+ status are reluctant to meet with TIP counselors because it would "out" them, resulting in numerous repercussions – stigma, rejection and worse – by other inmates and corrections officers. "Inmates are too scared about people finding out, they won't take their meds, so they're basically killing themselves." Some facilities manage to protect client confidentiality. For example, meetings with TIP staff are held in the same rooms that attorneys use. When clients are called for an appointment, other inmates and even corrections officers do not know the purpose of the appointment. Internal staff members have multiple roles so they also work with inmates who do not have HIV. At other facilities, however, inmates are afforded no privacy when they have appointments with infectious disease specialists. Some female clients reported that the quality of access to TIP services was much better in prison, where TIP counselors could schedule their own appointments and reserve meeting rooms, than in jails, where there are more restrictions and less time available for visits. On the other hand, one HIV coordinator estimated fewer than 20% of inmates with HIV were concerned about confidentiality, and felt that protecting confidentiality perpetuates unwarranted stigma. Irrespective of that view, virtually all staff have had the experience of an inmate or other associate of a client, who does not have HIV, asking for their services; if they disclose that HIV is an eligibility criterion, they risk "outing" the existing

clients. Although there was no formal protocol at first, most have developed a polite, credible, but evasive way to respond.

Several other obstacles were cited: (a) ignorance of the TIP program among prison personnel, as a result of turnover. "Some say they never heard of TIP but [another] inmate told them to call me" (staff). (b) Members of cultural groups that value self-reliance may have strong support systems on their own and do not need as much service. (c) Lack of trust among inmates toward other inmates and authorities (clients). (d) Some inmates' desire to change is not yet strong enough to take advantage of TIP (clients). (e) Lockdowns! (clients).

In the community, clients uniformly had no difficulty contacting TIP case managers. The clients had the case managers' cell phone numbers, and felt free to call at any time. In fact, some reported that TIP counselors contacted them even from vacation out of mainland US. Key factors reinforcing client retention were program flexibility and the ability to reconnect even months after a client had lost touch. Clients with substance abuse problems, severe mental health problems, homeless, or new to the area, may need more TIP services and "handholding." Some saw TIP counselors just to get out of jail and out of court.

The main reason for underutilization of TIP in the community and the main barrier to retention was substance abuse relapse. Clients and staff acknowledged that TIP counselors made it clear that services would not be withdrawn based on a client's substance use. Even so, clients said that when they were using, they did not contact anyone. One client who eschewed the label of "shame," explained that he simply did not want others (including TIP counselors) to see him in his dependent condition. A woman who has used TIP twice said she could only fully utilize the services once she was "clean," even though the counselor did what he could for her while she was still using. Irrespective of relapse, some clients do not want to feel like a burden, and "stay away instead of asking for help."

Prison staff pointed to territorial issues as an obstacle. Community workers in HIV housing, transitional, and substance abuse programs tend to not want their clients to work with other programs such as TIP. Also, some prison personnel use only one agency for services rather than calling on several, whereas TIP uses the model that the client should be referred to the agency where they will relocate, regardless of where they are incarcerated. Prison personnel described a

practice in the western part of the state of using a single-referral point as the main reason that TIP is not available there for clients coming from facilities in the eastern part of the state.

3. Outcomes

When the service outcome of case management events was recorded (Table 4), 75% were completed, 22% continuing or postponed, and 3% unsuccessful. Of appointment setups, 97% of setups were successful, and follow-up indicates that 93% of appointments were kept, 3% were rescheduled, and 4% were not kept. Consistent with this finding, staff asserted that doctors encourage enrollment in TIP because they know the client will show up for appointments and get their medications. Case review events and service procurement had success rates of 89% and 84%, respectively.

Of 197 cases with a known release date before 3/31/03 (189 first cases and 9 second cases), 14 (all first cases) were followed by another case, yielding a 1-year recidivism rate of 7%.

Without exception, clients in focus groups and interviews believed they would be worse off now without the TIP program – because they would be in relapse to their addictions, back in jail, or dead. Clients repeatedly expressed enthusiasm, awe, and gratitude for a program that treated them as individuals, and for counselors whom they often said had "saved [their] lives," by not "giving up" on them. Staff observed that TIP clients are healthier. "Those who use TIP are getting better. They take their meds; others don't. Even if they return to jail, they're still on their meds, they've gone to the doctors' visits. They might still be committing crimes, but at least they're healthy!" (HIV Coordinator).

Clients attributed success to the following elements of the program:

- Logistic and emotional support from the TIP case managers
- Case managers who were non-judgmental and respectful of clients, even if the latter relapsed
- Persistent and consistent efforts to help ex-offenders with HIV, and often multiple addictions, to stay healthy and learn more appropriate behaviors
- Accessibility at all times
- Hope and confidence in clients, human caring and friendship, even after families and friends disappeared. "They helped me when I had nobody else."

- Advocacy on behalf of clients in courts, medical areas, housing, and even with clients' families. All clients believed the TIP case managers as advocates were heeded as the clients themselves would not have been, and were able to procure services for clients that the clients could not have gotten for themselves.

4. System Issues

Clients in focus groups and interviews were universally reluctant to criticize TIP. The most common initial response on ways to improve TIP was to suggest expanding the program – especially in the western part of the state – and/or adding more staff. With encouragement, however, they did proffer a few suggestions, such as establishing a way for TIP clients in the community to get together periodically as a group to discuss their current status and experiences. Although there are groups for people living with HIV, TIP clients did not have as much in common with people who had not been incarcerated. While clients were generally pessimistic about improvements within correctional facilities, they did want TIP services to start as early as possible. Some clients had no difficulty contacting TIP workers from inside, but others wanted to be able to call collect and could not. They also believed that inmates need protection against disclosure of their HIV+ status, even though most participants themselves had not felt compelled to hide their own status.

Most of the clients' suggestions were for services that TIP might procure from other agencies. The focus group of women wanted vouchers for children's shoes and clothing, and recommended a group for children whose mothers live with the virus, to help normalize the children's experience. They reiterated the urgent need for housing, jobs, and education.

Staff had more concrete suggestions for improvement within TIP. Staff inside the corrections facilities need more information from parole officers about what is needed to prepare for hearings, when it is needed, and who is to do it. They would also like greater clarity on who the TIP workers are and their roles (especially regarding housing), and they suggested relationship-building between the HIV medical service team inside correctional facilities and TIP. Apparently, TIP case managers attend discharge planning meetings at some, but not all, facilities. Corrections officers also need to be educated about the TIP mission and how it can mesh with the corrections mission – for example, by explaining the community benefit of

keeping inmates with HIV healthy. Because of staff turnover both inside and out, this needs to be an on-going process.

In facilities where clients served by TIP cannot maintain privacy about their HIV status, staff defensively maintained that to do so would be impossible; nevertheless, they listened attentively while staff from other facilities described their successful precautions at length.

Linkages – preferably with face-to-face contact – are needed with every residential program. Developing and maintaining these takes time that those inside don't have. Even so, ID nurses at two corrections facilities reported that they used TIP only to find housing for difficult cases, specifically sex and arson offenders. Increasing housing options may also necessitate community relations work, because communities don't want ex-offenders. One suggestion was to hire someone at the state coordinator level to think creatively about such problems and develop resources. They also wanted TIP to be available in Western Massachusetts.

TIP case managers had suggestions that would enable them do their jobs more effectively: more supervision for new caseworkers coping with emotional strain, more interpreters with expertise in medical terminology, easier clearance to enter all corrections facilities without having to negotiate with corrections staff, gasoline charge cards with a fair rate of mileage reimbursement for use of their personal vehicles, and a mobile system for data entry away from the office so it competes less with direct service to clients. They were also mindful of a tension inherent in their role between advocacy for clients and the need to maintain a good working relationship with service organizations to ensure they'll "be welcome the next time you show up," but they did not have concrete suggestions for resolving the tension.

TIP case managers also had suggestions for more services for clients: more mental health services – especially for depression, which may be under-diagnosed – general life skills programs, a post-release segment for continuation of the Boston University college degree program for inmates, housing and walk-in community centers near public transit that provide easy access to doctors and medications. An infectious disease nurse recommended expanding TIP for the growing number of inmates with Hepatitis C.

Discussion

Limitations

Programmatic data were collected for quality assurance, e.g., to see if clients were "slipping through the cracks," rather than for evaluation. Therefore, a number of rigorous research protocols (e.g., mandatory skip patterns, instruction manuals and codebooks) were not built into the system, and inferences drawn from missing answers would be questionable. The problem of missing data affects results in several ways. In the early stages of data collection, there was some lassitude in officially closing out inactive cases, in particular those that started before the demonstration project was fully under way; thus, earlier cases appear to be open longer. In addition to record-keeping gaps, vague protocols about "loss to follow-up" prevent an accurate determination of who was lost and when. Finally, very few cases recorded explicit outcomes, such as housing, health care, medication adherence, and mental health treatment after discharge. For these, we rely instead on qualitative data.

The absence of a control group prevented evaluation of the effectiveness of *pre-release* case management, which is a signature component of TIP. Although data on clients' release dates were sparse, where they were available, the vast majority of cases (95%) began before the client's release, and this was confirmed by all staff and clients interviewed. Without a control group, it was not statistically viable to compare these cases with the few in which contact was deferred until the date of release or after. Nevertheless, clients and staff both affirmed the importance of the pre-release contact for building trust, as well as for lining up services in advance of release.

Although there was near universal focus group participation among staff, clearly there was selection bias in the clients who agreed to participate. Due to the short time frame and to human subjects concerns, it was not feasible to include clients during incarceration; eligible clients in the community would include more who had made a more successful transition. Logistically, having staff do the recruitment was the only feasible option. This, too, would tend to exclude clients who were not happy with the program or had not made a successful transition. Staff understood this problem and undertook diligent efforts to recruit a wide range of clients. Nevertheless, staff reported that clients struggling with a more difficult transition also had more

negative reactions to research participation, and greater difficulty in managing to attend a focus group or keep an interview appointment, and so they are under-represented in the qualitative research.

Conclusions

Clients who are incarcerated and living with HIV have multiple needs that must be met in order to ensure a successful transition to the community. These needs include not only services in the areas of health, mental health, substance abuse treatment and housing, but also – in large part due to the experience of incarceration – a range of services to help them successfully organize and access those primary services, such as planning, advocacy, support and transportation.

Staff attributed the slight drop in the number of new cases to a decrease in referrals, and inside staff confirmed a declining number of inmates living with HIV. Fiscal cutbacks at the state and federal level probably account for longer waits for agency appointments to establish entitlements.

Clients heaped glowing praise on the TIP program and felt that it met their needs very well. One of the more impressive findings from the programmatic data is the high percent of appointments that were kept by clients in the community (93%). This compares favorably with reported missed appointment rates of 35%.[21] This success could reflect the TIP practice of transporting and accompanying clients to appointments whenever needed. At the same time, TIP case managers felt that "no shows" might be under-reported. For example, since often it was the TIP case manager who had made the initial appointment, they would promptly re-schedule a no-show, and if the new appointment occurred before they had time to enter data, they might enter only one (completed) event rather than an unsuccessful and a successful event.

The main obstacles to TIP utilization were privacy (while incarcerated) and relapse (in the community). Privacy has been successfully addressed at some correctional facilities, which others would do well to emulate.

Relapse and recidivism are, naturally, a continuing concern. Picking clients up at release helps to get through that all-important 24 hours, and having a series of appointments seems

especially helpful in getting clients through the critical first week. Two-thirds of the clients served did not return to TIP during the five-year period. The estimated 1-year re-incarceration rate of 7% among cases with known release dates before 3/31/03 compares favorably to the 20% re-incarceration rate in Massachusetts.[14] Although using a return to TIP as a proxy probably underestimates re-incarceration, the low rate does comport with anecdotal evidence, and certainly strongly suggests that TIP is successful in reducing recidivism.

Cases of clients with multiple cases were longer and did entail more events and staff time. Possibly they still require case management due to pending legal proceedings and to arrange for substance abuse treatment (relapse being the most likely reason for return).

While it is to be expected that cases with high substance abuse needs, mental health needs and housing needs would entail more service events and/or staff time, it appears that ethnicity is also a factor, with Hispanic clients having longer cases, more events and more staff time, and staff expending less time on cases of African American clients. In follow-up interviews, staff suggested that cultural differences could be responsible. For example, if more Hispanic clients live with family members, their need for support and transportation would be greater than those living in more structured settings. Hispanics might be more accepting of assistance and African Americans less so. Although this evaluation was not able to test these possible reasons, possibly adding African American staff could help to increase TIP case manager time devoted to African American clients.

In summary, incarcerated persons living with HIV, when they are released, have multiple needs in the areas of health care, mental health, substance abuse, housing and transportation. These are complicated by the adjustments required upon re-entry in the community. The TIP program, by specializing in these particular clients, offers a unique form of intensive case management that, unlike other services, begins before release, and includes meeting the client at release, advocacy, transportation and accompaniment. From multiple perspectives it is doing an extraordinary job of meeting the very specific needs of these clients. Improving privacy in some correctional facilities could enhance access to TIP services, and communication among providers and service organizations remains an on-going need. Our findings strongly support the desirability and the feasibility of continuing and replicating this program. Finally, these findings

suggest that mental health services, substance abuse treatment, housing and other support services in the community should be expanded for former offenders living with HIV.

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Table 1. Description of TIP Clients and Study Participants

	Programmatic Data (n = 884)		Client Focus Group or Interview (n = 28)		Staff Focus Group or Interview (n = 25[a])	
Variable	**%**	**(n)**	**%**	**(n)**		
Sociodemographic Characteristics						
Gender						
Male	76	(674)	54	(15)	32	(8)
Female	24	(210)	43	(12)	68	(17)
Transgender	0	(0)	4	(1)	0	(0)
Ethnicity/Race						
African American	23	(203)	15	(4)	4	(1)
Hispanic	29	(257)	41	(11)	16	(4)
White	38	(339)	43	(12)	80	(20)
Cape Verdean/Portuguese	4	(37)	4	(1)	0	(0)
Native American	1	(9)	0	(0)	8	(2)
Other or unknown	5	(39)	0	(0)	0	(0)
Age *(n=882)* [b]	(mean = 38.7, sd = 7.4)					
17-29	10	(87)	0	(0)	4	(1)
30-39	46	(406)	32	(9)	16	(4)
40-49	37	(323)	54	(15)	28	(7)
50-79	7	(66)	14	(4)	52	(13)
Married or Committed Relationship [b] *(n=451)*						
No	76	(342)	52	(14)		
Yes	24	(109)	48	(13)		
Health history [b]						
Hepatitis C *(n=480)*	58	(278)				
Developmental Disability *(n=415)*	11	(45)				
Mental Illness *(n=435)*	48	(209)				
Substance Abuse *(n=423)*	96	(404)				
Number of Cases						
One	68	(602)				
Two	23	(200)				
Three-Five	9	(82)				

[a] *Actually, 26, but one participant did not provide demographic data.*
[b] *As of case intake. For clients with multiple cases, the first case intake was used.*

Table 2. Description of TIP Cases (cases = 1,265)

Variable	%	(n)	%	(n)
Year case opened /year closed *(n = 1079)*				
1998-99	4	(48)	1	(7)
2000	15	(194)	8	(80)
2001	23	(288)	2	(235)
2002	33	(412)	33	(342)
2003	19	(243)	25	(264)
2004 (partial)	6	(77)	11	(119)
TIP service site				
Central	15	(189)		
Northeast	25	(316)		
Boston/Cambridge women only	12	(150)		
Boston/Cambridge men, and Greater Boston men and women	31	(395)		
Southeast	17	(215)		
Status as of 5/1/04				
Completed	79	(997)		
On hold	3	(38)		
Transferred	3	(44)		
Active	15	(186)		
Recidivism - second case within 1 year of release *(of 197 cases released before 3/31/03)*	7	(14)		
First accessed TIP case manager… *(of 421 cases with release date)*				
Before release	95	(402)		
Day of release	1	(6)		
After release	3	(13)		
Case Characteristics *(1038 closed cases)*	**Mean**	**(sd)**		
Duration (months)	8.4	(7.0)		
Before release *(421 w release date known)*	47%			
After release "	53%			
Number of selected case-related events [a]	16.3	(23.0)		
Before release *(421 w release date known)*	45%			
After release "	55%			
Hours spent on those case-related events [a]	13.0	(18.8)		
Before release *(421 w release date known)*	43%			
After release "	57%			

[a] *appointments set up + post-release assessments + case management + chores + service procurement*

Table 3. TIP Service Events (events = 22,863), by Type of Event and Outcome

	Number	Outcome		
		Successful /Completed	Continuing /Postponed /Pending	Unsuccessful
	n	%	%	%
Appointment setup	**3,375**	97% [a]	2%	1%
Appointment follow-up	**1,136**	93%	3%	4%
Assessment	**1,792**	– –	– –	– –
Case management	**12,431**	75%	22%	3%
Advocacy	19%			
Build trust	9%			
Case management	29%			
Counseling	8%			
Escort /Transport	10%			
Follow up	17%			
Service planning	23%			
Other [b]	15%			
Case review	**2,670**	89% [c]	10%	1%
Service procurement	**546**	84%	14%	2%
Other [c]	**974**	– –	– –	– –

[a] *(Of 2,494 recorded)*

[b] *Administrative tasks (4%), documentation (2%), outreach (4%), resource investigation (2%), other (3%). Total exceeds 100% because some case management events involved more than one activity.*

[c] *Chores of daily living (157), housing event (54), monitoring (397), release (285), study enrollment (81)*

Table 4. Predictors of Service Utilization (Multivariate Regression Analyses)

	Number of Cases *(clients =884)*		**Duration of Case** *(closed cases =1035)*		**Number of Events** *(closed cases =1035)*		**Time Expended** *(closed cases =1035)*	
	r^2		**r^2**		**r^2**		**r^2**	
Variance Explained	.08		.03		.06		.11	
Sociodemographic Characteristics	**t**	**p(t)**	**t**	**p(t)**	**t**	**p(t)**	**t**	**p(t)**
Gender = Female		n.s.	-2.3	.02		n.s.	2.7	.01
Age (at First Case)	-2.6	.01		n.s.		n.s.	3.0	.003
Ethnicity = Hispanic		n.s.	2.9	.004	4.9	<.0001	2.1	.03
Ethnicity = AA		n.s.		n.s.		n.s.	-2.0	.04
Needs Assessed								
Substance Abuse		n.s.		n.s.		n.s.		n.s.
Medical /HIV	-2.5	.01		n.s.		n.s.		n.s.
Mental Health		n.s.		n.s.	3.0	.003	2.0	.05
Housing	-2.6	.01		n.s.		n.s.	2.5	.01
Transportation		n.s.		n.s.		n.s.		n.s.
More than one TIP case	– –	– –	2.1	.04	5.0	<.0001	6.7	<.0001