

D. Women

“There needs to be more available for the straight population, like more support groups and social activities. Remember this disease is not just a gay man’s disease and the heterosexual communities need help, too.” (African-American female PLWH)

1. Epidemiologic Profile

In King County, women represent 9% of the total cumulative HIV/AIDS cases. However, the proportion of AIDS cases among women and the number of women living with HIV infection have increased in recent years, and this trend is expected to continue. Women with HIV/AIDS tend to be younger than men, most acquire HIV through heterosexual contact, and women of color are disproportionately affected.

Population sizes: According to the 2000 census, 743,804 women age 13 and over live in King County. The estimated number of HIV positive adult or adolescent women in King County is approximately 750. This estimate includes HIV-infected women who have not yet been diagnosed and a smaller number of women who have tested HIV positive but have not been reported. The estimated number of women in King County who are at risk for HIV because they are drug injectors or sex partners of drug injectors is 9,000-15,000.

Status and trends in AIDS cases: As of 12/31/2002, there were 451 women age 13 or over reported to Public Health and presumed living with HIV or AIDS in King County. This is 9% of the total of 5,115 King County residents living with HIV or AIDS. Women represent 5% of the cumulative AIDS cases and 11% of the HIV non-AIDS cases diagnosed and reported in King County.

The number of HIV/AIDS cases diagnosed in King County women continues to increase. Cases in women have risen from about 30 women diagnosed with HIV annually from 1988-1990 to 50 per year in 2000-2002. The percent of King County HIV/AIDS cases occurring in women has increased over time, with female cases rising from 2% of total cases in 1983-1987 to 12% of cases diagnosed in 2000-2002.

The majority (64%) of women living with HIV/AIDS in King County acquired HIV through heterosexual contact. Thirty-two percent acquired HIV through the use of injection drugs, and 4% by blood transfusion. These percentages are calculated after adjusting for the 24% of all cases among females that are reported without known risk.

Among King County women living with HIV/AIDS, the prevalence rate for African American women is thirteen times higher than for White women. The prevalence rate is nine times higher among Native American/Alaska Native women and three times higher among Hispanic than in Whites. The rate is about one-third as high among Asian/Pacific Islander women.

HIV seroprevalence: Based on estimates of 750 HIV-infected women in King County, it is estimated that 0.1% of all women age 13 and over are infected. The rate is higher among African American, Hispanic and Native American women than in White women.

Sub-group highlights: Pregnant women and children: Only 32 pediatric infections (age 0 to 12 years at the time of HIV diagnosis) have ever been reported in King County. These represent 0.4% of cumulative diagnosed cases. The most recent case of documented perinatal transmission was in 1997. None of the estimated ten to fifteen infants born to HIV-infected mothers annually since 1997 have become infected.

2. Service Trends

Providers noted that the majority of women with HIV on their caseloads are in their 30's and 40's. Increasing numbers of younger women are also seeking services, especially women in their 20's. Many of these younger female clients have dependent children.

As in prior years, providers report that the majority of their female clients acquired HIV through heterosexual transmission. In many cases, the client's male partner was identified as having a history of injection drug use. Although the number of women reported as being IDU themselves has increased, the change has not been significant over the past two years.

Most King County female PLWH are Seattle residents, although a higher percentage of female clients reside in South King County than is seen among male PLWH. Female consumer survey respondents were almost three times more likely to be South King County residents as male respondents (27% versus 10%). Providers also noted that they are seeing an increase in homeless female PLWH. Female survey respondents reported more than twice the rate of homelessness in the past year as did male respondents (31% versus 14%).

Service providers report that a high percentage of their female clients are multiply diagnosed (HIV, mental illness and/or chemical dependency). Sixty percent of female consumer survey respondents report that they had been diagnosed with a mental illness, including clinical depression. Providers noted that many of their female PLWH clients are not engaged with the mental health system, unless the severity of their mental illness is impacting their day-to-day ability to function.

Substance use continues to have a significant impact on the lives of female PLWH. Providers noted that over half of their female clients have histories of substance abuse. This is particularly true of White and African American female PLWH, but much less common among Latinas and Asians/Pacific Islanders. Crack cocaine is the main "drug of choice" for female PLWH substance users, although providers report seeing increasing crystal methamphetamine use in this population.

Consistent with epidemiologic trends, service providers who work with HIV+ women note that a high proportion of their client caseloads are women of color. Providers report that they are seeing increasing numbers of women from all racial categories, particularly African-Americans, Latinas and Native American women. Female consumer survey respondents were almost three times more likely than males to be African American (29% versus 10%) and twice as likely to be of mixed racial backgrounds (12% versus 6%). During the past two years, providers noted that increasing numbers of women from the growing refugee populations in King County are beginning to utilize services. This represents both an overall increase in this PLWH population, as well as the results of ongoing attempts to engage these women in services.

Similar to previous assessment reports, female survey respondents were statistically less likely than males to be AIDS disabled (43% versus 65%). Women were also significantly less likely to report T-cell counts over 500 (12% versus 21%). Female survey respondents were significantly more likely than males to be unaware of their T-cell counts (20% versus 9) and viral loads (25% versus 11%). Providers noted that their younger female clients tend to present earlier in their HIV diagnoses, while older clients continue to enter care later in their diagnosis. The majority of female clients are reported to be in stable health.

Providers noted that their female clients have had relatively few access problems with HIV medications. This sentiment was echoed among female focus group participants (n=5). However, both providers and consumers reported complex adherence issues. These include lack of trust in HIV medications, unstable housing and living situations, and mental health and chemical dependency barriers. In particular, several women of color in focus groups stated that they feel like “guinea pigs” due to having physicians frequently change their medication combinations. Additionally, female immigrants may face cultural challenges when interacting with the medical system.

Despite these adherence problems, the percentage of female survey respondents who reported taking various forms of HIV medications has increased. In 2001, only 59% of female survey respondents reported being on antiviral medications, as opposed to 66% in 2003. The percent of female PLWH who reported taking protease inhibitors rose from 31% in 2001 to 45% in 2003. The gap between the percent of female and males that reported taking antivirals and/or protease inhibitors has also narrowed significantly during the past two years.

Providers reported that their female clients continue to utilize a wider range of social and support services with each succeeding year. However, female respondents on the 2003 consumer survey were slightly less likely to use several key medical care-related services than male PLWH. Women were slightly less likely than men to use primary care (90% versus 94%), the Washington State AIDS Prescription Drug Program (66% versus 71%), and health insurance continuation programs (53% versus 70%). Each of these figures, however, represents higher utilization rates for women from those reported on the 2001 survey, suggesting that increased outreach and enrollment efforts have been successful.

Women were more likely than men to use case management (84% versus 76%). Due to the geographically diverse nature of this population and increasing co-morbidities (mental illness, substance use, homelessness, etc.), ongoing involvement with case management is vital in helping many female PLWH access and maintain care services. Case managers appear to be successful in helping female clients access and maintain services, as female survey respondents demonstrated higher utilization than males of mental health therapy (69% versus 52%), substance use treatment/counseling (injection drug treatment: 14% versus 9%; non-injection treatment: 30% versus 16%) and help finding low income housing (42% versus 32%). Women were also significantly more likely than men to use a wide range of support services, such as one-on-one peer support (64% versus 28%), client advocacy (69% versus 31%), support groups (73% versus 40%) and transportation (51% versus 30%). Emergency financial assistance was also a highly utilized service for women, as 46% reported using grocery vouchers and 52% used help paying for utilities.

3. Service Priorities

Female survey respondents ranked ambulatory medical care and oral health care tied for the number one service priority (Table 32). Other highly ranked priority services include housing assistance, emergency financial assistance, and case management.

Several significant differences in service prioritization were observed based on sex. Women were significantly more likely than men to prioritize psychosocial support (43% versus 30%) and child care (25% versus 1%). Conversely, women were significantly less likely than men to prioritize the AIDS Drug Assistance Program (38% versus 62%) and health insurance (27% versus 44%).

Table 32. Service Priorities: Women (n=60; 5 missing responses)

RANK	SERVICE	# OF VOTES	% OF RESP.
1 (tie)	Ambulatory/outpatient medical care	36	60%
1 (tie)	Oral health care	36	60%
3	Housing assistance/related services	34	57%
4	Emergency financial assistance	33	55%
5	Case management	31	52%
6	Psychosocial support	26	43%
7 (tie)	AIDS Drug Assistance Program	23	38%
7 (tie)	Mental health services	23	38%
9	Client advocacy	22	37%
10 (tie)	Health insurance	16	27%
10 (tie)	Transportation	16	27%

4. Service Gaps

Women ranked child care as the number one service gap, followed by housing assistance, emergency financial assistance, oral health care, legal services and mental health services (Table 33). The overall percentage of women who reported child care as a gap has increased significantly in the past two years, rising from 5% of respondents identifying this service as a gap in 2001 to 31% in 2003.

Statistically significant differences in service gaps based on gender were reported in only two service categories. Thirty-one percent of female respondents noted difficulty in accessing child care, as compared to 3% of males. Women were also more likely than men to identify gaps in transportation (15% versus 6%).

On the FY01 survey, women of color exhibited greater access gaps than White female PLWH in almost all service categories. Data from the 2003 survey suggest this disparity seems to have lessened considerably. The sole service categories in which women of color exhibited significantly greater gaps than White women were child care services (36% versus 11%), housing services (36% versus 17%), legal services (24% versus 6%) and transportation (24%

versus 0%). Latinas, in particular, were more likely to identify service gaps, based largely on language barriers and concerns about confidentiality.

Table 33. Service Gaps: Women (n=65)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Child care	20	31%
2	Housing assistance/related services	19	29%
3	Emergency financial assistance	18	28%
4 (tie)	Oral health care	12	18%
4 (tie)	Legal services	12	18%
4 (tie)	Mental health services	12	18%
7 (tie)	Food bank/home-delivered meals	10	15%
7 (tie)	Transportation	10	15%
7 (tie)	Alternative, non-Western therapies	10	15%
7 (tie)	Buddy/companion care	10	15%

Data from the 2003 survey were also used to quantify the unmet needs of women. This was accomplished by applying the percent of women identifying service gaps across the population estimate of 451 women reported to Public Health and presumed living with HIV or AIDS in King County. Analysis indicates that approximately 140 women in King County have an unmet need for child care, 130 have an unmet need for housing assistance (particularly for help paying rent), and 125 have an unmet need for emergency financial assistance (including grocery vouchers and help paying for emergency utility bills).

5. Unmet Need for Medical Care

“We need to get the word out that there’s nothing to be ashamed of when you’ve got HIV. Get more people tested and work through the stigma. Make it about health, not death.”
(White female PWLH)

As previously noted, female survey respondents were slightly less likely than males to use primary care (90% versus 94%), the Washington State AIDS Prescription Drug Program (66% versus 71%), and health insurance programs (53% versus 70%). Each of these figures, however, represents increased utilization rates for women from those reported on the 2001 survey.

Providers reported that access to medical care is generally not a problem for their female clients, once they decide to engage in care. Barriers to initial engagement include:

- women living chaotic lives, with multiple challenges (mental illness, homelessness, domestic violence);
- fear of disclosure and loss of confidentiality, particularly for immigrant and refugee women, and

- difficulties in keeping medical appointments, due to lack of child care (particularly care for school age children and/or on an emergency basis), transportation, or being too ill to leave the house with their children

In early 2003, Public Health – Seattle & King County and the Washington State Department of Health (DOH) convened an Unmet Need work group across Titles I and II. The group adapted a framework for calculating unmet need for primary care that was developed for HRSA by a team from the University of California, San Francisco (UCSF). (A comprehensive discussion of how the Seattle EMA planned its “not in care” estimate process and derived its figures is contained in Part IV, Section H, “Unmet Need for Medical Care.”)

Estimates of unmet need included sub-population analysis based on sex, race/ethnicity and HIV/AIDS status. As a result, it is possible to quantify the number of female PLWH in King County who are believed to be not in care (defined locally as not having had a T-cell or viral load test in the past 12 months). Based on adjusted laboratory report data, it is estimated that 16.3% of all King County female PLWH who are aware of their serostatus are currently “not in care.” This represents approximately 89 women (95% confidence range: 71 low estimate and 109 high estimate.) The percent of female PLWH who meet the “not in care” definition is lower than for male PLWH (16.3% versus 24.7%).

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project include information about persons who received a “late diagnosis” with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that 37 out of 184 (20.1%) female PLWH who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 26.7%. This suggests that increased counseling and testing efforts directed towards at-risk women are necessary.

Female focus group participants (n=5) were all currently enrolled in primary medical care, and had all seen their providers within the past six months. None reported major barriers to accessing medical care within the past five years, either for themselves or for their peers. However, several female participants noted that changes in Medicaid had effected their ability to access some HIV medications. These women noted that their case managers were able to help them negotiate the system and ultimately restore their access to the drugs.

Several focus group participants reported knowing peers who were HIV+ (or at high risk for HIV) who were not engaged in medical care. The main reason they believed these women have not entered care was denial of their HIV risk or serostatus. They recommended increased education and outreach to women, with emphasis on informing women of the benefits and availability of medical care and prescription drugs.

E. Homeless Persons

“Being in a shelter was a nightmare. You’ve got to carry all your personal belongings with you. Everyone’s got an attitude, everyone’s always mad! I’d rather sleep in a tent outdoors or in a van.” (Homeless male PLWH)

1. Epidemiologic Profile

Although there have been no local population-based surveys of HIV infection in the homeless population in King County, studies from other areas of the country indicate that homeless men and women are at higher risk for HIV. Homeless people reported with AIDS in King County were more likely to be persons of color and to have been exposed through injection drug use compared to those who were not homeless.

Population sizes: The McKinney Act (Public Health Law 100-628, November 7, 1988) defines homelessness as:

“A homeless person is an individual who lacks a fixed, regular, and adequate residence or an individual who has a primary night-time residence that is either (a) a supervised or publicly operated shelter designed to provide temporary or transitional living accommodation or (b) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.”

Approximately 5,500 persons are homeless in King County on any day, of which 500-2,000 are youth/young adults. An estimated 25,000 persons have experienced homelessness in the past year in King County.

Among reported HIV/AIDS cases, homelessness is defined as having no resident zip code at time of HIV or AIDS diagnosis. This definition undercounts the number of homeless AIDS cases if, for example, the zip code of a shelter, friend’s home or provider’s office is reported as the zip code of residence. Eighty-nine (2%) of the 5,115 King County residents living with HIV or AIDS as of 12/31/2002 were reported as homeless. It is estimated that as many as 600 PLWH in King County may experience homelessness during any given year.

Status and trends in AIDS cases: Among homeless persons with HIV/AIDS, 49% were persons of color and 65% were injection drug users (including MSM/IDU), compared to 27% and 15%, respectively, among persons who were not homeless at time of diagnosis (Table 34).

Homelessness is a particular concern among injection drug users in King County. In a Public Health survey of 1,824 drug injectors at the King County Correctional Facility interviewed between 8/98 and 7/02, 60% reported having no permanent residence prior to their arrest.

HIV seroprevalence: In 1998, AIDS Housing of Washington analyzed the results of more than 5,650 surveys of PLWH conducted in twelve regions across the country between 1994-1998. Seven percent of all respondents reported that they were living on the streets, in a shelter, or in a residential hotel/motel at the time they completed the survey, and 41% of respondents had been homeless at some point in time.

Table 34. Demographic characteristics by homeless status of King County residents living with HIV/AIDS as of December 2002

	Homeless at time of diagnosis		Not Homeless at time of diagnosis	
	Number	%	Number	%
SEX				
Male	76	(85)	4,572	(91)
Female	13	(15)	454	(9)
RACE/ETHNICITY				
White	45	(51)	3,687	(73)
African American	30	(34)	740	(15)
Latino/Latina	7	(8)	405	(8)
Asian/Pacific Islander	0	(0)	108	(2)
Am. Indian/AK Native	7	(8)	77	(2)
Unknown Race	0	(0)	9	(<1)
EXPOSURE				
Male/male sex	22	(25)	3,562	(71)
Injection drug use (IDU)	33	(37)	311	(6)
IDU & male/male sex	25	(28)	440	(9)
Heterosexual contact	3	(3)	328	(7)
Undetermined/Other	6	(7)	385	(8)
TOTAL CASES	89	(100)	5,026	(100)

2. Service Trends

(NOTE: Due to difficulty in obtaining survey responses from consumers who were currently without a residence, the needs assessment survey asked consumers if they were currently homeless (without a permanent residence) or had been homeless during the past twelve month period. In this manner, it was anticipated that the survey would capture data from individuals for whom homelessness was either a recent or current problem. Of the 483 survey respondents, 82 (17%) reported homelessness within the past year. This represents a 41% increase over 2001 in the number of survey respondents reporting homelessness.)

Consistent with the previous two rounds of needs assessments, providers of services to homeless adults with HIV reported that their client caseloads are largely male, although increasing numbers of homeless female PLWH have entered the service system in the past two years. On the 2003 consumer survey, homeless respondents were twice as likely as non-homeless respondents to be female (24% versus 12%).

Providers noted that it was very difficult to determine the mode of HIV transmission for many of their homeless clients, due to multiple sexual and substance use risk factors. MSM sexual activity continues to be fairly common among the men, although many do not identify as gay or bisexual. Trading sex for money, drugs or shelter contributes to high-risk behaviors among both men and women in this population.

The population of homeless PLWH is more racially diverse than the general population of PLWH in the EMA. Only 45% of homeless PLWH respondents to the consumer survey reported themselves as White, with 21% being Latino/a, 15% African-American, and 5% each Native American, Asian/Pacific Islander and mixed race. In contrast, 64% of non-homeless respondents were White. Providers also reported that a higher percentage of their homeless clients are persons of color than are seen in non-homeless PLWH.

Rates of mental illness and/or chemical dependency in the population are extremely high. Homeless PLWH who responded to the 2003 consumer survey were significantly more likely than other PLWH to report being diagnosed with mental illness (70% versus 52%). Providers of services to homeless PLWH report that almost all of their clients have mental health issues, with the large majority being undiagnosed and untreated. Unlike other populations, in which clinical depression is the primary presenting mental illness, homeless PLWH present with a full range of psychiatric diseases. These include high (and increasing) levels of bipolar, anxiety and personality disorders.

According to King County epidemiology statistics, 65% of homeless PLWH have a history of injection drug use. Multi-drug use is also increasing among homeless PLWH, with some providers estimating that as many as 80% of their homeless clients are current or former substance users. Homeless respondents to the consumer survey were significantly more likely than other consumers to report histories of injection drug use (22% versus 5%) and alcohol abuse (31% versus 18%). Use of non-injection drugs was also high among homeless survey respondents, with the main “drugs of choice” being cocaine (reported by 34% of homeless PLWH) and methamphetamine (26%).

Providers noted that their homeless PLWH clients are generally less likely to be engaged in substance use treatment than in past years. Access to treatment remains difficult due to long waiting lists, complicated assessment processes, fewer detox beds and the closure of several King County substance use treatment programs (both out-patient and residential). For most clients, adherence to substance use treatment goes hand-in-hand with housing stability. If the client is released from in-patient treatment back to the streets, the odds of relapse increase dramatically.

Histories of incarceration are also common among this population. Homeless survey respondents were almost six times as likely as non-homeless PLWH to have been incarcerated in the past year (23% versus 4%). Providers report that the majority of their homeless clients have spent some time in jail or prison, with many clients having extensive criminal histories.

Data from the FY 2003 consumer survey reveal several differences between HIV-related health care status based on homelessness. Homeless PLWH were more than twice as likely as other PLWH to not have had a recent T-cell count or not know the results of their count (21% versus 9%) and to not have had a recent viral load test or know the results of the test (23% versus 11%). Homeless respondents were also significantly less likely to be receiving all forms of HIV medications: antiretrovirals (51% versus 76%), protease inhibitors (35% versus 49%) and medications for HIV-related side effects (28% versus 40%).

Providers of services to homeless PLWH and homeless focus group participants (n=11) noted that once homeless PLWH become connected to the care service system, either through the efforts of outreach case managers or placement in transitional or permanent housing, utilization rates are comparable to non-homeless PLWH. In fact, homeless PLWH were more likely than other PLWH to use case management services (86% versus 75%). This may explain the fact that homeless survey respondents reported utilization rates that were fairly similar to those of non-homeless PLWH. In several categories, homeless respondents reported higher rates of utilization, such as peer or client advocacy (54% versus 32%), support groups (57% versus 43%), and one-on-one peer support (47% versus 30%).

Homeless PLWH were also more likely than other consumers to utilize all forms of food-related assistance (fresh or canned food programs: 65% versus 46%, prepared meals: 53% versus 37%, and grocery vouchers: 55% versus 27%). The percent of homeless consumers who reported accessing injection drug use counseling or treatment (23%) and counseling or treatment for alcohol and other drugs (36%) also represents higher utilization rates than seen on previous surveys.

3. Service Priorities

Consumer survey respondents who reported themselves as currently homeless (or homeless within the past year) listed housing assistance and housing related services as their highest priority (Table 35). Other services that were ranked among the top five highest priorities were primary medical care, emergency financial assistance, oral health care and case management.

Table 35. Service Priorities: Homeless Persons (Current or in past year) (n=81; 1 missing response)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Housing assistance/related services	55	68%
2	Ambulatory/outpatient medical care	52	64%
3	Emergency financial assistance	48	59%
4	Oral health care	45	56%
5	Case management	44	54%
6	AIDS Drug Assistance Program	38	47%
7	Food bank/home-delivered meals	29	36%
8	Mental health services	25	31%
9	Psychosocial support	23	28%
10	Health insurance	21	26%

Homeless consumers were significantly more likely to prioritize housing assistance than other PLWH (68% versus 46%). The need for affordable, safe housing programs is obviously a high priority for most homeless individuals, particularly for homeless men and women living with HIV. Participants in the homeless PLWH focus group expressed concern that living in shelter situations as a person with HIV is extremely difficult. They expressed fears about being “outed” as HIV+ in shelters, by being seen taking HIV medications or overheard speaking on the phone

to medical and social service providers. Personal safety in shelter situations was also a concern, especially for homeless female PLWH. Several consumers also spoke of overt discrimination they experienced at the hands of shelter staff who did not want HIV+ individuals in their facilities. However, for persons who have not lived in stable housing situations for a long period of time, the transition into permanent housing can also be difficult without readily accessible support services. Providers emphasized the need to develop housing services that provide on-site access to substance use treatment, mental health counseling, and medication management.

4. Service Gaps

“Thus far, King County and Seattle in general seem to have really good services both for homeless and HIV positive people. Easier access for dental care would be beneficial and help with food is always needed, as well.” (Homeless male PLWH)

Current or formerly homeless consumers ranked emergency financial assistance as the service they most frequently needed but could not get (Table 36). Financial assistance was followed by housing services, legal services, oral health care, food programs, and alternative therapies.

Data from each of the past three rounds of consumer surveys suggested that service gap disparities between homeless PLWH and non-homeless PLWH had begun to decrease. However, the 2003 consumer survey revealed that access gaps for homeless PLWH in several categories have begun to reappear. The major service categories in which significantly greater gaps appeared were emergency financial assistance (particularly for grocery vouchers), with 45% of homeless PLWH reporting service gaps, versus 34% of other consumers, housing services (35% versus 24%), food/meal programs (20% versus 13%), and transportation (13% versus 7%).

**Table 36. Service Gaps: Homeless Persons (Current or in past year)
(n=82)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	23	40%
2	Housing assistance/related services	19	33%
3	Legal services	18	31%
4	Oral health care	17	29%
5 (tie)	Food bank/home-delivered meals	15	26%
5 (tie)	Alternative, non-Western therapies	10	17%
7	Referral for health care services	10	17%
8 (tie)	Child care	9	16%
8 (tie)	Transportation	9	16%
10 (tie)	Psychosocial support	7	12%
10 (tie)	Client advocacy	7	12%

Data from the 2003 survey were also used to quantify the unmet needs of homeless PLWH. This was accomplished by applying the percent of homeless PLWH persons identifying service gaps

across the population estimate of 600 homeless persons reported to Public Health and presumed living with HIV or AIDS in King County. In addition to the obvious need to find emergency, transitional or permanent housing placements for homeless PLWH, analysis indicates that approximately 240 homeless PLWH have an unmet need for financial assistance, with most of these expressing needs for grocery and/or meal vouchers. Other major areas of unmet need for this population include legal assistance (185 homeless PLWH estimated to have an unmet need), oral health care (175 homeless PLWH estimated to have an unmet need), and alternative/non-Western therapies (155).

Persons with criminal histories and/or current substance use issues face even greater challenges in obtaining housing. Focus group participants expressed a desire for “second chance” housing for persons with criminal records, particularly if the record is more than five years old. They suggested that housing providers need to look at criminal records with time consideration (so as not to penalize people based on older convictions) as well as the severity of the offense.

In response to this concern, a pilot housing and enhanced services project, named HEET (HIV Enhanced Engagement Team), has recently been implemented by AIDS Housing of Washington, Evergreen Treatment Center and the Downtown Emergency Services Center. The HEET Project targets individuals who are chronically homeless, HIV+ substance abusers. It is anticipated that many, if not most, of these individuals will have some past or current involvement with the criminal justice system.

5. Unmet Need for Medical Care

Although 95% of homeless PLWH respondents to the consumer survey reported currently receiving primary care for their HIV infection, this is probably an overestimate based on targeted sampling of homeless persons currently in the care system. It is probable that many homeless PLWH who are HIV-infected are unaware of their serostatus, and are not currently receiving primary care or supportive services.

Although the Seattle EMA has completed its initial process of calculating unmet need using the UCSF Unmet Need Framework, sub-population analysis to date has been limited to demographics based on sex, race/ethnicity and HIV/AIDS status. As a result, it is not possible at this time to use the UCSF model to quantify unmet primary care need based on homeless status.

At present, quantitative estimates of homeless PLWH who have an unmet need for primary medical care are based on two assumptions: (1) an estimated annual number of 600 persons reported to Public Health and presumed living with HIV or AIDS who will experience homelessness in King County and (2) the percent of 2003 homeless consumer survey respondents who either reported not receiving primary care, not having a T-cell count in the past year, or not having a viral load count in the past year. The percent of homeless PLWH on the consumer survey meeting the “not in care” definition was applied against the overall number of PLWH in this sub-population in King County to develop an overall not-in-care estimate. Using this model, it is estimated that 168 homeless PLWH annually are not in care (28.0% of the total annual homeless PLWH population of 600).

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project

include information about persons who received a “late diagnosis” with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that 36 out of 99 (36.4%) PLWH who were ever homeless who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 50.0%, suggesting that increased efforts to refer and enroll homeless PLWH into primary care are necessary.

Current and formerly homeless focus group participants (n=11) reported that medical care was very easy for them to access, once they decided to seek care. They did note, however, that initial information about HIV medical care was generally unavailable to them through homeless programs. As a result, most homeless consumers obtain their information about HIV disease and care through “word of mouth” from other PLWH. Surprisingly, focus group participants reported high utilization of HIV medications, despite multiple adherence challenges. Several consumers noted that the medication regimens helped to regulate their days, and motivated them to maintain engagement with medical and social services.

Homeless consumers expressed high levels of satisfaction with the care they had received, particularly in comparison to medical care many of them had received prior to moving to King County. However, several homeless consumers with substance use histories related negative experiences with medical providers whom they perceived offered them substandard care based on their substance use.

Providers echoed the sentiments of homeless consumers, reporting that access to care was not a problem for this population. Providers noted that ongoing engagement is often complicated by clients being lost to follow-up due to incarceration, enrollment in in-patient drug treatment programs, or when clients change providers. Due to complex, disorganized life circumstances, there may be a very small window of opportunity in which to engage and maintain homeless PLWH in services. Providers emphasized the need for consistent, comprehensive outreach efforts to maximize client engagement.

F. Youth and Young Adults (Ages 13-24)

“It’s so hard to hold this inside and not tell anyone. This is the first time I’ve even been in a room of people with HIV my own age.” (Young adult female PLWH)

1. Epidemiologic Profile

HIV infection does not appear to be widespread among the general King County adolescent population. Young men who have sex with other men (MSM) are disproportionately affected compared to other youth, and are at the greatest risk of HIV infection. Teenagers reported with HIV or AIDS through 12/31/2002 are more likely to be female or acquire infection heterosexually compared to older youth and young adults age 20-29.

Population sizes: The King County 2000 Census for ages 13-19 is 151,661, and for ages 20-24 is 116,597. Of these, the estimated King County estimated population of gay or bisexual males age 15-24 is 9,500 persons. Of the 5,115 King County residents reported as living with HIV or AIDS as of 12/31/2002, less than 1% were younger than 13 years old, 2% (102 persons) were age 13-19, and 10% (503 persons) were 20-24. Extrapolating from persons living with HIV infection, there are an estimated 170 King County residents age 13-19 with HIV infection, and 830 who are 20-24 living with HIV or AIDS.

Status and trends in AIDS cases: Over two-thirds of reported HIV diagnoses among persons age 13-24 are among males who had sex with males (with or without injection drug use). Seven percent were injection drug users (without male-male sex), 10% had heterosexual risk, and 3% were infected from blood products received before screening began in 1985 (Table 37).

Table 37. Demographics of Reported King County Youth and Young Adult PLWH as of 12/31/2002

	13-19 years (n=102)	20-24 years (n=503)
SEX		
Male	71%	86%
Female	29%	14%
RACE/ETHNICITY		
White	71%	70%
African American	17%	15%
Latino/Latina	9%	10%
Asian/Pacific Islander	2%	3%
Am. Indian/AK Native	2%	2%
EXPOSURE		
Male/male sex	44%	64%
Injection drug use (IDU)	10%	6%
IDU & male/male sex	17%	12%
Heterosexual contact	14%	9%
Transfusion/hemophilia	5%	2%
Undetermined/Other	10%	7%

HIV seroprevalence: An estimated 0.1% of teens age 13-19 and 0.7% of young adults age 20-24 are infected with HIV. Anonymous HIV prevalence surveys have been conducted in several specific populations in King County. Recent studies of HIV infection in youth and young adults reveal a wide variety of seroprevalence data. Because these surveys and other data sources all have unique features and results, they cannot be extrapolated to the general population.

Subgroup highlights: Young gay males: Results from the Seattle-area Young Men's Survey in 1997-98 show that 53% of MSM ages 15-18 and 64% of 19-22 year olds who had had anal sex in the past six months did not use a condom. The 1999 Seattle Public Schools Teen Health Risk Survey showed that 40% of high school students had had sex. Of those reporting sex in the previous three months, 61% had had sex without a condom at least once during that time.

2. Service Trends

Providers of services to HIV+ adolescents report that client demographics have changed in the past several years. Increasing numbers of HIV+ young women are now accessing services, with provider caseloads being equally comprised of male and female young adults. Of the young adult respondents on the 2003 consumer survey, 50% were male and 50% female, as opposed to 85% male and 15% female among those 25 and older. Additionally, providers noted that many of their young female PLWH clients have one or more dependent children, are pregnant, or are contemplating having children. All seven of the young female respondents on the consumer survey reported having dependent children.

Only 57% of the young adult respondents on the 2003 needs assessment survey (n=14) reported living in Seattle, with the remainder living in South or North King County. Providers also reported that an increasing number of their HIV+ young adult clients reside in areas outside Seattle. These individuals tend to be geographically isolated from the range of medical and support services available in Seattle. The population of street-identified youth includes a high percentage of transient adolescents, who have little or no employment history and may not be integrated into the social and health care delivery system in the area.

Homelessness is a significant issue for many young adult PLWH. Fifty-seven percent of young adult survey respondents reported having been homeless in the past year, and providers reported rates of homelessness in their caseloads ranging from 15%-33%. Many young adult PLWH are living in unstable housing situations, such as "couch surfing" with friends or being in imminent danger of homelessness due to inability to afford their current rent.

Drug and alcohol use continues to be widespread in the population. Providers report that as many as 50% of their clients are active substance users. Crystal meth use is especially prevalent among young MSM, while young women are more likely to use marijuana. Providers describe alcohol as the drug of "last resort" for their clients when other substances are not available. Young adult survey respondents reported higher rates of substance use (across almost all substances) than older PLWH, but these results were not statistically significant.

Mental health issues in this population are on the rise. Providers noted that well over half their young adult clients present with some level of mental illness. Clinical depression is the most

common illness, but providers are seeing increasing numbers of clients presenting with borderline personality disorders. Providers also noted that several of their clients have histories of suicide attempts. Sixty-four percent of young adult survey respondents reported having been diagnosed with mental illness.

Providers of services to this population report higher percentages of clients who are persons of color than are seen in the general population of PLWH. In particular, providers report seeing an increase among African American young adult PLWH, in some cases, up to 50% of their overall caseload.

According to reports from YouthCare (a Seattle-based social service agency for high-risk youth) and the University of Washington's Department of Pediatrics, access to the spectrum of medical, pharmaceutical, and ancillary services is not a significant problem for their young adult clients. A large majority of HIV-infected youth/young adults who know their serostatus are connected with and are receiving medical care. In general, providers of services to this population report that their clients are doing relatively well, clinically. As a result, it can be difficult to engage these adolescents in ongoing, consistent medical care, because they most often access care during times of crisis and/or illness. Providers report that their young adult clients have access to HIV medications, mostly through medical coupons, although adherence issues are relatively common. Several barriers serve to inhibit treatment adherence: chaotic life situations, substance abuse, homelessness, and mental illness.

Half of young adult survey respondents reported themselves as not being AIDS disabled, a rate much lower than for older PLWH. A significantly higher percentage of young adult PLWH were unaware of their T-cell counts (29% versus 11% of older PLWH), as well as being unaware of their viral loads (50% versus 12%). It is therefore not surprising that the percent of young PLWH taking all forms of prescription medication was much lower than for older PLWH: 43% of young adults taking antivirals versus 74% of older PLWH; 29% taking protease inhibitors versus 48%; 14% taking medications to treat or prevent opportunistic infections versus 37%, and 21% taking medications for HIV-related side effects versus 39%.

Utilization of case management services is very high among young adults with HIV, particularly for young women. Seventy-nine percent of 14-24 year old PLWH reported using case management services on the 2003 survey. Case managers for young PLWH report that their clients are extremely dependent on them for service access and require that the case manager initiate contact with almost all other social and health services.

3. Service Priorities

Unlike prior years, young adult consumers identified service priorities that were relatively similar to those identified by older PLWH. Oral health care emerged as the top service priority for this population, followed by emergency financial assistance, primary medical care, housing services, psychosocial support and the AIDS Drug Assistance Program (Table 38).

Data from the 2003 consumer survey revealed no statistically significant differences in service priorities between youth/young adult PLWH and older PLWH. However, it is unlikely that

statistically significant differences would emerge due to the low number of youth/young adult respondents.

It is interesting to note that case management did not emerge as one of the top five service priorities for young adult PLWH. Focus group participants (n=4) highlighted the importance of case management. The participants noted that ongoing, consistent case management was vital for them in accessing services and providing emotional support. They did note frustration with the high staff turnover they had experienced among their case management and medical care providers, noting that it becomes very difficult to establish trust among providers whom they feel are unlikely to remain in their circles of care.

**Table 38. Service Priorities: Youth and Young Adults (Age 13-24)
(n=14; 0 missing cases)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Oral health care	11	79%
2 (tie)	Emergency financial assistance	8	57%
2 (tie)	Ambulatory/outpatient medical care	8	57%
4 (tie)	Psychosocial support	7	50%
4 (tie)	Housing assistance/related services	7	50%
4 (tie)	AIDS Drug Assistance Program	7	50%
7	Health insurance	6	43%
8 (tie)	Client advocacy	5	36%
8 (tie)	Mental health services	5	36%
10 (tie)	Substance abuse services	4	29%
10 (tie)	Case management	4	29%

4. Service Gaps

Young adult respondents to the consumer survey identified housing assistance and housing related services as the highest survey gap. Other frequently cited gaps included food and meal programs, emergency financial assistance, transportation, mental health, and child care services (Table 39).

Data from the 2003 consumer survey revealed no statistically significant differences in service gaps between youth/young adult PLWH and older PLWH. However, it is unlikely that statistically significant differences would emerge due to the low number of youth/young adult respondents. (NOTE: Due to the low overall number of survey respondents, it is not possible to use these data to quantify unmet service needs among this population, as has been done with other populations with special needs.)

“Age is not the issue here, and neither is having HIV. It’s money. I could be 50 years old and I’d still be poor.” (Young adult male PLWH)

Lack of housing has been and remains a major problem for youth and young adult PLWH. Due to their age, lack of rental history and steady incomes, most youth cannot qualify for housing programs. Additionally, because most young adult PLWH are not yet AIDS-disabled, they do not meet eligibility requirements for placement in most AIDS housing facilities. As a result, many of the youth continue to live in unstable family situations, on the street, in shelters, or “couch surfing” with friends. Providers noted that, for this population, housing stability is directly tied to access to medical care. Getting their young adult clients to maintain access to health care was described as “almost impossible” in the absence of stable living situations.

**Table 39. Service Gaps: Youth and Young Adults (Age 13-24)
(n=14)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Housing assistance/related services	6	43%
2 (tie)	Food bank/home-delivered meals	5	36%
2 (tie)	Emergency financial assistance	5	36%
4 (tie)	Transportation	4	29%
4 (tie)	Mental health services	4	29%
4 (tie)	Child care	4	29%
7 (tie)	Oral health care	3	21%
7 (tie)	Psychosocial support	3	21%
7 (tie)	Referral for health care services	3	21%
7 (tie)	Legal services	3	21%

5. Unmet Need for Medical Care

According to focus group participants (n=4) and provider reports, access to the spectrum of medical, pharmaceutical and ancillary services is not a significant problem for their young adult clients. A large majority of HIV-infected youth/young adults who know their serostatus are connected with and are receiving medical care. Most of these clients are experiencing few, if any, health problems related to their HIV. Providers reported that there is very little HIV-related morbidity in this population. Providers did note problems with young adult PLWH making and keeping appointments. This is particularly true for young adult clients who are feeling well, and may not see a need to maintain engagement with the health care system.

Due to the low numbers of HIV-infected adolescents in the EMA, the small number of responses from 13-24 year olds on the FY 2003 consumer survey (n=14) was not surprising. As a result, it is difficult to effectively quantify specific service needs of this population. However, of this sample population, 100% stated that they are currently receiving primary care for their HIV.

Although the Seattle EMA has completed its initial process of calculating unmet need using the UCSF Unmet Need Framework, sub-population analysis to date has been limited to demographics based on sex, race/ethnicity and HIV/AIDS status. As a result, it is not possible at this time use the UCSF model to quantify unmet primary care need based on age.

At present, quantitative estimates of youth/young adult PLWH who have an unmet need for primary medical care are based on two assumptions: (1) an estimated number of 605 youth and young adults reported to Public Health and presumed living with HIV or AIDS in King County and (2) the percent of 2003 youth/young adult consumer survey respondents who either reported not receiving primary care, not having a T-cell count in the past year, or not having a viral load count in the past year. The percent of youth/young adult PLWH on the consumer survey meeting the “not in care” definition was applied against the overall number of PLWH in this sub-population in King County to develop an overall not-in-care estimate. Using this model, it is estimated that 303 youth/young adult PLWH are not in care (50.0% of the total youth/young adult PLWH population of 605). However, due to the low number of survey respondents in this age group, this figure lacks the statistical confidence generated for other sub-populations.

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project include information about persons who received a “late diagnosis” with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that 12 out of 108 (11.1%) persons 13-24 years of age received “late diagnoses” of HIV between 1996-2001. This percentage has not varied significantly from year to year, and is lower than for all other populations in the study cohort. Data from the Seattle cohort of the national Young Men’s Study (YMS) also suggest that lack of access to care is not widespread among this cohort. Only 1% (1 out of 111) of the participants in the YMS tested HIV+. This individual was receiving medical care for his HIV infection.

While data suggest that access to and initial enrollment in care are not major issues for young adult PLWH in the EMA, several barriers exist in ensuring that these individuals maintain consistent medical care and prescription drug adherence. Both providers and young adult PLWH survey respondents identified financial issues as the most common access barrier. The majority of young adult PLWH have limited or no income. According to providers, money management skills in this population are virtually non-existent. As a result, what little money these clients do have is spent either on necessities (such as food, rent and clothing), recreational activities or drugs. There is rarely money left over for co-pays, medical, clinical or social service care.

G. Incarcerated Persons

“Men just don’t talk about HIV in prison. When I got out of jail last year, I had no access to medications or housing. I’m homeless, and I’ve got no resources.” (Formerly incarcerated male PLWH)

1. Epidemiologic Profile

Incarcerated populations tend to have a higher prevalence of HIV infection than the general population, in part because they are more likely to have engaged in high-risk behavior such as injection drug use. There are also very high rates of chronic hepatitis C in this population, a virus that is also spread by sharing injection drug equipment. HIV and hepatitis C co-infection among inmates both locally and nationally continue to increase as the population of incarcerated persons also increases.

Population sizes: The average daily King County adult and juvenile detention populations increased from 1,946 in 1992 to 2,906 in 2001. The average length of stay was 18.9 days in 2001. Jail health staff estimate that on any given day about 1-2% of inmates, or about 60 people, are HIV positive. The annual estimated count of incarcerated persons in King County is approximately 36,000, of whom an estimated 710 persons annually (2.8%) are believed to be HIV infected.

Status and trends in AIDS cases: Of 13,025 persons voluntarily tested at King County correctional and detention facilities from 1992-2002, 247 (1.9%) were HIV positive. HIV prevalence was greatest among men who had sex with men (14%) and MSM who reported using injection drugs (8%). While the HIV prevalence rate was lower in male and female drug injectors, injection drug use was the risk category associated with the largest overall number of HIV infections: 29% of the HIV+ men and 50% of HIV+ women.

HIV seroprevalence: Between July 1992 and June 2002, 10,400 incarcerated males and 2,625 incarcerated females were voluntarily tested in King County. Seroprevalence rates among males and females were similar, with 2% of each population testing HIV+ (199 males and 48 females).

2. Service Trends

(NOTE: This is the first time that the population of incarcerated PLWH has been profiled in the Comprehensive Needs Assessment report. As a result, it is not possible to discuss historical trends in population demographics, service utilization, service priorities and service gaps.

Due to difficulty in obtaining survey responses from consumers who were currently incarcerated, the needs assessment survey asked consumers if they had been incarcerated at any time during the past twelve months. In this manner, it was anticipated that the survey would capture data from individuals for whom incarceration was either recent or current. Of the 483 survey respondents, 36 (7%) reported being incarcerated within the past year.)

Providers noted that the large majority of their incarcerated PLWH clients were male, but that females make up an increasing percentage of this sub-population. Incarcerated PLWH survey

respondents were almost exclusively male (34 out of 36 respondents; 94%). They were also significantly more likely than other respondents to be persons of color (55% of incarcerated PLWH versus 39% of other respondents). Among non-White sub-groups, the largest population of incarcerated PLWH was among African Americans (38% of incarcerated PLWH of color), with 19% identifying themselves as mixed race.

Rates of injection drug use and alcohol problems were significantly higher among incarcerated PLWH than other survey respondents. Incarcerated PLWH were over five times more likely to have used injection drugs in the past year (31% versus 6%) and over three times more likely to have had alcohol problems (58% versus 17%). The rate of non-injectable drug use among incarcerated PLWH was also significantly higher than among other survey respondents, including higher rates of cocaine use (47% versus 8%), methamphetamine (28% versus 11%) and Ecstasy (17% versus 4%).

Providers noted a high rate of poly-substance abuse in this population, with many going through involuntary withdrawal at the time they were incarcerated. Many of these individuals do not gain access to detox programs upon release (usually because treatment slots are not available), and they leave jail or prison before the drugs are fully out of their system.

Rates of homelessness were extremely high, with incarcerated survey respondents being significantly more likely than other PLWH to report having been homeless in the past year (53% versus 14%). Providers reported that approximately four-fifths of their incarcerated PLWH clients have experienced homelessness at some point in their adult lives. The majority of these clients cycle in and out of the judicial and correctional systems, with many leaving the King County jail system for longer terms at other state facilities. Only twenty percent of incarcerated PLWH clients are reported as being in jail or prison for the first time.

Data from the 2003 consumer survey reveal several differences between HIV-related health care status based on incarceration status. Currently or formerly incarcerated PLWH were more than twice as likely as other PLWH to not have had a recent T-cell count or not know the results of their count (22% versus 10%) and to not have had a recent viral load test or know the results of the test (24% versus 11%). Despite being equally likely as other consumers to report being AIDS-diagnosed, incarcerated respondents were significantly less likely to be taking antiretrovirals (47% versus 75%) and protease inhibitors (33% versus 48%). No significant differences emerged in the percentage of incarcerated PLWH taking medications to treat or prevent opportunistic infections or medications for HIV-related side effects.

3. Service Priorities

Consumer survey respondents who reported current or recent incarceration listed case management as their highest service priority (Table 40). Other services that were ranked among the top five highest priorities were primary medical care, emergency financial assistance, housing assistance, oral health care and the AIDS Drug Assistance Program. The sole service that was more likely to be prioritized by incarcerated PLWH than other consumers was substance abuse treatment (21% versus 6%).

HIV case managers from across the Continuum of Care applauded the recent addition of HIV-specific case management services in the King County Jail Health HIV/AIDS Service Program. They noted that this newly-funded Ryan White program decreased the likelihood that clients would be lost to the system while incarcerated or upon release. Of specific note is the ability of Jail Health case management to secure emergency housing for these clients upon release. This is key to ensuring ongoing engagement with medical care, mental health counseling, substance use treatment, and other social services.

Table 40. Service Priorities: Incarcerated Persons (Current or in past year) (n=34; 2 missing response)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Case management	24	71%
2	Ambulatory/outpatient medical care	22	65%
3	Emergency financial assistance	20	59%
4	Housing assistance/related services	18	53%
5 (tie)	Oral health care	16	47%
5 (tie)	AIDS Drug Assistance Program	16	47%
7	Food bank/home-delivered meals	14	41%
8	Psychosocial support	10	29%
9 (tie)	Mental health services	9	26%
9 (tie)	Transportation	9	26%

4. Service Gaps

Incarcerated PLWH survey respondents identified emergency financial assistance as their number one service gap. This was followed by housing assistance, legal assistance, psychosocial support and food and meal programs (Table 41).

Data from the consumer survey suggest relatively few service gap disparities between recently incarcerated PLWH and non-incarcerated PLWH. The two service categories in which incarcerated PLWH were significantly more likely than other consumers to identify gaps were legal services (noted as a gap by 31% of incarcerated PLWH survey respondents versus 17% of other PLWH) and substance abuse services (14% versus 3%). Unfortunately, the type of legal assistance required by incarcerated individuals is predominantly criminal in nature and is ineligible for Ryan White funding.

“My past history keeps my arms tied to shelter housing due to drug crimes and drug history. Will this ever change?” (Formerly incarcerated male PLWH)

Service providers have historically reported difficulty in housing PLWH with histories of incarceration, particularly persons with convictions for violent crimes, such as sexual assault and arson. Case managers have been especially frustrated by housing policies which deny placement to formerly incarcerated persons regardless of the length of time since the offense took place. In

focus groups, consumers reported being denied housing based on crimes they committed as long as 15 or 20 years ago. Recently, however, providers have noted that housing agencies have been more willing to compromise on this issue as long as the individual can demonstrate ongoing linkage to case management services.

Data from the survey were also used to quantify the unmet needs of incarcerated persons. This was accomplished by applying the percent of incarcerated individuals identifying services gaps across the annual population estimate of 710 incarcerated persons reported to Public Health and presumed living with HIV or AIDS in King County. Analysis indicates that approximately 255 currently or formerly incarcerated PLWH have an unmet need for financial assistance, with most of these expressing needs for grocery and/or meal vouchers. Other major areas of unmet need for this population include housing services (220 incarcerated PLWH estimated with an unmet need), legal services (220), psychosocial support (135) and food programs (135).

**Table 41. Service Gaps: Incarcerated Persons (Current or in past year)
(n=36)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	13	36%
2 (tie)	Housing assistance/related services	11	31%
2 (tie)	Legal services	11	31%
4 (tie)	Psychosocial support	7	19%
4 (tie)	Food bank/home-delivered meals	7	19%
6	Oral health care	6	17%
7 (tie)	Alternative, non-Western therapies	5	14%
7 (tie)	Client advocacy	5	14%
7 (tie)	Substance abuse services	5	14%
10	Child care	4	11%

5. Unmet Need for Medical Care

Although the Seattle EMA has completed its initial process of calculating unmet need using the UCSF Unmet Need Framework, sub-population analysis to date has been limited to demographics based on sex, race and HIV/AIDS status. As a result, we cannot at this time use the UCSF model to quantify unmet primary care need based on incarceration status.

At present, quantitative estimates of recently incarcerated PLWH who have an unmet need for primary medical care are based on two assumptions: (1) an estimated annual number of approximately 710 incarcerated persons who are reported to Public Health and presumed living with HIV or AIDS in King County and (2) the percent of recently-incarcerated consumer survey respondents who either reported not receiving primary care, not having a T-cell count in the past year, or not having a viral load count in the past year. The percent of recently-incarcerated PLWH on the 2003 consumer survey meeting the “not in care” definition was applied against the overall number of PLWH in this sub-population in King County to develop an overall not-in-care

estimate. Using this model, we estimate that 256 recently-incarcerated PLWH annually are not in care (36.1% of the total annual incarcerated PLWH population of 710).

Data on “late diagnoses” with HIV from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project are not available for this specific population. However, using the percentage of late diagnoses among IDU PLWH as a surrogate marker for incarcerated PLWH suggests that late diagnoses among incarcerated PLWH are probably significantly higher than for non-incarcerated PLWH. This further demonstrates the importance of on-site case management services in jail and prison settings that provide access and linkage for HIV+ inmates to medical and social services upon release.

Recently incarcerated focus group participants (n=5) noted few problems in accessing medical care once they had been released from jail or prison. They attributed this to the successful efforts of community and jail health case management. However, several participants noted that they had received their initial diagnosis of HIV while in prison. PLWH who had been incarcerated in out-of-county or out-of-state facilities reported that their experiences with HIV-related medical care in these facilities were highly negative: doctors who were unfamiliar with HIV disease and treatment protocols, and lack of access to prescription drugs and emergency medical care.

Problems in accessing HIV medications also exist within the King County Correctional System, although not to the same extent as exhibited in other systems. A key concern is the issue of which funding sources should pay for these drugs (i.e., Medicaid, ADAP, jail pharmacy budget). Increased education about HIV treatments for all levels of jail health personnel is recommended in order to ensure appropriate response to legitimate client health concerns and outcomes.