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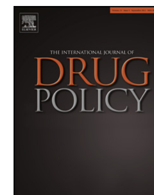

Research paper

Understanding interactions of formerly incarcerated HIV-positive men and transgender women with substance use treatment, medical, and criminal justice systems

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ABSTRACT

Background: Low levels of medical care engagement have been noted for HIV-positive people leaving systems of incarceration in the United States. Substance misuse frequently co-occurs with criminal justice involvement in individuals who are living with HIV.
Methods: We analyzed data from in-depth interviews with 19 HIV-positive individuals who were currently or formerly incarcerated in order to elucidate challenges faced in accessing care and maintaining HIV treatment regimens when cycling out of (and often back into) custody. Our thematic analysis used an ecosocial framework to describe participants' shifts between substance use treatment, medical care, and criminal justice systems.
Results: Dominant themes included the dramatic increase in HIV-treatment-related autonomy required following release from jail because of differences in care delivery between custody-based and community-based care systems; the important, but temporary stabilization provided by residential substance use treatment programmes; and the inconsistency of substance use treatment approaches with chronic care models of disease management.
Conclusion: Enhanced integration of criminal justice, medical care, and substance use treatment institutions in planning for reentry of HIV populations may ease the impact of the dramatic shifts in context that often dissuade linkage and retention. This integration should include coordination with custody release processes, periodic assessments for active substance misuse in HIV treatment settings, support for (re)establishing health-promoting social networks, and options for long-term, residential substance use treatment programmes.

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Current HIV strategic goals emphasize the importance of antiretroviral therapy (ART)-based interventions, including pre- and post-exposure prophylaxis and early, continuous of use of ART, for both maintaining the health of people living with HIV and reducing risk of HIV transmission to their partners (Centers for Disease Control and Prevention (CDC), 2017; Cohen et al., 2011; Office of National AIDS Policy (ONAP), 2015). These ART-based interventions require from patients both adherence to medication regimens and ongoing engagement with medical care systems. HIV-positive persons also participate in other systems that may either facilitate or hinder progress along the HIV continuum of care. For example, approximately 1 in 7 of the HIV-positive population in the United States experiences incarceration in any given year (Spaulding et al., 2009).

A majority of people in jail have comorbid substance use disorders (Karberg & James, 2005), and illicit substances are important reasons for arrest and incarceration (Harawa et al.,

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2009; Karberg & James, 2005; Wagner & Rabuy, 2016, March 14). Nevertheless, most US custody settings offer little-to-no services for addressing substance misuse (Chandler, Fletcher, & Volkow, 2009; Mumola & Karberg, 2006, October; Taxman, Perdoni, & Harrison, 2007). Those who leave jail and reenter the community move from an environment in which illegal substances and substance use are present but scarce and heavily surveilled, to one in which illegal substances and substance use may be plentiful and encouraged by social networks. Although they may have achieved abstinence while incarcerated, maintaining sobriety during reentry requires additional skills, support systems, and motivations, particularly in the face of the stressors associated with reestablishing social networks, securing housing, and securing one's livelihood.

Because of the well-documented links between substance misuse and HIV risks (Volkow & Montaner, 2010), programmes do exist to identify and address the needs of those living with both HIV and substance use disorders. These include needle and syringe exchange, HIV testing of substance use treatment[1] and needle exchange clients, HIV case management services to facilitate HIV care access, medication assisted therapies, contingency management, and directly observed antiretroviral therapy targeting this group (Springer, Spaulding, Meyer, & Altice, 2011). Substance use treatment has been associated with increased HIV medical care engagement (Gonzalez, Barinas, & O'Cleirigh, 2011), and HIV-focused substance use programmes have been shown to promote both HIV medication adherence and viral suppression (Gonzalez et al., 2011; Springer et al., 2011).

HIV disease and substance dependence both represent chronic, stigmatized, and generally incurable illnesses that, in addition to threatening mortality, can threaten individuals' sense of self, strain social ties, and require intensive treatment and self-management to address successfully. Models of HIV treatment are largely consistent with those for the management of other chronic illnesses (U.S. Department of Health and Human Services-Health Resources and Services Administration (HRSA), 2014). By contrast, approaches to addressing substance dependence, particularly for criminal-justice-involved patients, are much less consistent with a chronic disease model. Although methadone and buprenorpine treatment for opioid dependence are exceptions (Altice et al., 2011; Friedmann et al., 2012; Fu, Zaller, Yokell, Bazazi, & Rich, 2013), the most effective forms of medication assisted treatment for substance dependence are the least likely to reach the largely low-income and Black and Latino populations who are overrepresented in US prisons and jails (Duncan, Mendoza, & Hansen, 2015; Hansen et al., 2013). In community settings in the US, active management of recovery from substance dependence is generally restricted to short periods of detoxification or somewhat longer periods of residential treatment. Upon completion of these programmes, long-term care is generally self-managed and haphazardly supported by peers and para-professionals (e.g., 12-step groups and substance use counselors) outside of mainstream health care delivery.

Given the known associations of incarceration with other social determinants of poor health, HIV-positive individuals who go to jail or prison also likely experienced elevated rates of mental illness, trauma, and economic marginalization, compared to people living with HIV who do not (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010; Baillargeon et al., 2009; Surratt, O'Grady, Levi-Minzi, & Kurtz, 2015). While in custody, people living with HIV experience a system with structures and regulations that automate care and facilitate adherence (e.g., regimented schedules, pill calls, universal health care, shelter, proximity to services) (Jurgens, Nowak, & Day, 2011; Meyer, Cepeda et al., 2014). However, in the general community, many may lack such supports, and those with substance use-related incarceration histories may be restricted from housing and food resources. For example, until April 2015, all persons convicted of a felony drug offense in California were banned for life from receiving welfare (CalWORKs). If the conviction was related to drug distribution, they were also banned from Federal nutrition assistance benefits (CalFresh), with some exceptions (Committee on Budget, 2014). Other restrictions still limit access to public housing and housing assistance for people with drug-related convictions.

Custody-based services exist in many locations to facilitate linkage to care (e.g., transitional case management) and to minimize immediate HIV medication lapses (e.g., short-term medication supplies at release) post release (Jurgens et al., 2011). Nevertheless, significant declines in treatment and care utilization have been documented following reentry (Baillargeon et al., 2009; Clements-Nolle et al., 2008; Stephenson et al., 2005) and despite general improvements in HIV continuum of care outcomes while in custody (Iroh, Mayo, & Nijhawan, 2015). Studies of former prisoners and those who later experienced re-incarceration have found that release from prison is associated with a low likelihood of filling an ART prescription within two months (Stephenson et al., 2005), and a high frequency of ART discontinuation (nearly 50–60%) (Clements-Nolle et al., 2008; Meyer, Zelenev et al., 2014; Small, Wood, Betteridge, Montaner, & Kerr, 2009; Springer, Friedland, Doros, Pesanti, & Altice, 2007), as well as marked increases in viral load (Palepu et al., 2003; Small et al., 2009; Springer et al., 2007) in those who later recidivate.

Few studies, however, have examined how the contexts of criminal justice, HIV medical care, and substance use treatment systems influence individual patients' *agency*, perceptions, and behaviors; what circumstances lead HIV-positive CJI patients into and out of these systems; and how these systems interact with one another to impact management of their HIV disease and substance use disorders. *Agency* refers to the ability of individuals to act independently and to make choices according to their own desires and opinions—to exert power and to make things happen. Particularly relevant to this context is that sociologists frequently contrast agency with *structure* or arrangements that lead individuals "to be acted upon, to be the object of events, . . . , to be constrained and controlled: to lack agency" (Hewson, 2010). As part of the process of developing a peer navigation intervention to sustainably connect HIV-positive persons to treatment following jail release, we conducted in-depth interviews exploring the supports and challenges affecting linkage and retention following release from a major urban jail. We report here on analyses of a subset of those interviews. By focusing on the contexts in which the HIV-positive participants experienced and moved between substance use treatment, HIV care, and custody settings, our analysis explored how these dynamic and overlapping systems relate to each other and impact the lives of people who are living with HIV and have recent histories of incarceration.

Methods

Setting

The study was carried out in Los Angeles County and involved a direct collaboration between the Division of General Internal Medicine and Health Services Research in the Department of

[1] Although the term' substance use treatment' has been criticized because of the non-medical and stigmatized activities that some associate with the term 'substance use', it is the common name by which programmes for addressing substance dependence are known in the U.S. We use 'substance misuse' to describe harmful or hazardous use of subtances and 'substance dependence' to describe individuals whose patterns of substance misuse are severe enough to require comprehensive treatment.

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