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Preventing HIV & Substance Use in Incarcerated Women: Can an App Help?

Dr. Cheeley:
Although the rate of new HIV diagnoses in the United States is steadily declining, people in prisons are still disproportionately living with the virus, which is why researchers at Temple University are now developing an app aimed at improving HIV prevention and substance use treatment access for incarcerated women in Philadelphia. How this app works and other key considerations are what's to come on today's program.

Welcome to *Clinician's Roundtable* on ReachMD. I'm your host, Dr. Mary Katherine Cheeley. And joining me today is Dr. Sarah Bass. She is an Associate Professor of Social and Behavioral Sciences and the Director of Risk Communication Laboratory at Temple University.

Dr. Bass, thanks for joining me today.

Dr. Bass:
Thank you. I appreciate you having me.

Dr. Cheeley:
Let's jump right in. I'm really excited about this topic today. So can you kind of give us some information about the link between HIV and substance use?

Dr. Bass:
Sure. HIV has always been part of the risk for people who are using substances, either because they are using syringes and they're sharing those syringes, so you have HIV exchange that way, or it could be that using substances make them also participate in other kinds of high-risk behaviors, so whether that is sexual behavior, maybe sex work that puts you at risk or you have partners who are having risk behavior, and then they're bringing that home and back to you.

Dr. Cheeley:
So if we talk about the incarcerated population, with that in mind, what unique challenges exist when it comes to HIV prevention?

Dr. Bass:
Yeah. I mean, they have a lot of added risk for both HIV and substance use disorder, so we see people who are incarcerated—and especially women, which is the focus of this study—who are at risk for HIV because of all those things I just talked about; but then also prison itself, once you are released makes you more at risk for participating in some of these things once you get out, so whether that's because you don't have a steady source of income, you may not have stable housing, so you're kind of trying to situate yourself after you get out of jail or prison, and sometimes that can exacerbate that risk for some women, and so that becomes a really important place to try and intervene for them. So between the time that they are released from incarceration to the time that they might get more stable

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is a really important time to try and get them, and so that's really what this particular intervention is about.

Dr. Cheeley:
And not to mention, when you're incarcerated and you come out of prison, you usually don't have health insurance at that point.

Dr. Bass:
Yeah. So for a lot of them, they don't have that direct linkage between what they have been getting in prison, perhaps. So let's say they were on medication for substance use disorder in prison, so methadone or something like that. Then they may get a shot of Vivitrol as soon as they're released, but then they're on their own after that, and if they don't have those resources and don't know where to go to get those resources, that's an immediate place where you can try and intervene.

Dr. Cheeley:
I agree. A lot of people don't think about the gap after you are released from prison or jail, and that's a huge place that we have a gap in healthcare specifically. So if we look more specifically at incarcerated women—we talked about them a little bit—are there challenges to HIV medication adherence that we should think about in that post-incarceration stage?

Dr. Bass:
Sure. And honestly, it's the same for almost everybody who might be on medication for HIV prevention. PrEP, up until recently, has really just been a daily pill, and so if you are housing unstable, you are also using substances, maybe you're in an unsafe situation, whatever your circumstances are after you are coming out of incarceration, taking a daily pill can be quite hard. So I've worked with a lot of women who are using substances, and the interest in PrEP is very high, but the adherence to PrEP is very low. It's very hard for them to do that, especially just having like a pill bottle when you're on the streets, where do you keep it? You know I have had women who had have it stolen or other kinds of things.

Now that we have a longer-acting injectable PrEP, it's a little bit easier, but then that also requires a lot of coming in to the doctor, getting the shots, and so then that becomes that issue of the gap between healthcare and you. And there's still a lot of HIV stigma, especially for women. Women have the same kind of misconceptions of who are at risk for HIV as the general public, and often they are kind of left out of the discussion of who is actually at risk for HIV, and because of that as well as just the stigma around incarceration and sexual risk and substance use, all of those kinds of stigma kind of play along with non adherence to those kinds of things.

Dr. Cheeley:
Yeah, so we run a PrEP clinic at my institution as well, and we also see really similar things. It is really challenging to have the name on the bottle because the drug that is used for PrEP is also used for treatment, and so "Well, I don't want people to think that I have HIV." And you're exactly right. That stigma is very, very loud. But we also have noticed challenges in our institution just getting access to the drug before. So you were talking about the long-acting injectable with cabotegravir. You have to go through the Patient Assistance Program. Well, if you've been incarcerated, you may not have filed taxes last year, and so how do you get the information that you need to get the PAP, the Patient Assistance Program, to even get the drug? So these are huge challenges for anyone coming out of incarceration. But do you guys have those challenges?

Dr. Bass:
Yeah, absolutely. The community organization that we will be working with is Philadelphia FIGHT. That is a federally qualified health center, and they have navigators; they have social workers; they have people to do that case management to try and help people who are coming out of incarceration get those things that you just talked about. But the problem is getting them to actually get there first, and I think that is where we're really seeing that lack of linkage, especially for women. I think there are a lot of programs that are aimed at men; a lot of men who are accessing those programs, but it's like my colleagues and I are like "Where are the women?" Like, we know the women are being released from jail or prison, but they're not kind of grouping themselves into the types of services that have been historically there for men, and I think it's that key moment of trying to keep that linkage to get them to the person who can help them do those things.

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Dr. Cheeley:
Yeah, I totally agree. For those just tuning in, you're listening to *Clinician's Roundtable* on ReachMD. I'm Dr. Mary Katherine Cheeley, and I'm speaking with Dr. Sarah Bass about HIV prevention and substance use treatment access in the incarcerated population.

All right, Dr. Bass, this is what I'm most excited about. Let's talk about your research. How did your team come up with the idea of creating an app of all things for this population? It's so ingenious. I love it.

Dr. Bass:
Well, sure. I am a health communication researcher, so I have been kind of in this space my whole career, and HIV has always been my passion. And so I have also done a lot of work in people who use substances, and so, when I started talking to my colleague Emily Dauria, who is at University of Pittsburgh, she's done a lot of work with women who are incarcerated, and so we started talking, and kinds of conversations that we were just having like "Where is the breakdown for women when they're coming out?" and we really identified this time between release and trying to get them to get to the place where someone can help them get access to these lifesaving types of medications for them.

And so I said one of the ideas that I've had actually for a number of years is could we develop something that would be electronically based that could link them not only to those navigators at a kind of community clinic, but also link to each other, so trying to provide some type of peer support for each other so they could start to share some information because again, as I said, a lot of times it's like we just don't know where they're going and they're not having access to each other, and so the idea was could we develop this kind of application that they could get information on these resources in a way that is right for them, but then that would also link them to the navigator and the healthcare personnel who could get them that access to things like PrEP or medications for opioid use disorder.

So we're really at the beginning of this study where we're trying to listen to women who have been in this situation, to hear what they need and what would work for them.

Dr. Cheeley:
I love this idea. But all great ideas also have barriers. Do you guys kind of anticipate any barriers, both with the app uptake and also with the patient population that you're serving?

Dr. Bass:
Sure. I think one of the things that we talked about is should this be an app that you download on to a phone versus something that's web-based, and I think one of the things that we realized is that for a lot of these women, while we kind of think of cell phones as everyone has them, etc., they may not have them steadily. Right? So I've done like text messaging interventions with women around PrEP who are on substances, and sometimes they have text—sometimes they have that cell phone; sometimes it gets stolen; sometimes they're sharing it with someone.

So that's kind of how we're going is more this kind of web-based so that they don't have to download it. It also allows them to do more discreet logins than it would on a phone, especially if they're sharing those kinds of phones.

As far as the other, certainly, I think you have the same issues with adherence that you would otherwise in this population. One of the things that we're interested in is does this help with adherence in any way if they feel like they have that kind of more personal connection with the healthcare provider, with the navigator, so that if they're having issues, they can reach out, like they could message and say, "Hey I haven't been able to take my medication," or "I lost my medication," or something like that. This might facilitate that a little bit in helping them get what they need.

Dr. Cheeley:
So what outcomes are you looking for with your research?

Dr. Bass:
One of the main things we're doing is just looking does this actually link people to the services they need, and do they actually uptake it,

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right? Actually, a secondary outcome of this is do they actually use PrEP or medications for opioid use disorder. So in some ways we're really testing the concept of having this type of technology and whether that actually increases access rather than the actual uptake. If we can show the concept works, then the idea is you do a larger kind of more scientific randomized controlled trial to see if it actually increases uptake of the medications and adherence to those medications longer term.

Dr. Cheeley:
Well, I am certainly so excited to hear the idea. Do you have kind of any final thoughts for us?

Dr. Bass:
I would just say one of my passions is making sure that we are really reaching populations who are at risk for HIV or medication for overdose and opioid use disorder in a way that works for them. I think that's the main thing, is that we kind of tend to try an all-sizes-fit-all approach to HIV prevention sometimes, and I think we have to be cognizant that these subpopulations have very different issues that we have to be understanding of and listen to create interventions that work for them.

Dr. Cheeley:
Yeah. I think that's a great way to sum up exactly what we talked about today. So thank you so much for being with me, Dr. Bass. This is going to be such an exciting research to read later on, so please let me know when you're done with it, when you publish it, because I want to read it. Thank you for the work that you do with this vulnerable population living with HIV. It has been a pleasure speaking with you today.

Dr. Bass:
Thanks so much. It's been a pleasure.

Dr. Cheeley:
For ReachMD, I'm Dr. Mary Katherine Cheeley. To access this and other episodes in our series, visit ReachMD.com/CliniciansRoundtable, where you can Be Part of the Knowledge. Thanks for listening.

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