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Technology Use in Linking Criminal Justice Reentrants to HIV Care in the Community: A Qualitative Formative Research Study

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Abstract

Innovative interventions increasing linkage, adherence and retention in care among HIV-infected persons in the criminal justice system are needed. The authors conducted a qualitative study to investigate technology-based tools to facilitate linkage to community-based care and viral suppression for HIV-infected jail detainees on antiretroviral medications being released to the community. Twenty-four qualitative interviews were conducted in Rhode Island (12) and Washington DC (12) among HIV infected persons recently incarcerated to elicit their perceptions on the use of technology tools to support linkage to HIV care among criminal justice populations. This article discusses participants' perceptions of the acceptability of technological tools such as (a) a computer-based counseling and (b) text messaging interventions. The participants reported positive experiences when previewing the technology-based tools to facilitate linkage to HIV care and adherence to HIV medications. Successful linkage to care has been shown to improve HIV-associated and non-HIV-associated health outcomes, as well as prevent criminal recidivism and facilitate reentrants' successful and meaningful transition. These findings can be utilized to inform the implementation of interventions aimed at promoting adherence to antiretroviral medications and linkage to care for HIV-infected persons being released from the correctional setting.

Individuals diagnosed with HIV/AIDS and who are involved with the criminal justice system are confronted with challenges accessing care in the community after release. The importance of linkage to care for HIV-infected persons being released to the community from correctional facilities is a critical part of the continuum of care. For these individuals, effective HIV treatment can result in improvements in clinical outcomes including viral

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suppression that improves survival rates and also reduces ongoing transmission in the community (Baham, Bick, Giannoni, Harris & Ruiz, 2002).

When HIV-infected persons are released from correctional facilities and re-enter the community (re-entrants), the timeliness of engaging in HIV care is critical. Lapses in care disrupt any therapeutic benefits that may have been gained through treatment while incarcerated, where antiretroviral treatment (ART) administration is typically monitored. Reentrants face unique challenges accessing HIV/AIDS and related care in the community. Previous research has demonstrated poor antiretroviral adherence (Springer & Altice, 2007) and a low rate of filling (Baillargeon et al., 2009) prescriptions among recently released inmates.

Individuals attempting to navigate the healthcare system following release from jail — and particularly those with multiple comorbidities such as HIV/AIDS (Bickel, Christensen, & Marsch, 2011), substance abuse (Springer, Azar & Altice, 2011), and mental illness (Baillargeon et al., 2009) — may find the process to be particularly overwhelming even when they are receiving assistance from programs that are intended to facilitate linkage. Reentrants also have to navigate other social and structural challenges during reentry, such as homelessness and/or unemployment/underemployment (Springer, Azar & Altice, 2011). Any one or all of these challenges have the potential to interfere with access or adherence to HIV treatment (Gustafson, Hawkins & Boberg, 1999; Hahna, Choia, Griffitha, Yostb & Bakerc; Kiene & Barta).

Research has shown that case-management based interventions to improve linkage to care after release from correctional facilities have had mixed results (Wohl et al.; Rich, et al., 2001; Copenhaver, Chowdhury & Altice, 2009; Klein, O'Connell, Devore, Wright & Birkhead, 2002). Development of effective interventions that can be easily disseminated yet are not cost-prohibitive and investigation into the use of technological devices to facilitate linkage to care are needed. This paper reports the perspectives of HIV-infected individuals who were recently released from a correctional facility about the acceptability, feasibility and insights regarding the use of information and communication technology (ICT) tools to support linkage to care. The use of ICT tools in correctional settings and the use of cell phone text messaging after release from correctional facilities to improve linkage to community HIV care has not been studied. Therefore, the objective of this study was to explore the perceptions of using technology-based interventions among at-risk reentrants.

The CARE+ Corrections Intervention

We are conducting a study that is investigating the use of a combination intervention designed to improve linkage to community HIV care and adherence to ARVs among HIV-infected persons released from jail. The intervention consists of two parts: the first is a computerized motivational interview, CARE+ Corrections, delivered within the correctional facility and the second is the use of cell phone-delivered text messages in the community after release.

CARE+ Corrections is an adaptation of the existing CARE tool which is a computer-based counseling platform offering HIV risk assessment, counseling, risk reduction planning, and

facilitation of rapid HIV testing (Henry, Mackenzie, Kurth, Spielberg & Larkin, 2005). The platform uses narrated self-interviewing to ascertain behavioral risk, assess self-efficacy/motivation, and provide tailored feedback on specific risk behaviors. Prior to developing a health promotion plan around sexual risks or medications, users watch skill-building videos appropriate to their stage of readiness for behavior change. The CARE tool exists in several forms with different counseling content (rapid HIV testing and primary HIV risk reduction for persons with unknown HIV-status; and CARE+ delivers counseling on ART adherence and secondary risk reduction for persons already known to be HIV-infected), it has been adapted for use in several languages (English, Spanish, Kiswahili), and has been used in multiple settings including HIV clinics, community-based organizations, hospitals/emergency departments, and mobile HIV testing services (Skeels, Kurth, Clausen, Severynen, & Garcia-Smith, 2006; Spielberg et al., 2011).

CARE+ Corrections is based on the CARE+ platform yet the counseling content has been modified to not only include risk reduction and ART adherence counseling for persons known to be HIV-infected, but also include counseling designed to reduce barriers to linkage to care after release from correctional facilities. This is done through skill-building videos that review potential barriers to care in the community including relapse to substance use, unstable housing and unemployment; and provide ways to reduce these barriers such as the importance of working with an AIDS service organization case-worker after release. The CARE+ Corrections counseling session is intended to be delivered prior to release from a correctional facility. The second part of the CARE+ Corrections intervention is to provide clients with automated text message reminders regarding ARV adherence and medical appointments during their first six months post-incarceration. Text message reminders will be delivered via personal cell phone or a cell phone provided by the study. Frequency and content of messages may be customized to meet the needs and preferences of the participant. The effectiveness of the CARE+ Corrections intervention with respect to improving linkage to community HIV care and ART adherence after release is being tested in a clinical trial being conducted among HIV-infected persons incarcerated within the Washington, DC jail. A more detailed description of the clinical trial and the CARE+ Corrections intervention has been published separately (Kurth et al.).

Methods

In order to assess the acceptability and feasibility of using ICT tools such as the CARE+ tool within correctional facilities, and to guide content development of the CARE+ Corrections tool, formative qualitative interviews were conducted in Providence, Rhode Island and Washington DC among HIV-infected individuals with a history of recent incarceration.

Recruitment

Participants were recruited in cooperation with selected relevant local community-based organizations (CBOs) that provide services to individuals recently released from incarceration in Rhode Island and Washington, DC. Flyers were distributed at locations around the city where potentially eligible individuals show up and spend time. Flyers were also made available to appropriate staff at the cooperating CBOs. The staff members at the

CBOs were asked to distribute the flyers among their client populations who may meet the eligibility criteria for the study. Additionally, information about the study was disseminated by “word of mouth”. Individuals interested in participating in the study contacted a CARE Corrections Study team member for more information and to be screened for eligibility to participate in the study.

Sample

Twelve participants from each site-Rhode Island and Washington, DC - were enrolled and interviewed for a total of 24 participants. All of the participants were screened to verify that each participant met the following inclusion criteria: 1) 18 years of age or older; 2) able to complete the interview in spoken English; 3) HIV-infected; and 4) released from a correctional facility within the 6 months prior to the interview.

Procedures

Following completion of a brief demographic questionnaire, participants were asked to pilot test an existing version of the interactive CARE+ tool. This was completed in a single session that was approximately 60 minutes in length. The participants were guided through the computerized tool by a study staff member. After the participants used the tool in a mock counseling session, they were interviewed by project staff members with qualitative interview experience. Participants were asked questions regarding their opinions on the acceptability, practicality and feasibility of the tool as well as their ideas for the logistics of administering such a tool within a correctional facility. The qualitative interview also included a line of inquiry that allowed the participants to provide insight and opinions on ways that cells phones and text messaging can best assist with HIV care and treatment after individuals are released from incarceration. The interviews were audio-recorded and transcribed. Participants received $40 in compensation for their time. The entire interview session took approximately 60–90 minutes to complete. The study protocol was approved by the IRBs of the Miriam Hospital (Providence, RI) and George Washington University (Washington, DC).

Data Analysis

The data analysis procedure included a computer-assisted qualitative data analysis approach using ATLAS.Ti 6.0. Data from the qualitative interviews were coded by experienced project staff. The qualitative analysis utilized a constant comparative coding scheme that identified and characterized the relevant emerging domains. Codes were developed based on information provided by the study participants during the qualitative interviews. The data were analyzed using constant comparative principles which examined textual data for common themes elucidated during the interview and identified through the project aims.

Results

Participant Demographics

In Rhode Island, seven males and five females were interviewed, four being Caucasian, threefold African American and five Hispanic. The age range among Rhode Island participants was between 20 and 65 years old. In Washington, DC, six males, four females

and two transgender women were interviewed. All were African American, between the ages of 30 and 55 years old.

Acceptability of CARE+ Tool for Use in Correctional Facilities

During the interviews, study participants discussed their comfort level with computers in general and their opinions on the CARE+ tool. Additionally, the participants discussed opinions on how the CARE+ tool could assist with transitioning back to the community and linking to HIV care. Participants demonstrated varying levels of experience using a computer, ranging from no use to frequent use. Participants used computers for downloading and playing music, interaction on social networking websites, and searching for employment. In general, all participants, including a participant who reported never having used a computer, expressed that CARE+ was relatively easy to use and comprehend. The participants stated that they were comfortable navigating through the program without staff assistance.

After viewing the CARE+ tool, participants were asked about acceptability. Overall, the CARE+ tool received positive feedback from the participants in this study. Seen as an innovative idea to use with the incarcerated population, participants discussed how the intervention made them reflect on their personal habits and how important these personal habits are to their health. One participant stated:

> "It made me take a look at myself. It really did. Those questions that were asked were very important questions that I think I sometimes avoid, you know. When I know that I haven't been taking my medications on time, been in compliance with my treatment, I kind of avoid it because I know it's like 'bad girl'. So, those questions kind of put me on the spot. It really gave me; I felt the seriousness through it."

Another participant gave his overall perspective of the CARE+ tool:

> "Everything was constructive feedback and it was based on, you know, the answer that I gave, and I didn't look at it as being bad. It's just a wake-up call, you know. It's just a wake-up call for me to stay on top of my business a little more. You know what I mean? Because…like at home, when I'm down to like seven pills…or maybe six pills, you know, I'll call my prescription in…"

When discussing whether the CARE+ tool would be accepted within the correctional population, many participants expressed enthusiasm about having it available. Most participants stated the more information given to people about HIV prevention, care and treatment, the better. For example, a participant stated:

> "I think [CARE+] in my honest opinion, I think it would [work]…because more people need to be made aware of just how serious this situation is. They're aware of the situation; they just need to be made aware of how serious it is…"

Along with knowing the "seriousness of the situation," another participant described his experience of feeling alone when he was first diagnosed with HIV. Having information given through an intervention like CARE+ would have been helpful because information can be given to individuals who may not feel comfortable discussing their status with others,

including physicians. He described the video dealing with support groups as what impacted him the most:

> "…[CARE+] should be implemented though, stuff like what you just said, this should be implemented, because a lot of people don't realize if you don't have support out here man, it's hard. Trust me, it's hard coming out here in this, especially if you're dealing with what I'm dealing with, with disease and stuff, and you don't know nothing. You know, you have to make your way through all this, you know, you have to make it all through this by yourself…"

One participant talked about how CARE+ was interesting and informative. He also discussed how he would be more willing to take advice from a computer than a person:

> "Yeah, it had me stuck to the screen…[CARE+] asked me questions and then told me my good part and my bad parts and told me what I'm like, I understood that better…So if a person would have told me that, I'd probably look at him like 'man you don't know what you're talking about.' But the computer, I'm like, 'yeah, okay.'…I like computers…I'd rather listen to that than listen to somebody else trying to tell me."

Using the computer to assess sensitive behaviors affirmed participants' acceptance with the CARE+ tool. They felt their confidentiality was protected and felt comfortable with the computer-delivered counseling due to the lack of possible judgment coming from a counselor. Confidentiality was continuously brought up as a barrier to HIV testing, care and treatment within the correctional setting. Participants described how they did not trust counselors, nurses, and even some physicians with maintaining confidentiality. Several participants stated that they refused to discuss their personal circumstances while incarcerated. Because CARE+ addresses the importance of adhering to medications and taking care of one's health without interaction with others, participants thought it could be a good tool to use within the correctional setting. One participant stated:

> …Even though they say that they have to follow the rules on confidentiality a lot of people don't…People actually, they accidentally slip up and say something or somebody overheard a conversation which they shouldn't be talking about it unless it's with another doctor. You know so, I think for the people who got it in jail for being tested for HIV that this would be the best for them because that will give them more I think personally, more of a, more of how do you say it, more of a guarantee that it's going to be private."

In addition to improving confidentiality, participants felt the interaction with the computer allowed them to be more honest about behaviors. They discussed how the computer provides feedback to the individual based upon their own answers, so there is no judgment coming from a second party. CARE+ addressed some private behaviors, as well as behaviors (like medical non-adherence) that participants knew they should not be partaking in, but did. They felt they could answer these questions and get important feedback based on their responses without the judgment or lectures coming from a counselor. A participant when referring to others who may experience the tool addressed this point:

> "And then they might be more susceptible for doing it on the computer than talking. You know, they might not be comfortable talking to people than doing it on the computer."

And another participant added:

> "I couldn't talk back to them [the computer], so it was helpful. I couldn't rationalize to the computer. So, I had to take in what was being said and then process it. Whereas if a human person, I can make all of the excuses in the world and rationalize and I wouldn't take it and process it because it would be like bouncing off, bouncing off. But the computer just says it that's it and that's done. You've got something to think about, you know? "

However, one participant who was enthusiastic about the CARE+ intervention saying it was extremely informative, but a counselor needed to be present in case the participant has questions the computer does not answer. He explained:

> "That helped me. It was just very educational. I wouldn't need anyway, well… Probably counseling because that just tells me, the computer just tells me how to deal with it. I might need to talk to somebody more about the situation. Like I might need to know more than what they told me…"

Feasibility and Suggestions

All participants stated the intervention should be implemented within the correctional setting and felt, from the "inmate" standpoint, that it would not be an issue to implement. However, there was some discussion to suggest it might be a problem with the correctional facility having to manage the logistics of implementation and facilitating the inmate use of the tool. One participant stated:

> "It would have to be, the only way that I could see having it is whereas though a person could be able to get on it at liberty you know without having to go through complications of, okay well I have to go to Sick Call. I have to go here. I have to go there, you know, being it has to be at the disposal where a person is able to use it without having to go through all of the changes you've got with D.C. jail. Then you've got to wait for the count. You've got to do this, you've got to do that. You have to be monitored while you're using it and stuff you know. So, that's about the only thing is making it accessible for a person to be able to use it in D.C. Jail."

As far as the incarcerated individuals, as long as they could opt out, the tool would be positively received:

> Participant: "So, but to say I couldn't say negative about it, I mean, I'm thinking, yeah you know that would be just as well as the other part. I think, totally, it's a good package for both of them."
>
> Interviewer: "Okay"
>
> Participant: "It's just implementing it and how you, you know, you're going to have more problems trying to implement it and getting it started from the DOC side than I think any other, anything else, you know what I mean."

When asked about when to show the intervention to incarcerated individuals, most of the participants agreed that it should be implemented after the intake process so that participants have a chance to become "acclimated" to their new environment. One male participate summarized it as:

> "A few days, five days to a week, you know, because after that you know, a person is more relaxed…They're getting over their initial fears or what have you, people going through, 'Man, I'm locked up.' You know? People don't want to be dealing with nothing, you know? A lot of times if you're an addict, you sick the first week anyway, so after all that subsides…"

Other participants also suggested that the tool should be administered after the intake, and one participant recommended that the tool could also be administered again just before release.

Text Messaging Intervention

After the CARE+ intervention was shown and queried, participants were asked about access to cell phones after release, as well as their opinions, on a text message intervention assisting with linkage to care and medication adherence. All of the study participants had at least some experience with using cell phones previously and the majority (58%) was using a cell phone at the time of study participation.

For some participants, access to cell phones in the District of Columbia was not a major issue because they were aware of city services that provide cell phones to those who qualify. With respect to using cell phones to assist with ART adherence and linkage to HIV care after release, several participants shared concern that having a cell phone at this time could facilitate gaining access to and using drugs, because they would call individuals who would serve as a connection to illicit activities. One participant specifically stated she did not want a cell phone immediately after she was released because it would be a trigger and may be an obstacle to recovery. She stated:

> "…I don't need no phone cause I ain't going to do nothing but use it for drug dealers and tricking and everything. I don't need no phone. I know me…I'm a get one when I get out the program though. That way I'll be clean, I'll be strong then… I don't need one right now."

Aside from the concern mentioned by this participant, text message reminders for both appointments and medication adherence received positive feedback. The majority of participants stated they would be interested in receiving text messages for both appointment and medication reminders; even those who were not very familiar with text messaging stated they would be willing to try it. One participant stated he would rather have a text message versus a phone call because:

> "I'm going to read it and it's going to stick. As opposed to if you called me and start talking this yada about let me talk to you about your medication, I would go, 'oh gosh, I'm not trying to hear this right now.' But a text message is something when I get by myself I can go back to it and read it."

All participants discussed confidentiality as a potential barrier and the issue of privacy resonated very clearly. The following statement highlights concerns about receiving text messages to support HIV care:

> "That a help me if I don't let nobody use my phone…but if somebody using my phone, like I'm always letting a friend use my phone. And if that come up 'don't forget to go see your doctor,' they like 'Dude, what you going to see a doctor for, what you got to take medication for?' They going to ask you. What, are you going to lie…?"

One solution to the privacy concern raised by the participants was to personalize or "code" the text messages. A participant, who originally did not respond favorably to the idea of receiving text message reminders, responded differently after being asked about the option of creating a personal text message.

> "Interviewer: '…Let's say if you created your own text message.'
>
> Respondent: 'Now we're talking! …I'd be alright with it.'"

Participants liked the concept of making up their own code words versus choosing from a list of options.

In summary, the text message intervention received positive feedback as long as the text messages were coded in a way where it was not specific to HIV and maintained confidentiality.

Discussion

Various forms of technology have been successfully integrated into health interventions with equal or improved effectiveness (Baham, Bick, Giannoni, Harris & Ruiz, 2002). Technology can be used to help educate individuals and allow them to take a more active role in their health care decisions. This has been shown in individuals who have difficulty interpreting written medical educational materials and media such as persons with low literacy, persons with mental disabilities, and individuals with language barriers (Metzger et al., 2000; Vargas, Robles, Harris, & Radford, 2010).

The participants in this study provided positive feedback with regard to the use of the CARE + HIV counseling tool within correctional facilities. This feedback was not specific to type of correctional facility (jail or prison), but focused on use with persons leaving correctional facilities and re-entering their communities. Participants felt the tool was easy to use, suggesting that the tool would be accessible to all individuals regardless of the level of experience with computers. In addition, they felt that the risk assessment component provided an opportunity to reflect on their risk behaviors without fear of judgment from a counselor. Study participants expressed concerns about the confidentiality of their HIV diagnosis as well as knowledge about risk factors and other health concerns, and most felt that the use of the CARE+ tool within the correctional facility could provide an increased sense of confidentiality. A number of the participants mentioned that they recognized the need for assistance with access to care when they return to the community. In this case, the

CARE+ tool could be adapted to provide specific advice and feedback on how to successfully link to care after release.

When considering where and when to make the CARE+ tool available inside a correctional facility, a private location that would minimize concerns about confidentiality was seen as being optimal. There was a consensus among the respondents that the best time to administer the CARE+ tool would be at least several days after intake. In addition to the institutional challenges to administering the intervention during the inmate assessment phase during entrance to the correctional facility, inmates initially entering a facility may need time to deal with the reality of confinement, and for many entering jail facilities, the toxicity from substance use may have some effect on the participants' orientation.

The use of text messaging to support adherence to ART and appointment reminders received broad acceptance from the participants. The use of cell phones to receive reminder messages was perceived as a favorable tool for the majority of the respondents. Confidentiality remained a concern, but these concerns could be mitigated if the participant would have the ability to create coded statements that only the participant would understand. Another concern pertained to the participants' perception of the cell phone as a tool to gain access to individuals that may serve as conduits back to illicit behaviors. Although access to a cell phone could act as a trigger to relapse into drug abuse or other criminal activities, the use of a cell phone for this type of intervention could provide critical support in facilitating the use of social services that could mitigate a relapse into their previous lifestyle. Furthermore, the majority of participants reported using a cell phone in the community after release in the absence of an intervention, so it is likely the risks inherent with cell phone use after release would be present irrespective of using the cell phone to deliver this type of intervention. Our hope is to utilize the commonly possessed cell phone to minimize the risk of falling out of HIV care and stopping ART during community reentry.

This formative research supports the use of computerized counseling tools inside correctional facilities and using cell-phone delivered text messaging to support health promoting behaviors after release from correctional facilities. Developing and implementing these tools will enhance our ability to identify, treat and link HIV-infected persons to care, thus addressing essential components of the Seek, Test, and Treat strategy among criminal justice populations.

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