Burnett School of Medicine at Texas Christian University

Stigma as a Barrier to Care Among Justice-Involved Individuals Living With or At-Risk for HIV and Substance Use Disorder

Scholarly Pursuit and Thesis

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Abstract

Research Question: Do the sociodemographics among justice-involved individuals living with or at risk for HIV and substance use disorder impact baseline stigma scores?

Background: It is vital to provide justice-involved (JI) individuals living with HIV and/or substance use disorder (SUD) with linkage to care upon community re-entry. There are endless barriers preventing this population from receiving proper care after release. A less examined barrier is stigma and its impact on health service engagement. This study aims to investigate the differences in types of stigma as a barrier to care among a population of JI individuals randomized to two health delivery models.

Methods: 356 individuals with recent involvement with the criminal justice system, history of opioid/stimulant use and HIV risk behavior in 2 regions of Texas and 2 regions of Connecticut were identified. Participants' baseline Anticipated Stigma and Internalized Stigma were examined using the ACTION Stigma Scale. A combination of correlation analyses and independent samples t-tests were used to explore whether stigma scores varied as a function of participants' sociodemographic information.

Results: Women (M = 3.06, SD = 1.00; M = 3.27, SD = 1.03) reported significantly more Anticipated Stigma and Internalized Stigma when compared to men (M = 2.67, SD = 1.01; M = 2.86, SD = 1.08), $t(352) = \geq 3.02$, $p = \leq 0.001$. Those in a controlled setting (M = 2.61, SD = 0.94; M = 2.80, SD = 1.04) reported experiencing more Anticipated Stigma and Internalized Stigma as compared to participants in the community setting (M = 2.91, SD = 1.08; M = 3.10, SD = 1.09), $t(350) = \geq 2.61$, $p = \leq 0.005$.

Conclusions: The baseline data reveal both Anticipated Stigma and Internalized Stigma are significantly higher (1) among women compared to men and (2) among those in a controlled setting compared to those under community supervision (probation or parole). Although the study's health service delivery models will bridge many gaps to care, it is unclear how stigma plays a role. By identifying how stigma impacts care within these models, interventions can be implemented to lessen stigma and improve overall health outcomes for this unique population who experience three different layers of stigma: HIV, substance use, and justice involvement.

Research Question:

Do the sociodemographics among justice-involved individuals living with or at risk for HIV and substance use disorder impact baseline stigma scores?

We anticipate that factors such as gender, race, ethnicity, and current involvement with the justice system will contribute to variations in reported stigma levels. By exploring these sociodemographic variables, we aim to discern potential disparities in baseline stigma scores among justice-involved individuals facing the intersection of HIV and substance use disorders.

Introduction:

One in seven individuals living with HIV[1] and one-third of all opioid users[2] in the U.S. pass through the justice system each year. Opioid-related overdose mortality post-release is the leading cause of death among justice-involved (JI) individuals re-entering the community.[3] Deaths due to overdose are most prone to occur during the first two weeks after being released,[4] making immediate connections to care so crucial. In addition, multiple studies have revealed the association between substance use disorder (SUD) and poor HIV health outcomes,[5,6] expressing the need to address both diseases within this population.

According to the Texas Department of State Health Services' HIV surveillance report (2019),[7] both Dallas County and Tarrant County were among the top 25 counties with the highest cases and highest case rates of HIV. Specifically, Dallas County was ranked second for people living with HIV (PLWH) while Tarrant County was ranked fourth for PLWH. In terms of SUD, both Dallas and Tarrant Counties were among the top five counties with the highest number of accidental overdose deaths from any drug in 2017.[8]

The urgency to provide JI individuals living with HIV, OUD, or both with proper linkage to treatment upon community re-entry is apparent. Yet, there are endless barriers preventing this high-risk population from receiving proper, long-term care after release from the justice system. Some barriers include lack of transportation, unstable housing, substance use relapse, comorbid psychiatric illnesses, financial constraints, and limited health insurance.[6,9,10]

A less examined barrier is stigma and its impact on health outcomes. Stigmatization of individuals living with SUD and/or HIV is common within the healthcare community.[11] Additionally, there is a large presence of stigma surrounding those individuals involved in the justice system. Stigma has been found to contribute to this vulnerable population's decreased health utilization and poorer health outcomes, presenting as a barrier to care.[5,12]

Stigma, as defined by Erving Goffman, is negative attitudes and beliefs toward a group of people perceived to be undesirable by society.[13] It is important to note that stigma is not only the result of negative attitudes by others, but also of the self. When these negative attitudes are internalized by the individual, this is referred to as "self-stigma." A study done in St. Petersburg, Russia among people living with HIV (PLWH) and people who inject drugs (PWID) found a significantly negative correlation between internalized drug/HIV stigmas, the likelihood of health service utilization, and overall health outcomes.[12] Additionally, systematic reviews on HIV-related stigma and health outcomes have not only revealed significant associations between perceived stigma and decreased medication adherence,[14] but also poorer mental health outcomes.[15] This study aims to investigate the differences in types of stigma as a barrier to care among a population of JI individuals living with or at risk for HIV and SUD randomized to two health delivery models.

Methods:

Subjects. 356 individuals with recent involvement with the criminal justice system, history of opioid/stimulant use, and HIV risk behavior in 2 regions of Texas (Dallas County and Tarrant County) and 2 regions of Connecticut were identified as part of the "Addressing Risk Through Community Treatment for Infectious Disease and Opioid Use Disorder Now Among Justice-Involved Populations" (ACTION) study.[16] Each region was chosen based on their significant needs for SUD and HIV treatment or prevention among JI persons upon re-entry to their corresponding communities. All currently incarcerated participants must have a pending release date within two weeks, as well as have a history of HIV or SUD/injection drug use (IDU) within 12 months prior to incarceration. Additionally, it is required that participants be 18 years or older and able to provide written informed consent. Participants who are unable to provide informed consent, who are living with severe psychiatric illness, or who will not be remaining in the area post-release will be excluded from the study. After consent is obtained, participants will be randomized to either the Mobile Health Unit (MHU) or Patient Navigation (PN) intervention models.

Study Design. This is a cross-sectional randomized control trial comparing baseline stigma scores to the sociodemographics of participants prior to randomization.

Measures. Participants' baseline stigma was examined using the ACTION Stigma Scale, a Likert scale adapted from both the Substance Use Stigma Mechanisms Scale[17] and the HIV Prevention Trials Network INTEGRA initiative (HPTN 094). The scale examines two different types of stigma as described by Smith et al[17] in relation to substance use and HIV status:

I. Anticipated Stigma: expectations of stereotyping, prejudice, and discrimination from others in the future due to one's stigmatized attributes.
II. Internalized Stigma: the endorsement and application of negative feelings and beliefs about people who use drugs to oneself.

An example of questions examining Anticipated Stigma include "On a scale of 1-5, how likely is it that healthcare workers will not listen to your concerns because of your drug use history or HIV status?" For Internalized Stigma, an example is "Do you strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree with the following statements: Having used drugs makes me feel like I'm a bad person."

Participants' sociodemographics were also examined including sex, race, ethnicity, education, relationship status, and controlled setting (any type of jail, prison, halfway house/parole-appointed housing, or court-mandated treatment center) versus community supervision (probation or parole).

Statistical Analysis. A combination of correlation analyses and independent samples t-tests were used to explore whether baseline stigma scores varied as a function of participants' sociodemographic information.

Results:

The results showed that education level, ethnicity, and race were unrelated to stigma. However, women ($M = 3.06$, $SD = 1.00$; $M = 3.27$, $SD = 1.03$) reported both higher Anticipated Stigma and Internalized Stigma when compared to their male counterparts ($M = 2.67$, $SD = 1.01$; $M = 2.86$, $SD = 1.08$), $t(352) = \geq 3.02$, $p = \leq 0.001$, $d = 0.38$ (see Table 1, Table 2, Figure 1, and Figure 2). Participants who were in a controlled setting ($M = 2.61$, $SD = 0.94$; $M = 2.80$, $SD = 1.04$) were also found to report higher Anticipated Stigma and Internalized Stigma than those under community supervision ($M = 2.91$, $SD = 1.08$; $M = 3.10$, $SD = 1.09$), $t(350) = \geq 2.61$, $p = \leq 0.005$, $d = \geq 0.27$.

Of the 356 enrolled participants, 81 were women (22.8%) and 274 were men (77%). 174 were in a controlled setting (within the justice system or court-appointed housing/treatment centers) and 178 were in an uncontrolled setting under community supervision, likely on parole. See Table 3 for the complete demographics.

Table 1

Descriptive Statistics of the Substance Use Stigma Mechanisms Scale (5-point Likert Scale)

	Mean (*SD*)	33rd percentile	67th percentile	α
Anticipated Stigma	2.76 (1.02)	2.33	3.17	0.82
Internalized Stigma	2.96 (1.08)	2.35	3.50	0.87

Note. SD = standard deviation. α = Cronbach's alpha.

Table 2

Means and Standard Deviations of Stigma Scores by Sex and Supervision Level

	Anticipated Stigma		Internalized Stigma	
	M	*SD*	*M*	*SD*
Sex				
Female	3.06	1.00	3.27	1.03
Male	2.67	1.01	2.86	1.08
Supervision				
Controlled	2.91	1.08	3.10	1.09
Community	2.61	0.94	2.80	1.04

Note. M = mean, *SD* = standard deviation.

Figure 1

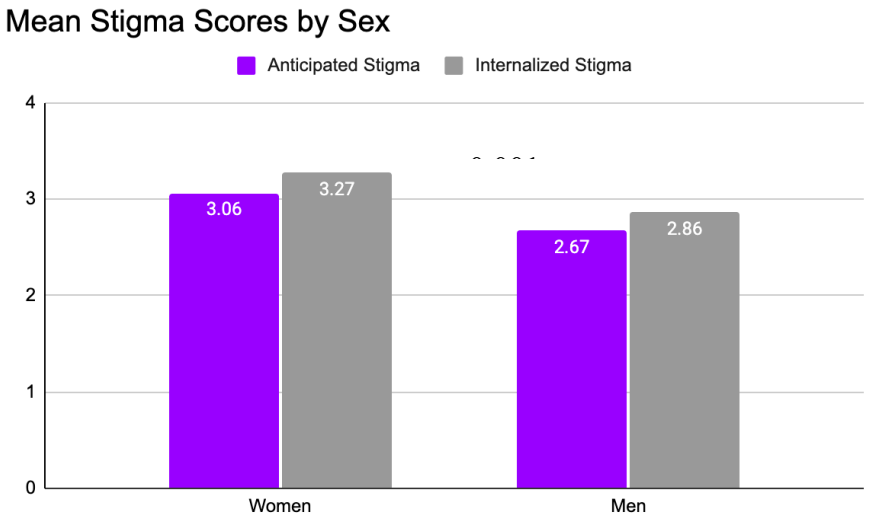

Figure 2

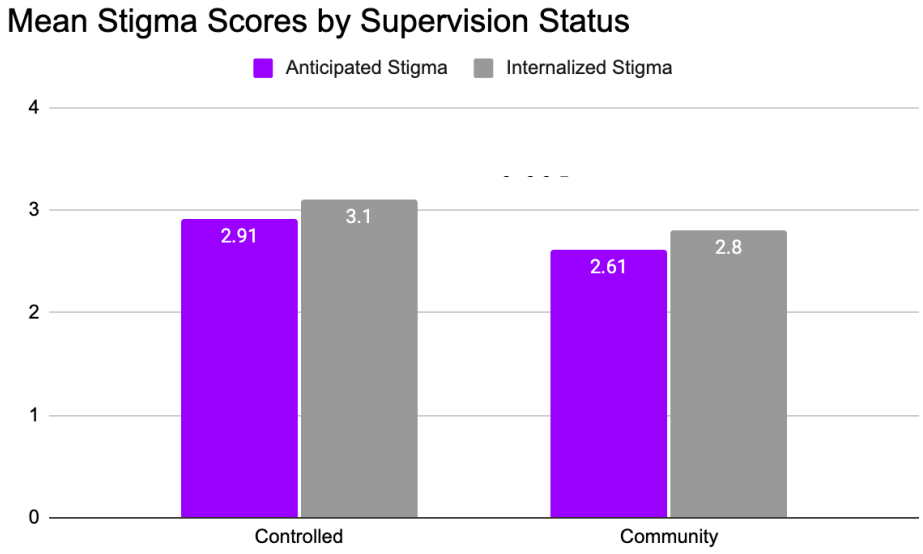

Table 3

Demographic Information (N = 356)

Characteristic	*n* (%)
Sex	
Female	81 (22.8)
Male	274 (77.0)
Race	
White	229 (64.3)
** BIPOC*	127 (35.7)
Ethnicity	
Hispanic/Latino	89 (25.0)
Non-Hispanic	266 (74.7)
Education	
Some High School	88 (24.7)
High School or GED Equivalent	144 (40.4.8)
Some College	80 (22.5)
College Degree or Advance Degree	38 (10.7)
Relationship Status	
Married	25 (7.0)
Widowed	5 (1.4)
Divorced	76 (21.3)

Separated	29 (8.1)
Never Married	219 (61.5)
*Controlled Setting	
Yes	174 (48.9)
No	178 (50.0)

Note. Variables that do not equal 100 contain missing data. Mean age = 41.32 (*SD* = 9.92).
**BIPOC* = Black, Indigenous, or People of Color.
**Controlled setting* refers to any type of jail, prison, halfway house/parole-appointed housing, or court-mandated treatment center. Uncontrolled setting refers to those in the community, likely on probation, but living freely for the most part.

Discussion:

Although the study's health service delivery models–Patient Navigation and Mobile Health Unit–will bridge many gaps to care such as transportation and health system navigation, it is unclear how stigma will play a role in health service utilization and health outcomes of participants, as highlighted by Taweh et al.[18] The results of this study suggest that both the sex assigned at birth and the custody status of individuals may impact both Anticipated Stigma and Internalized Stigma at baseline.

Particularly, women reported significantly higher stigma scores than their male counterparts. Women involved in the criminal justice system (WICJ) face multiple forms of stigma not only from their HIV status and substance use history, but also due to their gender and its associated stereotypes. This intersectionality results in compounded stigmatization, making their experiences perhaps more complex than those of incarcerated men. This discrepancy in stigma amongst WICJ may be explained by the SAVA syndemic, an anthropological concept coined by Singer (1996) to describe how substance abuse, violence, and HIV/AIDS are not isolated issues, but interconnected and mutually reinforcing within marginalized communities.[19]

A literature review conducted by Meyer et al. (2011) on the SAVA syndemic as it relates to women described how WICJ are uniquely impacted.[20] The interplay of criminalization with intimate partner violence, risky drug use, commercial sex work, and heightened HIV risk experienced by WICJ introduces a multifaceted dynamic that amplifies the stigma experienced by these individuals. It is important now more than ever to advocate for WICJ who are living

with or at risk for HIV and SUD, as the number of women incarcerated is surging at six times higher than that observed in 1980.[21]

It is also important to note that participants in a controlled setting reported significantly higher stigma scores than those back in the community. Being that a controlled setting refers to any type of jail, prison, halfway house/parole-appointed housing, or court-mandated treatment center, we must consider criminalization itself as a stigmatizing experience. The ways in which stigma related to sex and parole status may impact health utilization and health outcomes should be further examined.

Future Directions:

We hope to explore stigma dynamics among participants once recruited and randomized into either of the two intervention models (MHU vs. PN). Specifically, the analysis will focus on stigma in relation to health service initiation—measured by the time it takes to initiate medications such as antiretroviral therapy, pre-exposure prophylaxis, or medications for opioid use disorder—and health retention, reflecting adherence to medications. The impact of stigma on health outcomes within the PN and MHU intervention models remains uncertain. Therefore, by examining how stigma fits into the broader context of these intervention modes is crucial. This investigation will provide insights to enhance the models for future implementation.

Conclusion:

Overall, baseline stigma scores were high among JI individuals with SUD who had HIV or are at risk for HIV. The data reveal that both Anticipated Stigma and Internalized Stigma are significantly higher (1) among women compared to men and (2) among those in a controlled setting compared to those under community supervision (probation or parole). Despite the literature surrounding stigma in healthcare growing, further research needs to be done involving this vulnerable population who experience three uniquely different layers of stigma–HIV, substance use, and justice involvement–and how it impacts their health outcomes.

Compliance:

All project protocols have been reviewed and approved by the Texas Christian University (TCU) Institutional Review Board (IRB # 1920-275). Written informed consent was obtained from all project participants.

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