HIV and reincarceration: time for a comprehensive approach

Individuals who are released from prison have complex health needs that are too often unmet by health-care systems. In *The Lancet HIV*, Jaimie Meyer and colleagues describe longitudinal treatment outcomes for a cohort of people living with HIV/AIDS who repeatedly interact with the criminal justice system. Their analysis showed very low rates of viral suppression for individuals incarcerated more than once. Although national surveillance data suggest that more than 70% of people who are prescribed antiretroviral therapy (ART) achieve viral suppression, only 31% of patients incarcerated more than once, all of whom previously received ART, had viral suppression at the time of reincarceration.

Who are the so-called recidivists and why do they fare so poorly in the current era of highly effective and well tolerated HIV treatment? In Connecticut as elsewhere in the USA, incarceration disproportionately affects non-white people, poor individuals, and those with mental illness and substance use disorders. These same characteristics are markers for increased risk of HIV, viral hepatitis, and other chronic disorders. In those incarcerated and released, recidivism seems to place these people in a high-risk group within a high-risk group: in previous research, recidivism was associated with the presence of major psychiatric disorders, homelessness, and low access to medical care. The reported association between recidivism and suboptimum HIV treatment outcomes is therefore not surprising.

The extent to which incarceration leads directly to poor health or simply represents a frequent experience shared by those in society with the highest risk of disease is not fully understood. Cohort studies have suggested that for some patients with HIV who successfully achieve viral suppression while living in the community, incarceration is an independent risk factor for treatment interruption and viral rebound. The period immediately following release from prison is also clearly associated with very high vulnerability. During the first 2 weeks after release from prison, residents of Washington state were 129 times more likely to die from a drug overdose than members of the general public and 12 times more likely to die of any cause. Conversely, prisons provide medical treatment to many who do not access care in the community. Furthermore, by temporarily removing individuals from environments that reinforce hazardous behaviour, such as excessive drug and alcohol use, prisons can provide lifestyle changes that might be lifesaving. The challenge for both correctional facilities and public health, is to extend the obligation to protect and promote health for incarcerated people beyond the prison gate.

The disruptive effect of incarceration on HIV treatment is now well documented, but the long-term control of other chronic medical and psychiatric disorders is probably not any better. Diabetes, depression, bipolar disorder, and chronic lung disease are some of the common disorders overrepresented in among people in criminal justice systems, and they similarly require consistent adherence and medical supervision. Comprehensive strategies to support the complex health challenges of formerly incarcerated patients are needed. Various approaches to this have been implemented and are being assessed, including the Transitions Clinic model and post-release patient navigation. Prisoners with complex chronic medical disorders clearly need both comprehensive discharge planning, including efficient record transfer, and an understanding of the urgency of immediate linkage to care on the part of community providers. Development of successful strategies to support transitions in HIV care will have collateral benefits as correctional systems learn lessons that can be easily applied to other disorders such as hepatitis C virus.

Meyer and colleagues’ Article brings much needed information about a population of adults in dire need of extra support for the access and consistent use of health services. Achieving substantial reductions in HIV transmission through treatment as prevention will not be possible without focused interventions addressing the causes of treatment failure for patients in the criminal justice system. To date, incarceration has been generally deleterious for HIV control, but it nonetheless provides opportunities to test, treat, and link individuals to care who might otherwise go undiagnosed for years. We should take advantage of both the structured environments and mandated access to services given to those who are incarcerated as well as the opportunities available to many by the Affordable Care Act to improve health and promote sustained engagement in care after release.
Ryan P Westergaard, Josiah D Rich
Departments of Medicine and Population Health Sciences,
University of Wisconsin School of Medicine and Public Health,
Madison, WI, USA (RPW); Departments of Medicine and Epidemiology,
Brown University, The Miriam Hospital, Summit Avenue, Providence, RI 02906, USA (JDR); and The Center for Prisoner Health and Human Rights, The Miriam Hospital, Providence, RI, USA (JDR)
jrich@lifespan.org

We declare no competing interests. This work was supported by NIH grants K23DA032306, K24DA022112, and R01DA034179.