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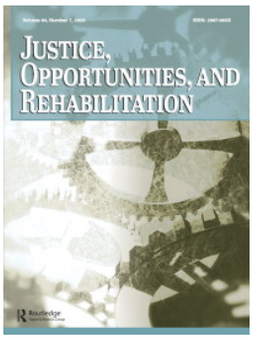

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"Wading through the water without a destination": addressing the persistence of HIV stigma and peer-supported reentry linkage to care models in the CalAIM era

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ABSTRACT

Incarcerated individuals frequently experience overlapping health conditions—HIV, HCV, mental illness, and substance use—that persist upon reentry and are often inadequately addressed due to fragmented care systems. This qualitative study examined pre- and post-release service coordination for individuals with syndemic health needs in Alameda and Los Angeles Counties. Through interviews with reentry providers (n = 16) and recently released clients (n = 14), we identified limited formal prerelease planning and widespread reliance on peer networks for support. While community-based organizations expressed strong interest in supporting clients prerelease, they faced barriers in accessing correctional facilities. Clients highlighted the value of peer-informed reentry guidance, particularly in the face of feeling overwhelmed by siloed service systems and stigma, including HIV-related stigma. Providers varied in their comfort and capacity to address HIV-related needs, often reflecting a culture of avoidance. Findings underscore the need for integrated, peer-based models of reentry support that proactively address stigma, leverage new reentry service funds under California's Medicaid 1115 demonstration waiver (CalAIM), and promote continuity of care for individuals with complex health needs. Strengthening cross-training and expanding formalized peer roles can help reduce service gaps, lessen stigma, and improve health equity for formerly incarcerated populations.

KEYWORDS

correctional health; linkage to care; persons with HIV; qualitative methods

Introduction

Incarcerated individuals experience intersecting epidemics—or syndemics—that reflect broader societal inequities and persist long after release (Manderson, 2012; Singer et al., 2017; Krsak et al., 2020; Singer, 2009). These include disproportionate burdens of hepatitis, HIV, sexually

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transmitted infections (STIs), tuberculosis, substance use disorders, and mental illness. In the United States, an estimated 65% of incarcerated individuals meet criteria for a substance use disorder, while 25% have a serious mental illness, 13% have chronic hepatitis C virus (HCV), and 1.1% are living with HIV (Ann, 2021; Maruschak & Bronson, 2017; Bronson & Berzofsky, 2017). Although people in correctional facilities represent less than 1% of the U.S. population, they account for a disproportionate share of communicable disease diagnoses: for example, approximately 15% of all people living with HIV in the U.S. pass through a correctional facility each year (Maruschak & Bronson, 2017; Maruschak & Bronson, 2023).

These burdens are not evenly distributed. Black/African American individuals represent about 13% of the U.S. population but comprise over 38% of the incarcerated population (Maruschak & Bronson, 2023) and nearly 42% of people living with HIV (Centers for Disease Control & Prevention, 2023). Similarly, Latinx individuals make up about 19% of the U.S. population but account for 30% of incarcerated people, and they also experience disproportionate rates of hepatitis C and substance use disorders (Maruschak & Bronson, 2023; De La Rosa et al., 2005). Structural racism, discriminatory policing, and socioeconomic inequities contribute to these disparities and compound negative health outcomes. Upon release, individuals frequently encounter barriers to successful reintegration, including housing instability (Lutze et al., 2014; Reece & Link, 2023), employment discrimination (Harding et al., 2014), and complex family reunification dynamics (Comfort et al., 2018; Comfort, 2007). People with HIV who have lived experience with the criminal legal system—especially African Americans—often navigate intersecting stigmas related to race, HIV status, and incarceration. These stigmas affect disclosure and care engagement, contributing to delays in HIV treatment and poorer health outcomes when compared to their White counterparts (Swan, 2016; Brinkley-Rubinstein, 2015). While HIV affects a relatively small proportion of those incarcerated, the consequences are significant: retention in care and viral suppression rates drop precipitously after release, placing individuals at higher risk for adverse outcomes and onward HIV transmission (Rowell-Cunsolo & Hu, 2020). These realities highlight the need for more robust and coordinated reentry planning that addresses not only HIV and related syndemic conditions, but also the stigma and structural barriers that hinder continuity of care (Rowell-Cunsolo & Hu, 2020).

The U.S. criminal legal system has traditionally emphasized incapacitation and punishment, but there is growing recognition that successful reentry is critical to public health and public safety. In California, the function of incarceration has shifted in recent years through reforms such as Assembly Bill (AB) 109, which realigned sentencing and supervision

responsibilities to counties, and Proposition 47, which reduced certain offenses from felonies to misdemeanors. These changes resulted in a greater burden placed on local systems to support reentry. While California does not uniformly mandate comprehensive prerelease planning, certain populations—such as individuals with serious mental illness or medical conditions—may be entitled to prerelease discharge planning under state correctional health care guidelines and Medi-Cal policies (California Department of Health Care Services, 2023). Furthermore, recent Medicaid innovations, including California's Section 1115 demonstration waiver, signal a paradigm shift toward integrating prerelease care coordination and community-based reentry supports as part of a broader public health and equity agenda. This aligns with criminal justice literature calling for a transformation from punitive models to health-oriented, continuity-of-care approaches that begin *before* release (Brinkley-Rubinstein & Cloud, 2020; Rich et al., 2014; Binswanger et al., 2012).

In January 2023, California became the first state in the nation to receive federal approval for a Medicaid 1115 demonstration waiver to greatly expand services for people enrolled in Medicaid (known as Medi-Cal) through *California Advancing and Innovating Medi-Cal* (Cal-AIM). Part of Cal-AIM is the Justice Involved Initiative, which offers a specialized set of services for youth and eligible adults in state prisons, county jails, and youth correctional facilities for up to 90 days prior to release. These services include enrollment in Medi-Cal before release, reentry care management, physical and behavioral health clinical consultant services, laboratory and radiology services, medications and medical administration, medication-assisted therapy, a supply of medicines upon release, and services provided by community health workers with lived experience of being formerly incarcerated. The eligibility criteria for these specialized services include, among other factors, people with or suspected of a mental health diagnosis or a substance use disorder or suspected diagnosis, and people with a positive test or diagnosis of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) (California Department of Health Care Services, 2023). To help inform the implementation of the groundbreaking services in the Cal-AIM Justice Involved Initiative, this study aimed to build upon the California Health Policy Strategies Brief on *California Advancing and Innovating Medi-Cal* (Cal-AIM) and its recommendation to improve coordination and support for individuals returning to the community from state prison and county-based correctional systems (California Health Policy Strategies, 2019). Specifically, we sought to identify current processes to link individuals with HIV, HCV, and behavioral health needs to appropriate medical and behavioral health services upon release from a correctional facility and to examine how these practices differed among various types of community-based reentry

service organizations, including HIV/medical providers, behavioral health providers, and general reentry service providers. While prior research has documented the lack of coordinated reentry planning and support services for individuals exiting incarceration (Visher & Travis, 2011; Semenza & Link, 2019; Western et al., 2015), our study builds on this foundation by specifically examining how community-based organizations address the needs of people living with or at risk for HIV, HCV, and behavioral health conditions. These syndemic conditions introduce additional barriers to care, often compounded by stigma, that undermines both disclosure and linkage to treatment

Understanding the current linkage to care practices in the context of these syndemic conditions can lead to recommendations on how to best strengthen coordination of needed services for people in reentry.

Methods

Study Design

This study deployed a rapid assessment consisting of qualitative interviews with individuals who have expertise in delivering (providers) or receiving (clients) reentry services. We aimed to identify policy-related recommendations to improve the linkage to and coordination of physical and behavioral healthcare services for individuals with chronic health conditions leaving jails and prisons in California. We received approval for this research from the University of California, San Francisco Institutional Review Board (IRB Approval #21-34735). All participants provided verbal informed consent.

Study Sampling and Recruitment

To answer our research questions on linkage to care practices and areas in need of strengthening, we sought to hear not just from reentry providers but also from their clients. Our research team included an investigator with extensive expertise in reentry services and HIV and behavioral health services policy researchers. We initially recruited a purposive sample (Patton, 2014) of providers involved in the clinical or administrative delivery of HIV, behavioral health, or social service reentry services for people returning to the community after incarceration. This effort included outreach to known reentry providers in Alameda and Los Angeles Counties, two counties with documented higher rates of people returning to the community after release from California Department of Corrections and Rehabilitation (CDCR) state prisons than other counties. Furthermore, both counties, because of their concentrated rate of individuals living with HIV, have been designated as an Ending the HIV Epidemic priority

jurisdiction (Fauci et al., 2019). Eligibility criteria for the provider interviews included being age 18 or older, able to complete an interview in English, and employed in an organization serving formerly incarcerated individuals and that provided HIV, HCV, and/or behavioral health services, including mental health or substance use disorder treatment. Snowball sampling (Naderifar et al., 2017) proceeded from that point forward. Prospective providers were contacted by an investigator via email using a script and invited to participate in the study.

We asked providers to facilitate access to individuals recently released from prison or jail to participate in client interviews. Eligibility criteria for the client interviews included being age 18 or older, able to complete an interview in English, been released from jail or prison in the past 12 months, and currently or have previously accessed any one or a combination of the following services: HIV, HCV, or behavioral health services at an agency serving formerly incarcerated individuals. Note, we did not ask providers to specify which services were accessed by the individuals they referred to the study. Nor were clients required to specify the services they had received from the referring organization.

Data Collection

Two member of the research team with extensive interviewing experience carried out the interviews in private settings, either in person at a clinic or via Zoom. Prior to the interview, a study information sheet was shared with the participant. At the beginning of each interview, participants were asked to consent to be recorded, and an interview then ensued, lasting 60–90 minutes. The interview guide domains for providers included organization and reentry services overview, effective linkage and retention strategies, challenges, and recommendations; the domains for client interviews included personal experience during reentry, perceptions related to HIV in correctional facilities and upon release, supportive reentry services, and unmet needs or gaps in services. Audio recordings were transcribed verbatim and uploaded to Dedoose, a qualitative data management platform (SocioCultural research consultants & LLC, 2018). Participants received a gift card in the amount of $75 for providers and $50 for clients.

Data Analysis

We conducted a thematic analysis (Ayres et al., 2003) initially based on a codebook consisting of a priori codes taken from the interview guide. The initial codebook was subsequently modified and extended to include inductive codes. Author PC served as the primary coder and applied the deductive codes to an initial set of randomly selected transcripts (n = 3).

After discussion with the broader team, the codebook was modified, and inductive codes were included. One member of the research team coded all interviews and a second member conducted a review of a subset of coded transcripts to verify consistent application of codes. For the analysis focused on identifying effective processes and gaps that link or reconnect individuals to care during reentry, the team extracted and summarized code reports on the following codes: prerelease preparation, outreach and referral, best practices, and challenges. Essential points were further refined and displayed in a table to enable pattern identification across cases. The analysis was initially conducted within groups, i.e., provider narratives compared against provider narratives. Once the key themes were identified within each group, they were compared against each other, i.e., client and provider comparison of prerelease preparation.

Findings

We conducted semi-structured interviews with reentry providers (n = 16) from February–December 2022, followed by interviews with clients (n = 14) from May–August 2023. See Table 1 for the geographic locations and key characteristics of the sample.

We present themes in sequential order as they relate to the journey of an individual in reentry - from prerelease planning while people are still incarcerated to post-release experiences and support. We conclude by identifying systematic stigma-related issues and their impacts on reentry services.

There is inconsistent or non-existent planning and coordination prior to and upon release

Both providers and program participants identified the lack of, inconsistent, or restricted access to prerelease planning and coordination for incarcerated individuals as a major challenge to reentry. While many of the participants described rehabilitative and self-help programs available to people while in prison or jail, most of the participants reported a lack of programs or services focused specifically on prerelease and reentry planning prior to release. Many participants identified their correctional counselor as the individual they felt should be helping them prepare for their release. However, participants acknowledged that prisons had relatively few correctional counselor positions, and existing counseling staff were charged with helping hundreds of people at a time. Thus, they perceived little to no capacity for these counselors to provide any prerelease planning support. Correctional health systems are also understaffed and stretched thin without the capacity to offer adequate health-related prerelease planning, such as ensuring that people are enrolled in Medicaid, have organized health records, or confirm that people are released with appropriate

Table 1. Informant key characteristics (N = 30).

Reentry Providers (n = 16)		
	Number (#)	Percent (%)
Location		
Alameda County	8	50%
Los Angeles County	7	44%
Statewide	1	6%
Provider/Program Type		
Medical/HIV	6	35%
Behavioral Health	3	19%
Social Services/Reentry	7	44%
Role in Agency		
Executive/Program Director	3	19%
Program Manager/Coordinator	5	31%
Clinician/Therapist	3	31%
Direct Service/Case Manager	5	19%
Program Participants (n = 14)		
	Number (#)	Percent (%)
Residence Location at Time of Interview		
Alameda County	6	43%
Los Angeles County	8	57%
Recruitment Source		
Medical/HIV Provider	2	14%
Behavioral Health Provider	4	29%
Social Services/Reentry Provider	8	57%
Self-Reported Health Condition		
Dual Behavioral Health: Substance Use Disorder and Mental Health	10	71%
Substance Use Order only	2	14%
Mental Health Issue only	2	14%
Living with HIV	2	14%
History with HCV	4	29%
Length of Time Since Release from Prison		
> 6 months	6	43%
6–12 months	8	57%

allocations of medications. When formal prerelease programs did exist within the prison, reduced capacity and strict eligibility criteria greatly limited access to these services. None of the participants interviewed were involved in any type of formal prerelease class, and many expressed the lack of any prerelease planning by correctional or medical personnel, as exemplified by the quote below (PT27):

> In the month or two months before I got out, CDCR did zero. There was no interview. I didn't know about any program in prison or out here. I had to do what I could, a little research, on my own or through my friends on the outside…and they couldn't look up things because they were told it has to come through the counselor, prison counselor, or medical personnel from prison. That's the only way they [community providers] would help.

People are motivated for self-preparation and peer-networking

Because of the limited access to such programs, many of the participants discussed their own self-preparation for release, which included making

lists, reaching out to family and friends, connecting to programs inside the prison that had community sites, or asking others in prison for information and resources. Individuals identified that they did not necessarily want to "wait until the prison said it was time to go." Instead, they took it upon themselves to prepare for release much further in advance. Often, participants explained that this effort was a motivator to stay positive and focused on their goals to return home or were steps to prepare for parole board hearings. PT19 described his preparation as follows:

> I created a list of things that I needed to get done, like get a bank account, get my ID, all that sort of thing. And then I was fortunate enough to get some information from [a peer in prison], who provided me with transportation support. I knew probably at least a year or two in advance that I was going to [program] to start over. But it wasn't [located] in my county of commitment, so I had to make some changes. I had to do some leg work on my own to make sure that I was going to be paroling to the right county…For me, I had been preparing for my release years before and just figuring out what I needed to do and what my moves were going to be, my immediate ones and planning all this stuff, conducting research on my own.

Some participants talked about the informal or peer-to-peer support they gathered in preparation for their release in lieu of accessing more formal programs, as described by PT17:

> The [pre-release planning] information, it doesn't come from the staff… but, from my community that I was a part of, we did have those conversations, And, again, we stay connected. We're a community, and we stay connected. So, guys had gone out before me. So, they report back their experiences. So, that gave me more insight on how I wanted to tackle my transition. And then I pass it on and do the same as I'm doing now with guys that are getting ready to come home.

Community agencies lack access to prisons but are motivated to connect

Providers routinely identified the lack of access to CDCR as one of the primary challenges they encountered in establishing connections to incarcerated individuals prior to their release to provide seamless reentry support. When asked as a reentry service provider if he had any connections with CDCR, PT02 clearly stated: "Nope. Nope, not even a little." Restricted or no access to prisons leads to a gap in services as well as an information void for individuals as they prepare for and actually experience reentry back to the community. Providers indicated a strong interest for in-reach into the prisons to begin relationship building and to initiate care planning with clients as described by PT04:

> If … the people inside, if they can make real meaningful connections with service providers on the outside, and you have this dialogue –real conversations. More than, 'Oh, yeah. I just pulled up such and such [community agency]. And you're going to go there, and they are open from this time to this time.' I think, if you really want

> to reduce the recidivism for people who are coming out, it's really making sure that they have those strong, established connections to community service providers before they get out. I'm like, Okay. How can I get inside, behind the wall? How can I connect with people before they even come out to let them know, 'Hey, we have this awesome program here to support you'?

Post-release is overwhelming and reentry service systems are complex

The period of release is overwhelming

Despite informally preparing for release, clients described the many challenges they faced in the first few weeks or months after release. Many participants spoke specifically about their experiences within the first 24–48 hours after release and how these first few days can be particularly daunting, especially if people are released without housing or close friends or family available to support them. PT18 reflected on his first morning waking up after release: "When I woke up that first day out, I asked myself, 'What am I gonna eat and how am I gonna get that food, right?' That really was reality for me, that you know what? It's going to be on me to fend for myself and make sure that I eat today." Other participants also shared their struggles, such as PT28's description of his first week after release after spending many years in prison, during which time he lost both his mother and his grandmother. Thus, PT28 came back to the community with no caregivers or stable housing, as he describes:

> Like, you know, where the f*%^ do I go from here? …. I didn't have a list of contacts or a list of something in my area. And I couldn't get into the places [housing programs] that people told me about because I didn't have an ID…and it can be a real hassle to get it when you're on the streets. You need proof, and if you don't have any ID, then how can you get proof that that's you? ….it was all a little confusing… it can be like, now we're just 'wading through the water without a destination.'

Competing life priorities may delay linkage to care

Participants also acknowledged their sense of being overwhelmed with having to address multiple tasks and responsibilities "all at once." More pressing life needs, such as securing housing and food, may take priority over linking to medical or behavioral healthcare, even for individuals with complex healthcare needs. This dilemma was described by PT18, who was diagnosed and treated for HCV inside prison and had received some post-treatment screening while still incarcerated:

> I mean, that's something that I know I needed to maintain, checking the [Hepatitis] viral count, making sure that it didn't return…But I've been out a little bit over three months. And I just seen the doctor two days ago because I really didn't know how to go about it. I was dealing with a lot of overwhelming information all at once. I mean, even going to the store was just overwhelming for me. And I had to get my ID and all this other stuff. I just had a lot on my plate. … I think it would have

> been helpful if somebody would have really took me by the hand. I think that's what people need sometimes…really showed me, 'Hey, look, this is the way you get your treatment.' And take me through that process. I had to do it on my own, and I wasn't in a good place last month or the month before. It took me three months to really find myself, where I was able to be calm enough to figure out the whole process and make my way on my own there to [community clinic] and get that treatment… That's where I was, as far as medical, it was on my own.

Siloed community-based services place the burden on individuals to navigate multiple systems upon reentry

Challenges participants faced upon release were compounded by siloed services that placed the burden on individuals to navigate multiple systems upon reentry. These systems include fragmented processes linking to insurance, complex prescription and medication systems, and disparate healthcare, behavioral care, and social service provider networks. As PT19 describes:

> I did 25 years, and I didn't know how to use a [cell]phone. Technology, I mean, I was lost, right. But, for me, I got help from a fellow guy who was in treatment… there was a guy there who knew all about the computers and all that, and he helped me get online and signing up for my [General Assistance or GA], signing up for my food stamps, stuff like that, right? But even so, I mean, I had challenges, getting my birth certificate, in order to get my license, in order to get GA and all that stuff, right? I couldn't get a license without a birth certificate. And Medi-Cal, right? I had to get my Medi-Cal too. And I mean, aren't those all things I think one could get before one gets out. Can't they help you to stand up IDs, and Medi-Cal at least?"

People continue to rely on self-motivation and peer resources upon release

Participants shared their motivations to seek support and engage in services upon release. Many participants explained that continuing medications to treat their behavioral health or physical health conditions was their primary motivator to linking to care upon release. The medicines most noted by participants were either HIV- or mental health-related prescriptions. Some participants distrusted the healthcare they received while incarcerated. These individuals wanted to connect with a community-based medical provider to receive, for example, an overall physical health exam to confirm a diagnosis received in jail or prison or verify that a treatment they received inside jail or prison was effective. This desire for a second opinion offered by a trusted source was expressed by a client (PT19) who was interviewed in the context of a community clinic. He shared: "I want to be checked out here. Everybody's thinking, well, maybe if check it out here, maybe it's different than in there. I don't know."

When asked how they identified community health providers and other social services, participants most often cited referrals or information they received from peers. Some participants also identified staff at their current

reentry programs who had been program participants themselves or formerly incarcerated people as their best source of information. In either case, peers or "near peers" were held up as one of the most valuable sources of reentry service information as shared by PT17:

> So, I was fortunate. Somebody that's in this [reentry] house, he was actually paroled the day after me. He lived life prior to being incarcerated. He served 12 years of incarceration on a life sentence. He had a career prior to his incarceration. So, he was familiar with a lot of the processes of life, right. And, thankfully I met him, and I buddied with him. And I seen him go to the doctor, and I asked him, 'How did you get to the doctor?' And he gave me a phone number of a lady from [clinic] that I called. And, as soon as I connected with her, the process started, right. The appointment was set, and the process started. But, if it wasn't for him introducing me to her– I probably would still be spinning my wheels, trying to figure out how do I get to that next point?

Given people are motivated to seek healthcare upon release, ensuring seamless continuity of healthcare post-release should be a priority in formal reentry planning. Yet our interviews revealed a glaring deficiency in such services. Our analysis uncovered systemic factors contributing to this shortfall, alongside what we have termed 'a culture of avoidance' specifically regarding HIV. This term encapsulates the broader societal reluctance to confront and address HIV-related issues, which was widely reflected in the attitudes of many of our study participants.

HIV-related stigma and its impact on reentry experience: "Ignorance runs rampant"

Social norms governed the level of openness in discussing substance use disorder, HIV, Hepatitis C, or mental health conditions, subsequently impacting the likelihood of referrals to prevention and treatment services. While both provider and program participants indicated little to no stigma related to Hepatitis C and decreasing levels of stigma related to mental health or substance use disorders, nearly all participants, including both participants living with HIV and participants *not* living with HIV, reported HIV as "a taboo subject" and that there was still a "huge stigma" associated with HIV in correctional settings.

Some clients explicitly acknowledged having had a history of bias against people living with HIV. For instance, when PT20, who had been trained as a substance use peer counselor inside prison, learned that someone living with HIV was placed in the general prison population rather than a separate unit, they expressed surprise or alarm at the situation. He said: "I was led to believe that they were isolated." As a peer counselor, PT20 learned of this individual's HIV status. While this information was initially concerning, he eventually became sensitized to the stress that accompanies

being secretive about one's HIV status. He explained: "There's a huge stigma. It came up once in a group conversation. And I could see this fella getting really, really uncomfortable because, other than me, nobody else in the group knew he was HIV." While PT20 shared he had not received any information related to HIV in his substance use peer counseling training, he took it upon himself to check in on this individual. He explained: "I wanted to make sure that he was doing well, that he wasn't being harassed, was always a major concern of mine." In this case, PT20 displayed compassion for this individual and served as a source of social support. Another client we interviewed had first-hand experience with HIV through friends and acquaintances who were living with HIV. PT24 spoke of HIV in caring and non-judgmental terms, as exemplified when he described his response to an individual who referred to another incarcerated person living with HIV in a derogatory way: "I'm *like, "Bro, he's in here just like you, bro. Me and you are here. He's here, too, bro."* Still, the pervasive attitude of ignorance and bias against people living with HIV is captured in PT29's comments:

> I'm sure there's still people with it, but they just don't talk about it, which I don't know is such a good thing because then the people that don't have it, they should have a right to know who they're associating with, or who they're eating with, or who they're sharing food with or, you know, stuff like that. I mean, I don't want to know everybody's health record or nothing like that, but, you know, if I'm sitting and eating with somebody or being right here with somebody that maybe cut their finger, I want to know if, hey, does this dude have HIV or not for my own protection.

Reentry providers may inadvertently perpetuate stigma related to HIV

Notions of HIV being easily transmitted through sharing food, plates, or being in proximity to someone with a cut on their finger were not limited to participants. Discomfort with HIV was a central theme in the provider interviews, as well. Echoing the HIV-related stigma expressed in client interviews, reentry providers described HIV as a "touchy subject." This description resulted in avoiding the topic altogether or referring to it in oblique terms.

We observed variations in providers' abilities to assess HIV-related needs when interacting with clients. General reentry providers reported that they did not systematically assess clients' physical health needs. Some, however, stated that they were prepared to assist clients with any unmet needs, including needs related to HIV or Hepatitis, if the client initiated the topic themselves. For example, as PT01 reported, they did not routinely ask about HIV during an intake visit but confidently asserted, "I do know that, if it's brought up, it's addressed." Some participants expressed hesitancy or tentativeness in response to questions about whether and how their organization addressed HIV. Our team noted low levels of knowledge

about HIV, e.g., some providers defaulted to the use of the term "AIDS" as an interchangeable substitute for HIV.

Conversely, providers who directly addressed HIV as a health concern of interest for people in reentry were fluent in speaking about HIV, yet they were not professionals within the HIV healthcare field. They did not appear to be avoidant, hesitant, or fearful of HIV. They tended to be knowledgeable about and sensitive to modern-day issues people living with HIV face. They had professional connections within the HIV service provider community and understood how to coordinate services. A general reentry provider developed strategies to address a client's reluctance to openly discuss HIV status. Staff in this organization were trained to ask two critical questions: "Are you a vet?" And "Do you have a disability?" Affirmative responses to either of these questions led to a set of unique services specific to these populations. Similar to specialized services for veterans, staff in this organization knew that people living with HIV would have access to a host of services reserved just for them. However, to link clients to these services, staff needed to ascertain a client's eligibility status. Yet, for a client to disclose their HIV status, they needed to feel rapport or some degree of trust in the reentry provider. This sentiment was expressed by multiple general reentry providers: "*most of the time, they're not, right off the bat, going to tell you that they're HIV. But, after a couple sessions if they're comfortable, it may come out.*"

On the contrary, providers who were less accustomed to or who were unaware of clients' HIV status lacked the opportunity to build the necessary skills and networks to forge effective linkages between clients and HIV care. PR16 explained:

> That is something I've never had anybody admit. And, I mean, it's—it's a touchy subject because, again, it—many of these individuals coming out out there, especially long-term incarcerated, these individuals got reputations, and they care more about their reputations. They will go to the utmost to protect that before they even worry about their health like that…? But that's the thing. You have to—they need to be comfortable talking about it. And, so, maybe what individuals might need is somebody in there to talk to the individual to let them understand, like, this is something serious, and this is something you need to take into consideration.

A positive case example of a general reentry provider (PR10) who was not HIV avoidant was asked about how they handled HIV and replied:

> It's not something I hesitate or anything about. It's just part of my natural assessment. I'm like, "Okay, so, tell me more about this." I don't know. I work a lot on the forefront of building a really good rapport with clients. … we're laughing during our assessments. It's not this clinical, sterile, scary time. And if you look, I'm only 4'11." I'm just a ball of fun energy, and we get through the assessments as best as we can. And it's just something very natural that I'll go down the list of and not stigmatize it myself. And I don't have any issues which way—if you're positive or not. And I hope that comes off. And so, for me, it's just not been a problem.

When we investigated this case further to identify characteristics that made this staff member unlikely to be HIV avoidant, we learned that they had previous experience working in sexual education programming on a college campus. This individual was an advocate and an educator on sexual health and recommended "really good training to just help people understand why we're asking these questions and what additional resources we can give if someone is positive. I think education and just practicing saying those words for someone who's not comfortable with it is going to be important." Of note, this participant reported that their county had recently been given a new billing code that allowed the agency "to bill strictly for medical linkage." This billing code was an incentive to encourage reentry providers to conduct thorough assessments with reentry clients so that the agency could provide billable medical linkage services, which could include referral to an HIV specialist. Table 2 presents proximity to HIV for all 16 reentry providers interviewed in this study.

Discussion and Recommendations

In this qualitative study, we found little evidence of prerelease planning or post-release coordination of care for the individuals interviewed as they prepared for release from California jails and prisons. In the absence of formal support, our participants reported struggling to navigate themselves through the obstacle course of services to meet their needs or turning to peers for advice and guidance. These informal peer supports were especially meaningful to participants. Individuals reported challenges related to complicated systems of care during a vulnerable period (Swan, 2016; Brinkley-Rubinstein, 2015; Rowell-Cunsolo & Hu, 2020). These findings are similar to what has been reported in the literature elsewhere. However, our analysis provides unique insight related to the phenomenon of the culture of

Table 2. Reentry provider connection to HIV (n = 16).

Connection	Definition	Number (#)	Percent (%)
Actively engages with PLWH and/or provides HIV services	Agency provides HIV-related services including HIV testing, prevention, linkage to care, HIV related medical care, and/or insurance enrollment. Displayed a strong fluency, knowledge, and comfort in talking about HIV and/or working with PLWH.	10	63%
Displayed HIV Hesitancy or Avoidance	Agency does not include HIV-related questions at intake, and/or takes a reactive "if it comes up, we'll address it" approach" to HIV-related services, Expressed know stigma within agency staff around HIV or hesitant to recruit known PLWH for study	5	31%
Unknown	Missing information or topic was not discussed in interview	1	6%

avoidance associated with HIV. Understanding the attitudes, assumptions, and behaviors of people *not* living with HIV is essential to understanding how HIV stigma operates and persists through HIV avoidance in reentry settings. The communities and systems of care that PLWH return to are shaped by people who do not share their lived experience, including providers, peers, and fellow clients who bring with them opinions, judgments, and discomfort that affect whether HIV is addressed directly, indirectly, or avoided altogether. This avoidance has serious implications and consequences that can undermine timely linkage to HIV care upon release.

Recommendation 1: Create more avenues to engage community-based organizations in prerelease services

Our findings underscore what has been published elsewhere: there are not enough prerelease programs or services available to people as they prepare to leave prison. Coordination and expansion of agencies providing prerelease planning is needed. The available programs often have limited capacity or strict eligibility criteria, which limit people's access and, therefore, do not meet the demands of those who want them. Furthermore, correctional agencies often have limited to no staffing to adequately provide prerelease planning for every individual as they prepare for their release. Without such support, key factors related to successful continuity of care upon release are not addressed before release. Thus, people are left to fend for themselves upon release and face a heightened probability of falling out of care and engaging in higher-risk behaviors that further jeopardize their health and well-being. On the other hand, community-based reentry agencies are available to provide services for people once they return to their local communities. However, these agencies typically do not have access to prisons to initiate in-reach and relationship-building efforts prior to an individual's release. Many of these providers would welcome the opportunity to initiate services with participants prior to their release, but lack contacts within the prisons. Three key areas to address during the prerelease phase are to 1) reinstate Medicaid coverage, 2) help individuals obtain formal identification documentation, and 3) ensure individuals have an adequate supply of physical and behavioral health medications at release. This support is essential for the many individuals who exit prison without a social network to assist them with navigating complex, bureaucratic systems.

CalAIM provides a new funding source for community-based organizations to engage in reentry planning prior to a person's release from a California prison or jail. The Enhanced Care Management (ECM) component of CalAIM allows community organizations to bill Medicaid for 90 days of in-reach planning and care coordination prior to an individual's

release. More community-based organizations should be informed on the ECM program and added to California county ECM provider rosters to engage in this work at local jails and state prisons.

Recommendation 2: Recognize the value of organic peer support systems by greatly expanding formal peer-based reentry service models

Our study supports peer-based models as a necessary component of successful reentry. The aim of our study was not to evaluate formal peer-based services, but rather to understand the natural journey people experience in reentry and the systems or supports they engage with upon release. Majority of participants described taking initiative to support one another and developing informal peer-based reentry strategies in the absence of formal systems. This *organic peer organizing* is a key positive finding of our study and highlights the potential for these practices to be formalized and resourced.

A large body of evidence supports the importance of formal peer-based models (Myers et al., 2017; Koester et al., 2014; Nixon, 2019; Elisha, 2023; Klee et al., 2019; Matthews, 2021; Marlow et al., 2015; Fuller et al., 2019; Koester et al., 2014). Peers, patient navigators, and community health workers (CHWs) with shared lived experience of incarceration have been shown to be effective in assisting individuals during prerelease and post-release. A recent literature review (Lenkens et al., 2024) on the effectiveness of peer support in the context of criminal justice and rehabilitation concludes that the most salient features of peer support include a non-judgmental orientation, which is experienced as empathic, peers as legitimate role models (Marlow et al., 2015; Portillo et al., 2017; Lenkens et al., 2021) who are seen as trustworthy (Lenkens et al., 2021; Reingle Gonzalez et al., 2019; Harrod, 2019), and who can serve as beacons of hope (Matthews, 2021; Marlow et al., 2015; Portillo et al., 2017; Lenkens et al., 2021; Nixon, 2020; Barrenger et al., 2019) for those early in their reentry experience. Therefore, peer-based models can help address the distrust many feel toward correctional health care. Peer navigators and CHWs assist with a host of general reentry needs, housing needs often being among the most common and pressing issue (Aminawung et al., 2021). Peer-based programs linking people living with HIV to care have also been shown to be efficacious (Myers et al., 2017; Westergaard et al., 2019). For example, a randomized control trial showed that employing peers to assist patients in maintaining HIV viral suppression post-release from jail or prison was more efficacious than the standard condition (Cunningham et al., 2018). Importantly, this peer-based intervention included providing social support and skill-building to address social stigma and discrimination, among other logistic supports.

Our primary focus in recommending peer-based strategies pertains to the *post-release* period, where disclosure of HIV status is safer and where peer models are already more established and resourced. However, our interviews did surface powerful examples of organically developed peer support practices taking place both inside and outside of carceral settings. While we acknowledge that disclosure in custody settings can be dangerous and stigmatizing, participants in our study described selective, voluntary self-disclosure that enabled informal peer mentorship, support, and linkage to care—even while incarcerated. For example, one participant shared how they were able to support others as a certified substance use disorder (SUD) counselor while still incarcerated, underscoring that when peer models are structured and trauma-informed, they can foster safe environments for disclosure and support even inside.

Greatly expanding formal peer-based models within community-based reentry services can help increase prerelease programs and post-release reentry services while also employing people with lived experience and ensuring that they are compensated at an equitable salary for these types of professional services. Furthermore, there are new funding opportunities and billing codes for "Peer Support Services" through Medi-Cal under the CalAIM initiative to scale these peer models both inside and outside correctional settings (California Department of Health Services, 2022). The professionalization of peer programs creates opportunities for standardized training, which should include HIV stigma and perhaps address homophobia.

Recommendation 3: Proactively and directly address HIV stigma and avoidance among reentry providers

Perhaps the most important finding in our study is the degree to which HIV related stigma, bias, and secrecy are still rampant within correctional facilities as well as within community-based reentry service organizations. Given the pervasive and ongoing presence of HIV stigma, many community providers, in their efforts not to bring up "taboo subjects" with clients, especially after release from prison or jail, do not proactively discuss or assess for HIV care or prevention needs within their reentry services. Even when agencies implement "comprehensive" client needs assessments that include questions about health-related needs, non-medical providers often take a *"don't ask, don't tell, but if it comes up"* approach toward discussing HIV. Yet, providing comprehensive reentry services requires a comprehensive assessment, including assessing the HIV status of a recently released individual. Furthermore, peer staff who have previous criminal legal system involvement may perpetuate bias and stigma that they experienced inside prison or jail or chose not to discuss HIV to support and

honor a "leave it all behind" mentality. But given the high rate of overlapping syndemics people with criminal legal system involvement experience, including HIV, Hepatitis C, mental illness, or substance use disorders, *all* organizations providing reentry services, including behavioral health and general reentry service providers, should consider taking on a more straightforward and universal approach toward discussing HIV care or prevention needs with their clients. This universal effort may help normalize living with HIV. Furthermore, we recommend that reentry agencies review intake policies and practices to ensure they are comprehensively and proactively assessing physical and behavioral health needs (including HIV and HCV). Agencies may also consider routinely training staff on HIV-related stigma and bias, including bias related to homophobia. Trainings that address advancements in HIV care and prevention information, HIV affirming assessments, HIV stigma, and effective HIV support service strategies with behavioral health and general reentry services providers would likely reduce the culture of HIV avoidance. Such trainings will ensure that a broader spectrum of reentry service providers are more conversant in syndemics and help to destigmatize HIV, substance use, and mental health issues among staff and their clients.

Routine HIV screening is happening in other health sectors, such as emergency departments and labor and delivery settings. HIV screening is a fully covered service as part of the preventative screenings under the Affordable Care Act. This routinization of HIV screening has helped to position HIV as a disease that can happen to anyone and, therefore, has a destigmatizing effect. Some participants interviewed in this study referenced people with HIV as "they're HIV," and basic training on person-first language may help to sensitive staff to the need for humanizing ways of referring to clients, e.g., people living with HIV or people experiencing homelessness or people who use substances. Clearly, additional work can be done to normalize an HIV diagnosis and to screen for HIV more broadly with people returning to the community after incarceration.

Limitations

Our study has limitations. First, this study does not represent individuals recently released from jail or prison who had not received reentry services. While all clients interviewed reported at least one behavioral or physical health condition, the voices of those with physical health conditions, particularly those who had been diagnosed with HIV, may be underrepresented in our client interviews, however, in 2021 approximately 1.1% of all individuals (1.2% of males and 0.9% of females) in state and federal prison were living with HIV. We are confident that the clients we interviewed (including 2 who had disclosed an HIV positive status) shared perspectives on HIV

that are likely transferable to other reentry populations elsewhere in California. We interviewed reentry providers and clients in two urban California counties; reentry providers or clients in reentry working or living elsewhere may have different experiences and opinions, particularly those in more rural areas. The goal of findings associated with qualitative studies is not to produce generalizable knowledge. Instead, the goal is to produce knowledge that may be transferable to similar populations in other geographic locations (Tracy, 2010). Given the literature on the pervasive presence of HIV-related stigma (Turan et al., 2019; Rzeszutek et al., 2021; Link & Phelan, 2001), we believe these findings would resonate with others in areas of the country with some shared features of the locations where we conducted our research, namely metropolitan areas in politically liberal environments.

Conclusion

Our findings contribute uniquely to the literature by identifying (a) the distinct forms of HIV-related hesitancy among general, non-HIV-focused reentry providers, (b) practical and actionable strategies these providers use or need to feel confident supporting clients with HIV, and (c) organically emerging peer-led reentry practices. These grassroots strategies point to scalable, community-informed models that can be bolstered by policy innovations such as California's CalAIM Justice-Involved Initiative. Given the complex needs of individuals as they release from prison or jail, the organic nature by which people are currently preparing for release and navigating support upon reentry, and the continuation of the siloed reentry services, more effort is needed to take a stronger syndemics and peer-based approach toward prerelease planning and reentry services in the community. California is a leader in taking a syndemics approach to undue health inequities and has a five-year plan to significantly improve health outcomes among those most impacted. In 2022, the California State Office of HIV/AIDS published the Ending the HIV Epidemic Integrated Statewide Plan, which, for the first time, addresses the emerging syndemics of HIV, HCV, and STIs in California. This plan is intended to facilitate the development, implementation, and monitoring of programs designed to equitably address the health needs of Californians, particularly among those most susceptible to syndemics threats. Until the blueprint is enacted, efforts to improve coordination between reentry providers and prisons and jails and to increase opportunities for enhanced prerelease coordinated care planning will require taking full advantage of Cal-AIM and other new policy developments that allow for billing reentry care planning, peer-led navigation programs, and reenrollment in Medicaid 90 days before release. It is also critical to strengthen reentry provider capacity to systematically assess physical health (including HIV) and behavioral health needs, as well as

cross-training behavioral health and general reentry providers on advancements in HIV prevention and treatment and the importance of destigmatizing HIV to ensure people have a more successful experience linking into care upon their return to the community. Finally, it is imperative to establish peer-based practices that include hiring people with lived experience with the criminal legal system to integrate these individuals into the growing number of reentry service programs. People who return to the community after incarceration are naturally facilitating this effort on a peer-to-peer and voluntary basis. It is time for peer navigators and other peer-based professionals to be recognized for the high value they carry and compensated at a professional level. Integrating all of these practices will not only advance the goals of Cal-AIM, but will have a global impact on increasing the number of people living with HIV or Hep C and/or with behavioral health conditions that successfully engage in continuity of care upon their return to the community after incarceration, thereby increasing the overall public's health.

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