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Understanding Interactions of Formerly Incarcerated HIV-Positive Men and Transgender Women with Addiction Treatment, Medical, and Criminal Justice Systems

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Abstract

Background—Low levels of medical care engagement have been noted for HIV-positive people leaving systems of incarceration in the United States. Substance misuse frequently co-occurs with criminal justice involvement in individuals who are living with HIV.

Methods—We analyzed data from in-depth interviews with 19 HIV-positive individuals who were currently or formerly incarcerated in order to elucidate challenges faced in accessing care and maintaining HIV treatment regimens when cycling out of (and often back into) custody. Our thematic analysis used an ecosocial framework to describe participants' shifts between substance abuse treatment, medical care, and criminal justice systems.

Results—Dominant themes included the dramatic increase in HIV-treatment-related autonomy required following release from jail because of differences in care delivery between custody-based and community-based care systems; the important, but temporary stabilization provided by residential substance abuse treatment programs; and the inconsistency of substance abuse treatment approaches with chronic care models of disease management.

Conclusions—Enhanced integration of criminal justice, medical care, and substance abuse treatment institutions in planning for reentry of HIV populations may ease the impact of the dramatic shifts in context that often dissuade linkage and retention. This integration should include

coordination with custody release processes, periodic assessments for active substance misuse in HIV treatment settings, support for (re)establishing health-promoting social networks, and options for long-term, residential substance abuse treatment programs.

Keywords

HIV care and treatment; Substance misuse; Criminal justice system; Antiretroviral therapy (ART); Long-term care

Current HIV strategic goals emphasize the importance of antiretroviral therapy (ART)-based interventions, including pre- and post-exposure prophylaxis and early, continuous use of ART, for both maintaining the health of people living with HIV and reducing risk of HIV transmission to their partners (Centers for Disease Control and Prevention (CDC). (2017); Cohen, et al., 2011; Office of National AIDS Policy (ONAP), 2015). These ART-based interventions require from patients both adherence to medication regimens and ongoing engagement with medical care systems. HIV-positive persons also participate in other systems that may either facilitate or hinder progress along the HIV continuum of care. For example, approximately 1 in 7 of the HIV-positive population in the United States experiences incarceration in any given year (Spaulding, et al., 2009).

A majority of people in jail have comorbid substance use disorders (Karberg & James, 2005), and illicit substances are important reasons for arrest and incarceration (Harawa, et al., 2009; Karberg & James, 2005; Wagner & Rabuy, 2016, March 14). Nevertheless, most US custody settings offer little-to-no services for addressing substance misuse (Chandler, Fletcher, & Volkow, 2009; Mumola & Karberg, 2006, October; Taxman, Perdoni, & Harrison, 2007). Those who leave jail and reenter the community move from an environment in which illegal substances and substance use are present but scarce and heavily surveilled, to one in which illegal substances and substance use may be plentiful and encouraged by social networks. Although they may have achieved abstinence while incarcerated, maintaining sobriety during reentry requires additional skills, support systems, and motivations, particularly in the face of the stressors associated with reestablishing social networks, securing housing, and securing one's livelihood.

Because of the well-documented links between substance misuse and HIV risks (Volkow & Montaner, 2010), programs do exist to identify and address the needs of those living with both HIV and substance use disorders. These include needle and syringe exchange, HIV testing of substance abuse treatment¹ and needle exchange clients, HIV case management services to facilitate HIV care access, medication assisted therapies, contingency management, and directly observed antiretroviral therapy targeting this group (Springer, Spaulding, Meyer, & Altice, 2011). Substance abuse treatment has been associated with increased HIV medical care engagement (Gonzalez, Barinas, & O'Cleirigh, 2011), and HIV-

¹Although the term 'substance abuse treatment' has been criticized because of the non-medical and stigmatized activities that some associate with the term 'substance abuse', it is the common name by which programs for addressing substance dependence are known in the U.S. We use 'substance misuse' to describe harmful or hazardous use of substances and 'substance dependence' to describe individuals whose patterns of substance misuse are severe enough to require comprehensive treatment.

focused substance abuse programs have been shown to promote both HIV medication adherence and viral suppression (Gonzalez, et al., 2011; Springer, et al., 2011).

HIV disease and substance dependence both represent chronic, stigmatized, and generally incurable illnesses that, in addition to threatening mortality, can threaten individuals' sense of self, strain social ties, and require intensive treatment and self-management to address successfully. Models of HIV treatment are largely consistent with those for the management of other chronic illnesses (U.S. Department of Health and Human Services-Health Resources and Services Administration (HRSA), 2014). By contrast, approaches to addressing substance dependence, particularly for criminal-justice-involved patients, are much less consistent with a chronic disease model. Although methadone and buprenorphine treatment for opioid dependence are exceptions (Altice, et al., 2011; Friedmann, et al., 2012; Fu, Zaller, Yokell, Bazazi, & Rich, 2013), the most effective forms of medication assisted treatment for substance dependence are the least likely to reach the largely low-income and Black and Latino populations who are overrepresented in US prisons and jails (Duncan, Mendoza, & Hansen, 2015; Hansen, et al., 2013). In community settings in the US, active management of recovery from substance dependence is generally restricted to short periods of detoxification or somewhat longer periods of residential treatment. Upon completion of these programs, long-term care is generally self-managed and haphazardly supported by peers and para-professionals (e.g., 12-step groups and substance abuse counselors) outside of mainstream health care delivery.

Given the known associations of incarceration with other social determinants of poor health, HIV-positive individuals who go to jail or prison also likely experienced elevated rates of mental illness, trauma, and economic marginalization, compared to people living with HIV who do not (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010; Baillargeon, et al., 2009; Surratt, O'Grady, Levi-Minzi, & Kurtz, 2015). While in custody, people living with HIV experience a system with structures and regulations that automate care and facilitate adherence (e.g., regimented schedules, pill calls, universal health care, shelter, proximity to services) (Jurgens, Nowak, & Day, 2011; Meyer, Cepeda, et al., 2014). However, in the general community, many may lack such supports, and those with substance use-related incarceration histories may be restricted from housing and food resources. For example, until April 2015, all persons convicted of a felony drug offense in California were banned for life from receiving welfare (CalWORKs). If the conviction was related to drug distribution, they were also banned from Federal nutrition assistance benefits (CalFresh), with some exceptions (California Assembly Member Catharine Baker, 2016). Other restrictions still limit access to public housing and housing assistance for people with drug-related convictions.

Even though custody-based services exist in many locations to facilitate linkage to care (e.g., transitional case management) and to minimize immediate HIV medication lapses (e.g., short-term medication supplies at of release medication) post release (Jurgens, et al., 2011), significant declines in treatment and care utilization have been documented following reentry (Baillargeon, et al., 2009; Clements-Nolle, et al., 2008; Stephenson, et al., 2005) and despite general improvements in HIV continuum of care outcomes while in custody (Iroh et al. 2016). Studies of former prisoners and those who later experienced re-incarceration have

found that release from prison is associated with a low likelihood of filling an ART prescription within two months (Stephenson, et al., 2005), and a high frequency of ART discontinuation (nearly 50–60%) (Clements-Nolle, et al., 2008; Meyer, Zelenev, et al., 2014; Small, Wood, Betteridge, Montaner, & Kerr, 2009; Springer, Friedland, Doros, Pesanti, & Altice, 2007), as well as marked increases in viral load (Palepu, et al., 2003; Small, et al., 2009; Springer, et al., 2007) in those who later recidivate.

Few studies, however, have examined how the contexts of criminal justice, HIV medical care, and substance abuse treatment systems influence individual patients' *agency*, perceptions, and behaviors; what circumstances lead HIV-positive CJI patients into and out of these systems; and how these systems interact with one another to impact management of their HIV disease and substance use disorders. *Agency* refers to the ability of individuals to act independently and to make choices according to their own desires and opinions – to exert power and to make things happen. Particularly relevant to this context is that sociologists frequently contrast agency with *structure* or arrangements that lead individuals “to be acted upon, to be the object of events, ..., to be constrained and controlled: to lack agency” (Hewson, 2010). As part of the process of developing a peer navigation intervention to sustainably connect HIV-positive persons to treatment following jail release, we conducted in-depth interviews exploring the supports and challenges affecting linkage and retention following release from a major urban jail. We report here on analyses of a subset of those interviews. By focusing on the contexts in which the HIV-positive participants experienced and moved between substance abuse treatment, HIV care, and custody settings, our analysis explored how these dynamic and overlapping systems relate to each other and impact the lives of people who are living with HIV and have recent histories of incarceration.

Methods

Setting

The study was carried out in Los Angeles County and involved a direct collaboration between the Division of General Internal Medicine and Health Services Research in the Department of Medicine, UCLA; the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP); and the Los Angeles County Sheriff's Department (LASD). The latter oversees the LA County Jail (LACJ) system, including its medical services. Generally, jails are short-term facilities housing individuals who await trial, who are unable to post bail and be released, or convicted of crimes involving less than 12 months of jail time. LACJ's average daily incarcerated population is approximately 19,000 (87% male), and 1.6–2.0% of its male population at any given time is known to have HIV (Personal communication; Cox G, LASD Medical Service Bureau). At the time of this study, the mean and median lengths of stay for men in the LASD jails were respectively 42 and 15 days (Malek, et al., 2011), and 68% of LASD's arrests of known HIV-positive males were for substance misuse offenses, including alcohol-related offenses (Internal report LASD Medical Service Bureau, 2010; Cox, Malek, & Deadmond). Approximately half of the male and male-to-female transgender HIV-positive incarcerated persons interviewed for this study resided in a protected custody unit designed for self-identified gay men and male-to-female transgender women. Although not the focus of this analysis, parallel interviews

were also conducted with 21 community-based case managers and clinicians who served HIV-positive patients with CJI.

Collaborations with the DHSP and community-based organizations provide for HIV transitional case management (TCM) in the jails; direct HIV medical care is provided by LACJ clinicians. Transitional case managers (TCMs) from community based agencies provide referrals to services in the community such as housing, mental health treatment, HIV medical care, and substance use treatment. The jail pharmacy also provides a short-term supply of ART when HIV patients are released from LASD custody. Few additional services are available to support linkage to HIV care or to other needed services in the community post release.

Recruitment

Potential study participants, both in custody and outside of custody, were recruited through the use of IRB-approved study flyers and through direct referrals by medical providers and HIV TCMs. The flyers included a dedicated project phone line that interested individuals in the community could call. In two LASD facilities, the public health nurses who deliver care to HIV patients described the study to potential participants during their regular clinical check-ups. Those incarcerated individuals who expressed interest were then encouraged to complete a study interest form that was then confidentially routed to the Study Coordinator.

Screening and enrollment

The Study Coordinator arranged for interviewers to meet one-on-one with interested individuals in the jail. During this meeting, the interviewers screened, obtained informed consent, and interviewed those who were willing and eligible. Interested persons who were formerly incarcerated were screened over the phone. Arrangements were then made for those who were eligible and interested to meet with an interviewer to conduct the interview after obtaining written informed consent. All participants were engaged in medical care, though not necessarily on antiretroviral treatment (ART) at the time of interview. They also fulfilled the following eligibility criteria: 1) diagnosed with HIV, 2) male or male-to-female transgender, 3) 18 years or older, and 4) able to speak and understand English or Spanish. Substance use was not part of the entry criteria but issues related to substance use were mentioned by all study participants. Although 20 participants were interviewed, one participant was excluded from this analysis because he was first diagnosed with HIV during the current jail stay.

Interviews

Confidential interviews with those in jail were conducted in a private room in the jail facility. Custody staff were not present nor within earshot but were generally nearby. Because recording devices were not allowed in the jails, a second interviewer was present and took detailed written notes of the participants' responses. Confidential interviews with those who were formerly incarcerated were conducted in private rooms of local service providers, such as substance abuse treatment agencies or medical clinics. These interviews were audio recorded and transcribed verbatim. Basic sociodemographic information was

collected via a short interviewer-administered survey. Each participant received \$40 – either directly or on their inmate account -- for completing the interview.

Interviews lasted approximately 90 minutes and utilized a detailed open-ended interview guide. Respondents were asked about their substance use, social support systems, and health status; the frequency with which they visited a doctor and took HIV medication; factors that challenged and facilitated their linkage, retention, and ART adherence in community-based HIV care; their opinions of peer navigation to facilitate reentry care engagement, and their preferences regarding potential peer navigators. After each interview, the interviewers completed post-interview notes describing the interview setting, the participants' state and appearance, and summarizing key themes related to 1) challenges of living with HIV, 2) linkage, retention in HIV care, and ART adherence, 3) support systems, 4) jails and community reentry, and 5) peer navigation. Data saturation, the point at which new interviews do not yield new data or insights (Strauss & Corbin, 1998), was reached with this sample.

Analytic approach and theoretical frame

Three members of the research team, including one who had conducted about half of the interviews, began this analysis by separately reviewing the data and each making notes on major themes that emerged. They then met to discuss potential research questions to explore in the analysis. The members also reviewed previously developed spreadsheets summarizing earlier coding that had been carried out to inform the development of the peer navigation intervention. These spreadsheets related specific aspects of the intervention model to the interview responses.

After this initial review, two members of the research team independently developed codes after reading two transcripts. They then met to refine and define these codes. Using this preliminary codebook, they next each independently applied the codes to three transcripts, meeting several times to review how they applied codes and to refine code definitions and add new codes as necessary. By review of the third transcript, the coders were independently applying the codes in a consistent manner. They then split up the remaining seven transcripts and nine interview notes for coding. They used Atlas.ti to facilitate coding and cross-case analysis, looking across transcripts and codes for similarities and differences and identifying how codes related to larger themes.

The themes focused on in this paper were the result of several discussions between the two coders and feedback from the study's principal investigator and were developed using an ecosocial framework (Krieger, 1994). Specifically, the analysis centered on the social and institutional-level forces that shape HIV treatment and substance abuse treatment.

Results

The shifting contexts within which individuals found themselves when moving between custody and community settings featured prominently in the interviews. The themes generated describe how systems of substance abuse treatment, HIV medical care, and criminal justice interact to impact CJI-involved patients' HIV care and substance use.

Study participants

As shown in Table 1, study participants were largely Black (11/19) males (16/19) who identified as gay, homosexual, or bisexual (11/19); a substantial proportion had not completed high school or a general equivalency degree, GED (7/19) and were uninsured (8/19); all had been living with HIV for more than two years. Low education and lack of health insurance were more common among currently than previously incarcerated participants. During their interviews, participants mentioned having been incarcerated several times, with 15 mentioning five or more stays and 14 indicating time in prison. All but five had participated in formal substance abuse treatment programs; with most of these mentioning having cycled through such programs multiple times. Commonly reported substances included alcohol, methamphetamine, crack cocaine, marijuana, and injection drug use with no indication of drug type.

Criminal justice system HIV care

The setting and design of both jail and prison-based HIV care was described as restrictive and generally efficient in its ability to identify and treat patients but not supportive of patient autonomy or privacy. Once an incarcerated person is known to have HIV, their status frequently becomes known to others, and they experience a course of treatment course described as automatic, frequently overriding personal agency.

So now they got it to where they set you up with a doctor when you get in, you let them know that you [are] HIV positive and they take blood from you and then they schedule you to see the doctor within three weeks.

At the time of a scheduled visit, the patient receives a pass to attend the specified clinic; he or she does not need to schedule, remember, or arrange for transportation. If placed on ART, he or she does not need to take any action to fill the prescription or keep track of significant amount of medications. Instead, it is entered into the electronic medical record and filled automatically. Although many HIV patients in the LASD jails are then assigned to self-medication regimens where they receive a 14-day supply of medications every two weeks to take on their own, all others obtain their medicine via pill call, for which minimal self-initiation is required for adherence. Three times per day, nurses bring prescription medications to patients' housing units. Patients then line up and to receive and take their allotted pills. Finally, when an HIV-positive patient is likely to be released, rather than sent to prison, he or she is also assigned an HIV TCM whose responsibility it is to assist with establishing linkages to HIV care and other needed services following release. Little-to-no patient-initiated action is required to obtain these transition services.

Custody's control over HIV disclosure and care limits options for patient autonomy—One of the reasons participants indicated that incarcerated people may keep their HIV status hidden is the lack of privacy and often intense HIV stigma placed within systems of incarceration. One participant, who had himself been diagnosed with HIV in the prison system in the late 1980s, discussed this phenomenon:

“At that time, at this time still, people don't tell people they have HIV in the county [jail] system because it's a threat, so people don't take their medication. There's a

lot of people in the county jail that are getting sick, some dying, because they refuse to put themselves out there with the disease because of the stigma.”

He later went on to discuss how policies that once led some California state prisons to house HIV-positive persons separately marked those individuals even years later. This, along with disclosure of HIV status by staff, rendered HIV-positives prisoners vulnerable to both marginalization and denial of benefits.

“So they took down the fences for the [HIV] segregation. Well now, people like me and others that have spent a lot of time in prison, they know them as being segregated in the HIV system, so we’re not confidential like they said we are. They say, “Oh, you came from the other side of prison, so you’re HIV positive, and they refuse to cell up with you. They refuse to sit at your tables ... They refuse to give us jobs where we can make money... And I’ve dealt with it in the county system. I’ve dealt with sheriffs, telling people that I had AIDS.”

Hence, the only autonomy left to those in custody is for those whose HIV status is not already known to the system to hide it completely and forgo HIV care until release -- the strategy of selective disclosure of HIV status that many patients enact outside of jail is not available inside custody.

Further highlighting how autonomy is compromised in custody contexts are the occasional reports of persons who generally were both adherent to their medications when in the community and open about their HIV status to custody staff but were, nevertheless, subjected to incarceration-related delays in treatment. A participant who had been incarcerated in a federal facility discussed this.

I told them I was HIV positive and I needed to take my meds. But they never actually [gave me medicines or] sent me to a doctor until a week [later].

Custody and reentry substance use contexts

Another aspect of incarceration-based care systems, like other medical systems, is the availability of medications for treating pain and psychiatric illnesses.

Some interviewees mentioned use of prescription pain killers, such as OxyContin, and psychiatric medications while incarcerated and described this as substance misuse. Here, a participant who had spent more than 25 years in the prison and county jail systems remarks on the relationship between the availability of prescription drugs inside custody and illegal substance use outside of custody.

The prison system and the county [jail] system will put you on any type of medication you want, and a lot of people go in there and they get on codeine, morphine... All you gotta do is see a doctor and tell him, “I was taking this on the street, and I got this degenerate disease in my back or neuropathy, and they’ll put you on the stuff.” ... It’s just like your drug habit on the street. So, you’re feeding your habit and it’s free.

A participant also discussed how the ease of access to such prescription medications while incarcerated impacted an individual’s desire to manage their HIV care.

The majority of people in prison are on what they call “hot meds,” which is morphine, methadone, codeine, even Vicodin... and then they neglect to take their HIV meds ... because it’s hard to take HIV meds and take “hot meds” at the same time ... because you don’t care.

Regardless of whether or not these substances were prescribed for legitimate treatment of pain and mental illness, access seemed to require little initiative or follow through while incarcerated. However, participants did not mention being made aware of any services for facilitating ongoing treatment or appropriate discontinuation from such medications upon release. In fact, at least two participants with long-term psychiatric comorbidities reported only receiving psychiatric treatment during periods of incarceration and never obtaining it in the community.

Contextual changes and challenges leaving incarcerated settings—When participants left custody, they frequently encountered both shifts in their access to substances and structural challenges.

In contrast to the frequent prescription substance misuse described, instances of reported illegal substance use in custody were rare. Instead, participants generally indicated that they would leave custody settings not using the illicit substances they had been using prior to entry, and with the intention to remain abstinent. Sometimes, however, these intentions often ended soon after release. Release from LACJ generally occurs from the Inmate Reception Center and often late at night. The Reception Center is located only blocks from the county’s *skid row* area where illegal substances are frequently for sale and open use is common:

I’d go into jail with nothing, coming from nothing and then, when I’d leave, I might feel better and feel sober, but it’s just like I’m released onto the street and I have no direction, no nothing. Sometimes I had intentions of doing well, however being released in downtown L.A. at 11:00 at night ...

The timing and location of release, combined with the lack of services open at that hour physically places those leaving custody within a high-risk context that increases their vulnerability to using illegal substances. Another problematic release context for those wanting to maintain sobriety was described by participants who reported that members of their social network facilitated their early post-release substance use by picking them up from jail with illegal substances on hand, as a way of welcoming them home.

For those individuals who did pass the first few days of reentry without using illegal substances, failure to achieve or sustain residential stability often led to a later relapse. For example, in describing the temporary support (i.e., bus fare and a short-term place to stay) that was established for him through the jail’s TCM program, this participant explained:

Yeah, I got released, that’s when they set it up [for] me. But, ... it was only supposed to be for a month after you get out. And then after that month’s up, then, you’d be like on your own, back out there using drugs or whatever.

His statement indicates that a return to unstable housing almost inevitably meant a return to substance use. Participants citing these experiences of unintended reengagement in

substance use frequently implicated it in their failure to engage or remain engaged in HIV treatment.

By contrast, successful HIV medical care engagement during reentry was facilitated by several factors, including achieving day-to-day stability, entering a residential substance abuse recovery program at release from jail, having been established in care with a specific provider prior to their most recent incarceration, and having supportive family members.

For example, the notes for one in-jail interview of someone diagnosed in prison in 1998 reported good HIV medication adherence in the community, despite several long incarcerations and recurrent drug misuse, indicated the following supports: 1) a place to stay or placement in a residential treatment program when not in custody, 2) family members who were aware of his HIV status and supported his medication adherence, 3) a medical provider that a) he liked and b) was located close to his residence, and 4) knowledge of local resources that supported access to HIV care.

Criminal justice involvement can lead to long-term destabilization and limit options—Even when an individual did manage to achieve longer-term sobriety, the criminal justice system often had long-standing and surprising effects on their stability and sometimes created negative incentives for achieving reentry success. For example, because this participant had secured legitimate employment after remaining sober post-release, he was ordered, to pay restitution and then reincarcerated because of failure to comply.

So, I ... tried to get my driver's license back because I got a job and I got some significant money, I went to see the judge and she told me that I had to pay the restitution to certain people, and I was like, "I don't know who these people are." And I remember she said, "Well, I'm gonna refresh your memory, so she put me back in jail." This is when I've been sober for like two or three years. You know the police.

In a related manner, criminal histories seemed to limit points of treatment entry for some participants. The transcripts, for instance, provide examples of opportunities for those with clear evidence of substance use disorders to have received treatment that were missed because of their criminal records. For example, one participant in his 40s, with repeated crack cocaine possession convictions, indicated he was never offered substance abuse treatment because of a burglary conviction he received as a teenager. Instead, it appears that his parole was violated, each time he relapsed:

And each time I got caught, I went right back to prison. They didn't even offer me a program. They never offered me a program. Every program that I've ever been in, I've come on my own.

Substance Abuse Treatment Linkages and Setting

Whereas treatment for substance misuse was rarely available in custody, many engaged in it during periods of reentry.

Substance abuse treatment can serve as the link to HIV care—Several participants engaged or reengaged in HIV care post release by being linked to it through

substance abuse treatment programs. The provision of transportation, appointment escorts, and other structures by many in-patient substance abuse programs helped to ensure that these linkages were established and maintained. We note, however, that accessing such programs could require determination, patience, persistence, and social support. This respondent discussed the need for more detoxification centers and then criticized the process associated with obtaining treatment when it is available, because of what it requires from patients who may be in a vulnerable state:

Yeah, so my way of detoxing was through a hospital and by saying I want to commit suicide, which at different times I did, but it wasn't true that time. I just needed a place to sleep, eat, rest where people wouldn't talk to me. Going into treatment centers like, a lot of them, you just go in and right away you're pushed into bookwork and all this and this and all that. Like, it took me the first 45 days to even be, like, halfway normal.

We note here too the manner in which patients can learn to manipulate systems, in order to meet their needs, a theme that was also described in some participants' interactions within custody.

Residential substance abuse treatment can serve as a short-term stabilizing force—By meeting participants' basic needs and providing rules and structure, residential treatment programs offered stability that supported consistent HIV care engagement. For example, in response to a question about whether substance abuse treatment helped him to attend his HIV appointments, one participant responded affirmatively because, "I have a place to live and steady meals, [I'm] healthy and sober." The importance of residential programs' provision of adequate housing and food security is further highlighted by the struggles of some interviewees who graduated from such programs sober but without a stable home to go to:

I went from [Treatment Center Name] to a hotel for two weeks and then they sent me to a shelter where I was at and then I got caught drinking again so they sent me over here.

Despite its provision of temporary housing, the treatment program did not appear to have articulated for clients the roles of political forces and living context on their recoveries. For example, this individual did not identify the impact of his unstable living situations in his relapses, but instead sought to blame the recovery program and himself. He even considered punishing himself or perhaps, relieving himself of what he perceived to be a hopeless, pursuit via suicide, "if it didn't work."

And I remember when I came over here, I was really broken spiritually and mentally, and I told myself if this program didn't work.... and I was going to give all I got, but that if it didn't work, I was going to commit suicide because there was no other help.

Substance abuse treatment fosters HIV care engagement at the cost of privacy—Treatment programs also supported HIV care engagement through provision of HIV education and counseling. These may have particularly benefitted those study

participants who indicated having known little about HIV prior to or immediately after their diagnosis. For the several who had avoided HIV disclosure to others because of stigma concerns, these educational services and personnel appeared to be their only sources of support and reliable information.

I found my counselor and a few other people that talk to me.... the nurse here. They talk to me about it, let me know the things I need to know about it, that I needed certain things that help me out.

We also note that there were participants who struggled with addressing their HIV medical care within residential substance abuse treatment settings, either because of the lack of privacy or the real or anticipated HIV stigma from staff and residents. Here, one participant discusses how the stigma was one of the biggest challenges for him to stay in care.

I think most of it revolves around the stigma that is around me. I still deal with it, even here, because this clinic is for HIV people – And I live in the [Program Name], which is a – [substance abuse] treatment center. Now people see that we come down here, so they automatically know that we're HIV positive.

Structures designed to minimize relapse further contributed to the loss of privacy in residential programs. For example, most required escorts out of the facility to attend medical appointments. The escort was generally another treatment center patient, who would then learn the participants' diagnosis—information that our interviewees did not believe that the escort or even treatment program staff would hold confidential.

Substance misuse-associated medical crises and criminal justice involvement can lead to HIV care—Ironically, substance misuse itself also sometimes led participants into HIV care by causing them to enter medical systems with which they did not generally interact. For example, one interviewee described a drug overdose that led to his hospitalization and reentry into HIV care. Another supported his substance use through prostitution and was incarcerated for both. The prostitution arrest mandated HIV testing, leading to diagnosis with and treatment for HIV while still in custody. In both examples, dependence on substances had subordinated the men's health priorities, and neither HIV care engagement nor HIV diagnosis would have likely occurred if not for these incidents.

Community-Based HIV Care Contexts

Participants consistently noted the challenges associated with managing their HIV care in the community.

Community-based HIV care requires extensive individual agency—Those released into community experienced a very different care system -- one that was less structured so that accessing services required a far greater level of individual agency than did custody-based HIV care. Many reported lacking knowledge and skills required for successful engagement including communicating effectively with providers, understanding HIV disease, remembering appointments, establishing and following routines to aid treatment adherence, keeping track of pills, and navigating various bureaucracies in order to receive needed benefits.

I went through problems with my medications because it took me a minute to get ADAP (eligibility for the AIDS Drug Assistance Program), and then my ADAP ran out, and so I couldn't get medications until I got on MediCal (California's version of public health insurance or Medicaid). And MediCal took forever, so since I've been out in March, I've gone three times without medication because of my refills.

Many participants reported that carrying out treatment was difficult or impossible for them when active in their substance misuse.

Engagement in community-based HIV care appeared to be particularly challenging and sometimes discouraging for those who had first initiated their care in custody. This individual's long journey from receiving no community-based care after first being diagnosed in the early 2000s within days of prison release to regular care engagement starting in 2009 reflects these challenges:

So when I come home, now I'm staying downtown..., I'm telling my parole officer I got HIV. What I'm supposed to do? So I've got to find my own sources. There wasn't no sources. There wasn't nothing.

After several more stints in custody, in which he received little-to-no HIV treatment or HIV education, he is released to the streets once again:

– and I remember one time, I was just walking. And I said, “Man, I know I need these meds” and this and that. So I go to the facility, one of them places that you can sleep in.

The facility refers him for care at a local outpatient medical center.

And they told me to go to [Facility]. So the next day, they gave me some bus tokens. I went to [Facility]... I stayed there, maybe, like five hours. At about an hour and a half, I'm talking to the doctor. So the doctor gave me two pills and tells me to come back. So I'm getting mad. They only gave me two pills! ... I'm not going to go back there.

He further explains that he was given two pills because a full bottle of medication cost too much for him. Despite receiving a prescription to obtain the medication elsewhere at little-to-no cost, he did not pursue it because “I don't got no money to get no meds.” Only after more comprehensive assistance from a social worker and medical provider – including access to a sober living, help attaining Supplement Security Income (SSI) benefits and medication assistance, information regarding HIV disease, and encouragement – did the respondent remain in care and out of custody.

Discussion

The marginalized and challenging post-release experiences of CJI HIV-positive people with substance dependence reveal significant institutional deficits. Study participants' frequent histories of both recurrent incarceration and substance misuse, despite participation in recovery programs, highlight potentially insufficient treatment modalities and problematic criminal justice policies. Furthermore, the criminal justice system may lessen the effectiveness of substance abuse treatment received in community settings by destabilizing

structures that often dissuade individuals from substance misuse (e.g., supportive relationships with non-users, stable housing, and employment), by providing at-best, limited treatment access, and by frequently punishing relapse.

Our findings resonate with the work conducted by Bourgois and Schonberg who, through anthropological investigation, describe the simultaneously resilient and precarious lives that those suffering from dependence and homelessness experience (Bourgois & Schonberg, 2009). This precariousness largely results from poverty and the intense surveillance resulting from criminal justice policies related to substances. In concert with their findings, our analysis indicates that the experience of CJI and HIV-positive men and transgender women is laden with symbolic violence. Symbolic violence refers to the processes by which practices and feelings lead to social domination and inequities that appear to be not only the natural but the appropriate order of subordinated groups due to their defects of character or immoral activity (Bourdieu & Passeron, 1990). Applied to this context, symbolic violence entails the living contexts, practices, and policies that increase the difficulty for individuals to remain in treatment for both HIV disease and substance use disorders, and the likelihood that their failure to remain sober will be criminalized and attributed to personal shortcomings (U.S. Department of Health and Human Services-Health Resources and Services Administration (HRSA), 2014).

The economic marginalization people experience post incarceration can worsen substance misuse, mental health issues, and housing needs, and their criminalization compounds these negative impacts by limiting access to publicly funded social services (Bracken, Hilliard, McCuller, & Harawa, 2015; California Assembly Member Catharine Baker, 2016). Additionally, HIV-positive incarcerated patients receive few opportunities to practice managing their own care while incarcerated. Although release from custody is accompanied by a dramatic increase in the opportunity to exercise autonomy over disease management, the complexities associated with doing so are persistently challenging due to poverty, stigma, and instability. These findings highlight the lack of community-based programs to facilitate navigation of post-release transitions and of chronic care models for addressing substance dependence. Medication assisted treatment is one effective model by which substance dependence is managed by medical professionals; however, it should not supplant approaches that holistically address material and psychosocial needs (Duncan, et al., 2015). For example, lack of housing and food insecurity are frequent barriers to care encountered by people living with HIV (Cunningham, et al., 1999).

The narratives highlight the ways in which people who use drugs and are also HIV-positive and CJI are uniquely vulnerable to these system-based shortcomings. For example, the National Institute on Drug Abuse (National Institute on Drug Use (NIDA), 1995) recognizes that relapse is a common experience in treatment recovery that might signal a need for shifts in treatment approaches (National Institutes of Health (NIH), 2012). Furthermore, the costs of providing residential treatment programs for individuals with histories of relapse and/or CJI are about half that of incarcerating them, and several studies indicate that substance abuse treatment services yield greater cost-benefits to society than does incarceration (McVay, Schiraldi, & Ziedenberg, 2004). Nevertheless, if detected in a person who is on parole or probation, relapse can lead to immediate reincarceration (e.g., parole violation).

We note that the 2001 California's Substance Abuse and Crime Prevention Act, mandated diversion to substance abuse treatment programs rather than incarceration for those arrested for being under the influence or in the possession of small amounts of illegal substances (Sharif, 2003). Those interviewed, however, did not appear to have been connected to such programs by the courts. It is unclear whether participants' long histories of CJI made them ineligible for diversion, but their criminalized statuses seemed to remain at the center of many participants' identities, eclipsing their needs and structurally locating them at the margins -- sometimes at a distance from needed services.

Where perhaps these interviews point to the most successful interactions of systems for medical care, substance misuse, and criminal justice is in linkage to HIV testing and treatment. Prisons, jails, and substances abuse treatment programs were frequently participants' sources of HIV diagnosis or initial HIV treatment. HIV diagnosis and the establishment of an HIV care routine; however, is more common in prison than in jail settings because testing is more common and lengths of stay are longer. Routine prison testing for HIV at entry now occurs in 38 state prison systems, but not in most jails. During the 2011–12 National Inmate Survey just 11% of people in jail reported having been tested since entry (Maruschak, Berzofsky, & Unangst, 2015, February).

We note two main study limitations. First, the small sample was limited to a single geographic area and largely reflected this one jail system. However, the LASD jail system is the largest in the US and many participants also discussed their experiences in other prison and other jail settings. We note this, both because it evidences similarities across US custody settings. Second, the interview was designed to elicit information relevant to intervention development for those leaving jail, not to fully elucidate the systems and related experiences discussed here. Despite this limitation, the interviews reached saturation even prior to the 19 interviews analyzed, the interactions discussed here formed a substantial portion of each interview, and the parallel interviews conducted with case managers and clinicians who serve CJI HIV-positive patients revealed many consistent themes.

To successfully manage chronic illnesses in community settings, patients must manage disease symptoms, along with the side effects and other consequences of treatment, negotiate bureaucratic processes, and handle the social and emotional impacts of their disease (McCorkle, et al., 2011; Riegel, Jaarsma, & Stromberg, 2012). Along with often lacking specific knowledge and skills sets, HIV-positive CJI substance users may lack the stability and support needed to so successfully. Efforts to ensure linkage to and ongoing retention in HIV medical care may be improved by enhanced integration of the institutions involved in substance abuse treatment, criminal justice, and medical care in the treatment planning for those with CJI. This integration should include ongoing assessments for CJI and active substance misuse in medical settings, proactive coordination with custody intake, release, and supervision processes, and options for long-term supportive residential services, particularly for those with repeated histories of relapse and recidivism. In concert with these efforts, peer-based interventions may be particularly useful for helping CJI individuals navigate substance abuse and HIV medical treatment systems. Such interventions engage patients as they walk through the daily processes of disease management, providing role-modeling, information, and support. Furthermore, peer navigators' experiences with

substance misuse or incarceration may allow them to help ameliorate the negative impacts of the HIV, substance use, and other stigmas that CJJ individuals may encounter.

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Table 1

Demographic characteristics of HIV-positive, criminal justice-involved (CJI) in-depth interview participants (n = 19)

Characteristic	Currently Incarcerated n = 9	Formerly Incarcerated n = 10
	Mean (SD)	Mean (SD)
Age	37.6 (8.2)	43.0 (8.7)
	n	
Race/Ethnicity		
Black/African American	4	7
Latino/Hispanic	3	2
White/European American	0	1
Multi-racial/Multi-ethnic	2	0
Gender		
Male	7	9
Transgender (male-to-female)	2	1
Sexual Orientation		
Gay/Homosexual	3	5
Bisexual	1	2
Straight/Heterosexual	5	3
Education		
Less than HS	6	1
HS or GED	1	6
More than HS	2	3
Health Insurance		
None	6	2
MediCal/Medicaid	3	7
Medicare	0	1
First tested HIV Positive		
In the past 6 months	0	0
6 months – 2 years	0	0
Over 2 years	9	10